CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

May 27, 2021
10:15 A.M.
(All Participants Appeared via Zoom or Telephonically)

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

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

CAPITAL CITY COURT REPORTING
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AGENDA

1. Call to order 5

2. Roll Call 5

3. Approval of minutes from the March meeting . 5

4. Old Business
   A. A request was made at the March meeting for suggestions on information to be posted on the DMS website. Here are some suggestions: .... 5 - 11
      1) Provider availability and type of provider for each MCO in each region.
      2) Kentucky ranking for heart disease, diabetes, cancer, COPD, SUD, and maternal/child health
   B. Missed appointments – Is the new site being used? Could a notice be sent out to providers regarding the availability of reporting "no shows"? .... 11 - 20
   C. Follow-up on request from the Hospital TAC regarding some IMD's not being paid by some MCOs as per Managed Medicaid 42 CFR Part 438 .... 20 - 22
   D. Our podiatry representative noted the paperwork for PA's for durable medical equipment must be mailed. Is there a website or fax number where these PA's may be submitted? .... 22 - 23
   E. Has any work been done to amend the Medicaid regulation to reimburse Certified Professional Midwives? .... 23 - 24
   F. Request amendment to the Rural Health Clinic regulation 907 KAR 1:082 Section 9(1)b)2 (on page 16) to extend the time to three days for providers to sign Medicaid participant's chart. The current regulation requires charts to be signed on the day services are provided. Three days would be in line with other regulations and more realistic in busy clinic settings........................ 24

AGENDA
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G. The Behavioral Health TAC submitted recommendations from the Acquired Brain Injury Work Group regarding proposed changes to the ABI Waivers to the MAC with the recommendation that the report and recommendations be forwarded to DMS for their review, response, and implementation, if indicated. Could we have a response from DMS regarding this recommendation? .... 24 - 31

H. Follow-up (update) to the report on maternal/infant health at the November MAC meeting.............................. 31 - 33

5. Updates from Commissioner Lee .... 33 - 59

6. Update of Legislative Session .... 33 - 59

7. Reports and Recommendations from TACs
 * Therapy Services .... 60 - 61
 * Primary Care .... 61 - 64
 * Podiatric Care ....(No report)
 * Physician Services ....(No report)
 * Pharmacy .... 64 - 69
 * Optometric Care 69
 * Nursing Services ....(No report)
 * Intellectual and Developmental Disabilities ....(No report)
 * Hospital Care .... 70 - 71
 * Home Health Care ....(No report)
 * Nursing Home Care .... 71 - 73
 * Dental .... 73 - 78
 * Consumer Rights and Client Needs ..... 78 - 80
 * Children's Health ....(No report)
 * Behavioral Health .... 80 - 83

8. New Business
 A. Judge Phillip Shepherd, Franklin Circuit Court, ruled in late April that the bidding process (the second one) for awarding the MCO contracts was flawed and must be rebid. What are the immediate and long-term effects of the Judge's ruling that the MCO contracts must be rebid? How does DMS plan to proceed? .... 84 - 85

AGENDA
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B. The MAC meetings are recorded. So that stakeholders who are not able to attend the meeting may stay informed, would it be possible to post the recording of the meeting shortly after it is held? ...... 85 - 86

C. Other .... 86 - 87

9. Adjourn 87

1 MS. HUGHES: As a quick count, I
2 think you do have a quorum but I know you all do a
3 roll call.
4 DR. PARTIN: Okay. If we're
5 ready to get started, let's go ahead and do roll
6 call.
7 (ROLL CALL)
8 MS. ALDRIDGE: That's the roll
9 call, Dr. Partin, and we do have a quorum.
10 MS. HUGHES: Can you all see the
11 agenda now?
12 DR. PARTIN: Yes. Next up on
13 the agenda is approval of minutes. Would somebody
14 like to make a motion?
15 DR. HANNA: Motion to approve.
16 DR. COMPTON: I'll second.
17 Steve Compton.
18 DR. PARTIN: Any discussion?
19 All in favor say aye. Any opposed? So moved. Thank
20 you.
21 So, under Old Business, at the
22 last meeting, a request was made for suggestions on
23 information to be posted on the DMS website and here
24 are some suggestions that I had. And if anybody else
25 has any other suggestions, please speak up.

1 First is provider availability
2 and type of provider for each MCO in each region, and
3 Kentucky ranking for heart disease, diabetes, cancer,
4 COPD, substance abuse disorder and maternal/child
5 health.
6 Does anybody have any other
7 things that they would like to see posted on the
8 website?
9 DR. GUPTA: Dr. Partin, this is
10 Dr. Gupta. I just have a question about the provider
11 availability part.
12 So, that would be what the MCOs
13 have listed as doctors or providers accepting that
14 insurance, correct?
15 DR. PARTIN: I'm sorry. My
16 connection isn't very good, I don't think. I'm
17 breaking up.
18 DR. GUPTA: I just wanted to
19 confirm----
20 DR. PARTIN: I heard part of
21 what you're saying.
22 DR. GUPTA: Can you hear me?
23 DR. PARTIN: Yes.
24 DR. GUPTA: Okay. I just wanted
25 to confirm that that would mean that the providers

1 listed under that MCO would be accepting that
2 insurance, would be able to see those patients.
3 That's the thought behind that, correct?
4 DR. PARTIN: The thought behind
5 it is that all the providers in the region for the
6 MCO would be listed. So, for instance, under
7 Ophthalmology, it would show all of the provider
8 availability for each region that would be available.
9 DR. GUPTA: Okay. I just
10 remember like maybe it was the last meeting or some
11 of these past meetings, I think more so maybe in
12 dentistry, that that's not always the case, that
13 maybe it will show up under the MCO as a particular
14 dentist accepting that; but when the patients
15 actually try to reach out to that dentist, they don't
16 accept it.
17 DR. PARTIN: Correct. So, if
18 the providers are listed, then, I think there might
19 be a better idea for providers when we're making
20 referrals and also for DMS when there are providers
21 listed who then are not participating. It might be
22 easier to detect that.
23 DR. GUPTA: Right. I think it
24 just all comes down to the basic issue of
25 reimbursement, but, anyways, I just want to say that.

1 It might be a little bit misleading but I don't know
2 really how to address that.
3 DR. PARTIN: I don't think we
4 can address that through this.
5 DR. GUPTA: Right.
6 DR. PARTIN: But I think that
7 it's helpful to know, for instance, from my
8 perspective, when I'm trying to refer a patient, it's
9 helpful to know what options are available for
10 referrals.
11 And, also, in making those
12 referrals, we always call to schedule the appointment
13 for the patient and, therefore, we would know if that
14 particular provider is listed. And the MCOs are
15 required to have a certain number of providers in
16 each type of specialty available for the
17 participants.
18 And, so, if MCOs' listings are
19 not accurate, I think DMS needs to know that.
20 MS. EISNER: This is Nina, just
21 to bridge on that discussion. It would seem to me
22 that on some regular and periodic basis, there should
23 be a requirement that the MCOs verify access is still
24 available from that provider.
25 And I would assume that's done

1 through the recredentialing process but I'm not sure
2 how often that happens, but we've experienced here as
3 well in terms of patient follow-up from my hospital
4 that sometimes folks who are listed under an MCO are
5 actually not accepting any more patients or just at
6 capacity or a reduced capacity and so on.
7 So, I don't know what the
8 answer to that is but I would think that the
9 recredentialing should verify that availability. If
10 we can just verify that.
11 DR. PARTIN: And I would agree.
12 MS. EISNER: Thank you.
13 COMMISSIONER LEE: This is Lisa.
14 I'm sorry. I was just a little bit late.
15 The suggestion, I think, is
16 just to have some sort of either a searchable
17 database so that you could find out which providers
18 are in maybe a specific county and which provider
19 types and if they are enrolled in a specific MCO.
20 And I think that that could
21 possibly be configured. I believe at one time, many
22 years ago we did have a listing of Medicaid providers
23 by county.
24 Updating that shouldn't be an
25 issue now with the improvements in technology, but we

1 can go back definitely and look at this and see if we
2 could get some sort of a searchable database. I
3 think it does then become are they taking new
4 Medicaid members.
5 I'm not sure how we could get
6 that information without doing a provider survey or
7 something like that, but definitely it's a start and
8 I think getting the information on the web page would
9 be the start to trying to figure out how accurate
10 that information is and, then, we could drill down
11 into it later on.
12 MS. EISNER: Thank you. That
13 would be so helpful. Appreciate it.
14 DR. PARTIN: And that was kind
15 of my thought because that information used to be
16 available to us in the big super binders that we
17 received.
18 And, so, I thought that since
19 it was available in the binders, it would be
20 available to post.
21 MS. HUGHES: Dr. Partin, I know
22 when you had those - I mean, and I think we still
23 brought some reports on network adequacy and that was
24 the reports that we put in the binders, not
25 necessarily a searchable database, I mean, not a list

1 of every provider that they had in their network. It
2 was more like an Excel spreadsheet that provided some
3 reports based upon the type of provider and what
4 percentage of the network adequacy they were meeting.
5 Is that what you're talking
6 about because the MCOs do have searchable provider
7 directories on their websites; but when you mentioned
8 the binder, I thought maybe you were actually looking
9 for the network adequacy reports.
10 DR. PARTIN: Well, actually
11 both, Sharley. I thought that could be combined. We
12 did have that adequacy in the binders, but I was also
13 looking for the actual providers and, then, providers
14 could help DMS as far as the accuracy of those
15 listings that each MCO has.
16 COMMISSIONER LEE: And I think
17 the issue now, even though the MCOs do have
18 searchable databases on their website, in looking for
19 a specialty, the provider would have to go to each
20 and every website rather than have one listed area to
21 find that information.
22 DR. PARTIN: Right. Okay.
23 Anything else?
24 Then, moving along, the next
25 item is missed appointments. Is the new site being

1 used and also could a notice be sent out to providers
2 regarding the availability of reporting no shows?
3 COMMISSIONER LEE: The missed
4 appointment, it's a screen and Kyhealth.net is
5 active. It is working. We have had forty distinct
6 providers use that platform to report 610 missed
7 appointments. So, providers are using it. We think
8 that's a great thing.
9 Again, the whole reason for the
10 missed appointments, we would really like to look at
11 that information and track by region, by area, by
12 reason why they missed the appointment so that we can
13 actually do some outreach and follow up with those
14 individuals to make sure that we are doing everything
15 we can to get them to their doctors' appointments and
16 so they can receive health care.
17 So, I'm not sure if we need to
18 do more training or what we can do to get more
19 providers to take that up because, again, we're only
20 going to be as successful as the number of providers
21 that use that, and that needs to increase a little
22 bit for us to get a bigger picture statewide, but
23 definitely providers are using it. As I state, forty
24 providers have that software.
25 DR. PARTIN: I had talked to a

