CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
January 26, 2023
Commencing at 10:03 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

Elizabeth Partin - Chair
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Dr. Garth Bobrowski - Co-chair
Dr. Steve Compton
Heather Smith
Dr. John Muller
Dr. Ashima Gupta
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace
Annissa Franklin (not present)
Sheila Schuster
Bryan Proctor (not present)
Peggy Roark
Eric Wright

CHAIR PARTIN: Let's go ahead and call the meeting to order, and let's go ahead and take the roll call.

MS. WALLACE: All right, Beth. I think that's me now as your official new secretary. So I apologize in advance, anyone, if I mispronounce your name. And please message me in the chat if I do, so I won't next time.

Beth Partin.

CHAIR PARTIN: Here.

MS. WALLACE: Nina Eisner.

MS. EISNER: Here.

MS. WALLACE: Susan Stewart.

MS. STEWART: Here.

MS. WALLACE: Dr. Jerry Roberts.

DR. ROBERTS: Here.

MS. WALLACE: Heather Smith.

(No response.)

MS. WALLACE: Dr. Garth Bobrowski.

(No response.)

MS. WALLACE: Dr. Steve Compton?

DR. COMPTON: Here.

MS. WALLACE: Dr. John Muller.

DR. MULLER: Here.

MS. WALLACE: Dr. Ashima Gupta.

DR. GUPTA: Here.

MS. WALLACE: John Dadds.

(No response.)

MS. WALLACE: Dr. Catherine Hanna.

DR. HANNA: Here.

MS. WALLACE: Barry Martin.

(No response.)

MS. WALLACE: Kent Gilbert.

MR. GILBERT: Here.

MS. WALLACE: Mackenzie Wallace, here.

Annissa Franklin.

(No response.)

MS. WALLACE: Sheila Schuster.

DR. SCHUSTER: Yes. I'm here. It's Dr. Schuster, please.

MS. WALLACE: Dr. Schuster. My apologies.

Bryan Proctor.

(No response.)

MS. WALLACE: Peggy Roark.

MS. ROARK: Here.

MS. WALLACE: Eric Wright.

(No response.)

MS. WALLACE: And Commissioner Lee.

(No response.)

MS. BICKERS: Mackenzie, I want to let you know Dr. Bobrowski is on. I think he was muted when he said here.

MS. WALLACE: Okay. Thank you.

MS. BICKERS: Welcome.

MS. JUDY-CECIL: And Commissioner Lee is ex officio, so we don't count her towards the quorum.

MS. WALLACE: Thank you, Veronica.

CHAIR PARTIN: Okay. So do we have a quorum?

MS. WALLACE: Yes, ma'am.

CHAIR PARTIN: Thank you.

Next up is approval of minutes from the last meeting. Would somebody like to make a motion to approve the minutes?

MS. STEWART: Susan Stewart. I'll make a motion.

MS. EISNER: This is Nina. I'll second that.

CHAIR PARTIN: Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say

aye.

(Aye.)

CHAIR PARTIN: Any opposed?

(No response.)

CHAIR PARTIN: So moved.

So we'll move on to old business. And first up is update on reimbursement for multiple visits on the same day. Where are we with that?

MS. JUDY-CECIL: Good morning. This is Veronica Judy-Cecil, Senior Deputy Commissioner for Medicaid. And just to refresh everyone's memory, this is the Primary Care TAC's recommendation. We -- it is still pending and under review. I don't have an anticipated decision date.

I do know that there may be some additional conversations about the model for paying FQHCs and RHCs, federally-qualified health centers and rural health centers. So it's just an ongoing conversation, and the review as to changing the current model is still under consideration.

CHAIR PARTIN: Veronica, what seems to be the problem with it? I mean, it seems

to me like a no-brainer. It's two different providers seeing the patient.

MS. JUDY-CECIL: So it's more complicated than that. We develop their rate, their daily rate based on the services they provide. So all of that is taken into consideration for the one rate they get. It's called a PPS rate.

The difficulty is that if you unbundle that, it's going to affect providers differently. So for them, their rate would change, and they would -- if they don't provide -- for example, if we unbundle the dental and behavioral health, they don't provide the service that date. They don't get, then, that part of the rate.

So it really -- it affects providers differently. I don't think there's a consensus on the model, and states do it very differently. So it's a pretty deep -- deep dive into the reimbursement model. And, you know, again, I think there are conversations about -- because there are different models to consider, so I think there's additional conversation about whether it's -- it's even

the one to pursue.

But, you know, this is something the Primary Care TAC is taking up and, you know, we're happy to continue that conversation there.

MR. GILBERT: I have a question.

CHAIR PARTIN: Go ahead.

MR. GILBERT: You -- I can well imagine that it's complicated. However, it's also not transparent. How is it in Kentucky that I, as a new member of the MAC, for example, might actually be able to learn? Because I'm -- I think everybody on the call is relatively smart, and I don't want to take our time right now. But it's complicated is probably not a sufficient answer and probably won't get us to solutions.

How is it that I could learn more about what's actually the formula and how it works? Because I don't know how to advise if -- you know, lots of things are complicated. Where could I un-complicate my little mind?

MS. JUDY-CECIL: Sure. So if it's the pleasure of the MAC for us to give a presentation about the reimbursement

methodology of FQHCs and RHCs, we're happy to do that in a future meeting.

Otherwise, you know, I think that this, again, is an issue that is discussed at the Primary Care TAC, and certainly you could attend that meeting to stay up to date on -- on the conversation.

MR. GILBERT: Thanks.

DR. SCHUSTER: Beth.

CHAIR PARTIN: Yeah.

DR. SCHUSTER: This is Sheila Schuster. You know, my memory may be flawed, but I've been coming to the MAC meetings for a lot of years before I was on the MAC. And this issue has been under discussion for years literally. And I don't -- I'm glad the Primary Care TAC took it up more formally but, Veronica, this discussion --

MS. JUDY-CECIL: Dr. Schuster, there was an issue with other providers being able to -- non-FQHC and RHC providers being able to bill for different services on the same day. That problem no longer exists. That -- I am not aware of any problem with any other provider being able to submit

claims for different services on the same date. This is --

DR. SCHUSTER: Oh, okay.

MS. JUDY-CECIL: This is strictly a -- whether or not we pay one PPS daily rate to FQHCs and RHCs, or we change the model.

DR. SCHUSTER: Okay. So can that -- it is complicated. It's kind of a different -- because we used to -- we, in behavioral health, used to be so concerned because somebody would go see their primary care physician or nurse practitioner and then come to us. And it was a race, quite frankly, to see who could get their claim in first because only one provider was going to get paid.

So I appreciate that explanation. I didn't realize this was a FQHC/RHC. So they get paid a set rate --

MS. JUDY-CECIL: They get a daily rate called a PPS. That rate is developed based on their cost report. The rate can change if there are -- there are regulation, and there are federal rules, by the way, that govern FQHC and RHC reimbursement.

And so, again, we take -- for the development of that rate, we take all the services that that provider may provide, dental, behavioral health, primary care. And we develop one rate per day.

And so if somebody comes in, the belief is that that rate is supposed to cover all services delivered that day. And so that's the way that that model works. And they're --

DR. SCHUSTER: I have a follow-up question on the behavioral health side, Veronica, and that is that, you know, more and more of our community mental health centers are becoming CCBHCs, and they will receive that PPS rate. So are they going to be caught up in this as well?

MS. JUDY-CECIL: No. This is strictly for the FQHCs/RHC.

DR. SCHUSTER: Okay.

MS. JUDY-CECIL: The CCBHC is paid under a different regulation. Now, you know, it follows very much the same reimbursement methodology where, you know, it's an integrated daily rate. But they don't --

just because we changed the model with FQHC/RHC doesn't mean we have to for CCBHCs. And that's a lot of acronyms. My apologies.

DR. SCHUSTER: Yeah. I see where Dr. Gupta was just asking about rural health centers and federally-qualified health centers which are federal designations, I believe.

MS. JUDY-CECIL: That is correct.

DR. SCHUSTER: Yes.

MS. JUDY-CECIL: There are federal rules that do drive a lot of the requirements, but states do have some flexibility. And it is -- the other thing we've been doing is looking at different states. Of course, when you see one state Medicaid, you only see one state Medicaid because we're all very different in various ways.

So, again, it's very complex, and I'm going to be very candid with you. We have a lot of priorities on our plate. And, you know, we have to allocate our resources, and it just -- sometimes we can't devote all of our time to -- to one issue. So that's been

a reason why this has been languishing for a bit, too.

CHAIR PARTIN: Okay. Since -- since the State has changed the regulations regarding rural health clinics and FQHCs to include behavioral health to a greater extent, I think it would be helpful for us to have a presentation on this so that we could have a better understanding.

All of us are really busy (audio glitch) in the TAC meetings, and I think it would be helpful for us to understand how that bundling works and what we can do.

I guess -- I guess it sounds like what we can do right now is you can't -- you can't see the patient for a behavioral health problem and a primary care problem on the same day. You have to make --

MS. JUDY-CECIL: No. You can, and the rate that they get is calculated anticipating more than one visit, more than one specialty. If -- if, for example, a current FQHC or AHC starts to cover behavioral health services, that's called a change in scope, and it would trigger a new

cost report and the development of a new rate.

So I do want to make it very clear that the rate they get is based on the services that they say they deliver, the cost to deliver those services, and then that is put into a daily rate.

CHAIR PARTIN: Okay. Then let me ask the rest of the MAC what your pleasure is. Would you like to have a presentation on this, or are you good with the explanation that we've just received?

MS. EISNER: I don't feel the need for a presentation.

MR. MARTIN: This is Barry, and I'm on the TAC as well, the Primary Care TAC as well. I think it would be good to have maybe a 10- or 15-minute presentation, Veronica, on this because it is a very unique situation. And, actually, Kentucky Medicaid and rural health and FQHCs are unique, and it is hard to find other states that compare to us.

So I think it would be worthwhile to spend a little bit of time to educate the other members on the uniqueness that we have

and what we have done to address and look at other states.

CHAIR PARTIN: Okay. Well, thank you. So let's go ahead and do that for the next meeting, then.

DR. SCHUSTER: Oh, that could --

MS. JUDY-CECIL: And I would --

DR. SCHUSTER: Could we include CCBHCs in that, just at least three minutes out of the 15 or something? I think -- because behavioral health is such a piece of all of this, and I think the CCBHCs are going to be in parallel model, if not in exactly the same model.

MS. JUDY-CECIL: I was going to ask, Dr. Partin, if we could potentially update the -- the wording of the old business item because it does continue to be confused with the past issue of non-FQHCs and RHCs being able to bill for different services on the same day.

CHAIR PARTIN: Absolutely. I just made a note here that --

MS. JUDY-CECIL: Okay. Thank you.

CHAIR PARTIN: RHCs, FQHCs, and

CCBHCs. So -- and this has been helpful for me because I didn't know that other problem was fixed, so that's one of the reasons why it looked like that on the agenda. So already this has been educational. Thank you.

So the next thing is just a reminder. I try to keep things on the agenda to keep us reminded what we're going to be doing. So in March, we'll have an update on missed and cancelled appointments, and how is that reporting going, and is there a common thread.

Next up is: What is the status on Anthem MCO?

MS. JUDY-CECIL: There is no change in the fact that we have six MCOs, and Anthem is currently an MCO. That court case is still pending.

CHAIR PARTIN: Okay. Thank you. So I'll put that next meeting.

Okay. And I guess, Veronica, you're still up.

MS. JUDY-CECIL: I do think, if Pam Smith is on, she was going to take a --

CHAIR PARTIN: Okay.

MS. JUDY-CECIL: Let me see if Pam is on.

MS. SMITH: So we are in the process right now of doing the -- an Appendix K modification that will enact the 10 percent for fiscal year '23 for the waivers. The residential providers, that 50 percent increase has been in place since the beginning of PHE, so since 2020, so that -- that change will not occur.

We also will not be removing the extra 50 percent allowance that's in Appendix K right now for those providers that sign the attestation to pass through at least 85 percent to direct care workers. So providers will have the option of billing the extra ten percent or doing that attestation and billing 50 percent for those services that are outlined in Appendix K.

And I realize that is very confusing, so we will be sending out kind of a one-page document that explains it better as well as if we need to -- if we get a lot of questions or there is a desire for it, we will have

a -- kind of a webinar just for people to ask questions.

And in addition to that, the adult day and -- adult day training retainer payments, we are targeting them to go out by next week. We're finalizing the calculations on those.

And then we will do mass adjustments. The 10 percent increase will be retroactive back to the start of the fiscal year, so July 1st, and we will work with Gainwell to do mass adjustments on those for claims that had already been billed and paid so that the providers do not have to do adjustments themselves or void any claims and delay receiving those payments.

So we're anticipating by middle of February that we can get that -- that in place. I just have to have the final approval from CMS on the Appendix K modification.

CHAIR PARTIN: Okay. So you'll be sending out something to the -- to the MAC members about this, so we can have a better understanding?

MS. SMITH: Yes. We can -- I'll

send it to -- I'll work with Kelli and Erin and get that to the MAC members as well as we're going to send it out through our distribution list to all of our provider -- the waiver provider groups so that they have that direct communication as well and so that they understand where to come with questions or what they need to do.