1 few people and they weren't aware of the ability to
2 do that. And, so, that's why I was asking if maybe a
3 notice could be sent out so that people could become
4 more aware of that site.
5 DR. GUPTA: Sharley, this is Dr.
6 Gupta again. Like, for example, in my practice, if
7 it were not for me, our practice would not know about
8 it. Maybe like posting it through like the different
9 medical societies or like the Kentucky Medical
10 Association, the local medical societies.
11 I think that would be really
12 helpful because then it can be sent to all the
13 providers along with maybe a mailing as well but I
14 think just getting it sent out electronically would
15 be really helpful.
16 DR. BOBROWSKI: I've got a
17 question. This is Garth Bobrowski. At what point
18 does DMS say that on these failed appointments for a
19 patient that enough is enough?
20 Dental offices have their own
21 guidelines and rules based on what the dentist will
22 tolerate. Some will, if you miss one appointment,
23 you're out of luck. Some are three strikes and
24 you're out.
25 This morning, I've already had

1 two this morning that just didn't even show up; and
2 one of them, I looked back on her chart and, well,
3 she's missed the last three appointments. It's like,
4 well, when is enough is enough?
5 And when they do come and when
6 they call, we talk to them about these missed
7 appointments but it just falls on deaf ears so many
8 times. Just a comment.
9 COMMISSIONER LEE: Thank you for
10 those comments, Dr. Bobrowski. I think our role is
11 to make sure that individuals receive treatment. And
12 if they are not making their appointments, I think
13 this missed appointment tab or whatever on the
14 Kyhealth.net page is one way to help us identify
15 those individuals and outreach to them, find out what
16 underlying conditions may exist that prevent them
17 from going to their appointments and just kind of
18 helping them navigate a little more.
19 We won't say enough is enough
20 because we can't do that. Our role is to definitely
21 make sure that they get their medical services.
22 DR. GUPTA: I'm sorry. I have
23 one more comment on that.
24 I'm a pediatric ophthalmologist
25 and the University of Louisville is losing their

1 pediatric ophthalmologist and that leaves four
2 pediatric ophthalmologists left in the whole city and
3 four years ago, we had eight.
4 So, most of those children are
5 Medicaid patients. Like, our practice policy is if a
6 Medicaid patient has two no shows, they're dismissed
7 from the practice because we just can't - we're a
8 private practice and we can't survive on that.
9 So, I just worry about all
10 these kids, like, where are they going to go? The
11 only other pediatric ophthalmologists are in
12 Lexington.
13 So, this is a really serious
14 problem with these no-show appointments. And, again,
15 I think it all boils down - and this is not the place
16 for this discussion, I know - but is reimbursement of
17 the Medicaid patients and how much loss a practice
18 takes by, first of all, seeing these patients and
19 also having them not show up to a visit. I just
20 wanted to make that comment.
21 DR. THERIOT: This is Dr.
22 Theriot. We do also have a Medicaid practice and
23 we're actually very lenient, and I think it's just
24 because it's usually not the child's fault that
25 they're late or that they missed the appointment.

1 And I really feel strongly that
2 when we dismiss patients, we would be punishing the
3 child for the parents' actions or inactions. And,
4 so, it's a tough situation but we usually don't fire
5 our patients.
6 COMMISSIONER LEE: Thank you for
7 those comments, Dr. Theriot. I think that the role
8 of the Medicaid Program is to serve a very vulnerable
9 population. The individuals that we serve, we have
10 aged, blind, disabled, children.
11 And the only way that we're
12 going to make headway into those missed appointments
13 is to start tracking them and outreach because there
14 could be extenuating circumstances - transportation,
15 all kinds of different things that could impact this
16 population from getting to their appointments.
17 And I think that the more
18 education we can do, the better, but I don't think it
19 - I would like to do more of the targeted outreach
20 and information rather than a broad blanket, sending
21 out letters to every Medicaid member about missed
22 appointments.
23 I think that that's the point
24 of the missed appointment tracking is to identify
25 those individuals and intervene so that providers can

1 receive their payments, so that there are reduced no-
2 show visits.
3 That's the only way we're going
4 to be able to intervene is on that very specific
5 person-by-person level to kind of find out what their
6 circumstances are and help them get in.
7 And I do agree with Dr. Theriot
8 that children, they can't drive themselves, for
9 example, to the doctor. And I think that the
10 overarching goal of the Medicaid Program is to
11 definitely build a healthier population, and the way
12 we do that is going to be, I think, targeted
13 interventions when we can identify those individuals
14 who need our services.
15 DR. PARTIN: Thank you for all
16 the comments. And, Commissioner, that's exactly the
17 kind of thing that I'm looking for as far as my
18 practice goes. We don't dismiss patients either for
19 no shows.
20 In a rural area, we find that
21 transportation is a big problem and people don't have
22 reliable transportation or, in the Medicaid
23 population, they either don't have a vehicle or they
24 have a poorly-run vehicle. So, a lot of times, it's
25 because their vehicle broke down or because they

1 couldn't find somebody to bring them.

2 And another thing that we find

3 is that some people who don't have a vehicle have to

4 pay somebody to bring them to their appointment and

5 sometimes they just can't afford it.

6 And I find it kind of sad

7 because these are friends supposedly of these people

8 and they charge them five or ten dollars to drive

9 them to their appointment, and sometimes they just

10 don't have that five or ten dollars to get there.

11 COMMISSIONER LEE: These are----

12 So, I think - go ahead. I'm

13 sorry.

14 COMMISSIONER LEE: I'm sorry. I

15 said these are the kinds of issues that when we hear

16 about them, it is heartbreaking because we have a

17 non-emergency medical transportation program that

18 should be taking individuals to their appointments.

19 So, again, I mean, why do the

20 individuals not know about the services or are they

21 just being denied because they have that poorly-

22 functioning vehicle in the household? It's

23 definitely something that we're looking into right

24 now.

25 We do know, for example, in 2020, the

1 number one reason that individuals were denied non-
2 emergency transportation is because they did have a
3 vehicle in the household but sometimes that vehicle
4 may not be running. They may not have gas money for
5 that vehicle.
6 So, trying to drive down again
7 into those missed appointments, the more information
8 that we do have, the better we can maybe change a
9 policy or transportation policy concerning the
10 vehicle in the household.
11 But we provide millions of
12 trips each year, and I think digging down into that
13 information may give us some insights, too, as to why
14 or where individuals are not receiving that
15 transportation.
16 DR. PARTIN: You hit it exactly
17 the nail on the head. A lot of people do have a
18 vehicle but it's poorly functioning or not
19 functioning at all.
20 But a lot of them, you know,
21 I'll say your car isn't working, and if it hasn't
22 worked in a year, maybe you should sell it. And
23 they're like, no, I can't sell that car. My kids
24 might need it or something like that.
25 I think it's sometimes just a

1 matter of pride just to have that vehicle even though
2 it's not running, but, anyways, I guess we're
3 belaboring the point but lots of reasons.
4 MS. EISNER: If I may just one
5 more, please. I understand all the transportation
6 challenges and I think that there are real gaps in
7 terms of the non-emergency transportation.
8 But I just want to say that the
9 problem is bigger than transportation because at
10 least in the behavioral health world, at my hospital,
11 we have continued vast telehealth services.
12 So, individuals don't have to
13 drive to get that follow-up care that's so critical
14 and critical to the managed Medicaid company, too,
15 because they have that NCQA criteria to meet, and we
16 have as many problems with telehealth as we do in-
17 person appointments.
18 So, I'm just saying, that's
19 why, again, telehealth, the continuation of some of
20 the telehealth regulation changes during the pandemic
21 are critical but it doesn't get rid of this problem.
22 DR. PARTIN: It's many-faceted,
23 for sure. It's not just one thing.
24 Next on the agenda is a follow-
25 up on the request from the Hospital TAC regarding

1 IMDs not being paid by some MCOs per Managed Care
2 Medicaid 42 CFR Part 438. And, Nina, I think that
3 was your issue.
4 MS. EISNER: It is. And this
5 has been going on now for months, as you all know.
6 You've heard me bring it up. The TAC has brought it
7 back as well.
8 There have been discussions.
9 We have sent and re-sent the information to the MCO
10 that doesn't pay for emergency services, and
11 obviously there are two issues.
12 There's do they contract with
13 the IMD, and do they pay for the emergency care
14 that's provided which does fall under 42 CFR Part
15 438? And I will say that on both fronts, there is
16 not a solution yet.
17 What we're talking about in
18 terms of access, just in the Louisville market,
19 that's 388 beds that are not able to be accessed on
20 any regular basis by individuals who fall within that
21 IMD category under Managed Medicaid.
22 So, it's got to stay on the
23 list until it's resolved and it still isn't. Thank
24 you.
25 COMMISSIONER LEE: Thank you,

1 Nina. I think I have seen some information related
2 to this topic. I haven't taken a deep dive into that
3 information yet but we will continue to work on this.
4 DR. PARTIN: So, Nina, do we
5 need to keep this on the agenda for our next meeting?
6 MS. EISNER: Yes, please.
7 DR. PARTIN: Okay. Next up, our
8 podiatry representative noted the paperwork for PA's
9 for durable medical equipment must be mailed. Is
10 there a website or a fax number where these PA's may
11 be submitted? That was at the last meeting.
12 DR. ROBERTS: So, Lee reached
13 out to me. I think the issue was it wasn't the
14 original PA. It was the supply and supporting
15 documentation.
16 And there was a fax number
17 which was one that we had originally tried but the
18 fax number was having technical issues I guess over
19 that week. And, so, they had provided an alternate
20 fax number that was also having issues.
21 When our DME staff actually
22 snail-mailed the supporting documentation in, the PA
23 was corrected.
24 And I had asked her if this had
25 come up in the past or this was kind of a one-off

1 thing, and she said she had the same issues before,
2 but it may have just been a technical issue on their
3 end at that moment in time.
4 So, there is a system in place
5 to prevent that but it may have just been technical
6 issues.
7 DR. PARTIN: Okay. So, you're
8 okay now? There's not a problem?
9 DR. ROBERTS: Yes. I think we
10 can mark it as resolved. If it continues to be an
11 issue, we'll follow up to see on a technical side, on
12 the fax technology side, if there's an issue that
13 needs to be corrected on the other side; but I think
14 for the MAC's purposes, this can be checked off.
15 DR. PARTIN: Okay. Thank you.
16 The next item, has any work been done to amend the
17 Medicaid regulation to reimburse Certified
18 Professional Midwives?
19 COMMISSIONER LEE: We have not
20 opened that regulation yet. It is on our radar but
21 we have not amended that regulation yet.
22 DR. PARTIN: Do you think that
23 that's something that's going to be coming in the
24 future?
25 COMMISSIONER LEE: We're still

1 considering it, and right now, we're focusing on
2 other projects, other priorities, but we definitely
3 are looking at it.
4 DR. PARTIN: Okay. Then, I will
5 keep that on the agenda for next meeting.
6 Okay. The next item is again
7 request amendment to the Rural Health Clinic
8 regulation 907 KAR 1:082, Section 9(1)(b)2 to extend
9 the time to three days for providers to sign Medicaid
10 participant's chart.
11 The current regulation requires
12 charts to be signed on the day services are provided,
13 and three days would be in line with other
14 regulations and more realistic for busy clinic
15 settings. Where are we in that?
16 COMMISSIONER LEE: We do plan on
17 aligning those time frames. Again, it's on our list
18 to do but we haven't gotten to that yet.
19 DR. PARTIN: Okay. I'll put it
20 on for the next meeting.
21 The next item may have been
22 addressed because we got the responses late and we
23 hadn't had responses from the TACs when I did the
24 agenda.
25 So, that had to do with the

1 Acquired Brain Injury Workgroup proposed changes, and
2 DMS provided an extensive response to that
3 recommendation.
4 So, I'll leave that off until
5 the TAC gives their report and they can let us know
6 if that response was satisfactory.
7 COMMISSIONER LEE: So, what
8 we're talking about the recommendations, I don't know
9 if it's COVID or I think that there's been a little
10 bit of a slack I think in the formal process because
11 I had to address this at the MOAC last week or so
12 before, so, I'll speak to it again.
13 But I think that we need a
14 process and what I was thinking is maybe if the TACs
15 would submit their recommendations to Sharley at
16 least two weeks or so prior to this meeting and,
17 then, we could compile all of those recommendations,
18 get them to the MAC at least a week before the
19 meeting so that you all have time to digest them and,
20 then, could actually do a vote on the recommendations
21 that you would like to put forth.
22 I think sometimes - I know that
23 the TACs do give their presentations to the MAC and
24 they fold their recommendations into it. And, so, we
25 just get the blanket recommendations, and I would

1 like to see that get back to like more of a formal
2 process where we get the recommendations and, then,
3 make sure that we respond back to them, the
4 Department, and what we would do is respond back to
5 the MAC and, then, copy the TACs so that we keep
6 everybody in the loop and everybody on the same page
7 as far as the recommendations are concerned and our
8 response to those recommendations.
9 DR. PARTIN: Okay. Let me make
10 sure I'm understanding what you're saying.
11 The recommendations from the
12 TAC are given at the meeting. And, then, generally
13 what the process has been is within thirty days after
14 that recommendation is made which is halfway between
15 when the next MAC meeting would occur, that's when we
16 used to get the responses.
17 So, I guess I'm not
18 understanding. Do you want the TACs - the TACs can't
19 submit their recommendations before they meet.
20 COMMISSIONER LEE: Right. So, I
21 think we need some sort of a process. I was under
22 the impression that the MAC would get the
23 recommendations and vote on which ones they wanted to
24 push forward rather than every single recommendation
25 coming forth.

1 So, I'm under the impression
2 that once the TACs meet, then, they can form their
3 recommendations to push up to the MAC and we, the
4 Department, would compile every one of those
5 recommendations and give them to the MAC for
6 consideration rather than pushing every one of them.
7 I mean, if you want to just
8 consider every single recommendation they make, but I
9 think the formal process is the TAC makes the
10 recommendation. They submit it to the MAC and, then,
11 the MAC would vote on which recommendations they want
12 to put forth and, then, the Department would respond
13 to those recommendations.
14 DR. PARTIN: Okay. And,
15 generally, the MAC has accepted all the
16 recommendations that the TACs have made unless
17 there's some resolution that occurs at the MAC
18 meeting itself.
19 COMMISSIONER LEE: And those
20 recommendations, we would not be making a - when the
21 TACs send them to us, we would not be making that -
22 we would compile all recommendations to send to the
23 MAC from one comprehensive document for the MAC to
24 consider.
25 And, then, those

1 recommendations would come back to the Department,
2 the ones that the MAC wants to push up would come
3 back to the Department for a review and response.
4 DR. PARTIN: Okay. So, the
5 process is basically the same, that the Department
6 will respond within thirty days to the
7 recommendations. Okay.
8 COMMISSIONER LEE: Yes, and
9 thirty days of the MAC giving them which is we would
10 respond within thirty days, yes.
11 DR. PARTIN: Okay.
12 MS. HUGHES: I'm sorry. Just to
13 clarify because there's a comment in the Chat. Yes,
14 no recommendations can come forward before the TAC
15 actually meets.
16 And I think what we're just
17 trying to do is get the - I got recommendations this
18 morning from a couple of the TACs and that doesn't
19 give me time to get the information out to the MAC
20 members for you all to review prior to your MAC
21 meeting. But, Beth Ennis, yes, the TAC has to
22 approve the recommendations.
23 And just as another point of
24 clarification, we usually have forty-five days to
25 respond to any recommendations. That's what is in

1 the bylaws.

2 COMMISSIONER LEE: What we're

3 trying to do and the purpose is to get that

4 formalized process in place because there was, for

5 example, the Pharmacy TAC I think in November came to

6 the MAC and they did read off their recommendations,

7 and the Department did not formally respond.

8 So, it appears that we didn't

9 review those recommendations but we did but we didn't

10 have that formal response back.

11 So, what we're trying to do is

12 just get a very formal outline structure so that all

13 recommendations are presented to the MAC. The MAC

14 votes on which recommendations they want to submit to

15 the Department. The Department reads, reviews,

16 considers and then responds, and we want that all to

17 be documented and formalized, so, going forward, that

18 the TACs and the MAC know that we are definitely

19 looking at their recommendations and that they're

20 being voted on.

21 DR. PARTIN: Okay.

22 MS. ASHBAUGH: This is Cindy

23 Ashbaugh and I'm trying to take the minutes. So, for

24 this line item, I want to make sure that I'm clear.

25 So, the deliverable is that the

1 recommendations are given to the TAC. The TAC will
2 then send them to MAC. MAC will review, send their
3 responses to DMS and, then----
4 COMMISSIONER LEE: What we will
5 do is the Department will develop some written
6 guidance to send out to all the TACs and the MAC.
7 MS. ASHBAUGH: Okay.
8 COMMISSIONER LEE: That will be
9 the action item here. We'll do that and, then,
10 everybody will be on the same page going forward.
11 MS. ASHBAUGH: Okay. Perfect.
12 MS. HUGHES: Ms. Ashbaugh, who
13 are you taking minutes for?
14 MS. ASHBAUGH: Just for - I'm
15 sorry. Just for Passport by Molina.
16 MS. HUGHES: Okay. All right.
17 I thought you meant official records. Okay. Thank
18 you.
19 MS. ASHBAUGH: Oh, no, ma'am.
20 MS. EISNER: And just to clarify
21 again. Only recommendations from the MAC will go to
22 DMS, not discussions or anything like that. It has
23 to be a formal recommendation from the MAC.
24 COMMISSIONER LEE: Yes.
25 MS. EISNER: Thank you.

1 DR. PARTIN: The only thing that
2 I would ask as this is formalized is that I have to
3 provide a draft of the agenda two weeks before the
4 MAC meeting.
5 So, if I could have the
6 recommendations from DMS at least a couple of days
7 before I have to do the agenda, that would be helpful
8 because sometimes the TACs want me to bring forward
9 the issue again if they don't feel like the response
10 is adequate, so, just to give me time to read it.
11 COMMISSIONER LEE: We'll outline
12 time frames and things in the directions.
13 DR. PARTIN: Okay. Great.
14 Thank you.
15 And, then, the next item on the
16 agenda is just actually to help keep me reminded that
17 we're going to have an update on the report for the
18 maternal/infant health at our November MAC meeting.
19 So, there's no action on that.
20 It was just a reminder, and I'll keep that on the
21 agenda just to help me stay reminded that that's what
22 we're going to do.
23 COMMISSIONER LEE: Dr. Theriot
24 is participating in the meeting. I'm not sure if she
25 has an update at this time.

1 DR. THERIOT: We have been
2 working with our sister agencies as well as non-
3 profits on maternal and infant health. We've
4 continued to work with the nurse midwives to really
5 look more at the midwife model of care and what they
6 can provide for the state.
7 And we're really looking
8 (inaudible) were accepted for the Affinity Group, the
9 CMS Affinity Group and we've chosen to really look at
10 that with an equity lens, and most of our maternal
11 deaths are after the baby is born. A lot of our moms
12 don't go to the postpartum visit and obviously a lot
13 have - more than 50% have substance use related to
14 that death.
15 And, so, we are trying to look
16 at that population to see what is needed and what can
17 be done on a state level to improve the care.
18 So, we are working on it and
19 hopefully I'll have some good stuff to report later
20 on.
21 DR. PARTIN: Great. Thank you.
22 Again, that report was so excellent and just really
23 appreciate it.
24 So, like I said, this is just a
25 - I didn't even expect you to give any update today.

1 It's just a reminder to met to keep it for the
2 November meeting.
3 Okay. Next up is the
4 Commissioner.
5 COMMISSIONER LEE: On the 20th
6 of May, I did give an update to the Medicaid
7 Oversight and Advisory Committee. Dr. Partin was
8 also there and gave an update. Thank you, Dr.
9 Partin, for your update.
10 Basically, I went over some of
11 the impact of COVID on the Medicaid Program, and
12 nationwide we have seen growth in the Medicaid
13 Program. Kentucky was third in the number of
14 individuals who enrolled and the increase in
15 Medicaid.
16 We have enrolled I think about
17 300,000 new individuals in the program since the
18 pandemic began. We did see an increase in child
19 enrollment as well. We saw 52,000 individuals, new
20 children enrolled in the program.
21 We think that's important to
22 note that there are children in the program because
23 we've also been noticing, for example, that the
24 preventive services have decreased a little bit. So,
25 we're concerned about children who didn't receive

1 their well-child check or who may not have received
2 the full array of services in their well-child check
3 and what that means for our future costs related to
4 serving the population.
5 We do notice that the well
6 visits aren't on the increase. They are not to pre-
7 COVID levels yet but they are increasing which is a
8 good sign.
9 We do know that the increase in
10 enrollment was the result of changes in the economy.
11 Individuals who had income loss or job loss
12 definitely turned to the program in a time of need.
13 The majority of the individuals were in the Medicaid
14 Expansion population which is between the ages of 18
15 and 65.
16 So, we also currently, just a
17 reminder, that the ACA has a special open enrollment
18 period that runs through August 15th of 2021, and
19 the----
20 (INTERRUPTION)
21 COMMISSIONER LEE: Is everybody
22 else hearing the recording in progress and recording
23 stopped?
24 DR. PARTIN: Yes.
25 MS. HUGHES: Sorry.