CHAIR PARTIN: Okay. Thank you.

MR. CHRISTMAN: Hello. This is Rick Christman with the DDID TAC. Pam, did you say that the retroactive payments would be coming in the middle of February?

MS. SMITH: Yeah. The process will be put in place that we hope to have the approval and for providers to be able to bill the rate with the additional 10 percent in the middle of February.

The mass adjustment process will take a little bit longer than that just because it will be so large. But I will provide an update on when those -- that will start and when providers can expect those payments.

MR. CHRISTMAN: And when you say mass adjustment, does that refer to

retroactive payments?

MS. SMITH: That would be any claims that have already been billed and paid at the current -- at the current rate.

MR. CHRISTMAN: So yes, it's -- that will be retroactive payments? When you say mass adjustments --

MS. SMITH: The mass adjustments, yes, will apply -- will apply to make the payments, any that have been billed since -- with dates of service July 1st, 2022, forward, any of those that have been billed. Any claims that have not been billed, then the provider would go ahead and bill with that extra 10 percent.

Due -- however, you need to wait until we tell you that that has been -- that has been approved to do that. So -- because if you billed that today, it's going to just pay at the regular rate until we get those changes -- the approval from CMS and the changes in the system.

But it will be -- the increase is retroactive back to July 1st of 2022, the start of fiscal year '23.

MR. CHRISTMAN: Now, is this because CMS approved it, the Guidehouse study, a rate study?

MS. SMITH: This is -- so the rate study is a separate -- is a separate track. This is the initial -- that 10 percent increase. However, the rate study is still ongoing, and there will be more information about those rates. And that still requires waiver amendments and legislative -- the reg changes and legislative approval. So this is separate than the rate study. This is based on what was in House Bill 1.

MR. CHRISTMAN: You have shared some of those rates from the Guidehouse rate study. Are those still applicable?

MS. SMITH: Those, as we've communicated, were all draft and for discussion only, so they may be -- so some of what we discussed in the workgroups may be what the final rate -- and, Rick, honestly, I can't -- I don't have any of that up in front of me, so I don't remember.

But those, as we had talked about, were all for discussion at that point. And so

those will go out for public comment --

MR. CHRISTMAN: Okay.

MS. SMITH: -- once we get into that process of updating everything.

MR. CHRISTMAN: All right. Thank you.

MS. SMITH: You're welcome.

CHAIR PARTIN: Okay.

DR. SCHUSTER: Beth?

CHAIR PARTIN: Yes.

DR. SCHUSTER: This is Sheila Schuster. I think there are a lot of questions out there about the waivers in general, and I wonder if there aren't a number of MAC members that are not clear about how those home and community-based waivers -- what we call the 1915(c) waivers -- operate, who they cover, the fact that we have almost 11,000 people on the waiting list, and what happens when there are changes.

We had a big discussion at the BH TAC about the acquired brain injury waiver, and I wonder if -- and, you know, I've been doing this a long time, and there still are lots of

questions that I have about the waivers.

But I wonder if that's something that other MAC members might want to -- again, at a different meeting -- have a presentation, kind of an overall presentation about what the waivers do, who they serve, and, you know, what kind of money we're putting into the waivers, what we hope to do with them. Just a thought.

MS. SMITH: I would be more than happy to -- if that is something that you all would like in a future meeting, would be more than happy to do that because I understand. The waivers are very confusing, especially if you don't deal with them day in and day out.

And even when you do deal with them day in and day out, there still are nuances, and it can be complicated to understand. But I would be more than happy, if the MAC members would like that, to do that in a future meeting.

CHAIR PARTIN: Okay. I would like that. I don't have a clear understanding about all the waivers.

DR. SCHUSTER: It looks like you're

getting some other agreement in the chat as well.

MS. SMITH: Okay.

DR. SCHUSTER: We'll have to start meeting for four and five hours to get in all this information. I'm not proposing that. And the earlier discussion is one that should take priority, but I do think that the waivers are just incredibly important.

And people don't think necessarily about Medicaid and the waivers, you know. I think it's -- and we're trying to develop a waiver for folks with severe mental illness. So, you know, even that needs some explanation. So thank you, Pam.

MS. SMITH: You're welcome.

DR. BOBROWSKI: Information on the State's website on waivers, but I didn't know if there would be any kind of an info sheet or something that could be emailed to the MAC members ahead of time that --

MS. SMITH: We can do that. We actually have some of that already, so I can -- I'll get with Kelly, who is our wonderful communication liaison, and I

will -- we can get some of that out to you all, just as reading -- as some light reading ahead of time.

But no, we have some kind of one-page, just quick documents that we could send that have background on the waivers that probably would -- we call it Waiver 101, basically, so it's kind of from the start to understand them. So I'm more than happy to go ahead and get that sent out to you all.

CHAIR PARTIN: Okay. Great. Thank you.

Okay. Let's go on to the next item. That would be still under the commissioner's report.

MS. JUDY-CECIL: Yes. So I think you asked -- were seeking a conversation about increased reimbursement for providers. You know, this is something we've been struggling with because we have had almost every single provider type that we deal with make a request for increases, and across-the-board increases are just not feasible for us.

And, instead, what we've been trying to

do is look strategically at each of the different fee schedules and the services that are provided to see where could we maybe increase some of them, to incentivize services that we know will lead to improved outcomes, preventive care.

So that -- that is what we did with the recent addition of adult services for dental, vision, and hearing, is we, you know, looked at research and some of the codes that we cover and services we cover for our population and where can we sort of get the biggest bang for our buck, in other words, because we have limited dollars.

You know, we -- we do have a budget that we do have to stay in, and so what we've started to do and what we plan to do is start asking the TACs to sort of refocus and look at the services that they provide, the codes that they use. And, you know, what are ones that we could raise to increase access, to -- you know, and that goes not just from the provider side but to -- you know, to improve the member's care and improve overall health.

So those are the conversations that

we're having because, candidly, we do not have the budget to just do across-the-board raises. We get that costs have increased. We understand that. We feel it, too, here. We've had difficulty recruiting and retaining staff and, you know, we -- but, again, we have to work within our budget.

So that -- that is kind of where we're at right now. Again, we do ask and are asking the TACs to help us with this issue by looking at, you know, what can we work on together strategically to increase or incentivize -- to increase rates, to incentivize outcomes.

CHAIR PARTIN: So which -- which providers recently received an increase in rates?

MS. JUDY-CECIL: So what we did with dental, vision, and hearing is that we added services for the adults. So now adults have access to glasses. They have access to hearing aids.

And then dental is probably the most significant change. We added a second cleaning. We added -- Dr. Bobrowski, I see

your hand raised. You know, we -- and we did increase the rates for adults to the children's rate. And we took also some additional increases for access to -- to oral surgeons.

So that's -- that's what we've done so far. And, of course, we have the increases in the waivers which, again, is a pretty significant amount. But I'll -- I see hands up, so I don't know if, Dr. Partin, you want to hear from the members.

CHAIR PARTIN: Let me look at the -- look and see who have their hands up.

MS. JUDY-CECIL: Dr. Bobrowski had his up first, I think, and then Nina Eisner.

CHAIR PARTIN: Okay. I'm having trouble seeing that on my iPad.

Okay. Go ahead, Dr. Bobrowski.

DR. BOBROWSKI: Well, No. 1, as from dental, you know, we appreciate the time, effort, and the increases that have been made. One question I had was -- you know, were all the adult rates moved up to the children's rate, is one question I had.

And I know the -- there's been more

Kentuckians added to the Medicaid rolls. It just seems like every time we have a meeting, there's been more added. And that's not in my control, or commenting is probably not going to help anything there.

But one of the things that we see even, you know, from our staff, from our other patients, it's like there seems to be plenty of money available for MCOs to give -- they just call them freebies or added -- value-added benefits, I guess, is the technical word.

But it just seems like that there's more and more money available to the MCOs to give away perceived -- not always but perceived needs or benefits that -- those used to not be there. And they're spending millions of dollars per year on those.

And, you know, we've got staff in our offices that say, well, boy, I never did get any help for this. But I know I'm preaching to the choir, but I'm just trying to think of ways that, you know, maybe money could be garnered to help with the -- just the cost of our services, you know, from our healthcare

professionals. And I just wanted to put that out there.

Just not -- not totally my views but, you know, the things we hear about from dental staff from multiple offices through the Kentucky Dental Association, phone calls. So I just wanted to pass that on to the MAC. Thank you.

MS. JUDY-CECIL: So to answer your questions, we did not raise all of the adult services to the children's. We only did those that we added, again, trying to be strategic in driving the increase in those services that we think will reduce, first of all, hospital ER visits.

We pulled, and we have an enormous problem with people -- with adults going to the ER for dental care. So, you know, we're trying to redirect that to services that could be provided by a dentist outside of the ER. So there's that.

The value-added benefits that Managed Care Organizations provide are not part of the funds that we pay them. So we pay a per-member-per-month capitation rate to the

MCOs, and they have to spend 90 percent of that money on healthcare services. If they do not, we will claw that money back. We will require them to pay it back.

So they -- you know, they have to spend 90 percent, and the other -- the other 10 percent is for care coordination and administrative costs and taxes and other expenses, but at least 90 percent has to be paid for healthcare services.

So the value-added benefits, while I understand, you know, there are some really great incentives on that for members, it is to incentivize their utilization of services, especially preventive care, for maternity care. You know, you have to remember who our population is.

DR. BOBROWSKI: Right.

MS. JUDY-CECIL: So we're talking for 138 percent, which is just the expansion population, they make $18,000. So -- and, you know, a lot of the commercial programs offer incentives to incentivize behavior.

So they're really trying to focus -- and a lot of those programs are focused on their

social needs, too. I mean, food is medicine and, you know, GED, covering GED. So it's really trying to look at the person as a whole to try to help them better their situation.

So I think that hopefully those answers your questions.

CHAIR PARTIN: So when you say the increase was for adults, are you talking about dental, or are you talking about the E&M codes?

MS. JUDY-CECIL: So I'm happy to send you the fee schedule which can -- I don't have the codes in my head. But they were -- you know, they were various dental codes.

CHAIR PARTIN: Okay. So not, like, primary care codes. They were dental. The dental codes you're talking about?

MS. JUDY-CECIL: For dental services, yeah.

DR. BOBROWSKI: They're on the State's website listed for hearing, vision, and dental. They're already all up on the State's website.

CHAIR PARTIN: Okay. I just wasn't clear which rates she was talking about. So did the physician rates also get increased? Did I read that?

MS. JUDY-CECIL: No. We've not done an across-the-board or any other strategic. We are currently looking at the physician fee schedule, and we are updating it like we normally do annually with CMS but, again, trying to consider, you know, what -- where can we be strategic for maybe increasing some of the -- a handful of the codes. We are considering that, especially around preventive.

And then for behavioral health, we are also looking at that, and we have codes on the behavioral health fee schedule. They're called H codes that aren't tied to Medicare, and so they've gotten no adjustment since they were added. And so we're looking at those to see what we can do to do an annual review of those codes.

So these are all, you know, under consideration. And, again, I mean, I think what we would like for the TACs and the MAC

to do is to think more strategically on: What are the codes? What are the services that we can increase the reimbursement for those codes and actually drive better outcomes?

CHAIR PARTIN: Okay. So the increasing reimbursement that you're looking at strategically, is that coming from savings that were supposed to go to providers from Senate Bill 50?

MS. JUDY-CECIL: So there was nothing requiring savings from Senate Bill 50 to go to providers.

CHAIR PARTIN: Okay. I guess I have that confused with something else, then. Okay.

MS. JUDY-CECIL: But we have -- from Senate Bill 50, we have seen, due to -- well, primarily increased rebates that we get on drugs. You know, we are getting higher rebates that, you know, can help offset the costs of the program.

But keep in mind, those -- you know, provider reimbursement increases have to be sustainable. So if we have one-time funding,

that is not sustainable. We have to make sure that, first of all, you know -- because if we give something, it's hard to take it away. So, you know, we would need budget authorization in our future budget to sustain those increases.

CHAIR PARTIN: Okay. Could I ask that in future meetings that we can just get an update on where we are looking at these different codes?

MS. JUDY-CECIL: Sure. Absolutely.

CHAIR PARTIN: Okay. So I'll put that -- I'll just keep that on the agenda to get updates at each meeting.

MS. BICKERS: And, Beth, Nina and Dr. Gupta both have their hands raised as well.

CHAIR PARTIN: Thank you. I'm so sorry. I can't see that. I don't know how to -- I guess I'm not technologically savvy enough to see that. But anybody who has your hand up, go ahead and speak up, please.

MS. EISNER: Veronica, it's Nina Eisner. Just a quick question. I know the

BHSO rate increases are supposed to be out sometime in January, I thought, and retroactive back to January 1. Are they out yet, or have I missed them?

MS. JUDY-CECIL: No. In fact, thank you for that question. We -- CMS released updated rates as early as a couple weeks ago, so we were on track and then they threw that loophole. So we are -- we're really close to making those changes and hope to have the fee schedule up sometime in the next week.