1 COMMISSIONER LEE: So, back to
2 the information that I presented to the MAC.
3 Again, the ACA has open
4 enrollment through August 15th, 2021 with reduced
5 premiums for individuals who qualify for a product on
6 the Exchange. So, if individuals have lost their
7 health insurance, they can go ahead and apply for a
8 product on this Exchange so that they remain covered.
9 We have been monitoring the
10 pre- and post-COVID expenditures by provider type
11 just to monitor the impact it's having on our
12 provider community. We have been monitoring that
13 both by fee-for-service and MCO.
14 One particular thing that we're
15 definitely keeping an eye on is our ER utilization.
16 We have noticed a drop in both emergent and non-
17 emergent ER utilization post-COVID.
18 We'd like to examine the trends
19 prior to the public health emergency to see what we
20 can identify and compare it to the utilization now to
21 see if there are any interventions that we could
22 identify that may help keep non-emergent use of the
23 ER in check because we definitely want individuals to
24 receive services in the appropriate location at the
25 appropriate time.

1 We have noticed a lot of
2 increase in telehealth use. That trend is still
3 continuing. Even though we are a year and a half
4 almost into the pandemic, we are still seeing
5 utilization of telehealth services.
6 We had 18,839 distinct fee-for-
7 service members - those are members who are in Home-
8 and Community-Based Waivers and long-term-care
9 facilities - diagnosed with COVID.
10 We have noticed that the amount
11 per claim for these individuals was definitely higher
12 at the beginning of the pandemic; but as we learned
13 more about COVID, I believe that the cost of the
14 treatment is coming down somewhat.
15 In our Managed Care arena, we
16 had, that we can identify, 47,188 distinct members
17 who had been diagnosed with COVID.
18 At the Medicaid Oversight and
19 Advisory Committee meeting, I also talked a little
20 bit about some of the legislation that we're
21 implementing, and I talked just a little bit about
22 Managed Care Directed Payment Programs.
23 So, anytime the Department
24 mandates or directs the Managed Care Organizations to
25 pay a particular provider group a set dollar amount,

1 that's considered a directed payment and CMS requires
2 that we submit a preprint, not a State Plan
3 Amendment, but a preprint, and in that preprint, we
4 have to identify quality measures.
5 What exactly is that enhanced
6 payment or that set payment amount point-of-view for
7 the Medicaid population? Is it going to increase
8 quality to care? Are we going to have better access?
9 So, we have to identify those types of quality
10 measures for CMS to approve that program.
11 So, you all know that one of
12 the biggest pieces of legislation that we have been
13 working very hard to implement is Senate Bill 50
14 which requires the State to use a single MCO PBM.
15 We have contracted with
16 Medimpact and Dr. Fatima Ali and Senior Deputy
17 Commissioner Veronica Judy Cecil and Angie Parker,
18 the Division Director for Program Quality and
19 Outcomes, have been working very hard to implement
20 that single PBM come July 1st.
21 They've been holding routine
22 meetings, been talking about benefit design, things
23 like that. They're updating the reimbursement
24 methodology that's going to align with our fee-for-
25 service program.

1 We are providing a $10.64
2 dispensing fee and we are aligning the Formulary
3 across all MCOs. We are working on a process for
4 prior authorizations to ensure that no individual
5 loses or has a disruption in care for their
6 medication.
7 We definitely have engaged the
8 MCOs. They have been at the table to assist and
9 they're working very diligently and collaboratively
10 with us to implement Senate Bill 50.
11 We had some webinars for
12 providers and we definitely are, again, working to
13 make sure that no member has a disruption in service
14 come July 1st when we fully implement the single PBM.
15 And providers will receive
16 their payment - if they have an electronic funds
17 transfer information on file with Medicaid, then,
18 that's how their payment will be made, but if they
19 do use a PSAO and that PSAO is on file as the payee,
20 the payment will go their PSAO.
21 We definitely want to look at
22 how Senate Bill 50 and the single PBM impacts the
23 Medicaid Program. So, we're looking at certain data
24 sets, what do we need to look at to see the true
25 impact of this legislation on our program.

1 We also are working on House
2 Bill 183, the Hospital Rate Improvement Program. We
3 have received approval from CMS for one year. We
4 have recently submitted another preprint to them for
5 a three-year time frame.
6 We are working on and are very
7 excited actually about House Joint Resolution 57.
8 This requires the Cabinet to establish a workgroup to
9 assess the feasibility of implementing a Bridge
10 Insurance Program.
11 So, what that would mean for
12 the Department and for the State is a Bridge
13 Insurance Plan would cover individuals who don't
14 qualify for Medicaid but yet can't afford a premium
15 on the Exchange. It's kind of like a gap insurance
16 coverage to make sure there's a full continuum of
17 affordable insurance for individuals in Kentucky.
18 That workgroup is scheduled to
19 meet in July, the first meeting, and it's a short-
20 term workgroup and it goes up to December 31st with a
21 report given to the Governor and the Interim Joint
22 Committee on Health and Welfare.
23 Also, the 1115 Waiver is still
24 pending. The (inaudible) for incarcerated
25 individuals is still pending.

1 And I think with that, I will
2 stop. I'll take a breath and see if anybody has any
3 questions.
4 MS. EISNER: I do. Sorry. It
5 seems like I'm talking all the time. Two things,
6 please.
7 One of the things that the
8 behavioral health providers throughout the state have
9 really benefitted from during the pandemic was the
10 MCOs not requiring a preauthorization, rather a
11 notification. Continuing care authorization was not
12 required and discharge is only a communication.
13 With all of the dire elements
14 from the pandemic with the increase in suicides and
15 substance use disorders and overdoses and all of
16 that, do you believe that the Cabinet will - and we
17 really appreciated not having the authorization
18 required for BH.
19 Commissioner, do you see that
20 as something that will be continuing?
21 COMMISSIONER LEE: Nina, as you
22 just said, there is definitely a lot of focus on
23 behavioral health right now.
24 We have authorized the MCOs to
25 implement prior authorizations on services except for

1 behavioral health and substance use disorder
2 treatment services at the current time. So, the
3 behavioral health and substance use disorder
4 treatment currently are not - currently no prior
5 authorization, but I think that we need to actually
6 take this time instead of going back to the way we
7 did things before and we can really look at the
8 services. Is there some way to modify the prior
9 authorization process or really do a deep dive into
10 it to see what makes sense going forward?
11 But at this time, we do not
12 have a prior authorization on behavioral health and
13 substance use disorder. I do think it's an
14 opportunity for us to dig into some of those services
15 and see what makes sense going forward.
16 MS. EISNER: I really
17 appreciate that.
18 And one other question. You
19 were talking about Senate Bill 50 and the requirement
20 for a single PBM and so on.
21 It's my understanding that
22 Senate Bill 50 does not discriminate in any way under
23 340(b). Is that correct?
24 COMMISSIONER LEE: That is
25 correct. There was a little bit of confusion I think

1 at first, that we were going to apply some of the
2 lesser-than logic that we do in the fee-for-service
3 to a 340(b) but we are implementing in compliance
4 with Senate Bill 50.
5 MS. EISNER: Thank you very
6 much.
7 MR. POOLE: This is Ron Poole
8 and I have a few questions. I'm Chairman of the
9 Pharmacy Technical Advisory Committee in case anybody
10 wanted to know.
11 I've got two topics, both
12 totally different topics to speak of. First of all,
13 on the pricing methodology, Senate Bill 50 was passed
14 and signed March 27th of 2020.
15 And it being done in other
16 states this way and it has saved money in other
17 states, I don't know if the design that we have in
18 our state is geared to the savings that we're seeing
19 in other states. I certainly hope so.
20 And certainly I've had it
21 explained to me by Jessin and others and yourself of
22 why it has taken this long to actually implement.
23 So, I'd like, first of all, a
24 comment on the time period there, why it was
25 required, but, secondly, here we are. Pharmacists

1 are really struggling in the state, pharmacy owners.
2 And effective January 1st, CVS Caremark was granted a
3 reduction of twenty cents in their already-abysmal
4 dispensing fee of $2.35 to $2.15.
5 And just in my pharmacy alone
6 for the first six months of this year, my pharmacies,
7 my company, that's $5,500 off of my back that's
8 coming out. So, you multiply that if you have a good
9 wide range of busy and slower pharmacies. And, so, I
10 would think I would average out to be the normal
11 pharmacies in the state.
12 So, you multiply that times
13 1,100 pharmacies in the state and you've got a
14 windfall for CVS Caremark of $6,350,000.
15 Maybe it's because the outgoing
16 CEO of CVS Health, Larry Merlo, got paid $15,350,000
17 during the pandemic - I don't know - but I would
18 really like to know the decision-making and the logic
19 of why that was allowed to happen.
20 COMMISSIONER LEE: Going back to
21 your first point about the time frame of implementing
22 Senate Bill 50, there are a lot of moving parts and
23 this is the first in the country the way that we're
24 implementing.
25 We are moving to a single PBM

1 but we're still holding the MCOs accountable. They
2 will be paying for the administration. The State,
3 however, sets the rate and we are using the fee-for-
4 service formulary.
5 And as far as the CVS rate
6 reduction, when we look at our system in Medicaid and
7 we look at our encounter claims, we can tell exactly
8 how much money was paid to the pharmacy for their
9 dispensing fee, how much the MCOs paid and we do have
10 that information.
11 It's my understanding that the
12 pass-thru, some pharmacies use a PSAO and that there
13 were contracts that were on a national level rather
14 than on a state level.
15 When that claim comes through,
16 it appears that the MCOs are paying that $2 fee, but
17 somewhere in between what the PSAO and the PBM and,
18 then, the contract that the pharmacist has with that
19 PSAO is where those funds are being removed. It's
20 not at the claim level but at least it's within the
21 PSAO or the PBM.
22 And I don't know if I'm
23 explaining that right and I may have to have either -
24 I don't know - maybe Dr. Ali, if she's on the phone,
25 to assist with that, but we in our system do not see

1 that reduction based on the $2.

2 MR. POOLE: Okay. So, this was

3 not at all driven or asked for by Medicaid?

4 COMMISSIONER LEE: No, it was

5 not.

6 MR. POOLE: This had to do

7 between the contractual MCO and the providers

8 themselves and the PSAO's.

9 COMMISSIONER LEE: Yes, sir.

10 MR. POOLE: Okay. And, then,

11 secondly, and you will think I've gone definitely in

12 a different direction, but I want to put this in

13 everybody's mind and this is the best committee, I

14 think, to bring it up.

15 I am really tired of going to

16 funerals of individuals who have committed suicide

17 that have had their medication changed.

18 I have five young people in my

19 community over the last seven to eight years that

20 have committee suicide, and on every single occasion

21 when I talk to the parents, they were either waiting

22 to be seen by the doctor again because the change in

23 medication wasn't working for them, or they had just

24 been changed on a new medication.

25 I realize this is a very

1 complicated issue, but I would really like for the
2 Medical Board or a Therapeutics Board to come up with
3 a solution.
4 There needs to be a protocol
5 set out there that when you are adjusting mental
6 medications to help alleviate any kind of depression
7 or any kind of mental disorder, that there needs to
8 be something followed, whether there's checks and
9 balances every two to three days, whatever that
10 protocol is.
11 Obviously I'm not a prescriber
12 but I certainly have seen the results, and I in my
13 little world in Western Kentucky have had too many
14 deaths just due to dose changes or drug changes.
15 And I would really like for
16 some of the mental health people on this call to
17 weigh in because this isn't just needed in Kentucky.
18 It's needed nationwide.
19 And I think those of us who
20 know about your antidepressants or any of the wide
21 range of medications, many times it's a trial and
22 error whenever a practitioner is going off of, yes,
23 the literature that's out there. but it's not like we
24 can do blood tests of norphenylephrine, serotonin or
25 any of the brain chemicals. We can't get levels of

1 them nor can we - if we did have levels of them, is
2 there a standard that helps us point in the right
3 direction?
4 So, again, I think this is a
5 big problem and it seems to be affecting the
6 adolescents up to the early twenty-somethings, and I
7 just think it's a tragedy every time. And when
8 you're just talking about dose changes and drug
9 changes causing this issue, I would like for us to be
10 able to put our minds together and do something about
11 it. Thank you.
12 COMMISSIONER LEE: Thank you.
13 MS. EISNER: I'd like to comment
14 on that real quickly. Part of the things, and I
15 absolutely agree with what you're saying, Ron.
16 One of the things that
17 exacerbates this issue as well is when a patient is
18 discharged from a hospital, they go out with a
19 certain amount of medications that they have been put
20 on, and the docs are reluctant to write too long of a
21 prescription because of access to medications and
22 potential risk and harm.
23 However, the problem is often
24 exacerbated by not being able to get post-discharge
25 patients from a behavioral health hospital or an

1 acute hospital with these meds into followup care in
2 a timely way.
3 And the MCOs have a standard
4 with NCQA that there's supposed to be an ambulatory
5 followup within seven days and within thirty, and
6 that guideline is often met but it's with a
7 therapist, not a prescriber.
8 And, so, I'd love a deeper dive
9 into this problem, but I think that is one thing that
10 is additionally challenging to the physicians who
11 prescribe in a hospital and how long they can and
12 should prescribe after discharge.
13 COMMISSIONER LEE: Thank you
14 both for those comments. And I agree, Mr. Poole,
15 anytime we lose anybody in our society, it's
16 devastating on many levels, for the parents, for
17 those of us who are supposed to be caring for these
18 individuals.
19 And we're not going to solve it
20 today but what does our data tell us? Can we do
21 retrospective reviews on some of these individuals?
22 What do we need to look at to tell us what is and is
23 not being done for our Medicaid members? What sort
24 of reports can we look at that can point us to
25 information and help us identify interventions we can

1 do now to prevent this in the future?
2 Again, we're not going to solve
3 that today but it's something that this committee
4 definitely needs to think about. And, again, it goes
5 back to using our information and our data to drive
6 policy decisions and to drive interventions.
7 Medicaid covers now one out of
8 every three Kentuckians and we have a whole lot of
9 data. We just need to be able to turn that data into
10 information to help us move forward.
11 And, again, when we think about
12 these issues, what would our data tell us? What
13 reports do we need to look at, and, then, what
14 interventions do we need to put in place as we move
15 forward to ensure that we are doing the best thing
16 that we can and making this population in Kentucky
17 healthier and informed about decisions?
18 So, that's my ask of this
19 committee. Help us. We are here for the same
20 reason. Medicaid - and you all have heard my
21 philosophy, you know my standpoint - Medicaid was
22 created for the Medicaid member. We can't take care
23 of our members if we don't listen and take care of
24 our providers.
25 So, help us solve this problem

1 by designing those reports, moving forward in a very
2 thoughtful manner so that we can identify those
3 interventions that we need to implement and, again,
4 short- and long-term targets.
5 What can we do in the short
6 term and what do we have to look at in the long term
7 and what's our baseline data? How do we measure our
8 success going forward? If we're not being
9 successful, what do we have to do to go back and re-
10 evaluate our plan.
11 MR. POOLE: Commissioner Lee, I
12 would love for us to put an ad hoc committee together
13 on this, and I know we're all kind of committee and
14 meeting-out but this is - I mean, obviously, this is
15 very important.
16 Hopefully I'm pronouncing your
17 name right. Nina, I think she hits upon a really
18 good kind of deficit problem, and I would definitely
19 encourage you, Commissioner Lee, I know that I could
20 help put a network of pharmacies together statewide
21 that would help with those behavioral health
22 discharges to where we could do a transition of care
23 in pharmacies that we would check up on them.
24 I would like for us to be able
25 to hopefully bridge that gap, that we would keep the

1 communication line open with the patient and the
2 provider, the prescriber and even counselors, that we
3 could definitely report when there's potentially an
4 issue or, hey, this person failed to pick up their
5 medicine. We've called them. We've tried to deliver
6 it. We've done whatever.
7 I think there's gaps that we
8 can really help fill that would make it hopefully -
9 and the only success that we would ever be able to
10 measure is obviously a decrease in the suicidal rate,
11 and we would hope that over time, that would show
12 what the progress is.
13 COMMISSIONER LEE: And I think
14 that the Behavioral Health TAC would definitely be
15 interested in this topic also. And we have access,
16 of course, to Dr. Benzel, and we have several
17 behavioral health experts in the Department,
18 including Leslie Hoffmann.
19 So, let's figure out what we
20 need to do, what we need to look at and move forward
21 with a clear plan in place.
22 MS. EISNER: Dr. Theriot also
23 had a comment just now in the Chat box which I think
24 is important to consider as the committee is put
25 together and that is the impact on primary care

1 doctors when they are not able to refer their
2 patients to a behavioral health provider in a timely
3 way because many of them are not comfortable
4 initiating or managing the medications for substance
5 use and psychiatric conditions. So, thank you.
6 DR. BOBROWSKI: This is Garth
7 Bobrowski. I've got two questions. The first one,
8 is Senate Bill 50, you talked about the $10 - did I
9 write it down right - dispensing fee? So, does that
10 mean it's going to be increased from $2.15 to $10, or
11 did I write it down wrong?
12 COMMISSIONER LEE: So,
13 currently, the Department for Medicaid has a fee-for-
14 service pharmacy benefit, and in fee-for-service, we
15 do pay $10.64 for our dispensing fee.
16 The six MCOs, they currently
17 have different Pharmacy Benefit Managers and I think
18 their dispensing fee may vary some based on different
19 variables. And, so, all MCOs, all dispensing fees
20 for medications will be $10.64.
21 Now, that does include some
22 compound pharmacy drugs. I know that some of the
23 MCOs pay a higher dispensing fee for those compound
24 drugs, but following the fee-for-service, it will be
25 $10.64. So, that's one area to try to take note of.

1 DR. BOBROWSKI: My second thing
2 - this is Garth Bobrowski again - I had a question a
3 little bit off this subject here, but I got this
4 email yesterday and I noticed Dr. Adam Rich was on
5 the call.
6 And, Commissioner Lee, I'm not
7 trying to put anybody on the spot on this because I
8 see this kind of as a good thing, but, then, I can
9 see some other things going on with it.
10 But the email says this is from
11 a dentist that said he has a staff member that works
12 at Kroger part time, but they noticed United
13 Healthcare was giving out healthy food cards which I
14 guess was in the email was that the Medicaid
15 recipient could use anywhere from $50 to $75 on
16 healthy foods, not Pepsis and Cokes, and that's the
17 good thing. It's healthy foods but I guess this was
18 something new to the dental office person that sent
19 me this email.
20 So, I didn't know if anybody -
21 and, like I said, I'm not judging. I just wanted
22 information on that.
23 COMMISSIONER LEE: If you send
24 me that email, I can get some information, but we all
25 know about social determinants of health. An

1 individual's health is not simply just giving access
2 to care. There's housing, transportation, food,
3 those sorts of things to keep individuals healthy.
4 And that's one thing that the
5 Managed Care Organizations definitely bring to the
6 table. They have more flexibility to reach out to
7 those members and identify areas that are going to
8 improve that individual's health. A really good
9 example is a voucher for healthy food.
10 So, again, that's taking care
11 of the entire member rather than just their medical
12 needs to make sure that they can remain healthy.
13 DR. BOBROWSKI: And that's good.
14 Even the Dental TAC was kind of like, Ron, what you
15 were just saying about trying to get different TACs
16 together and forming some ad hoc committees of just
17 working together on some of these issues to improve
18 the whole health of people. So, I welcome your point
19 on the pharmacy folks. So, thank you.
20 DR. HANNA: I just want to make
21 a couple of comments since we're on Senate Bill 50.
22 As we've all heard today and going back over the past
23 few years, we've had several pieces of legislation
24 pass just with the end goal of ensuring appropriate
25 reimbursement for pharmacies.