I do want to say -- and I think one thing the commissioner has really tried to emphasize -- and she said this to the Dental TAC and I think maybe to a couple of other TACs -- is that, you know, we're proposing some changes, like we did with dental, vision, and hearing. And what we appreciate is that it has started a conversation and allowed us to have -- get feedback and continue to have that discussion for a future change.

So I guess I just want to make sure everyone understands that, you know, if we

publish the fee schedule and it's not to your satisfaction, you know, we really want to continue the conversation and look forward to having, again, those strategic conversations about what can we do working together to improve the health.

MS. EISNER: Thank you, Veronica.

DR. GUPTA: This is Dr. Gupta. Veronica, thank you for everything that you all are doing for all of us. I just want to reiterate a little bit. This is a major topic in our Physician TAC, access to health care.

MS. JUDY-CECIL: Dr. Gupta, I'm so sorry. I can barely hear you. I don't know if it's me. I apologize.

DR. GUPTA: Can you hear me?

MS. JUDY-CECIL: Yes. It just sounds a little muffled for some reason.

DR. GUPTA: Okay. I'll try to speak a little bit louder. This is a major topic in our Physician TAC, addressing access to health care. And, you know, this is a very long investment, but increasing reimbursement to primary care physicians

especially will really save money in the end.

You know, we're on a brink of a physician crisis, trying to keep residents in Kentucky going into primary care. We're seeing fewer and fewer residents wanting to go into primary care and especially staying in the -- in the state.

So, you know, as you all think about the fee schedule, please try to keep -- and I know you all already are. Keep the physician reimbursement, especially for primary care, in mind. Because otherwise, you know, it's going to end up costing more money with people getting less access to health care or a lot of duplication. I just wanted to put in my two cents on that.

MS. JUDY-CECIL: Yeah. Thank you for those comments. Workforce is an issue. And sadly, I think it always has been, but you're right. It kind of is reaching a crisis point in several of the different provider types.

And so -- and we recognize that, and I know there are efforts beyond Medicaid, more of a statewide effort to try to deal with

those. And we are -- we are willing to be at the table and try to be part of the solution there. And we are looking at, again, you know, a handful of primary care codes, that, you know, it might make sense to go ahead and raise those.

And then the other thing is, you know, we really want to monitor. We just don't want to throw money at the problem. We want to make sure that we're spending our money wisely. I mean, we're stewards of the taxpayer money. We have a lot of people to serve and cover and limited funds.

So I think that's why we try to step back and take a more strategic approach. And I'm sorry. I keep using that word. But, you know, to try to find ways to use the funds we have more efficiently and more effectively. And that's why, again, we want the conversations. We want the TACs focused on this and helping us solve the problem.

DR. SCHUSTER: Veronica --

MS. BICKERS: Dr. Bobrowski had another question. Oh, I'm sorry, Dr. Schuster.

DR. SCHUSTER: I was just going to ask, with the governor's executive order, physicians now are being asked to do certification of these diagnoses so that people can go to other states and get medical cannabis.

Is there -- is that a service that's being reimbursed for Medicaid patients?

MS. JUDY-CECIL: No. Kentucky Medicaid cannot cover that.

DR. SCHUSTER: Cannot cover the physician's time in doing that certification?

MS. JUDY-CECIL: So if the physician -- I don't think I'm prepared to answer that question, Dr. Schuster.

DR. SCHUSTER: Okay. Well, it's been a conundrum because some of those diagnoses are behavioral health, and we're trying to figure out, you know --

MS. JUDY-CECIL: I think --

DR. SCHUSTER: -- I, as a psychologist, make that -- I'm not in the executive order. I'm just trying to figure out how all of this is going to work.

MS. JUDY-CECIL: Well, I will tell

you that we cover medically necessary services, and that includes a physician or a practitioner, you know, office visit. And so that's a covered service. That's probably about the extent to which I can address the question.

DR. SCHUSTER: Okay.

CHAIR PARTIN: Sheila, I think that those certifications will probably be based on history. So if a patient has those 21 conditions, that would be in their history. And so the provider could just write a note stating that the person has that condition.

MS. JUDY-CECIL: What we can't pay for is the cannabis.

DR. SCHUSTER: You can't pay for -- yes. Right. I understand that.

MS. JUDY-CECIL: But, you know, again, a physician seeing a patient, making a diagnosis, I mean, that, to me, is an office visit.

DR. SCHUSTER: Okay. So the physician looking at the record because they've got a request and coming up with something and signing it is just --

MS. JUDY-CECIL: If it meets the requirements of the code.

DR. SCHUSTER: Yeah. Right. All right. Thank you. You know, obviously, as this thing rolls out, we're going to have to -- there's going to be a lot more questions. Thank you. I appreciate it.

MS. JUDY-CECIL: You're welcome.

MS. BICKERS: Dr. Bobrowski, did you have another question, or is your hand still just raised? I think you're muted.

DR. BOBROWSKI: Oh, I'm sorry. I just kept waving at you. I don't get to see you in person. I just kept waving. I'm sorry. I'll get it down. There. Sorry.

CHAIR PARTIN: Okay.

MS. BICKERS: You have your hand raised. Do you have a question?

CHAIR PARTIN: Who, me?

DR. BAUTISTA-CERVERA: This is Patricia Bautista-Cervera, Dr. Patricia with the Disparity and Equity TAC and also a member of the Board of Health in Louisville Metro. And just I think the reimbursement update for providers -- I'm part of the

immunization committee. I was -- and there's been several talks about the reviewing for the fee reimbursement for vaccinations.

Have you reviewed that, and could you share something about it?

MS. JUDY-CECIL: I don't have any information to share at this time. I'm sorry. Happy to take that back, though.

CHAIR PARTIN: Okay. Do you have anything else in your report, Veronica?

MS. JUDY-CECIL: Just a couple of things. So one is we're going to start provider forums, our reconnect, reunite tour. And those will be in April and May, and we will share more information about that as we -- as we confirm things. And we'll make sure the MAC and the TACs are aware, and we'll do doing a campaign, outreach campaign to providers to make them aware we'll be in your area.

We did file our Community Health Workers State Plan Amendment with CMS that's currently pending. We're -- we did request an effective date of July 1, 2023, so that we can be prepared because it's requiring system

and policy and several changes to implement that. But we'll keep you posted on the approval of that state plan amendment.

As you all may have heard, renewals -- annual renewals are going to start. So the Public Health Emergency has not ended. But at the end of December, Congress passed and the president signed a Consolidated Appropriations Act that delinks the requirement for us to continue to cover folks.

And so we will be starting with those who have a renewal date of May 31st, 2023. We will restart annual renewals. We have been working for this day to come, and we -- we will have 12 months to renew every person in Medicaid, so over 1.7 million folks.

We'll be allocating those cases over the 12 months to try to help with our workforce issues and to make sure that we are able to provide the support and outreach to folks who will -- who will be going through that renewal.

I think fortunately, for Kentucky Medicaid, we have a really great system that

is capable of going out and pinging the federal hub and other databases to be able to automatically renew somebody because we can verify their information that way.

So they will be what's called passively renewed or automatically renewed if we're able to verify. If we're not, then we'll have to request information from them. And then there are other Medicaid members who have to go through an active renewal, and so they'll receive a renewal packet and will have to provide information to us for us to be able to make that determination.

We are planning lots of campaigns around the renewals. We'll be tracking individual -- at the individual level, somebody who is going through a renewal, to make sure that they are responding to our requests.

Our Managed Care Organizations are going to outreach to their members directly to make sure they know that they're up for a renewal, and they're taking the appropriate action.

The other thing to keep in mind is that we do know that people probably will -- are

no longer eligible, and the primary reason for that is income. They make over the income limit. So we will make sure that they understand they can choose a Qualified Health Plan on the Exchange, or they can move to employer-sponsored insurance if they have insurance available through their employer. We'll be helping those folks understand what their options are.

And then for anyone who aged 65 or older during the pandemic and did not enroll in Medicare, they will have to enroll. And they'll have a special enrollment period of six months when they're discontinued from Medicaid, and they'll be able to do that without a penalty.

So those are the folks we're really going to focus on. We do not want gaps in coverage. We do not want to disenroll somebody who is eligible because they didn't return information. So we'll be working really hard to keep those folks covered.

CHAIR PARTIN: So this is part of the unwinding?

MS. JUDY-CECIL: It is. It's just

that what's confusing is the Public Health Emergency has not ended, but renewals will have to start.

CHAIR PARTIN: Okay.

MS. JUDY-CECIL: Then the last thing is that we -- and honestly, Dr. Partin, if you want us to talk a little bit more about our plan at the next meeting -- because, you know, we'll be -- we'll be restarting renewals at that point, we can maybe provide more information.

But the only other thing is we're monitoring legislation. The general assembly session started early January. They come back February 6th, I think, and -- and so, you know, we'll continue to determine if there's any impacts to the Medicaid program.

CHAIR PARTIN: Yes. That would be helpful, I think, at the next meeting, to let us know how that's going.

MS. JUDY-CECIL: Okay. That's all I have.

CHAIR PARTIN: Okay. Thank you.

Okay. So next up is maternal/child health update.

MS. BICKERS: Dr. Theriot, you should be a cohost now if you need to share your screen.

DR. THERIOT: Thank you. I shall attempt. We'll see what happens. Okay. What are you guys seeing? Oh, I can -- are you guys seeing my screen?

CHAIR PARTIN: We can, but it's real little.

DR. THERIOT: Oh, let's see. It's probably showing the wrong screen. Let's see.

CHAIR PARTIN: It looks like the correct slide. Maternal health updates, January 26, but it's real little.

DR. THERIOT: All righty.

MS. BICKERS: Dr. Theriot, I think if you go to the top to view options, you should be able to change the format. How you had it a moment ago, we could see it clearly.

DR. THERIOT: I don't see where it says to view options. Let's see. Show task bar. No. Oh, gosh.

MS. BICKERS: Maybe that's on my screen because I'm the host. I apologize.

DR. THERIOT: I know. It usually has a view option thing and -- now what do you see? Still small?

CHAIR PARTIN: It's a little bigger.

DR. THERIOT: A little bigger.

MS. JUDY-CECIL: Dr. Theriot, do you want to send it to me, and I can share?

DR. THERIOT: Yes. I shall maybe. To who -- to you, Veronica, or to you, Erin?

MS. JUDY-CECIL: Yeah. You can send it to Veronica.

DR. THERIOT: Okay. Let me stop sharing and then -- I am so sorry. I was actually very worried about this.

MS. BICKERS: Beth, do you want to go to 6A while we're waiting on Veronica to get that pulled up?

DR. THERIOT: And I think it's because I have two screens, and so I always mess up when there's more than one.

CHAIR PARTIN: Okay. So that issue is DMS brief overview, what was covered before the overturn of Roe v. Wade and what's covered now.

DR. THERIOT: There is really no difference -- go ahead, Veronica.

MS. JUDY-CECIL: So I just -- we want to remind everyone that we're required to follow state law. And so prior to the overturning of Roe vs. Wade and other law -- federal and state laws that went into effect, we covered abortion in three situations because the state law allowed us to. And so that is the health of the mom, rape, and incest.

Since the state law has changed, we are not allowed to cover abortions with the Kentucky Medicaid funds.

I need to be able to share, Erin.

DR. GUPTA: I have a question.

MS. BICKERS: Dr. Gupta has a question, but she's frozen.

MS. JUDY-CECIL: Okay. There we go.

DR. THERIOT: Yay. It works. Okay. Thank you very much.

Well, I guess I can't forward them, but we're just going to have an update from -- last May, I believe, was our last talk about

maternal health.

So next slide. And last time, we talked about -- a little bit about serious maternal morbidity, and that's when moms have a near miss. So they might -- they did not have a mortality, but it was close.

And so we found that 20.5 -- moms with a serious morbidity were 20.5 times more likely to die within that year postpartum, that -- the postpartum period than moms that did not have a severe morbidity. We also learned that 79 percent of our maternal deaths are preventable which means -- which is a sad number, but that means we can do something about that.

And then suicidal ideations was the most common reason for moms to be admitted to the hospital during that year postpartum. And that was for 2018 and 2019, which it's very uncommon for moms to be admitted to the hospital within that year, but the fact that suicidal ideations was the primary reason is real scary. And so we kind of talked about all that stuff last year -- or last time, so next slide, please.

So when you think about maternal health, again, we have the pink, which is really the prenatal period. And we have labor and delivery, which is green, and then the postpartum period, which is purple.

So today, we're going to talk a little bit more, because we haven't yet, about the green circle, about things that are happening within labor and delivery, low-risk C-sections, things like that.

And then we'll switch gears, talk about postpartum in that purple circle, and that will include some information about moms and babies. Because you can't really talk about the babies -- the mamas without the babies. Thank you.

So next slide. And then overarching everything, we have pretty large racial disparities within Kentucky maternal health population, so we will touch on health disparity as well.

So next slide. When we're talking about racial disparities, Kentucky's population is primarily white, so 87.5 percent white and 8.5 percent black, and that's statewide. We

also know that the majority of women live in the metropolitan areas, and black and white women have access to the same hospitals and the same specialists, the same referrals. Both are just being cared for by the same system within those metro areas, yet our racial disparity is huge.