1 So, I want to say that these
2 efforts are greatly appreciated, as are the efforts
3 of those who are working to implement and have worked
4 and continue to work to implement Senate Bill 50.
5 As Dr. Bobrowski mentioned of
6 the dispensing fee, we truly do appreciate the $10.64
7 dispensing fee because it does recognize the value of
8 what a pharmacist can bring as far as their
9 professional services, that it's very, very
10 important.
11 But I just want to - and,
12 Commissioner Lee, you mentioned this before - this is
13 a very challenging thing and we're working through it
14 obviously, but as we implement, I'm happy to hear
15 that we're going to evaluate and monitor this closely
16 to see not only how this affects Medicaid but also to
17 ensure that pharmacies are fairly compensated to the
18 point that they can be sustainable.
19 And at the end of the game, the
20 primary goal is to make sure that our beneficiaries
21 have access to pharmaceutical care and services. I
22 think that's very important.
23 And, so, to go forward, I'm
24 glad to hear that you all are going to be monitoring
25 it very closely, and I think it's important that all

1 stakeholders and the Department for Medicaid Services
2 continue to work together collaboratively and keep
3 those open lines of communication. So, thank you for
4 that.
5 DR. PARTIN: On the formulary, I
6 have a couple of comments and also related to what
7 Ron said.
8 Of course, suicide is the most
9 horrible end point for it all but there's other
10 consequences when patients don't get their
11 medication, whether it's medical or psychiatric.
12 But for the psychiatric people,
13 as we move into this single formulary, I think
14 ultimately it's going to be more beneficial because
15 we'll have more consistency with the medications;
16 but, in the short run, people are on medications, and
17 with the change in the formulary, they're being
18 required to switch to other medications.
19 And I would ask that maybe
20 there be more consideration and make it easier for
21 providers to continue to keep patients on the
22 medications that they're stable on and that they're
23 currently taking rather than forcing them to be
24 switched in a way because, one, it takes a while to
25 get medications preauthorized, and, two, with the

1 psychiatric patients, if you can't meet their need
2 almost immediately, sometimes they're lost to you
3 totally because they just don't have the patience and
4 a lot of times it's because of their illness that
5 they can wait to have you go through the process of
6 getting drugs preauthorized.
7 So, in the short term, I would
8 ask that there be some more leniency to allow people
9 to continue on their current medication so that they
10 can remain stable while we're making this change to
11 the single formulary.
12 COMMISSIONER LEE: And Senior
13 Deputy Commissioner Veronica Judy Cecil has been
14 working very hard on this, but that's our goal is to
15 ensure that there's no disruption of services for
16 individuals and that this is actually pretty seamless
17 for our members.
18 And I'm not sure, Deputy
19 Commissioner, if you want to add anything to Dr.
20 Partin's comments related to grandfathering in
21 certain medications.
22 MS. CECIL: Thank you. We
23 agree with you, Dr. Partin. There will be a ninety-
24 day grandfather period and there's letters going out.
25 Providers, prescribers should be getting a letter

1 that goes out June 1st and we'll post this
2 information as well to make sure everyone understands
3 about the ninety-day grandfather period. Members
4 will get a letter as well about it.
5 We will be assessing during
6 that ninety days looking at is there another drug
7 that the person could be moved to. This is about
8 making sure that the member has the appropriate drug
9 and that's what we will use those ninety days for is
10 to see if does it make sense to move them to another
11 drug or does the member need to stay on the drug that
12 they're on.
13 There will be a lot of review
14 of that during that period of time, and that's the
15 reason we did the ninety days. We want to make sure
16 that we're doing everything we can for continuity of
17 care.
18 DR. PARTIN: Thank you.
19 DR. ALI: This if Fatima. I do
20 want to mention that the PDL drugs that we currently
21 have in place, those will not change. The ninety-day
22 grandfathering applies to the drugs that are not on
23 the PDL.
24 So, currently, some of the MCOs
25 manage these drugs a little differently. So, we're

1 going to follow the fee-for-service formulary with
2 that respect.
3 COMMISSIONER LEE: Thank you,
4 Dr. Ali and Deputy Commissioner.
5 DR. PARTIN: Okay.
6 Commissioner, was your report including Number 6 on
7 the agenda, an update on Legislative Session?
8 COMMISSIONER LEE: Yes. Yes. I
9 didn't give an update of every piece of legislation
10 but those that we're working on, and if you want all
11 of the legislation reviewed at the next MAC. I just
12 gave the highlights for you.
13 DR. PARTIN: Okay. Thank you.
14 I just didn't know if we were ready to move on to the
15 next agenda item.
16 So, next up we have the TAC
17 reports, and we have a couple of other items on the
18 agenda following the TAC reports.
19 So, I would like to ask the TAC
20 members to keep your reports to the most important
21 information that the MAC needs to know and, then,
22 your recommendations so that we can give everybody an
23 opportunity to speak and if there's any questions and
24 also to end our meeting on time.
25 So, first up is Therapy.

1 DR. ENNIS: Good morning. This
2 is Beth Ennis. I'm the Chair of the Therapy TAC.
3 The TAC met on May 11th virtually. We did have a
4 quorum and members of most, if not all, of the MCOs
5 present.
6 The big items - we don't have
7 any specific ask. We're working through two big
8 issues. One is ongoing administrative burden issues
9 that just continue to pop up and we've provided DMS
10 with a list of the most frequent reoccurring issues.
11 We are continuing to add to
12 that document. So, I'm going to give them an updated
13 one soon.
14 The other piece is our fee
15 schedule. When it got updated, there was about a 10%
16 cut in already ridiculously low reimbursement rates
17 and it was explained to us that that was due to
18 Medicare cuts.
19 My understanding is that
20 Medicare had planned 9% cuts but have decreased that
21 to a 2% cut. So, we've asked them to revisit that
22 fee schedule and hopefully correct it; if not, to
23 provide us an explanation why it was so much deeper
24 of a cut than what Medicare did because people are
25 not able to keep their doors open with what is being

1 reimbursed. Between that and the way the MCOs are
2 adjusting payments and removing modifiers, it's just
3 been a really difficult six months so far.
4 We don't have an ask of the MAC
5 at this point but appreciate the Cabinet continuing
6 to look at these issues with us. Thank you.
7 DR. PARTIN: Thank you. Primary
8 Care.
9 MR. CAUDILL: Good morning.
10 This is Mike Caudill. I'm the Chairperson of the
11 Primary Care TAC.
12 In our last meeting on May 6th,
13 we talked with Ms. Cecil about the workgroup that was
14 going on. We've had one meeting, and since that, a
15 second one has been scheduled.
16 It was a very informative
17 meeting. It went very well and the next meeting
18 intends to go a little bit more further into what was
19 raised. About nine people submitted comments, and
20 this next meeting of the workgroup will be
21 concentrated on the provider end which is a good
22 thing.
23 The other thing we'd like to
24 talk about is our presentation by former Justice Gene
25 Smallwood concerning the payment methodology for

1 same-day Medicaid multiple visits. He had done
2 research, had looked at twenty states including
3 adjoining states around Kentucky; and of that,
4 Kentucky was the only state that did not make
5 payments for same-day multiple visits.
6 And fifteen of those twenty
7 states made payments based upon three different
8 areas, and that's primary care, behavioral health and
9 dental.
10 Based upon his study, he felt
11 there was a strong trend going on for payment of
12 multi-day visits and felt like that the current
13 methodology of the state to only pay for one visit
14 was hindering.
15 It was a burden upon our
16 elderly and people on fixed incomes and trying to
17 arrange to go to doctors, and that it was a burden
18 upon primary care and rural health in trying to hire
19 and to retain qualified providers on the one hand,
20 and, on the other hand, it restricted their ability
21 to be able to expand services to their patient
22 population and to open new clinics which, in turn,
23 had an adverse affect upon our patients and our
24 Medicaid recipients.
25 To that end, a recommendation

1 was made to forward to the MAC and I'll read that at
2 this time. It is this committee's recommendation to
3 the MAC that they request DMS to review their same-
4 day multiple-visit payment methodology and report
5 back to the MAC comparing Kentucky's methodology of
6 that of surrounding and other states to determine if
7 Kentucky's approach is in parity with the majority of
8 other states, and if not, to suggest an approach for
9 Kentucky to become more mainstream with the trends
10 across the country in reimbursement for same-day
11 multiple-visit payment methodology.
12 And, again, out of those twenty
13 states that were reviewed, Kentucky was the only one
14 that did not pay for multiple visits in some type of
15 an approved procedure.
16 And that's my report and
17 recommendation, Madam Chairperson.
18 DR. PARTIN: Thank you, Mike.
19 I thought at the last meeting, the Commissioner told
20 us that that problem had been fixed and that patients
21 were able to receive or providers were able to
22 receive reimbursement when patients had multiple
23 visits on the same day. Is that not correct?
24 COMMISSIONER LEE: I think
25 that's a different issue, Dr. Partin. What Mike is

1 talking about is the FQHC/RHC reimbursement
2 methodology. When they receive a PPS rate, a
3 prospective payment system rate, that rate is all-
4 inclusive.
5 However, at the clinic, if an
6 individual sees two different providers at two
7 different locations, that's a different issue.
8 DR. PARTIN: Okay. Thank you.
9 MS. HUGHES: Mike, could you
10 send me your recommendation from the TAC, please. I
11 haven't received a recommendation from the Primary
12 Care TAC. I think you just gave one.
13 MR. CAUDILL: I did give one.
14 It is my understanding it was sent in. If not, then,
15 certainly I can follow up on that.
16 MS. HUGHES: Okay. I may have
17 missed it but I don't think I've seen it. If you
18 don't mind, I would appreciate it.
19 MR. CAUDILL: You're awful good,
20 Sharley. I wouldn't think you would miss anything.
21 MS. HUGHES: Oh, I do sometimes.
22 I'm sorry.
23 DR. PARTIN: Thanks, Mike.
24 Podiatry.
25 DR. ROBERTS: No TAC.

1 DR. PARTIN: Physician Services.
2 DR. McINTYRE: Hi. I'm Dr.
3 McIntyre. I'm the Vice-Chairman of the TAC and we
4 did not meet.
5 DR. PARTIN: Okay. Thank you.
6 Pharmacy TAC.
7 MR. POOLE: Madam Chair, this is
8 Ron Poole from the Pharmacy TAC. I have three
9 motions that came out of two meetings. And even
10 though they are short motions, I want to let the MAC
11 know that a lot of work and research went into each
12 one of these.
13 Anyway, the first one is - and
14 what I would like, again, with Commissioner Lee's - I
15 appreciate her coming with a more formal I guess
16 response to what the TACs report to the MAC, but it
17 would be nice to get a formal response from Medicaid
18 on these.
19 Recommendation of standard
20 dispensing fee for specialty drug claims. We looked
21 at all kinds of national data, the requirements that
22 are put into place for specialty pharmacies to
23 dispense but basically came up with specialty
24 pharmacy accreditation status would not be required
25 in defining a specialty pharmacy.

1 The P&T Committee needs to
2 define specialty pharmacy drugs and apply a $73.58
3 dispensing fee as a standard dispensing fee for
4 specialty pharmacy prescription drug claims.
5 So, that is one that we would
6 like to be considered. And, Sharley, I will be
7 sending you a copy of these three that I'm talking
8 about today.
9 We have taken on quite a bit of
10 topics, and respecting the need to save time, I won't
11 go over all the topics that were discussed, just the
12 ones that we came up with motions on.
13 The next one is on the
14 reimbursement per prescription guidelines.
15 Basically, it's what the dispensing fee needs to be
16 applied to. Certain arguments would say, well, if
17 you fill a prescription every two days for fifteen
18 days, that's a thirty-day supply. And if somebody is
19 trying to get a dispensing fee on each one of those,
20 we're hoping that there's going to be processes put
21 in place to audit these people and take back those
22 dispensing fees.
23 But due to the nature of the
24 treatment of using Suboxone if the Suboxone clinics
25 are even in regular primary care, we would request

1 that the minimum be placed down to seven days. So,
2 the official wording is: Due to cases like Suboxone
3 dosing and prescribing limitations of certain
4 prescribers, a motion to recommend single MCO pay
5 full dispensing fee for every claim down to a minimum
6 of a seven-day supply.
7 Now, just adding something to
8 that would be we realize that some methodology will
9 be put in place to make sure that people aren't
10 taking advantage of that, and we certainly understand
11 that and respect that. So, that's the second one.
12 And, then, the third one and
13 last one, I worked on this particular workgroup.
14 This motion: The following is a recommendation to the
15 Department for Medicaid Services on a compounding
16 reimbursement model.
17 I'll just read: The situation
18 is Kentucky Medicaid recipients need coverage for
19 both non-sterile and sterile compound medicines to be
20 reimbursed by DMS so they can receive the best drug
21 therapy for their medical conditions.
22 I'll just add, many times this
23 is at a cost savings. Part of this testimony, if
24 this moves along, but the background information we
25 put in there, the University of Kentucky Medical

1 Center, how much they just write off in the compounds
2 that they make a lot of time for their pediatric
3 patients because it's the best therapy, even though
4 it's not reimbursed, and it's the cheapest way to go
5 for the patient.
6 But, anyway, the assessment is
7 non-sterile and sterile extemporaneous compounds are
8 necessary for optimal treatments. We need a compound
9 reimbursement model in place where the claims
10 processor and Medicaid are confident in paying the
11 legitimate claims to avoid a fraud or potential for
12 fraud.
13 So, goals on both sides. The
14 goals for the providers is providing the service at
15 the cheapest and best therapy possible, and we
16 realize the goal of Medicaid is going to be paying
17 legitimate claims and not allowing for fraud or
18 potential for fraud.
19 So, this is actually an SBAR
20 statement that I would like when Commissioner Lee and
21 her staff look over it. I would really invite even
22 Dan Yeager with Medimpact to work with us, maybe with
23 just a workgroup, to come up with this model that
24 would work for him and his company with the single
25 payer model.

1 So, anyway, I will get all this
2 to you, Sharley. And, Madam Chair, I yield to you
3 and thanks for your work and thanks for Commissioner
4 Lee to come up with a more standardized way of
5 responding to these requests from the TACs. Thank
6 you.
7 DR. PARTIN: Thank you, Ron.
8 Optometry.
9 DR. COMPTON: Madam Chair, this
10 is Steve Compton from the Optometric TAC.
11 We met on May 6th. We had a
12 quorum and I think all the MCOs and subcontractors
13 were there.
14 We had various topics of
15 discussion concerning credentialing and payment for
16 some claims, but we're working through them and I'm
17 optimistic that things will keep getting better and
18 better, and we have no recommendations at this time.
19 DR. PARTIN: Okay. Thank you.
20 Nursing Services. Intellectual and Developmental
21 Disabilities. Do we have a report from Intellectual
22 and Developmental Disabilities?
23 MS. HUGHES: They did meet but I
24 don't believe they have anything on here to present.
25 DR. PARTIN: Okay. Thanks,

1 Sharley. Hospital.

2 DR. RANALLO: This is Russ

3 Ranallo, the Hospital TAC Chair. The Hospital TAC

4 met on April 27th with a quorum. We don't have any

5 recommendations. There were several items that were

6 gone through, just follow-ups from prior meetings, a

7 couple for this group.

8 One, we talked about patient

9 transportation. We've had numerous reports of

10 hospitals all over the state with transportation

11 issues. When a hospital is full, we need alternative

12 levels of care and we're having a lot of problems

13 getting timely and secure transportation.

14 This is causing some patient

15 safety issues and some constant criticisms. You have

16 hospitals that are calling in more expensive

17 transports like air transports in order to move their

18 patients.

19 We realize the Cabinet doesn't

20 regulate the ambulance but we wanted to bring it to

21 their attention because it's an access issue for one

22 from our viewpoint.

23 The Hospital Association has

24 had a workgroup that has met and they are documenting

25 specific issues and problems and they're going to

1 attend the next TAC meeting to share some of that
2 information that we will send up to the MAC.
3 And, then, the other item was
4 on the agenda today, the psych hospital EMTALA
5 requirements but we still don't have resolution on
6 that issue. I know the detailed information has been
7 sent numerous times. That's going to happen again
8 and we're going to follow up at our next meeting in
9 June.
10 DR. PARTIN: Thank you. Home
11 Health.
12 MS. STEWART: The Home Health
13 TAC did meet. We have no recommendations at this
14 time. Thank you.
15 DR. PARTIN: Thank you. Nursing
16 Home.
17 MR. MULLER: This is John Muller
18 from KAHCF.
19 The TAC did meet virtually on
20 May 19th. We discussed several issues affecting
21 nursing facility providers. The agenda included a
22 followup on the Association's request for a Medicaid
23 rate add-on for 2021, a 2020 COVID add-on and bed
24 reserves, an update on inflationary adjustment to the
25 price and many Medicaid billing issues, and, then, a

1 request for Medicaid to re-base the price.

2 The Department for Medicaid

3 gave an update on a State Plan Amendment that has

4 been filed regarding the nursing facility provider

5 request for the rate add-on and CMS just yesterday

6 approved that. So, the Association and DMS are

7 working on implementing the 2021 COVID add-on.

8 Also, several billing issues

9 were raised and discussed including during the

10 pandemic, the inability to change patient liability

11 and also Medicaid eligibility for State Guardian

12 residents. That has been an ongoing challenge.

13 So, the Association is going to

14 share documentation on how surrounding states process

15 the guardianship for Medicaid eligibility and will

16 report back at the next TAC.

17 And, then, lastly, the TAC

18 members requested the Department for Medicaid

19 consider rebasing the nursing facility price, make

20 the necessary changes to the Medicaid price-based

21 regulation in order to re-base the price for January

22 1st, 2022 and going forward.

23 We're asking for this

24 regulation change because the price component was

25 last set in 2008 using 2007 data. So, that's really

1 incongruent with attracting and retaining the staff
2 we need to operate by using wage data from fourteen
3 years ago.
4 So, the Association will ask
5 for the Department's decision to change the
6 regulation at the next TAC meeting which will be held
7 June 30th. That's all we have to report. Thank you
8 very much.
9 DR. PARTIN: Okay. Thank you.
10 Dental TAC.
11 DR. BOBROWSKI: Yes. This is
12 Dr. Garth Bobrowski and I'll be shorter.
13 The Dental TAC met on May 14th.
14 We did have a quorum. Just a little background. The
15 dental access to care is continuing to decline. One
16 factor is that many of the procedures are being
17 reimbursed at below cost, especially for adults.
18 There's a separate fee schedule for adults than there
19 is for children.
20 The TAC had recommended a fee
21 increase from the State on some procedural codes but
22 recent correspondence has denied this request.
23 So, the motion from the Dental
24 TAC is that the Dental TAC recommends the MAC start
25 discussions on additional funding for Medicaid that

1 may include a soda tax to be used to help fund oral
2 health and other health initiatives and those funds
3 are to be used exclusively for Medicaid.
4 This has been done in other
5 states and municipalities. I believe Philadelphia
6 was one of the last ones to get this passed, but some
7 states are funding most of their Medicaid Program
8 through this means.
9 And I hate taxes worse than
10 anything, but in dentistry, the soft drinks and
11 sugary drinks are just killing our smiles in this
12 state.
13 We had a good lengthy meeting
14 with our TAC. We went over a lot of other items but
15 this was the emotion that we came up with, and I will
16 respectfully submit this and thank you very much.
17 DR. GUPTA: Dr. Bobrowski, this
18 is Dr. Gupta, if I may make a comment, Dr. Partin.
19 The soda tax that you bring up
20 is something that I've actually been working on or
21 trying to work on for a couple of years, and my
22 brother actually submitted a proposal to the KMA a
23 few years ago about that. It was turned down.
24 But you are absolutely right.
25 I have done a lot of research on this and there are

1 several states in the country who support their
2 entire or a lot of the Medicaid budget through a soda
3 tax and there's different ways to do it. It does not
4 necessarily have to be a tax on the actual consumer.
5 It could be on the company.
6 There's a lot of different ways
7 to approach it but that gets to the root of the
8 problem. Either Medicaid gets the funding or the
9 consumers choose not to purchase it and, then, in
10 itself reduces their health risks. So, I totally
11 support that.
12 DR. BOBROWSKI: I had a lady, a
13 patient just last week that she's drinking twenty-
14 four soft drinks a day and I won't go any further but
15 I appreciate your support.
16 DR. GUPTA: It gets to the root
17 of so many problems - diabetes. If we could prevent
18 these things from happening in the first place, then,
19 our cost to all of us significantly drops.
20 DR. PARTIN: Dr. Bobrowski, I
21 also think that that's an excellent idea and I know
22 that not only for dental but, as it was just pointed
23 out, that it's also a problem for I think everybody's
24 health in so many ways.
25 In order to do something like

1 that, the professional organizations would probably
2 have to get together to have a bill sponsored in
3 order to increase that funding for Medicaid.
4 So, perhaps that's something,
5 if the Dental TAC or one of the other groups wants to
6 reach out to the professional organizations, I'll be
7 glad to reach out to the Kentucky Association of
8 Nurse Practitioners and Nurse Midwives on that, and
9 that is something that we could all work together on
10 to promote in the next Legislative Session or beyond.
11 DR. ROBERTS: Please include the
12 KPMA. I'm on the KPMA Board. So, I would certainly
13 be happy in bringing it to their attention as being a
14 co-sponsor for this.
15 DR. GUPTA: That'S something
16 that each of our TACs could work on because what we
17 did just as the KMA, it was just one group, and it
18 was turned down; but I think that if it came from, as
19 you mentioned, several different medical groups, it
20 would be so much more effective in legislation.
21 DR. PARTIN: Absolutely.
22 DR. GUPTA: So, how would we go
23 about doing that, something like that?
24 DR. PARTIN: I think we need to
25 talk to our professional organizations. I'm sorry.