Next slide. So our maternal mortality annual report tells us that 42.1 percent of our maternal deaths are for African-Americans, and 17.2 is for white. So that's huge. So even though we don't have -- we only have 8.5 percent of our population as black, black moms are dying at a much higher rate even though they're within the same system of care as the white mom.

So that's something to think about and something that we, as a system, can probably address and do something about, just with the people in this room.

Next slide. When we talk about serious maternal morbidity, black women are also at increased risk -- they're 1.7 times more likely to have a serious morbidity, one of those near misses, than the white women. And

if we can decrease those serious morbidities, we can decrease maternal mortality.

And those are hard. So the serious morbidities -- if you remember, those were hemorrhage, needing a transfusion, cardiac events. Those were those serious morbidities. And women who undergo a cesarean delivery are at an increased risk for developing one of those morbidities.

Next slide. So when we look at our cesarean deliveries in 2020 nationwide, 31.8 percent of births were born by cesarean. And in Kentucky, it was 34.3 percent of births, which I think is nuts. I mean, that's -- more than one in three babies are born in Kentucky are born by a C-section.

And I know you're saying, well, nobody does a C-section for no reason. Everybody has a reason. And that's true. So one thing we can look at is the low-risk cesarean deliveries, and those are the deliveries where you have a new mom, so they -- the first time being pregnant. They're term. It's only one baby. You don't have twins or triplets, and the baby is positioned head

down. They're not breach.

So that's considered a low-risk delivery. And even in that case, 27.4 percent of Kentucky births for low -- are born by C-section in that low-risk population, so more than one in four. And, of course, you know, if you have your first baby by C-section, you're probably going to have subsequent deliveries by C-section.

So our rate is 27.4. The national rate is still incredibly high. It's 26.3. But if we can lower these -- the low-risk C-sections, we will lower the subsequent C-sections, and our moms will be safer when they have babies because they'll have less morbidity.

Next slide. So let's shift a little bit. So that's part of the green Venn diagram circle for L&D. Let's talk about postpartum care and the mother and baby outcomes.

Next slide. So when -- we know we have a big problem with substance use in our state. We have looked at five years of Medicaid data, and we found that 22,451

births, babies were born to moms with SUD in those five years. Of those babies, about 6,000 were diagnosed and treated for neonatal abstinence. So we kind of concentrate on this neonatal abstinence number, but we forget the bigger picture, that only about a quarter of the babies born to moms with substance use actually develop neonatal abstinence. But the babies are still exposed to drugs in utero. So this is a big deal.

Also, women who have substance use disorder are more likely to have a premature baby, and so it will affect the baby from the beginning. So let's see what our numbers are for the babies.

Next slide. So the March of Dimes report card comes out in November, and this is from the 2022 March of Dimes report card. And we actually went up in our preterm birth rate, which is terrifying. The preterm birth rate is based on 2021 numbers, so that's 12.0 percent. The national number was 10.5 so 10.5, 12.0. That's not good.

Infant mortality rate, as expected, kind of follows that preterm birth rate. And in

2020, our infant mortality rate went up to 6.2 percent. So this is -- this is terrifying to me that these rates are going up.

Now, when you look at it, I mean, you can -- all right. At least -- I think I can justify in my head at least some of the increase being due to COVID, you know, because of the timing of this data. But I don't think you can account for all of the COVID -- you can't put it all in the COVID's shoulders, so something else is going on.

Next slide. And then, again, we see that there's a big racial disparity there. So in Kentucky, the preterm birth rate among black women is 31 percent higher than the rate among all other women, so that's -- that's huge.

Next slide. We know that we have about a 60 percent attendance rate at our postpartum visits in Kentucky. You know, some areas are doing a little bit better than the other, and we have a program going on to try and increase that postpartum attendance rate.

And I'm justifying it because I know the goal is 75 percent, and it just seems kind of -- kind of like a wimpy goal because, really, it should be 100 percent but...

Next slide. When we looked at the postpartum visit rate by race and MCO, we saw that our black women are having a harder time getting to their postpartum visits almost across the board. And whether that's lack of transportation, you know, other barriers coming into play.

But our moms have -- are having more preterm babies; our black moms, more preterm babies. They're having more serious morbidities, and they're having a harder time getting to these postpartum visits. So we really need to try and focus on that and try to get -- you know, make it easier for moms to get to these visits.

Next slide. And why is a visit important? You know, it assesses the mother's physical recovery from the child birth, obviously. It's a time to monitor our moms for serious morbidity. If they had a morbidity in labor and delivery, you know,

how have they recovered from that?

It also gives you time to assess for chronic conditions such as hypertension, diabetes, also looking into screenings for SUD and postpartum depression, and then the ongoing care of the woman including family planning, contraception, birth spacing.

It's an opportunity to counsel on breastfeeding, on nutrition, other preventive health issues, exercise, and linking moms to other services in the healthcare field or community-based services, if needed.

So next slide. I wanted to point out it's an opportunity to screen for postpartum depression. And I -- if you think back, we already said only about 60 percent of our moms get to these visits. So yes, we need to include that, but we need to make sure that our moms are getting screened at the visits.

Next slide. So about one-third of our Medicaid moms have an ER visit within that year postpartum. I thought that was a high number, and I guess it's not when you consider all these other high numbers that we've talked about today.

But these are young women in the prime of their lives, you know, with other responsibilities at home, yet one-third of them go to the ER for a personal problem during that year postpartum. And one out of ten of those ER visits are due to a behavioral health concern, is -- you know, depression, anxiety, substance use. So that's a big -- big group of people.

And so if moms are going to those postpartum visits and they're getting screened for substance use, depression, anxiety, then they might not be going to those visits. And we can link them to services sooner, so they don't end up being admitted for suicidal ideations.

So next slide. So, really, a very simple thing to do is screening moms during that postpartum visit for behavioral health concerns. That will allow for earlier referral, earlier treatment, and really can lead to much better outcomes for our moms and our babies.

And that's it. Thank you.

MS. BICKERS: Dr. Theriot,

Eva Stone had a question in the chat. Did you see that?

DR. THERIOT: I did not.

MS. BICKERS: Dr. Stone, did you want to ask a question? Or Eva. I'm sorry. I'm not sure if you're a physician. I apologize.

DR. STONE: I was just curious, Dr. Theriot, if women -- as far as the HANDS program in Kentucky, if black women are less likely to be participating in that program than white women, or has the data been looked at in comparison with their participation in the HANDS program. Because part of that work is supposed to be to make sure women have healthy birth outcomes.

DR. THERIOT: I do not know the answer to that. We can get with Dr. Bhatia and her group in public health and find out. That's a great question. Thank you.

DR. STONE: Thanks.

DR. THERIOT: Dr. Schuster?

DR. SCHUSTER: Yeah. Dr. Theriot, this is great, and I look forward to getting the slides. I wonder: Back on the cesarean

deliveries, did you look at that by race of the moms? I'm just curious.

DR. THERIOT: I --

DR. SCHUSTER: And also whether the cesarean rates are different for Medicaid moms than for non-Medicaid moms.

DR. THERIOT: I -- I did not look at that, but that is on my list. That is the next thing that we're looking at.

DR. SCHUSTER: Yeah. I just think that -- just anecdotally and something that we've been concerned about for a long time is that Medicaid is a reliable payer. The rates may not be great, but I just wonder if there is a higher cesarean delivery rate for Medicaid moms over commercially-covered moms. And then I wonder also about the racial disparities.

DR. THERIOT: Right. And we'll look at that. I do know, for our fee schedule, the providers are reimbursed the same for a cesarean delivery and a vaginal delivery.

DR. SCHUSTER: Oh, okay.

DR. THERIOT: So there is no

incentive, monetary incentive to do one over the other.

DR. SCHUSTER: And the hospital reimbursement is the same?

DR. THERIOT: Yes.

DR. SCHUSTER: Okay. I did not know that. Thank you.

MS. BICKERS: Dr. Gupta has her hand raised.

DR. THERIOT: Dr. Gupta?

DR. GUPTA: Hi. This is a two -- (audio glitch) -- of the new changes.

CHAIR PARTIN: Doctor, we can't hear you.

DR. GUPTA: Can you hear me? No?

DR. THERIOT: Oh, that was better.

DR. GUPTA: Okay. I -- (audio glitch) -- Ms. Cecil about the new changes of Roe v. Wade. Did she say that now Medicaid will not cover for rape, incest, or risk of harm to the mother; is that correct?

MS. JUDY-CECIL: That's correct, Dr. Gupta. The state law does not allow us to do that.

DR. GUPTA: Okay. So my second

question is: Dr. Theriot, do you think that our report card is going to worsen with these changes?

DR. THERIOT: It may, yes. Our March of Dimes report card may get worse because of that change.

CHAIR PARTIN: Dr. Theriot, as always, this is a wonderful presentation, and I think we're all glued to -- (audio glitch) -- because it's such an excellent presentation that you always give.

I had a question. We had asked about Hepatitis C prenatal screening and the number of cases and number of people treated. Do you have that information?

DR. THERIOT: We had looked for that, and because a lot of the Hepatitis C screenings are within bundles, it's not -- we can't just check one code and find the rate. But they're within, like, a prenatal bundle, things like that. But I do know that we checked with universities, with the teaching programs. The Kentucky Perinatal Quality Collaborative has also checked. And all of the OBs say it's standard of care.

CHAIR PARTIN: Okay.

DR. THERIOT: That they do it with every -- every delivery.

I also know from the pediatric side, when we're in the nursery, we make sure that lab is done before we let the baby go. So there's a double-check there.

CHAIR PARTIN: Okay. So the missing piece, then, is the number of cases and the number of people treated because it's bundled in, so we can't see that?

DR. THERIOT: Uh-huh. That's true.

CHAIR PARTIN: Okay. Okay. Well, thank you very much and --

DR. SCHUSTER: Beth, I have one other question, if I may. Dr. Theriot -- I can't believe I just lost it. Oh, I know.

So the screening for postpartum depression -- I think it's now called perinatal mood and anxiety disorders, PMAD they call it -- can be done at that postpartum visit by the OB and get reimbursed.

What are the guidelines for pediatricians in terms of should they be

doing that screening all through the postpartum period? Somebody told me it was for the whole 12 months afterwards and then I heard it was only up to six months postpartum. Do you know that? Do you know the answer to that?

DR. THERIOT: It is recommended that pediatricians conduct a postpartum depression screen on moms throughout that first year of life. I do not think that happens a lot of times, but people will go up to -- people who are -- the pediatricians that are screening for it will go up to about six months on those screens.

Kentucky Medicaid reimburses for -- you know, because you can argue, well, that's not my patient. The baby is my patient. How can I do a screen -- a depression screen on a baby? But Kentucky Medicaid allows you to do that screen on the mom and then bill it as part of the baby's chart.

DR. SCHUSTER: Okay. So you think the common practice is maybe up through six months.

DR. THERIOT: Yes.

DR. SCHUSTER: But, you know, we would really like to see it -- because I understand from my psychology people that treat this in women that sometimes it doesn't show up until toward the end of that first year of postpartum.

DR. THERIOT: Yes. That is true.

DR. SCHUSTER: Thank you.

DR. THERIOT: And you're right. You really want to keep that in mind. It's kind of easy to keep that in mind when you have a little infant. But when you have a -- you know, a little crawling thing there, you know, you kind of forget about the whole birth stuff because you're chasing them to keep up.

DR. SCHUSTER: Thank you. This has --

DR. THERIOT: But you're right.

DR. SCHUSTER: This has been eye-opening and discouraging in some ways but so glad that you're looking at this data and that we're looking at the -- particularly the health equity issues around this. Thank you.

DR. THERIOT: Thank you.

CHAIR PARTIN: Just one follow-up question. Is that covered in primary care for the --

DR. THERIOT: Yes. The screening?

CHAIR PARTIN: Okay. Because a lot of mothers are not showing up for their OB screen postpartum exams, but they are showing up in primary care.

DR. THERIOT: Yes. And I think that's the reason. I mean, that's the reason that it's paid for because you're right. Moms may not show up for that -- for their OB visits postpartum because they're busy, but they're bringing the baby to a provider.

CHAIR PARTIN: Right. Or they're coming in for a sore throat, you know.

DR. THERIOT: Yes.

CHAIR PARTIN: Okay. Great. Well, thank you. And I will put this on the agenda for an update in six months.

DR. THERIOT: All righty.

MS. BICKERS: And Dr. Bobrowski has his hand raised.

CHAIR PARTIN: Okay.

DR. BOBROWSKI: Just a quick

question. In kind of being new on the MAC, I'll just -- a lot of new information for us guys here, too. But just as part of the postpartum visits, training, whatever you word that as, do the moms get any, like, oral health training, like, to help prevent baby bottle syndrome with what they put in those little babies' mouths?

Because they -- at about five, six, seven months is when they start getting teeth in and, you know, sometimes by 14 to 18 months, their teeth are rotted out already. So I just wondered if there's any training on baby bottle syndrome.

DR. THERIOT: That -- there is as part of the pediatric curriculum and warning -- I mean, there's, you know, what to put in a bottle, what not to put in a bottle, things like that. So yes, there is training on that.

I used to have -- I have them somewhere -- my teeth, my milk bottle carries teeth that I had, you know, a little teeth thing. And I can whip it out of my pocket, and I can show it to moms.