1 Go ahead, Garth.

2 DR. BOBROWSKI: You're exactly

3 right, Dr. Partin. This is something that even the

4 Kentucky Dental Association can initiate and we've

5 actually got some MCO support for this.

6 But like you just said, if

7 we've got other TACs, other state organizations that

8 will co-sponsor and sign on with the sponsor of a

9 bill and, then, it takes a grassroots effort of

10 working with each of our lobbyists or working with

11 our legislators throughout the summer, fall because

12 once January hits, the legislators are swamped, don't

13 have much time.

14 It's going to take some time to

15 work on it and there's a lot of data that the

16 American Dental Association has already gathered on

17 this situation.

18 So, it is kind of one of those

19 things that the more sponsors or co-sponsors that you

20 get and work the legislators because the soft drink

21 industry is also, they're a bigwig in all this, and

22 if we could work with Behavioral Health and other

23 groups, Children's Health and start making an

24 initiative that, man, this much soft drink and sugar,

25 it's just not healthy, like you said, diabetes,

1 obesity, teeth, face, whatever, but I think it's
2 going to be a cooperative effort to get results.
3 DR. PARTIN: Okay. Thank you.
4 I think we can talk about that outside of the MAC
5 meeting more.
6 Next up, Consumer Rights and
7 Client Needs.
8 MS. BEAUREGARD: Good morning.
9 Emily Beauregard. I'm the Chair of the Consumer TAC
10 and we had a meeting on April 20th. We met virtually
11 with a quorum present. We had no recommendations to
12 put forward and we discussed a number of issues that
13 are in the report that I sent to you, Dr. Partin,
14 just really yesterday. So, hopefully, everyone has a
15 copy of that to review.
16 In the interest of time, I just
17 want to highlight one of the issues that we
18 discussed. This is something that we have raised at
19 MAC meetings for probably the past two years now
20 which is the Public Charge Rule.
21 This Public Charge Rule, there
22 were restrictions put in place in 2019 under then
23 President Trump, and these restrictions had a
24 chilling effect on Medicaid enrollment with
25 immigrants regardless of their immigration status

1 being afraid to enroll in Medicaid even if they or a
2 family member was eligible.
3 And, so, the good news to
4 report is that after going through a couple of years
5 with these restrictions, the Biden Administration has
6 reversed course and those restrictions are no longer
7 in place.
8 So, we have gone back to the
9 prior guidance which was set in 1999, and what this
10 effectively means is that people that apply for
11 Medicaid, KCHIP, SNAP benefits, if they are eligible
12 for those benefits, it won't have an effect on their
13 ability to at some point get U.S. residency.
14 So, that's good news, but I
15 think it's important to note that this chilling
16 effect continues. We need to make sure that people
17 are educated about the change and that people trust
18 that they can enroll in benefits without it having a
19 negative impact on their ability to gain residency or
20 citizenship status in the future.
21 And, so, it's work that we all
22 need to be doing, and we appreciate that the Cabinet,
23 that DMS has been working with us to update the memo
24 on the Public Charge Rule and get information out to
25 workers and to beneficiaries.

1 So, that's all I'll share for
2 today. Thank you.
3 DR. PARTIN: Thanks a lot.
4 Children's Health.
5 MS. KALRA: Hi. This is Mahak
6 Kalra, Chair of the Children's Health TAC.
7 Unfortunately, we did not have a quorum but we did
8 meet. So, I don't have any recommendations for
9 today.
10 DR. PARTIN: Thank you.
11 Behavioral Health.
12 DR. SCHUSTER: Good afternoon.
13 Sheila Schuster, Chair of the Behavioral Health TAC.
14 We met via Zoom on May 11th. We
15 had all six of our TAC members there, as well as
16 representatives from Medicaid and from the Department
17 for Behavioral Health, and all six of the MCOs were
18 represented as well as a number of members of our
19 behavioral health community.
20 Good news and we thank
21 Commissioner Lee. We're still continuing to work on
22 targeted case management. I've talked to you all
23 about the importance of this.
24 It is still not being prior-
25 authorized which is great, and Commissioner Lee has

1 put us in touch with her data specialists and we are
2 doing a very targeted data pull on adults with severe
3 mental illness to look at the impacts of targeted
4 case management.
5 So, we're very excited about
6 this and I thank Commissioner Lee. We thank you for
7 your leadership and using data to influence policy.
8 You mentioned the single
9 formulary. We continue to hear problems with
10 particularly our child psychiatrists being able to
11 get necessary medications for kids, with all of the
12 changes.
13 People are being changed from
14 their medications; and as has been discussed earlier,
15 this has sometimes some catastrophic effects on
16 people.
17 I do appreciate Dr. Ali being
18 so prompt in responding to a question we had about
19 the upcoming changes around the non-PDL drugs and we
20 will be circulating that information. Veronica Cecil
21 also has been very helpful.
22 We continue to struggle with
23 dual eligibles. I think I brought this up last time
24 and Medicaid staff has gotten some examples from us.
25 These are people that have Medicaid and Medicare both

1 or have Medicaid and private insurance and we
2 continue to have problems with reimbursement.
3 We're anxious for the SUD
4 waiver for incarcerated persons to be able to get the
5 services starting in the jail or prison and we hope
6 that CMS will be responding soon.
7 We thank you for the responses
8 to the brain injury waiver recommendations.
9 We have no recommendations at
10 this time, but I would like to respond, and I
11 certainly appreciate, Ron, your bringing up the issue
12 of suicides and medication.
13 And you all who have been on
14 the MAC have heard me probably talk about this twenty
15 times over the past six or seven or eight years, but
16 if our people particularly with severe psychiatric
17 disorders have a glitch and don't get their
18 medications, terrible things happen
19 We see that often people end up
20 not coming back to get it after the glitch is
21 supposedly resolved. We see people ending up in jail
22 because their behavior is problematic for society.
23 We see people ending up being re-hospitalized. We
24 see people in homelessness, and, yes, we do see
25 people with successful suicides.

1 So, certainly, the Behavioral
2 Health TAC would like to work with the Pharmacy TAC.
3 I think, Nina, your forum for your hospitals that are
4 doing psychiatric disorders, we need to put our heads
5 together, and I do think that we have significant
6 problems still with medications.
7 I think what's happening - and
8 we should have some of our psychiatrists and
9 psychiatric nurse practitioners in this workgroup -
10 is I think they will tell you that they are so
11 overworked because there are so few of them that when
12 there are multiple prior authorization requirements,
13 they simply change their prescribing behaviors and
14 they give into that kind of pressure because they
15 simply cannot take the time to submit and submit and
16 submit and submit.
17 And the other problem is that
18 we're still waiting for days sometimes for those PA's
19 to be approved and that gap is something that we
20 really cannot tolerate.
21 So, I really welcome the
22 opportunity to work with you all on this and I will
23 be in touch with you. Thank you very much.
24 DR. PARTIN: Thank you, Sheila.
25 I had just a couple of things to add related to some

1 of the things that we've talked about with the TAC.
2 And Sheila just mentioned it
3 but I would also like to have, if any group is
4 formed, psychiatric nurse practitioners included in
5 that because they are practicing a lot in our rural
6 areas and providing psychiatric care and I think that
7 perspective is important.
8 And, then, the other thing is,
9 Commissioner, I had a question. I'm wondering if you
10 know or have any idea - you probably don't know
11 because nobody knows - but if you have any idea when
12 the emergency orders are going to end?
13 COMMISSIONER LEE: Not at this
14 time. I don't know at this point.
15 DR. PARTIN: I'm sorry. You
16 broke up. I couldn't hear what you said.
17 COMMISSIONER LEE: We don't know
18 at this point.
19 DR. PARTIN: Okay. That's what
20 everybody says. Thank you.
21 Moving on to New Business, the
22 first item is Judge Phillip Shepherd of the Franklin
23 Circuit Court ruled in late April that the bidding
24 process, which was the second one, for awarding the
25 MCO contracts was flawed and must be rebid.

1 What are the immediate and
2 long-term effects of the Judge's ruling that the MCO
3 contracts must be rebid, and how does DMS plan to
4 proceed?
5 COMMISSIONER LEE: Currently,
6 the Judge's Order is not final. So, we are waiting
7 on the Order to become final and what additional
8 information may be included.
9 DR. PARTIN: So, the next
10 meeting or do you think you will know something
11 before then?
12 COMMISSIONER LEE: We may know
13 something by the next meeting. I think there may be
14 a hearing on June 3rd. So, we will know more
15 information after that hearing.
16 DR. PARTIN: Okay. So, I'll put
17 that on the agenda for the next time.
18 And, then, the other item, I've
19 had several requests from people who are able to
20 attend the MAC meetings, if the recording of the
21 meeting could be put on the website so that they can
22 know what was discussed at the meeting.
23 COMMISSIONER LEE: We do post
24 the minutes after they are approved, but we'll look
25 into the recordings and see if they can be posted.

1 DR. PARTIN: If they could be
2 posted, our minutes are basically not minutes in the
3 traditional sense. It's basically a transcription of
4 everything that was said.
5 So, our approval of that is
6 based on the recording, not on somebody's
7 interpretation of what minutes usually are is an
8 interpretation or a summary of what was said.
9 So, if the recording could be
10 posted shortly after the meeting, that would give
11 people who were interested in what was going on an
12 idea of what happened at the meeting and just hear
13 everything that was said just as everybody was at the
14 meeting hears.
15 COMMISSIONER LEE: We'll look
16 into that and see what all is involved.
17 DR. PARTIN: Okay. Thank you.
18 And, then, last which I didn't report but the
19 Commissioner reported it for me was that I was
20 invited - and I put invited in quotation marks there
21 - to present a report to the Medicaid Oversight and
22 Advisory Committee last week, and I just basically
23 gave the committee a summary of everything that we
24 discussed in 2020 and so far in 2021.
25 So, basically, I looked at our

1 minutes and I reported what we had discussed.

2 Does anybody have anything else

3 that they would like to bring up?

4 Well, we did really well today.

5 It's two minutes after. So, if there's no other

6 business, would somebody like to make a motion to

7 adjourn?

8 MS. EISNER: So moved.

9 DR. BOBROWSKI: Second.

10 DR. PARTIN: Any discussion?

11 All in favor say aye. Opposed? So moved. Thank

12 you, everybody. Look forward to seeing you in a

13 couple of months.

14 MEETING ADJOURNED

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