And yes, pediatricians teach as soon as you have teeth, you start brushing those teeth. You know, when you go to bed at night, you treat them like your teeth. So if you brush your teeth and you go to bed, then the baby should not have anything but water after that time, or you're going to have to brush it again.

You know, it's nothing magic. They're just like your teeth. You have to take of them. They only have to last 100 years, so hopefully -- so hopefully, you'll take care of them. I guess --

DR. BOBROWSKI: Great job. Thank you.

CHAIR PARTIN: Okay. Thank you. So let's move along because we're going to -- we're going to run short on time, I'm afraid.

Next up is update on workforce shortage from Dr. Sheila Schuster.

DR. SCHUSTER: Thank you. And this will be quick, and I appreciate Erin sharing my screen because I'm so bad at it.

So next slide, please, Erin. This issue of workforce shortage is one that I've been

working on in a licensure vein since the late '70s, early '80s. We know we have workforce shortages. We think we're pretty good at estimating what the need is. We've seen those estimates, for instance, on nurses coming from the Kentucky Hospital Association and from the Kentucky Nurse's Association. But I'm going to tell you we have lousy data on what our current workforce capacity actually is.

So the State commissioned Deloitte back in 2013. So it's been ten years since we've had a statewide or a state-authorized study on this. And they pointed out that their data sources, which were the licensure boards, created raw data, and some provider groups were omitted.

Next please, Erin. So I gave you the link. That Deloitte Kentucky Workforce Capacity Report is still available on the CHFS website. And as I said, it was commissioned by the State, published in May of 2013, around the time of the implementation of the Affordable Care Act and the Medicaid managed care.

So the licensure boards and the health care professions that they looked at were physicians including PAs; nurses including APRNs, RNs, and LPNs; dentists, optometrists; and then they kind of lumped together this group of mental health providers.

So some of you who are on the MAC and some in the audience will say, well, we weren't in there and we're health care, and that's absolutely true. So the therapy providers, OT, PT and speech; the chiropractors; the podiatrists -- I mean, there's a number of other healthcare providers that they didn't survey at all. So it was a narrow focus in some ways.

Next, please. So just on the mental health side, since I'm a psychologist, I look particularly at this. And this is how they define the mental health providers. Psychiatrists; licensed psychologists, which in Kentucky are those at the doctoral level, did not include those that are licensed at the master's level; licensed clinical social workers; licensed professional counselors; marriage and family therapists; and then

alcohol and drug counselors.

They did not include any of the psych mental health APRNs, which was certainly an oversight, nor did they include any of the mental health professionals working under supervision. And there is a requirement in every mental health profession, probably different for medicine and for APRNs but in all the others to work in supervision for X number of years, some with a master's degree and some while in training. And they provide services and are billable, some of them, by Medicaid and other insurers.

So when they defined the need for mental health -- and they used some national statistics to try to figure out how many psychologists do you need per 100,000 people, how many marriage and family therapists and so forth -- they didn't do it for the individual professions. They lumped all the mental health professionals together as if we all provide the same mental health services, which we do not.

So some prescribe, and others do not. Some are able to diagnose, and others do not.

Some treat certain conditions, only, for instance, the alcohol and drug counselors or the marriage and family therapists are only treating some mental health or behavioral health situations and not all.

Next, please. So the Deloitte report actually consistently noted the shortcomings of licensure board data which include, just for starters, the location of practice sites, whether the individual was practicing full or part-time or whether they were practicing at all.

And I will use myself as an example. I've been licensed since the late '70s, just to show you how old I am. I stopped clinical practice in 2000 when I went full-time into my advocacy work in Frankfort, but I kept my license. So I've kept up with my CEs and all the requirements to keep your license.

And I did that because I testify fairly quickly in the legislature, and I want to be able to identify myself as a licensed psychologist so that they kind of know where I'm coming from.

So I'm counted in that. You know, if

you go to the Board of Examiners of Psychology and count how many licensed psychologists, Sheila Schuster would be in there, but I'm not providing services. So in terms of our workforce -- because we're looking at service providers, you know -- you get a false impression.

Also, most of the boards don't ask the graduation date that you got your professional degree. And you think: Well, why do you need that? Well, there are estimates that you can make in terms of about when people will retire because we're losing people. People may be retiring earlier than 65, or whatever that date is. But we at least ought to be able to estimate that.

Other problems that Deloitte noted were that some of the boards had duplicative or missing data. They also failed to note that some individuals held multiple licenses, which is not uncommon among, for instance, the mental health providers.

So someone may start out in the field of social work and then decide to specialize, if you will, in alcohol and drug counseling, get

additional training, and then they keep both licenses. Well, we're obviously not doubling the number of providers, but we're just halving the person, if you will.

The most common data point that was missing was the county of the individual's practice. Most of the boards only have your single address, and for most of us, it may be our home address since we may have various practice sites.

The Kentucky Board of Nursing was noted to have the most accurate data, and it consistently included the county of practice. And I will say that they recently updated their renewal form. So they are asking a lot of the questions that we're going to cover in the next slide.

So next slide, please. So while KBN, Kentucky Board of Nursing, comes the closest, no licensure board currently requires all of these data responses, the addresses of all practice locations, and the percentage of practice in each.

So we know there are people that have offices in several counties, for instance.

And when we're trying to look at access to services, we really need to know if services are being provided by that provider in multiple counties, the percentage of your full-time practice, which is that you're actually doing. And, again, my example, I would put down zero because I don't think you can count what I do with legislators as delivering mental health services.

What are the specialty areas of practice? Many of the physicians, the nurse practitioners, many of us in psychology and in other fields specialize, and it would be really helpful to know that.

What's the race and ethnicity of the licensee? This may be more important in terms of behavioral health because I think it's really important for somebody coming into therapy to sit in the therapy office and look across the room and see someone that looks somewhat like them, may have some of the same lived experience. I also wonder if it isn't true across healthcare providers, and it would be really helpful to have that information.

What's the capacity for meeting some specialized patient needs, English as a second language, or interpreter services? Is the provider specialty trained to address LGBTQ+ kinds of issues? Are they equipped to deal with different disabilities?

And I see Eric Wright is on here and knows very well there are people that are trained to deal with people with intellectual developmental disabilities across healthcare professions and others who are not.

Age. I've been a child psychologist all my life including, I guess, when I'm in Frankfort. But we know that there are some providers who don't want to see anybody under the age of 18. There certainly are a lot of providers that wouldn't see anybody under the age of six, and yet there are young children and their families that need care. And, again, the culture, ethnicity, racial balance, and so forth.

Do they -- what kind of payer sources are they willing to take, if any? We have a number of providers that are doing what we call boutique practices or taking cash on the

barrel head and not billing at all for insurance. Are they Medicaid providers? Are they Medicare providers?

And then more recently, do they offer telehealth in addition to in-person services? And I do know, from work on another committee, that the State is creating a website for providers who are providing telehealth, so that's another way to get at that.

So the bottom line, folks, is that the current licensure board data overestimates the number of practicing professionals and gives little to no information about where services are actually being delivered, again, because they have only a single address.

So I have a recommendation on this last slide, if you can go to that, Erin. Thank you. To require all healthcare licensure boards to collect the following information at the time of application, in other words, at first licensure and then with each renewal -- license renewal period, so we can accurately assess our capacity.

And, again, these are the things that I

just went over that most of the boards are not collecting at all. Again, the Kentucky Board of Nursing does the best job.

We are working -- there's several groups working on this. Kentucky Voices For Health is working on it from a network adequacy point of view. If we don't know what our workforce is, it's very difficult to hold the MCOs and other insurers responsible for having accurate provider directories and really making them useful for people so that they really can match up with the kind of provider that they're going to be most comfortable in seeing, the one that they think will be most able to relate to them and to their issue.

A new coalition called the Kentucky Coalition For Healthy Children and also My Mental Health Coalition are working with KBH to find a sponsor -- we may have one in the senate -- that would put forth this legislation to make this requirement of the licensure boards.

There is some cost involved, and so there may need to be some allocation of state

funds because when -- the websites have to be upgraded to be able to receive this information, but I think it's well worth it.

So I guess I would say to you, when people talk about the workforce shortage, and we do have it, I think it would really be helpful if we would all say back, you know, we really don't have accurate information about what our overall capacity is.

So last slide has my email address if you want to be a part of this movement in the legislature, and I won't take -- well, if there's a pressing question, Beth, I'm happy to answer it. Otherwise, if people want to just email me with follow-up questions, I'm happy to respond to that.

CHAIR PARTIN: Okay. This is something a little bit different in regards to what the MAC has looked at before, so I'm wondering how we move forward with this because I think, indirectly, this affects Medicaid participants. Well, it affects all Kentuckians at every level.

So I guess I'm wondering where we go from here and what suggestions MAC members

might have in regards to these recommendations. Do we think that this is something that we could send on to the licensure boards?

I'm not sure where our authority starts or ends in that respect, but I would like some discussion about what we think we can do about this.

MR. ROBERTS: Beth, I think you're right. This is probably a little bit beyond the purview of the MAC. But, Sheila, that was a great presentation. All of the items that you brought up are things that we have addressed in one form or another. I know Dental TAC has had, you know, network adequacy concerns. All of the MCOs are being scored and required to have certain network adequacy, you know, metrics.

And it's -- right now, it's a shot in the dark. I mean, you're chasing a ten-year-old ghost trying to figure out if you have network adequacy or not.

This is something that I think should be championed by the different specialties, you know, because that's not -- not only is it a

service to our patients, you know, our constituents in Kentucky but, I mean, this is -- you know, for a new practitioner looking to come in, they don't want to be beside 25 other people doing the same thing. They want to go to an area where they can be useful.

I do think this is probably going to need to come from either the Cabinet directly or the -- or with new legislation. I certainly will get, you know, our board behind your efforts, and I'll email you individually and see what we can do to help.

DR. SCHUSTER: Thank you. I appreciate that. I think the other issue that I didn't put on here and the Deloitte survey talks about is the urban versus rural divide. And, of course, we can't really accurately assess that until we really know where the services are being delivered.

So, again, it's an access-to-care issue for Medicaid members and obviously for all Kentuckians. But I appreciate that, Jerry. Thank you.

CHAIR PARTIN: Veronica, would this

be something the MAC could make a recommendation to the governor's office perhaps to -- since there hasn't been any work done on this since 2013 -- for another study to be done and maybe noting some of the shortfalls in the Deloitte review and asking for a more comprehensive review of the workforce?

MS. JUDY-CECIL: Certainly, we could pass that along if you all made that recommendation. I think, as someone kind of alluded to before, having the different associations contact the governor's office or even -- you know, this is something that could be put in state law and going directly to legislators to have something put in state law.

Having that direct contact is probably more meaningful. Not that you all's recommendation isn't important. But, you know, the more you hear from folks, the more you'll maybe move to do something.

So, again, I mean, if you all have a recommendation and ask us to pass that along, we can do that. But it is out of our

jurisdiction and -- you know, and I do think it would bear more weight to have this -- have each of the associations contact the -- or have the providers contact either the governor's office or the legislature directly.

CHAIR PARTIN: So how about this? How about if we make a recommendation to the governor's office and that we also request that the TACs, through their professional organizations, also make recommendations to the governor's office? And that kind of covers all the bases.

DR. SCHUSTER: Is your recommendation for the governor to authorize another study, Beth, or --

CHAIR PARTIN: Yeah. I think that would be a good starting place, to ask the governor's office to look at doing another study that would be more inclusive and comprehensive than the one that was done in 2013. I think that's a good starting place.

MS. EISNER: This is Nina. I think it's also going to be important to support potential legislative action like you were

talking about, Sheila, so I'd just add that in to the other recommendations, Beth.

DR. SCHUSTER: Yeah. I think the recommendations to the TACs could really be around not only the communication to the governor's office but communicating to legislators. Because, as Veronica said, you know, it's really those people getting to the legislators and, you know, hopefully we get a bill sponsor. And I could let you all know what it looks like and so forth.

I wonder if there's any information that the MCOs have about providers that could be helpful. And I'm not real sure what it would look like because the network adequacy is the flip of this, certainly.

And we -- you know, I've raised questions about network adequacy from the behavioral health standpoint because I think most of the insurers and MCOs count one behavioral health provider the same as another. And, again, they really are not.

I've really advocated that they look at those behavioral health providers that can prescribe, for instance, those who can do

diagnostic testing, and those who do therapy. I mean, there's really three kind of classifications of services out there. And I think for people trying to figure out who they need to go see -- because I get those calls all the time, you know -- would be helpful. So I don't know what role perhaps or what data the MCOs might bring to this as well.

CHAIR PARTIN: So it's really a complicated issue. So to try and hone down on any recommendation that we would make, is it reasonable, do you think, to -- as far as the MAC is concerned, to make those two recommendations, that the -- that we recommend to the governor's office that another workforce study be done, more comprehensive and more inclusive?

And then, secondly, that we recommend that the TACs through their professional organizations contact their legislators or -- I'm not sure -- I'm not sure where to go with that.

DR. SCHUSTER: Well, why don't we ask the TACs to also follow up on the MAC

recommendation to the governor's office and to make -- you know, reenforce that recommendation. And then if we have legislation in this session, for them to reach out to support legislative initiatives to make this happen when they're filed.

And if it doesn't happen in 2023 because it's a short session, it will happen in 2024. There will definitely be legislation around this. I think that's the only way to accomplish it with the licensure boards.

CHAIR PARTIN: Okay. So does somebody want to make a motion to accept that recommendation?

DR. SCHUSTER: Well, since I presented on it, I'll make that motion.

CHAIR PARTIN: Okay. Do we have a second?

DR. BOBROWSKI: Bobrowski.

CHAIR PARTIN: Thank you. Any further discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Anybody opposed?

(No response.)

CHAIR PARTIN: Okay. So moved. So we will send that recommendation to the governor's office and to the TACs.

DR. SCHUSTER: Thank you very much.

CHAIR PARTIN: Thank you, Sheila.

DR. SCHUSTER: Yeah.

CHAIR PARTIN: Okay. So we've still got quite a bit of ground to cover and not a lot of time to do it.

So I'm going to ask the TACs to be brief in your presentations and just give us your recommendations so that we can make sure that we cover all of our other business. We do have new business and then -- we have two items of new business that we have to cover.

So we'll start with Therapy.

MR. LYNN: Yes. This is Dale Lynn. I'm the chair of the Therapy TAC, and I have three items that we'd like to bring to the attention to the MAC, is the -- the first one is the First Steps. The extensive coaching training requirements added in 2018 has resulted in a huge time burden for providers

with no reimbursement and no pay increase. Therefore, many providers have just dropped out of the program, leaving it -- you know, shortages for providing services to these children.

And, also, the same -- we have -- First Steps providers received the same pay since 2005, and they're requesting an increase. And it is -- we're requiring providers to use the coaching and educational model in the home to provide services, but providers are required to bill therapeutic CPT codes based on a medical model. And educational services are not reimbursable by insurance companies and should not be billing and using those codes.

And we're asking the MAC to facilitate by bringing the interested parties together for a meeting to look at what can be changed to decrease the burden on providers who are already stretched to the limit and a decreasing therapy workforce. That is the first item.

The second item we'd like to bring to the MAC, we're jumping on the wagon of

wanting more reimbursement for our services and our CPT codes. The flat Medicaid rates have not increased more than a few cents, and many of them actually have decreased since 2010. The Therapy TAC is asking for the MAC to support increasing the therapy fee schedule.

And the third and last item that we were -- was going to be brought to the MAC was the Therapy TAC brought to the attention of Medicaid the financial burden of the NCCI Cotiviti edit and the pains that it causes providers financially.

We discussed this with -- last week with Medicaid, and actually over the last few TAC meetings, to support removing those Cotiviti payers from the NCCI edits that have -- you know, affect therapy financially.

And last week, we discovered that CMS has removed most of the Cotiviti pairs that impact therapy effective April 1st, 2023. And we just want to thank Medicaid for supporting that.

CHAIR PARTIN: Okay. Thank you.

Next up is Primary Care.

DR. CAUDILL: Thank you. This is Mike Caudill. I'm the chair for the Primary Care TAC. I'm also CEO of Mountain Comprehensive Health Corporation, an FQHC.

We met in a meeting on January 5th of 2023. A quorum was declared. Our next meeting will be March 2nd, 2023, at 10:00 a.m., and we did not have a recommendation for the MAC.

We did have a few things go on there. We had a presentation from Tal Curry, the executive director of the Kentucky Office of Autism on autism and the Department's efforts and also to talk about it, that autism is now the rate of 1 in 44 of people are on the autistic scale and about the barriers, the barriers in trying to find qualified people like BCBAs.

They're very, very hard to get extensive requiring, talking about the barriers that people with autistic children are having trying to get care, that the only two main centers in Kentucky is University of Louisville and University of Kentucky and otherwise out of state. There is one in

Cincinnati. And there's small groups such as Pikeville Medical Center that start their AVA Center in Pikeville, Kentucky.

And, of course, it's of interest because we're trying to get one, but there's a lot of barriers to that, not only personnel. You also have reimbursement problems in this. Because when you start talking about autism, you're talking about sessions lasting multiple hours as opposed to 15 minutes like in a primary care setting and certainly something that DMS probably needs to look at and be more active in it.

We also updated on a signature provision on the discrepancy between FQHCs for one day and other primary care providers for three days, and that is being changed. It's currently in front of the regulatory review, and it's not being enforced. But it was one of the things we discussed.

We made the recommendation on the dental workforce before that the MAC accepted, and we discussed that, the -- we received a letter where it was presented to the secretary and is being taken under

advisement.

But at the same time, we were told that there's been a coalition formed made up of the two dental schools in Kentucky and the Pikeville dental school that is getting ready to start, to look at those type of programs. And we would perhaps be solicited to have a member of the Primary Care TAC be -- to meet with them.

And we also talked about the establishment of core quality indicators across all MCOs to give providers some type of consistency rather than trying to -- try to serve different regulations for each of the MCO providers. And the Department is looking at that.

Veronica Cecil told us at that time the goal was that we do aligned effort across all the different levels so that DMS, the MCOs, and providers are all working toward the same set of measurable goals.

We've not been there before. We just started it. It is a heavy, heavy lift. The difficulty is in choosing those measures. We can't do everything, and that's going to be

reported back to us on a quarterly basis.

And Veronica also told us about the submitting of a state plan amendment referencing community health workers and to add them to the plan as reimbursable services being looked at to begin as early as July 1st of 2023, and that is currently pending in front of CMS.

And that's it.

CHAIR PARTIN: Okay. Thank you.

Physician Services.

DR. GUPTA: We met on the -- (audio glitch).

MS. BICKERS: Excuse me. Dr. Gupta dropped this in the chat, so we -- since we can't hear her, I'll read that off really quick. It says, "We met on Friday, January 20th, and had a presentation from the Milbank Memorial Fund on ways that the State can enhance primary care for Medicaid recipients. The Physician's TAC will continue to focus dialogue on this subject and other barriers to access. We had no recommendations."

CHAIR PARTIN: Okay. Thank you.

Pharmacy.

DR. HANNA: This is Cathy Hanna. The PTAC did not meet since our last meeting so no recommendations. Thank you.

CHAIR PARTIN: Thank you.

Persons Returning to Society From Incarceration.

MR. SHANNON: Yeah. This is Steve Shannon. We met. We had a quorum. We approved minutes. We hadn't had a quorum in the last two meetings.

We got an update on the implementation of Senate Bill 90 and a report from our managed care partners as well as we discussed potential agenda items. And we have no recommendations. We're still eagerly anticipating the approval of the 1115 SUD waiver. Thank you.

CHAIR PARTIN: Thank you.

Optometry.

DR. COMPTON: Yes. This is Steve Compton. We met, had a special-called meeting mid-December to address our concerns and questions with the enhanced vision Medicaid benefits that the Department had announced.

The Department asked us to submit our concerns and outline specific areas of our concern in writing, and we did that. As of today, we have not received any response to this communication from the Department.

At this time, the TAC is not making any formal recommendations to the MAC because we are hopeful to hear back soon and would like to give the Department the opportunity to properly address the concerns raised at the TAC. But we do remain frustrated with the lack of information and lack of response we've received.

We will meet next Thursday, February 2nd. And we may very well have some recommendations coming out of that meeting, but we have none at this time. Thank you.

CHAIR PARTIN: Thank you.

Nursing Services.

DR. STONE: I don't think Lisa was able to join, so I'll give the update.

So we met on December the 8th. We reviewed some of the data -- outstanding data requests that we had submitted, just reminded of those, and we've since gotten those.

We spent most of the time talking about expanded Medicaid billing for school-based services with the changes that allow for students with -- that do not have IEPs to be -- those services to be billed in schools. Specifically, we talked most about reimbursement rates because nurse practitioners are being paid 7 and 8 dollars for preventive health exams. They're not being paid on the preventive fee schedule, and so I think there was some work to look into why that is happening.

We requested that there be an update to the school-based Medicaid billing Technical Assistance Guide, to look at the services that are included because there's a lot of services allowable on a federal level that haven't been included in that document and that reimbursement.

And so a committee has been formed. That committee actually met yesterday. Erin had spearheaded that, and so that's some really good work.

And there were no recommendations for the MAC at that time. We'll meet again this

month.

CHAIR PARTIN: Okay. Thank you.

Intellectual And Developmental Disabilities.

MR. CHRISTMAN: The IDD TAC did not meet in January. Its next meeting is scheduled for February 7th.

CHAIR PARTIN: Okay. Thank you.

Hospital.

MR. RANALLO: Sorry. This is Russ Ranallo. I was on mute. We met in December, the Hospital TAC. We went through some old and new issues, but we don't have any recommendations at this time.

CHAIR PARTIN: Okay. Thank you.

Home Health.

MR. REINHARDT: Thank you. Evan Reinhardt with the Home Health TAC. We continued discussion on reimbursement rates for home health, and we had two recommendations, for Medicaid to cover PleurX drains and to make supplies coverage and MCO charges for supplies public information.

And that's all we have.

CHAIR PARTIN: Thank you.

EMS.

MS. SMITH: Yes. This is Keith Smith, the new chairman for the EMS TAC. The only issue we have -- not to make a formal recommendation. However, we have a number of EMS providers across the state of Kentucky that are not being reimbursed for trips that they are making because of a new preauthorization form process that has been handed down to us.

The form is nearly impossible for EMS providers to be able to complete because it's asking for information that is hospital specific, and hospitals can't really do it because it's also asking for information that's EMS specific.

So we are meeting with these individual insurance companies, and we are supposed to bring back more information for our February meeting. That's it.

CHAIR PARTIN: Okay. Thank you.

Disparity and Equity.

DR. BAUTISTA-CERVERA: Hi. This is Patricia Bautista-Cervera. We had our second meeting on Wednesday, January 4th. We're

just exploring on what are the main issues that we need to address.

We have discussed the barriers about transportation for many of the populations in the rural and in the urban areas and also the accessibility to immunizations, but we don't have any other reports or recommendations at the moment.

CHAIR PARTIN: Okay. Thank you. Dental TAC.

DR. BOBROWSKI: Yes. This is Dr. Garth Bobrowski. We did have an emergency TAC meeting on January the 13th. We had 100 percent attendance for a quorum.

But, again, I wanted to thank Commissioner Lee and all her staff that worked with her on helping us work through some serious dental issues across the state. We're just trying to move the needle. Excuse the pun. But Kentucky oral health is 49th in the nation.

But we wanted to bring up one thing that a lot of folks may not be aware of, and I don't know how many of you all use the locum tenens to help fill in on staff. Like, for

maternity leave, this thing has been on the books for a few years. And for some reason, it's being taken out of the regulations to allow this. But it has been a very good way to have help come in to fill your offices, but it's being taken out. So I just want to make you aware of that.

And the other thing that we're working on is this community health worker. Our next TAC meeting is February the 10th. At the present time, we do not have any motions to present. But I'm sure after this next meeting, there will be some coming forward.

Thank you.

CHAIR PARTIN: Okay. Thank you. And I was just informed that I skipped the Nursing Home TAC. It's not on the list that Erin sent out, is it? Oh, it is.

DR. MULLER: There we are.

MS. BICKERS: They have not met since, I believe, October of last year. Their next meeting is in March.

DR. MULLER: But -- but I am here.

MS. BICKERS: Oh.

DR. MULLER: Greetings. Last but

not least. We're used to that. No problem.

Right. That report is correct. We do have a recommendation, though, to DMS. We have a mutual problem. CMS, for the MDS, is going to sunset Section G by this October 1st. That is a critical component of the rate that sets the case mix. It's the physical assistance required for the patients in the nursing home. They're sunsetting that. There's no great solution.

We've had an MDS task force that has sent over a recommendation for a crosswalk to DMS, and we'd like DMS to test this crosswalk using the historical data to see if we can get to a consistent output of the rates.

There is another optional state assessment that can be done, but that's going to take -- we've heard a great deal about workforce here on this call and meeting, and that's just going to take more time from nurses away from patients to do that other -- that optional state assessment when there is a crosswalk.

So if you all can test that proposal and get back to Kentucky association, that's our

ask. So thank you.

MS. BICKERS: John, just a quick question since it's been so long since your last meeting. Did the TAC vote on that recommendation to be presented to the MAC?

DR. MULLER: We -- it's within an MDS task force, so we had not been able to meet on that. But I will get back to them and see if we need to do the emergency, as Dr. Bobrowski just mentioned.

MS. BICKERS: Thank you.

DR. MULLER: You're welcome. Thank you.

CHAIR PARTIN: Okay. I'm sorry about missing that. I didn't see that on the list.

DR. MULLER: I'll believe. Thank you.

CHAIR PARTIN: Consumer Rights and Client Needs.

MS. BEAUREGARD: Good afternoon, everyone, Emily Beauregard. I'm the chair of the Consumer TAC, and we did meet on December 6th and had a quorum present. And we do have a few recommendations.

One of the items that we discussed most at our last meeting, and actually for a number of meetings now, is network adequacy. It's something that has been a big concern of ours and -- for some of the reasons that Dr. Schuster already presented.

We also know that most Medicaid members -- or we assume, I should say, but -- and the ones -- you know, with the members that we talked to who are having issues finding a provider who will -- you know, is in their area and will take new clients, new patients.

We hear that pretty frequently and learned that patients aren't necessarily aware of network adequacy rules and the rules that the MCOs, you know, have to follow in order to provide an adequate network. And those rules are time and distance standards that, again, Dr. Schuster presented on.

But these are in statute, in regulation, and that's not enough. You know, just having that regulation isn't enough to really have that network adequacy met. And we know that there are requirements of the MCOs to provide

reports of their network. But when you don't have great data from the licensure boards and there are a lot of gaps, you know, that translates into networks that aren't necessarily as accurate as they can and should be.

And all of this, you know, translates into provider directories that consumers are using and finding that when they make a phone call to a provider, they're often being told they either don't accept that, you know, MCO at all or that they're not taking new patients, any number of things. Or if they are taking new patients, it may take three months to get an appointment. We hear that all the time.

And so one of the things that we thought we could do through the Consumer TAC is to work with DMS on a one-pager that at least provides consistent, uniform information about network adequacy requirements, what those standards are, what the process is to follow whenever you're having trouble finding a provider. And so we really appreciate DMS pulling together that one-pager.

In that process, we kind of recognized some gaps in how the policy, you know, really works in practice. And one of the things that we noticed is that while there's a process for, you know, reaching out to your MCO and working with your MCO to find a provider, and the MCO is, I believe, encouraged but not required, although I think it should be required, to provide out-of-network care whenever they're unable to provide in-network care within those time and distance standards.

There's no higher level of -- in that process to report whenever network adequacy is not being met, when your request for an in-network provider, you know, just simply isn't being filled. And you end up not being approved for that out-of-network care.

And so that is an area where I think we need to make some improvements in the Medicaid program. I think that DMS should have a role in, you know, tracking any network adequacy violations and also making sure that those issues are resolved for the member.

Right now, the recourse is that if a provider isn't available within those standards and the MCO isn't providing an out-of-network provider, then the member can choose to switch their MCO. But we know that this takes time. It puts a burden on the member who would ultimately -- you know, it doesn't even necessarily ensure that they're going to still get that provider within that amount of time. And they may have enrolled with that MCO for other reasons.

So to make that their only option, I think, is putting more burden on the member than the MCO, in this case. And, again, it means that, you know, you're telling people, okay, well, you can switch. But that means that we have not a lot of good data on why people are switching. And we assume that a lot of people don't even realize that this is an option for them and probably just accept that they can't find a provider and end up not getting the care that they need or having to wait many months in order to get that care.

So there are lots of reasons that we

need to improve this process and make sure that DMS does have more of a role in -- you know, in tracking when network adequacy isn't being met and also in helping to resolve those situations.

We know there are secret shopper audits going on and, at the same time, you know, we're hearing from MCOs that they're meeting network adequacy standards more than 95 percent of the time while the secret shopper audits are finding it's sometimes 30 or 40 percent of the time. So there's a discrepancy there that we really need to dig into.

And, you know, beyond having better information and a better process for Medicaid members, you know, to -- again, the recommendations that Dr. Schuster put forward, I do think that going, you know, to the Kentucky legislature and asking for that uniform data to be collected from licensure boards would give us the information that we need to identify gaps in our networks and to start to be more targeted in interventions.

It's definitely a first step in the

process. It doesn't solve our network adequacy woes, but it's information that we need to be more targeted in how we approach network adequacy and the workforce issues.

So we do have one recommendation related to the one-pager at this time. We don't think that one-pager is enough. So during our upcoming TAC meeting in February, we'll be developing additional recommendations to bring to the MAC.

And then something else that we discussed at our last meeting that really relates to the presentation that Dr. Theriot gave today -- Theriot, excuse me -- is related to doulas. And we have seen that, you know, with many of the MCOs -- while this is a value-added benefit, many are now starting to provide some amount of doula service and access to doulas. For some, it's a relatively small program or may only be offered in certain areas of Kentucky, but I think that's good progress.

We were excited to, you know, see that there's a lot of work being done by many MCOs, and some of them have pilot programs

that are collecting data and finding improved health outcomes for moms and babies.

You know, I think that this data and the data, you know, that we have just beyond our Kentucky MCOs on the value of doulas and the impact that having a doula can make on the health of a mom and baby is enough for us to really strongly consider Medicaid reimbursement for doulas so that it's -- it would be a service available to all moms and one that would be, I think, more accessible. Because, you know, any time you have reimbursement, you have more doulas that are able to participate, and you end up having more access to those services.

So that was the other item. And, of course, the Medicaid renewals has been a big topic for us as well. And, you know, I think that it was good to hear Veronica's update earlier. We're very, you know, encouraged by all of the work that DMS has done to prepare for the renewals.

Renewing 1.7 million Kentuckians in one year is going to be a herculean task, and I do really want to just emphasize --

re-emphasize, because I think I've brought this to the MAC's attention before, just how important it is for this to be an all-hands-on-deck sort of approach and that providers and other Medicaid stakeholders will need to be sharing consistent information with Medicaid members and doing outreach and making sure that people understand what's happening and are updating their addresses and contact information and that we're getting everyone enrolled or renewed, you know, who is still eligible. And for those who aren't, that we're helping them to find other types of coverage.

But we're talking about at least 250,000 people and about 50,000 or more of those people being children. So we really do need to all be planning on doing our own communications and outreach along this -- for this process.

And I think that having some stakeholder meetings is going to be an important way to get everybody on the same page so that we're all sharing that consistent information and participating in outreach strategies.

And so I'll just end with the recommendations that we made at our last meeting -- actually our last two meetings. So the first is that DMS notify all CACs, so certified application counselors, and connectors on an annual basis of the release of the Medicaid open enrollment side-by-side value-added benefits. That's a really valuable tool that connectors use whenever they're helping somebody enroll and choose an MCO.

Our next recommendation is that DMS post the network adequacy one-pager that I mentioned on the DMS website and require each MCO to post the one-pager on their respective websites and include it in their member handbooks.

And the third recommendation is that DMS create a process for Kentuckians to apply for emergency time-limited Medicaid in advance of an emergency and be pre-approved to receive emergency time-limited Medicaid in the event of an emergency occurring within a 12-month period from the date of their application.

So those are the three recommendations.

We also voted to approve our 2023 meeting schedule. And our next meeting will be on February 21st at 1:30 p.m. And it will be virtual. Thank you.

MS. BICKERS: I think Dr. Bobrowski has his hand up, Beth. I'm not sure if he has a question.

CHAIR PARTIN: What?

MS. BICKERS: Dr. Bobrowski has his hand raised.

CHAIR PARTIN: Okay.

DR. BOBROWSKI: Just a question for the Consumer TAC concerning the network adequacy. I'd be interested to find out if -- in dentistry, four of the six MCOs, as soon as they came into the state -- well, shortly after they came in, they -- we took our -- they took our 2002 fee schedule and took ten percent off of that. And that's what we've been getting in reimbursements across the board for years now.

And I was just interested in, for consumers and not being able to find dentists, it's like, are other TACs -- did the MCOs do the same thing to other TACs or

to other professions?

CHAIR PARTIN: I don't know. I guess that would be -- that would be a question for DMS.

DR. BOBROWSKI: I'll ask them.

MS. BEAUREGARD: Yeah. Those contract rates, I think, are usually private, but I think it is something that we have heard, at least anecdotally.

And I will say that there was a bill filed by Senator Alvarado last year to require a particular -- you know, the fee schedule be the minimum payment, I believe, for dentists. And it may be re-filed again this year. I heard that there was some interest in re-filing that bill under a different sponsor.

DR. BOBROWSKI: Working on it. Thank you.

CHAIR PARTIN: Thank you.

Children's Health.

Jennifer, are you giving the report for the Children's Health TAC? If so, you're muted. Jennifer, are you trying to give the report for the Children's Health TAC? If so,

you're muted.

MS. DUDINSKIE: I'm not sure which Jennifer you're trying to reach. I had accidently unmuted a few minutes ago. I'm with Medicaid, but it's not me.

CHAIR PARTIN: Okay. Sorry.

MS. BICKERS: I was trying to scroll through, and I don't think I see anyone from the Children's TAC on today.

CHAIR PARTIN: Okay. Thank you.

And then last up is Behavioral Health.

DR. SCHUSTER: And I will go. Just two items that tie into our recommendation and two other items that are on the -- under new business. We met on January 5th. We had a quorum and so forth.

One of our TAC members, Mary Hass, representing the Brain Injury Association, presented her concerns about the potential loss of therapy services for members with acquired brain injury who are being served on the ABI acute and ABA -- ABI long-term 1915(c) waivers. There was a robust discussion about that, and some of the background was presented by Pam Smith from

DMS who you heard from earlier.

The change in therapy services across the waivers to the state plan as required by CMS, and DMS has tried to be in contact with providers, members, and families. The billing mechanism is apparently quite different if you go to state plan billing as opposed to waiver billing. And Mary continued to express concern that therapy providers who are very skilled and who have worked with the same clients for years -- because, remember, with acquired brain injury, those services are going to be ongoing, that they will no longer be willing to provide services under the new model.

Several avenues for improving the flow of information between DMS and all stakeholders were discussed, and we do have a recommendation on that. We agreed that the best interest of all would be served with more frequent communications, if only to say that nothing has changed.

And this issue comes up repeatedly, and I feel for DMS because it takes so long. They're working on things that they know are

going to happen down the road. But once that word gets out to consumers and their families and to advocates that a change is coming, the anxiety level shoots up immediately. And it's true with providers, too. Because, immediately is there more red tape? Is there going to be lower reimbursement charges and so forth? And then when there's dead silence for long periods of time, that anxiety just multiplies. And I keep saying to people, you know, let people know that you're still working on it even if nothing has changed. That's information that they need. Because, otherwise, you get all of these rumors and people kind of playing off each other in terms of what's going to happen.

So our recommendation to the MAC from the Behavioral Health TAC is that DMS communicate on a regular basis regarding the changes in the ABI waivers with regard to access to the various therapies which will now be covered under the state plan and not under the waiver.

These communications should include ABI providers, therapy providers, Medicaid

members and their families or caretakers and advocates including representatives of the Brain Injury Association of America and the Brain Injury Alliance of Kentucky.

Specifically, we also recommend that DMS communicate with the BH TAC, the Therapy TAC, and the Consumer Rights TAC at regular intervals to assure that the stakeholders have pertinent information on the proposed changes, their implementation, and any problems in accessing therapy services.

Under our new business, one of them was the issue that Nina brought up earlier, and that is that the BHSOs and the alcohol and other drug entities, AODEs, have not seen what the new rates are. And, obviously, there's a lot of anxiety about that. So we appreciate the clarification given earlier in the MAC meeting from Veronica about that.

We also had a discussion about the RFP to manage mobile crisis services across Kentucky, and we were able to get some background information about that.

The final issue is really a very significant one, and it's listed under new

business for discussion. But it has to do with the change in CPT service codes which now are no -- our information was that they are now no longer available for extended time periods; in other words, for therapy services, for instance, that run more than one hour and that those have been deleted.

I will tell you as a child psychologist that the more significant the illness -- and we're talking about, for instance, children with extreme forms of autism. We're talking about children with severe emotional disturbance -- that therapy sessions very often go longer than an hour and need to go longer than an hour.

And we need to come up with some way very quickly -- I know the children's alliance, which is our child care delivery service for these kids, are really encountering problems. So I hope our discussion under new business will help with that.

The next meeting of our TAC will be March 9th, and I appreciate your support for our recommendation about the ABI waivers and

therapy services. Thank you.

CHAIR PARTIN: Thank you. Okay. So we've got about four minutes, so obviously we're going to go overtime a little bit. But let's try and stay as close to time as we can.

Under new business, what Sheila mentioned, the American Medical Association has deleted the CPT code for add-on codes for extended services, codes 99354 and 99355. These claims are no longer being accepted as of the 2nd of January of this year.

This is a serious issue affecting behavioral health services throughout Kentucky. And what does DMS plan to do to remedy this problem? And, Eric, did you want to speak to this?

DR. WRIGHT: Yeah. I became aware of this from Transformations For Hope which is a provider agency here in Louisville, Kentucky. And I guess the information was disclosed to providers in early January about these changes, unbeknownst to a lot of people. And I think the biggest thing is just clarification about this and what the

plan is moving forward.

Often the case, like I had suggested when talking with Dr. Schuster about this issue, it's often the case you're working with clients, as I do in the area of clinical mental health, there's still work that has to be done to process some emotional trauma. And that -- those codes often allow you to be able to extend the session up to 30 minutes, which is necessary at times, 30 minutes to an hour, which is necessary at times.

But currently now those codes, as we understand them being removed, has provided a real complicated situation with clinical and mental health providers and behavioral health professionals. And so that's the reason I wanted to bring it to the MAC and just see what remedies are going to be out there, what solutions are going to be out there for patients under a medical model that do have needs that go beyond an hour at a time.

MR. ROBERTS: I would request a clarification with -- I was in D.C. with CMS representatives back in November, and the -- I believe they had changed the add-on code.

It was an incremental add-on code, 99418, and you would bill, you know, a unit for every 15 minutes. Is that not being reflected in the Kentucky Medicaid fee schedule?

MS. JUDY-CECIL: So we -- let's just talk about: What do we normally do? Annually, the AMA updates coding guidelines. They add codes. They delete codes, and we implement those. We don't generally -- though I understand the impact that this is having to providers in certain services. We don't normally send anything out that -- because what we -- we require our providers to do is to follow coding guidelines, and we don't provide guidance on coding.

You know, providers should understand what the changes are. They should consult a professional coder if they need assistance with that. So, you know, again, I mean, these happen annually, and we don't generally send anything out.

We have to follow coding guidelines. And we are preparing a letter, and we've finalized it. We'll be getting it out there that just is basically going to say this.

You know, we have to follow what the coding guidelines are. So for the codes that are deleted, they are going to be removed from our fee schedule.

You are correct that there is guidance out there about -- and this is AMA guidance. Let's be clear of who is driving this. There is guidance out there about what to do to -- you know, what the change -- how the change affects the services and the codes being billed and what you're supposed to do. So, you know, we're providing links to that.

You know, had we -- and this came out -- I mean, this was being discussed back in October, I think, by the AMA. Had we understood a little better about the impact that it was going to have to providers, we would have done perhaps a communication sooner.

But there isn't really anything we can do. We have to follow coding guidelines. So, you know, certainly welcome to hear your feedback, but we're following the AMA guidelines.

DR. WRIGHT: Just to clarify, too,

though, those codes -- because I was brought into this by Terry Lloyd from Transformations because of the work I do contractually through them. Often the case, I do work with clients, and we do go beyond a typical one-hour session. Not often, but it does happen at times.

Therefore, what I'm understanding is that this was a topic that had been discussed earlier, though; right? And there is a workaround, is what I'm understanding. Is that correct?

MS. JUDY-CECIL: The AMA has guidance on what to do to replace those prolonged codes, and we will put the link to that guidance in the chat so that you all can quickly get to it if you've not already found that information.

Kelly, can you do that for me, please?

MS. KITCHEN: Yes. This is Kelly Kitchen. I'm actually a certified coder, and I've done research on this topic for Medicaid. And there -- just like Veronica said, there is no replacement codes for the add-on additional 15-minute or hour

increments. And at this time, AMA has no intentions on replacing those add-on codes.

I know the mention of 99417 and even, I believe, 99418, but those are codes that are not allowed to be used as a replacement code for these. So my understanding is, from some of the trainings that I've taken on the behavioral health add-on codes, is there is not going to be a replacement for the ones that were deleted. And at this time, they are suggesting that there is only going to be the one-hour, 60 minutes.

Now, they do notate that should you do a psychotherapy at the time of an E&M service, then there is a code, an add-on code for the E&M service. That will be the only add-on code allowed with psychotherapy.

CHAIR PARTIN: Okay. Anybody else have any comments regarding this?

DR. SCHUSTER: Did the AMA have a psychiatrist in their group? I mean, this is just unbelievable.

MS. JUDY-CECIL: Yeah. So we are -- we are continuing to dig into it, trying to find out what other states may be

doing. We're planning a conversation with the Managed Care Organizations. We -- again, we're all in a very difficult position here and so, you know, we'll continue to see what options are. But for now, we also have to follow coding guidelines.

DR. WRIGHT: I'll use a distinct example. If -- you know, we see clients in a medical model approach with behavioral health being one, and we're talking about capacity in our state to be able to provide these services. And right now, the capacity is lacking in behavioral health professionals. And the result is, is that oftentimes, we find ourself in very complex situations with clients that do require additional time that's not previously scheduled; right?

But I would suggest, too, that if you're in a true medical model approach, you don't just stop a procedure in the middle because they only say you have an hour; right? If you need to be able to do a medical procedure -- and I'm using this in a medical model approach; right? You don't just stop seeing a client and say, hey, listen, sorry.

We've got to stop. You know, it's not fair to the consumer. It's also not fair to the provider, in my opinion.

And I think it definitely needs to be something we do advocate and try to seek solutions to in our commonwealth. Because the truth is that we're in a mental health crisis, and we need to be able to address these clients by utilizing additional services and add-on codes appropriately when needed.

If they're in the -- that would avoid us to have to go hospitalization, psychiatric care, EMS involvement, those type of services, which are going to be more expensive for Medicaid in the long term. So I'm fervently advocating that this definitely needs to be reviewed and evaluated further.

MR. ROBERTS: For clarification on the AMA 2023 coding guide -- coding assistance where it states 99354 and 55 have been deleted, it specifically says use 99417 for prolonged evaluations.

UNIDENTIFIED SPEAKER: That was just for medical, though, not behavioral.

MS. KITCHEN: Yeah. 99417 -- if you look at 99417 in the coding guidelines, it tells you what codes it can be (inaudible) and what codes it cannot. Sorry. I'm trying to turn to that page now. I should have had it up.

MR. ROBERTS: And that may be medical, not therapy. I would qualify that but...

MS. KITCHEN: That is correct. They're using 99417 which specifically states you can only use that with medical 99205, 215, 245, 345, 15483. So that is not going to be allowed to be used with behavioral health codes.

MR. BALDWIN: I have a question, Dr. Partin, if you don't mind making a comment. I'm not on the TAC -- or on the MAC.

CHAIR PARTIN: Okay. If you can brief because we really do need to move on.

MR. BALDWIN: Sure. Well, I just want to reenforce that I think this potentially puts some providers in some very awkward positions in terms of providing

services that their clients need but aren't allowed to bill for it.

So, I mean, I know that Medicaid has to follow the guidelines for the codes, but is there -- and I'm sure -- Veronica, I'm assuming this is what you all are looking at. Is there a way to work around this or have other codes that are billable and are reimbursable by CMS?

I mean, because, obviously, the need is there, and the ultimate requirement for Medicaid is to provide the services that the members need. And I think this, in many cases, flies in the face of that.

So I just think that -- I mean, I don't know if that's what you all are looking at as another set of codes. If you look, there's some suggestions for that in the chat about other types of codes that you could use that allow them to go beyond one hour.

MS. JUDY-CECIL: We are exploring other options. But for now, we do have to follow coding guidelines.

MR. BALDWIN: Okay.

CHAIR PARTIN: Okay. So --

MR. SHANNON: This is Steve Shannon. I'm on the Behavioral Health TAC and other stuff. But regardless, it's such a pressing issue because it was a code that was used as needed. If providers weren't using the code as needed previously, this would not raise to people's attention.

And I understand, Veronica, it may not be your issue, but we need to figure out some way. Or we're going to have -- we're going to further aggravate the behavioral health shortage because people are going to be reluctant to be a Medicaid provider at risk of providing services that are currently maybe undercompensated to services that aren't compensated.

I just think it's an access issue. We're putting parameters around services that -- that it's just going to impact the individuals who are supported by the behavioral health system. It's just bad policy, in my opinion.

CHAIR PARTIN: Can we -- can we put this back to the Behavioral Health TAC to work on this with DMS and perhaps even get

some more information from the people at the AMA that do the coding? I think it's the RAC. And then we can bring this back at our next meeting.

DR. SCHUSTER: Yes. We will -- we will do that, Beth. The BH TAC will meet again before the next MAC meeting.

You know, there are services like EMDR that are so important, and it's a 90-minute session. I mean, that's what it takes to do that service. And Eric's analogy with the surgery or whatever, although that's not usually time-based.

And, you know, Veronica, I understand that you all have your hands tied. But let me be in touch with you because I really think every state has to be looking at this; right? And what is -- what's CMS' response to this?

MS. JUDY-CECIL: CMS' response is they're following the correct coding guidelines, and they expect states to follow the correct coding guidelines so that --

DR. SCHUSTER: Regardless of the disaster that it's creating? I mean, that's

the part that I just -- I'm just befuddled.

MS. JUDY-CECIL: Yeah. I can imagine that they're hearing from folks. But, you know, again, we reached out because we're trying to find other options. You know, what are our options?

DR. SCHUSTER: Yeah.

CHAIR PARTIN: Okay.

DR. SCHUSTER: Yeah. Let us take it up, Beth, and we'll see what we can do. We're the ones that are most affected by this, but it's -- it really feels like --

CHAIR PARTIN: We'll talk about --

DR. WRIGHT: Sheila, is it possible to find out when the AMA board meetings are and get a representative from our Medicaid to be -- to be heard on the AMA board meeting?

CHAIR PARTIN: I think this --

DR. SCHUSTER: I don't know. I don't know how all of that happens but --

CHAIR PARTIN: I think this takes place at AMA meetings. I think this takes place at a -- it's called RAC, R-A-C, and I don't know what that acronym stands for. But that's where these discussions take place,

and I can probably get you some more information about that, Sheila.

DR. SCHUSTER: Okay. Yeah. And, you know, there may be some pressure that could be brought to bear by some of the national mental health organizations, too, like NAMI and Mental Health America and that kind of thing. I mean, I think we need to be playing at that level, would be my guess.

If they're saying that they just willy-nilly deleted them and there's no workaround and they don't intend to put them back, we need to change their mind about that, quite frankly. And in the meantime, we need to try to figure out how we get services to the kids -- particularly to the kids but also to the adults with serious behavioral health issues.

So I'll be in touch with folks. Thank you. And, Eric, I'll let you know when our next BH TAC meeting is, so you can be a part of that discussion as well.

DR. WRIGHT: Thank you very much.

DR. SCHUSTER: Yeah.

CHAIR PARTIN: Okay. Thanks,

everybody.

And under new business, also, Peggy Roark had an issue she wanted to bring forward. And, Peggy, I am so sorry. We are running short of time. So if it's possible, could you keep it very brief?

MS. ROARK: Yes. This is Peggy. I -- with some parents, and it's been brought to my attention that with rehabs, that Medicaid is only paying 28 to 30 days for inpatient. As we all know, chronic users, that's not enough time. They need, like, six to twelve months and then some intensive outpatient programs.

I was looking at my notes here. We need evidence-based studies. We need to create longevity of use and dual-diagnosis and trauma factors and intensity of that. One size does not fit all.

Another barrier, that we have teens, as we all know, that's getting on drugs, and there's not much access to help them. They have to wait till they're 18 to get help.

We have people -- a lady was in jail. She got released, and she died. She OD'd.

We need to do better and have -- you know, people that's been on drugs for ten years, 30 days -- you know, having mental health and substance abuse. Maybe the lady that got out of jail, if we could have got her to a rehab, maybe she'd be here today.

That's all for right now, if anybody can comment or would like to chime in.

CHAIR PARTIN: Do you have a recommendation for us, Peggy, or were you just providing information?

MS. ROARK: Yeah. I would like to recommend that all the MCOs take a look at this and come back and see what we could do. You know, I know money is a factor. There's probably a lot of things, just like what we was just talking. You know, one hour of counseling is not -- not for everybody.

MS. JUDY-CECIL: Yeah. I think, Ms. Roark, we have a lot of information we could provide back. So maybe the best approach, given the time constraint, is we'll take that recommendation if the MAC passes it and then we can provide additional information in response.

MS. ROARK: I appreciate that.

CHAIR PARTIN: Okay. So we have all of the recommendations from the TACs. We have recommendations from our new business.

Would somebody like to make a motion to accept these recommendations?

DR. SCHUSTER: I'll make that motion. Sheila Schuster. That includes the recommendations around the workforce shortage as well; right, Beth?

CHAIR PARTIN: Absolutely. All of the recommendations that have been made today.

DR. SCHUSTER: Yeah. Thank you. I'll recommend --

MS. ROARK: I'll second it.

CHAIR PARTIN: Who was the second?

DR. SCHUSTER: Peggy.

MS. ROARK: Peggy.

CHAIR PARTIN: Thank you.

Any discussion?

MS. ROARK: No.

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Anybody opposed?

(No response.)

CHAIR PARTIN: Okay. So moved. Thank you.

Anybody else have any other business they'd like to bring forward?

MS. BICKERS: Beth, this is Erin with Medicaid. I just wanted to make a quick announcement. I wanted to introduce Kelli Sheets. This is her first MAC meeting. She's going to be my new partner in crime helping me tackle all the MAC and TAC meetings. I am not going to be with you guys for your March meeting, and I will be on maternity leave. So I will make sure that you guys have her email address, and I've been introducing her to the TACs as we've had meetings. If you could just please make sure you're copying her on any MAC and TAC correspondence, I would greatly appreciate that, and I will see you guys in May.

CHAIR PARTIN: Okay.

DR. SCHUSTER: Good luck.

MS. BICKERS: Thank you.

CHAIR PARTIN: Yeah. We wish you

all the best, Erin.

Okay. Anything else?

(No response.)

CHAIR PARTIN: Okay. Motion to adjourn?

DR. BOBROWSKI: So moved.

DR. SCHUSTER: So moved.

CHAIR PARTIN: Okay. Is that --

DR. SCHUSTER: I think you do it by acclamation, Beth. Everybody says yes, let's adjourn.

CHAIR PARTIN: Yes. Thank you.

(Meeting adjourned at 12:50 p.m.)

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C E R T I F I C A T E

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

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

Dated this 8th day of February, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR