CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
March 23, 2023
Commencing at 10:01 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

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

MS. WALLACE: All right. Well, I'll go ahead and take roll, then, if we're ready.

So Elizabeth Partin?

(No response.)

MS. WALLACE: Okay. Nina Eisner?

(No response.)

MS. WALLACE: Susan Stewart?

MS. STEWART: Here.

MS. WALLACE: Dr. Jerry Roberts?

DR. ROBERTS: I'm here.

MS. WALLACE: Heather Smith?

MS. SMITH: Here.

MS. WALLACE: Dr. Bobrowski?

DR. BOBROWSKI: Here.

MS. WALLACE: Dr. Compton?

DR. COMPTON: Here.

MS. WALLACE: Dr. Muller, Muller?

DR. MULLER: Muller, here. Thank you.

MS. WALLACE: Muller. Thank you.

Dr. Gupta?

DR. GUPTA: Here.

MS. WALLACE: John Dadds?

(No response.)

MS. WALLACE: Dr. Hanna?
DR. HANNA: Here.
MS. WALLACE: Barry Martin?
MR. MARTIN: Here.
MS. WALLACE: Kent Gilbert?
MR. GILBERT: I'm here.
MS. WALLACE: Mackenzie Wallace is here.
Annissa Franklin?
(No response.)
MS. WALLACE: Dr. Schuster?
DR. SCHUSTER: I'm here.
MS. WALLACE: Bryan Proctor?
MR. PROCTOR: Here.
MS. WALLACE: Peggy Roark?
(No response.)
MS. WALLACE: Eric Wright?
MR. WRIGHT: Here.
MS. WALLACE: Commissioner Lee?
COMMISSIONER LEE: I am here.
MS. WALLACE: All right. We have a quorum.
COMMISSIONER LEE: Since Beth isn't on, do we have a co-chair that is going to lead the meeting?

DR. SCHUSTER: Good question.

DR. BOBROWSKI: I can -- I can start it and --

MS. SHEETS: I have just admitted Beth, so -- out of the waiting room, so she's joining us.

COMMISSIONER LEE: All right. Great. Thank you.

MR. MARTIN: That is a good question, though.

CHAIR PARTIN: Good morning. Can y'all hear me?

COMMISSIONER LEE: Yes. We can hear you, Dr. Partin.

CHAIR PARTIN: Sorry I'm late. Okay. Did we already start the meeting?

COMMISSIONER LEE: We just finished roll call, so now we can jump into the agenda. So you are on board to lead us, lead this wonderful group through the meeting.

CHAIR PARTIN: Okay. Thank you, Commissioner.

Okay. So next up on the agenda, do we have a quorum?

COMMISSIONER LEE: Yes, I believe

we do.

MS. WALLACE: Yes, ma'am, we do.

CHAIR PARTIN: Okay. Thank you. Approval of the minutes. Would somebody like to make a motion?

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

CHAIR PARTIN: Thank you.

DR. SCHUSTER: And I'll second. Sheila Schuster.

CHAIR PARTIN: Thank you. Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Any noes?

(No response.)

CHAIR PARTIN: Okay. The minutes are accepted, then.

Next up is a thank you to DMS for removing the limitation on E/M codes on 99214 and 99215. That will be much appreciated by providers across the board, I think.

My question is: Will the MCOs also

follow suit with this?

COMMISSIONER LEE: Yes. The MCOs will. And as a matter of fact, I think some had been following those guidelines prior to. They did not have any limitations, so the MCOs will be following the new regulation.

CHAIR PARTIN: Okay. Wonderful. Thank you.

Okay. Moving on to old business, then. Update on missed or cancelled appointments, and how is the reporting going? And is there any common thread as to why patients are not showing up for appointments?

COMMISSIONER LEE: I think I'll defer to Justin Dearinger for this update.

Justin?

MR. DEARINGER: Yes. Thank you, Commissioner. So we are currently working on a system, and it's in progress. I was hoping it would be done before this meeting, but they're not quite finished yet. I think integrating some of the different software has been a little bit more challenging than I thought, but we're right on schedule.

One of the things that this new software

system is going to do, it's going to be available to the public, to everyone online. It's going to be an online dashboard where you'll be able to log in, and you'll be able to see each provider type, the number of no-shows that each provider type has.

You'll be able to break it down by county. You'll be able to look at the reasons why each no-show occurred, and you'll be able to look at percentages of the reasons why those no-shows happened.

And so that's what we've been really kind of focusing on and putting our time in. We've been encouraging providers and provider groups to make sure that they reach out and that they get an actual reason.

One of the biggest reasons that we have currently from -- or that we're getting back is either no response or unknown, and that's the leading -- you know, leading response that we get back for a no-show.

And so, you know, we've tried to make that an emphasis moving forward, and I think that will become something that is even more apparent. As providers see this new portal,

as it's out in the public, they'll be able to see, you know, how important it is in that data so that we can better hone our responses of trying to fix that problem and come up with solutions to that issue.

But this is, you know, kind of a first step, for us to be able to -- be able to have that data immediately at our fingertips at any point whoever you are. And so we've also got some -- we're pulling some more information that drills down a little farther, you know, breaking things down by counties, by zip codes, by areas.

That might not be available immediately when it comes out, but they've already started kind of putting the framework in place for people to be able to drill down into those parameters, you know, as we get going.

So this will all be a public -- public information on a public website, so everybody will be able to access this. So it's kind of a bigger project, and it's taking a little more time than we thought it was going to take and we were originally told it was going

to take.

But I think it's exciting, and I think it's going to be a great tool for providers and for us and for the MAC, for everybody that has an interest in trying to solve and fix the no-show solutions and come up with solutions for this no-show issue, to be able to access and have that information.

CHAIR PARTIN: Okay. Thank you. That sounds wonderful. So much appreciated. I know that's a lot of work that's gone into that, and I think that will be very helpful, for us to be able to see that and will help our practices, I think, maybe hone in on some of the problems as well as DMS working on it, so thank you.

Any comments from the council?

DR. SCHUSTER: I'll just second that, Beth. Justin has been great in working with the BH TAC because we've had this on our agenda for probably the past year. We were concerned that more of the missed appointments were with -- from members who had behavioral health issues, and we wanted to be sure that the social determinants of

health, if that was part of the problem, were being addressed. So Justin has been great to work with on this. And every two months, we're like, okay, we're almost there. So it sounds like we're almost there, Justin. We appreciate all your work on it.

DR. BOBROWSKI: This is Dr. Bobrowski. I just wanted to comment. And, again, we appreciate all the efforts of working on this to get data on it.

And it was just like yesterday, I talked with a young lady that has already missed four appointments. And I asked her about, well, can you just, you know, at least give us a call, you know, when you know you can't come? And then that way, if somebody else has a toothache or whatever, we can get them in in your spot. Well, she said, well, I'll -- just nonchalantly, well, I'll just get me another appointment.

But -- and I know different offices have different rules. You know, some offices do three strikes, and you're out. You know, you move on to a different office. But, you know, as we look forward on this, I think --

and Dr. Schuster -- and I don't know through the behavioral health part of this. It's just that working together on figuring out -- you know, it's like we don't really want to dismiss patients. But at the same time, they need to realize they have a responsibility.

But anyway, I'll just -- I'll hush. Thank you.

CHAIR PARTIN: Thank you, Dr. Bobrowski, and thank you, Sheila.

Any other comments?

(No response.)

CHAIR PARTIN: Okay. Next up, status of Anthem MCO.

COMMISSIONER LEE: Yes. This MCO is still pending litigation, so we're -- I think it's at the Supreme Court level, so we're just waiting on the legal process to work it out.

CHAIR PARTIN: Okay. Thank you. We'll ask again about that at next meeting.

DR. BOBROWSKI: I've got a question. Is Passport moving in with Anthem April 1st?

COMMISSIONER LEE: I don't believe

so.

MS. BASHAM: We are not.

COMMISSIONER LEE: Yes. That is a no.

MS. BASHAM: I don't know what that relates to, but we are not.

CHAIR PARTIN: Okay. Great.

Next up on the agenda is an addition, and this relates to old business from our last meeting. Peggy Roark raised some questions at the end of the last meeting, and there wasn't really a lot of time to have any discussion or for DMS to form any response to her questions.

So she had two questions. One was: Will the MCOs (audio glitch) more drug rehab time to what's allotted for rehab and then also what are the provisions for team rehab?

And, Peggy, if you'd like to add something else or speak to that, you may.

MS. ROARK: Yes. This is Peggy Roark. I appreciate you letting me speak. As we know, a lot of people with mental health and substance abuse, 28 to 30 days is not long enough for them to recover or to get

any type of help that's going to keep them from relapsing or ending up in jail or dead. As some people's been chronic users for ten years and, you know, going into a 30-day program and getting back out or being in jail and then coming out.

Suggested six to twelve months and then IOP, intensive outpatient program, I think some of this would help with some of our people that's struggling with mental health and drugs and having dual diagnosis.

And, also, we have a lot of young adults, teens that's getting into the drug use as well. So I feel like that we need some more time and health in those areas. If anybody wants to address this, I'd appreciate it.

COMMISSIONER LEE: Good morning, Peggy. Thank you for those questions. Yeah. We agree that services, you know, should definitely be based on a recipient's needs. Sometimes our hands are tied, for example, with the IMD exclusion.

Medicaid can't pay for those sorts of services, but we do offer a really wide

continuum of care for substance use disorder services from early intervention through inpatient hospitalization, and the services are available for all ages. And the length of service is usually determined by medical necessity criteria based on a recipient's needs and guided by the American Society of Addiction Medicine, or ASAM, that assessment, to determine appropriate level of care.

And for residential care, I talked about the IMD exclusion a little bit. So we have a waiver. Our 1115 waiver allows us to provide individual residential stays that exceed 30 days. However, the overall statewide average can't exceed 30 days.

So what that means is we may have somebody who's in rehab, for example, and their length of stay is 40 days and then we have somebody who's 20, and that's 60 days together. So on average, it's no more than 30 days. So at the federal level, our hands are tied just a little bit, but we're trying to work around through that through some of our waivers.

And as far as the teen drug rehab goes,

we do have substance use disorder services that are covered for adolescents, and we do see an expansion in the programs with more adolescent programs becoming available. And there are existing providers in specific programs such as residential and intensive outpatient programs that specialize in adolescent treatment in different areas of the state.

So definitely know this is -- this is a topic of great concern for us, and we work closely with our partners in behavioral health to make sure that we are continually looking at the services we provide and adding to our continuum of care when possible.

So if you have anybody that needs services that are having a difficult time accessing them, if you'd reach out to us, we'll make sure that we can connect them with the appropriate person or entity to help schedule their services.

MS. ROARK: I appreciate that, Lisa.

CHAIR PARTIN: Okay. Any other comments?

(No response.)

CHAIR PARTIN: Okay. Thank you. Thank you, Peggy, for bringing that up.

MS. ROARK: You're welcome. Thank you for listening and giving me time to talk.

CHAIR PARTIN: Okay. So the other two items on the agenda are a reminder. As you know, I like to add things on the agenda just to keep us reminded of what's coming up and also so that I don't forget those things.

So we'll have a maternal/child health update again in July. And then at our next meeting, we'll have information regarding increased reimbursement for waivers.

And next up is the commissioner.

COMMISSIONER LEE: Okay. So just jumping into the updates here. So update on unwinding for Medicaid following the state of emergency.

So we do have a high-level timeline for renewals. As you know, the Public Health Emergency prevented us from removing anybody from the Medicaid rolls. So what that means is we have basically two groups of people that we need to focus on -- or actually

three.

One are those individuals who have been enrolled in Medicaid for the very first time and are not familiar with the recertification or renewal process. We have those other groups that are in Medicaid that have gone through the recertification in the past but not recently so may need a little bit of help. And we have those individuals who we think may roll off of Medicaid as we start our unwinding process.

We are going to start -- you know, the continuous coverage will end March 31st of 2023. So we're just coming right up -- just a few days, it's going to end. And so that means that we're going to start doing our renewals for individuals whose coverage would end on May 31st. And so we're going to spread all of those renewals out over a 12-month period. And, again, individuals -- we're starting with May, individuals who will be renewed during that month.

We do have some caseload planning because, as you know, some of these cases are -- rather than doing everyone who would

have rolled off at a certain point, for example, we're going to spread those cases out over a period of 12 months so that our workers have time to process those cases and that our individuals have plenty of time to plan for their renewal.

Our priority cases in May -- in addition to some of the general cases that we're going to process, our priority cases in May are going to be those Medicare-eligible individuals who can enroll in Medicare. And then in June, we have a special circumstance population, which is about 14,000 beneficiaries, that we will prioritize in June. And then July ongoing, we're going to prioritize those individuals who we know may be leaving Medicaid but would qualify for a Qualified Health Plan on our state-based exchange.

And overall, for example, our renewal snapshot, we know that -- of those about 240,000 individuals that we anticipate to not qualify for Medicaid, we know that the bulk of those individuals are aged 19 to 64. That accounts for about 67 percent or 158,000

individuals out of that 236. And then we have about 60,000 children 18 or younger. That's about 25 percent of the population we anticipate may lose coverage. And then the rest, or 8 percent, are 65 or older.

We have been having stakeholder meetings. We had one yesterday. Senior Deputy Commissioner Veronica Judy-Cecil has been facilitating and been delivering those presentations. She had one yesterday. We have another one coming up March 27th, and we have ongoing stakeholder meetings the third Thursday of each month around 11:00.

One way that individuals in this group can stay informed of our unwinding is our unwinding website which I am going to put in the chat, which is MedicaidUnwinding.ky.gov. So I'm going to put that website in the chat so that you all can go to that website and get information on unwinding and stay updated and informed on that.

So I'll pause and see if there are any questions related to the unwinding.

(No response.)

COMMISSIONER LEE: Okay. So I'll

go on down, then, to reimbursement updates and thoughts of us regarding improved reimbursement to providers.

So many of you all may know that this past -- this week, I think, Monday, Governor Beshear signed Senate Bill 75, I believe, House Bill 75. I'll get the number later. But he -- and this was the outpatient reimbursement improvement program for our hospitals.

So what this means is we have a special payment to our hospitals that will allow them to receive the average commercial rate. And one of the reasons that we were able to do this special payment is because the hospitals -- in partnership with all of the hospitals, they will be putting up the state match for that increased reimbursement for the hospitals.

So when we talk about improved reimbursement rates for providers, you know, we would love to pay the providers whatever amount we could to make sure that we retain our providers and that we recruit new individuals, new providers into the Medicaid

program.

And the issue is: Where do we get the state match? Because we know that the Medicaid program is largely funded by federal funds. So coming up with that state match is where we kind of struggle. I know that, you know, the legislators have to allocate funds in the budget for us to be able to increase reimbursement.

So outside of that, what we would like to start looking at, and we would like all of the TACs that are represented here, is to start helping us look at our reimbursement rates, our fee schedules for all the different services we provide and see if there's one or two codes or maybe a handful of codes that we could look at increasing reimbursement or changing reimbursement, which would be a little bit more easier to do than just a sweeping-wide, across-the-board raise for all providers or service codes.

So I think we need to be very strategic when we're looking at our reimbursement rates. And that's what I ask of the TACs, is to just kind of help us identify a handful of

codes that would make a big difference in the lives of those we serve and would help -- help the providers cover some of -- more costs of the services that they deliver to our Medicaid members.

And I know that's a topic of great -- great concern and a topic that is very popular these days among our providers. So I will see if there are any questions. I'll stop and see if there are any questions about -- about what I just said.

DR. SCHUSTER: Commissioner, this is Sheila Schuster. Are you asking the TACs also to look at our ability among our providers to put up the state match?

COMMISSIONER LEE: Yes. I mean, any -- again, where else are you going to get a return on your investment? Because if the Federal Government -- for example, for our expansion population, they pay 90 percent of the cost. So if the providers could put up -- somehow, you could find a way to get that state match, I know the hospitals are doing this through a provider tax.

So I know that it's easier for the

hospitals because all hospitals take Medicaid. Not all dentists take Medicaid. Not all behavioral health providers take Medicaid. And so a tax would have to be broad-based around each provider type.

And I know that our finance -- our CFO, Steve Bechtel, has looked at this at several different times. Not every provider type is subject to that tax or could pay that tax. So if you want, we can go into a little bit more of that at our next meeting, maybe, you know, which providers are currently paying a tax, which one could.

DR. SCHUSTER: I think that would be helpful. Some of us have not ventured down that road yet, and if there's time, Beth, at the next meeting to add a short presentation from Medicaid.

We all want improved rates for sure. I think behavioral health has not had one since 1999, so we're not even in this decade, two decades. But I think that would be helpful.

Thank you, Commissioner.

MR. WRIGHT: Yes. Commissioner, this is Eric Wright. And as a member who

represents many families who have children with intellectual and developmental disabilities that are on the Medicaid roll and receive services through person-directed support, you know, personal person-centered supports, what do you envision in that regard for an increase in Medicaid (audio glitch) and services there?

COMMISSIONER LEE: And are you specifically referencing the waiver services?

MR. WRIGHT: Yeah. I'm specifically waivering -- you know, I'm talking about waiver services as it relates to person-centered supports when they control their own budgets.

COMMISSIONER LEE: Yeah. So I think at the next MAC meeting, we're going to have director Pam Smith, in May, I think, provide a presentation on reimbursement waivers and some of the things that we're looking at as far as a rate study. So Pam will be presenting on that, and I see it's on the old business.

So I think, Mr. Wright, next -- in May, we'll have more information on that topic for

you.

MR. WRIGHT: Thank you very much.

MS. EISNER: Nina Eisner. I just wanted to thank you and DMS and the Cabinet and the governor's office for support on House Bill 75. It makes a huge difference to hospitals, and I think that it is really the epitome of an amazing partnership that we've had for a number of years around HRIP.

And so just thank you very much for all of your support and that of everyone at the Cabinet.

COMMISSIONER LEE: Thank you, Nina, for your partnership and support. We think that that House Bill 75 was definitely a monumental task. It was bipartisan. It had a lot of support, and it's going to do great things for hospitals in Kentucky, in particularly rural hospitals. So we're very excited about what House Bill 75 is going to do for the future of Kentucky.

CHAIR PARTIN: Commissioner, I have a couple of questions. For the provider TACs, would that -- it almost sounds to me -- and maybe this will be explained at the

presentation at the next meeting that we just discussed. But it sounds like providers are paying a tax to pay themselves more money, so they're funding their own reimbursement. Is that --

COMMISSIONER LEE: That is correct. And our CFO just put a little -- in the chat, he put the actual statute that governs those, and it's 42 CFR 433.56. And it details allowable services for provider TACs. And, again, we'll kind of make that a little bit more understandable. We'll put it in laymen's terms.

But sometimes it gets a little bit wonky, I think, when we start talking about statutes and stuff like that. But if any of you are interested in going out and looking at that statute, you can. But at the next meeting, we'll definitely be able to give you a little broader overview of what that means. So I think it will be very interesting for this group to hear.

CHAIR PARTIN: And then my other question is, for APRNs, they're reimbursed at 75 percent of the physician rate, and that is

probably the lowest in the country as far as reimbursement goes. And so I think that the TAC should look at the codes, as you suggested, that could help to improve reimbursement for certain services.

But I would also like DMS to consider raising that percentage on the reimbursement for APRNs because that is really low, and it doesn't really cover your overhead, you know. The expenses for running a practice are the same as everybody else, but the reimbursement is less. So it makes it more difficult for them to provide services to Medicaid recipients.

And I'd also like to add that I think a lot of nurse practitioners do accept Medicaid patients, and so it would be, I think, an improvement for -- what do I want to say? It would help to improve access to care if that reimbursement overall percentage could be increased. So it's something to think about maybe and talk about later.

COMMISSIONER LEE: Okay. Thank you for that.

CHAIR PARTIN: Any other questions

for the commissioner on that?

DR. COMPTON: This is Dr. Compton. I have a couple of questions for the commissioner.

CHAIR PARTIN: Go ahead.

DR. COMPTON: In light -- it's about the enhanced dental, hearing, and vision benefits. It's my understanding the regulations were found deficient recently, and if that's the case, I'm wondering where we go from here.

Is DMS still going to keep their application in with CMS, and do the MCOs, do they revert to the 2022 benefits? Where do we stand if that's the case, if the regs were found deficient? That's my understanding.

COMMISSIONER LEE: So thank you for that, Dr. Compton. Yes, that was going to be in my other update, so I'll jump into the legislative update.

DR. COMPTON: I apologize.

COMMISSIONER LEE: That's perfectly fine. That's a good segue into legislation. So as Dr. Compton just stated, our regulations regarding vision, hearing, and

dental, where we expanded services to adults, were found deficient. We are still providing those services right now.

And then one thing that may impact our provision of those services is Senate Bill 65. Senate Bill 65 states that we cannot file another regulation, and it kind of null and voids our services.

So the governor can override Senate Bill 65. And if that happens, you know, the legislators are back in town on the 29th and the 30th, and they can override his veto. So if the governor vetoes Senate Bill 65, the legislators can override his veto, which would make that in effect.

So what I would recommend is that those of you on this -- in this meeting who would like to see those services continue for adults, to contact your legislators and tell them that you support the services, those expanded services that we're providing in vision, hearing, and dental.

We do -- our plan is to continue to provide those services as long as we can be in compliance with state law. We are looking

at all options as we move forward if Senate Bill 65 is vetoed and then subsequently overwritten, we're looking at all options as are the MCOs.

You know, I know there's been some conversation about reimbursement rates and, you know, can we keep the increased reimbursement rates. And my response to that is a lot of those rates are contingent upon the service. So, for example, we have extended dental services to two cleanings per year. If adults can only get one cleaning per year, then there's nothing to reimburse. Likewise, with some of those services, there would be no services to reimburse.

So I think that both the department and the MCOs are exploring all options and keeping our eye on legislation. And as soon as we determine the outcome of Senate Bill 65, we will try to communicate with providers.

We have been a little hesitant to do a lot of communication to providers and members regarding these services given that the regs were found deficient and given that

Senate Bill 65 may impact our ability to continue those forward. So, again, we just recommend to everybody on this call that supports those services to contact their legislators and voice their support as we go forward.

And then the other piece of legislation that I wanted to talk about was House Bill 75. The bill was signed on Monday. And, again, House Bill 75 is -- we have a -- it's a directed payment, basically, for the hospitals. And we had that on inpatient services which allowed the hospitals to garner that average commercial rate for inpatient services. House Bill 75 extends that out to outpatient services.

So now hospitals will be able to receive that outpatient -- that increased reimbursement for both inpatient and outpatient services. So, again, a very big win for the hospitals and the state as a whole as we continue to try to find ways to improve the delivery of healthcare services throughout the state and continue to take care of our providers so that they can remain

viable.

Another update that I would like to give is that we did receive approval from CMS for our community health worker program. So beginning July the 1st of 2023, providers -- certain provider types will be allowed to bill for services provided by community health workers.

We'll give a bigger update at the next -- in May, at the MAC meeting in May. And we can actually do a little presentation with the community health workers and who can bill and what codes and the rates and that sort of thing.

But we have to make sure that some providers right now -- I think some FQHCs and RHCs may be receiving grant funds from the Department For Public Health to deliver those community health services right now.

So our goal is to have some sustainable funding for community health workers going forward, and so those providers who are currently utilizing grant funds will not be able to bill until those grant funds go away. Otherwise, that would be a duplication of

payment. So those are some other things that we just need to talk about. But community health workers will be effective -- providers will be able to bill for those services effective July 1st of 2023.

And I think that that is -- that's all the updates that I have right now. I'll stop to see if there are any additional questions.

CHAIR PARTIN: So at the next meeting, Commissioner, that DMS will give a report on billing for community health workers?

COMMISSIONER LEE: Yes.

CHAIR PARTIN: All right. Thank you. Okay. It doesn't sound like there's any questions.

So let's see. Next up is a presentation from DMS regarding rural health clinics' and FQHCs' reimbursement and reimbursement for multiple visits on the same day.

COMMISSIONER LEE: And Senior Deputy Judy-Cecil couldn't be here with us today, so I'm going to step in and give the presentation if -- Kelli, if you can allow me to share my screen.

MS. SHEETS: You should be able to right now, Commissioner.

COMMISSIONER LEE: Okay. And let me see. Can you all see my screen?

CHAIR PARTIN: We just see you.

COMMISSIONER LEE: Let's see. Is it -- are you seeing it now or --

MS. BRINDLEY: Nope.

COMMISSIONER LEE: Okay. I've got to hit share. There we go. So let's see. Let me pull up my presentation. There we go. Okay. Let me see if I can try to get this a little bit -- okay. My computer is giving me a little bit of a -- there we go.

Now, can -- you all can see just the presentation itself?

DR. THERIOT: Perfect.

COMMISSIONER LEE: Okay. Great. So here are just some quick facts about community -- I mean, rural health clinics and federally qualified health clinics. So a rural health clinic is a clinic -- let's see if I can -- there we go -- a clinic located in a rural or underserved area with a shortage of primary care providers, of

personal health services, or both.

And there's some links down here at the bottom, and we will share this presentation with you all so that you can look at these links if you have further questions.

A list of the services that these rural health clinics, FQHCs, and CCBHCs provide are here. I don't think I'll need to read all of this to you. But, basically, rural health clinic and a federally qualified health center have been around for quite a while, and they're very similar.

An FQHC can also -- there can also be an FQHC look-alike. The only difference between an FQHC and FQHC look-alike is that the FQHC receives grant funds from the Federal Government, and the look-alike does not. But they both look -- have the same services. They provide physician services, Medicare Part B covered drugs, homebound visiting nurses services.

And then the CCBHC, or the certified community behavioral health clinic, is fairly new. This type of clinic primarily focuses on providing services to individuals with

serious mental illness, substance use disorders, child and adolescents with serious emotional disturbance. And we'll talk a little bit more about them in the presentation. But they do provide community, mental, and substance use disorder services.

We have 205 rural health clinics in Kentucky with a final PPS rate. We'll get into a PPS rate here in just a minute so that you know exactly what that is. We have 140 with interim PPS rates, and rural health clinics are located in 99 of our 120 counties.

We have 32 federally qualified healthcare centers in Kentucky with our final PPS rate and 6 FQHCs with an interim PPS rate. And our FQHCs are located in 28 of our 120 counties.

Again, our certified community behavioral health clinics are fairly new. They are actually a demonstration program. We have four right now providing services in 42 of our 120 counties.

Well, I'm sorry about that. My computer is not -- there we go.

So here are our locations of our FQHCs and RHCs. The blue dots represent FQHCs, and they only include their headquarters. And no satellite offices are included. So you can see where we have our FQHCs. The orange dots represent rural health clinics.

And as you can tell, we do have some areas that overlap here in eastern Kentucky. We have FQHCs and RHCs in some of the same locations, so that kind of tells you where all of those facilities are.

So what is a PPS rate? A PPS rate is a prospective payment system rate, and it's a type of reimbursement in which we make a payment based on a fixed amount. So rural health clinics, FQHCs, and CCBHCs are the only providers in Medicaid that have this PPS rate, and it's an individual rate setting process.

Clinics are eligible to receive one reimbursement, one PPS reimbursement per patient per day regardless of the intensity of services provided. The reimbursement rate is based on the average of the provider's cost per patient per day. We'll get into it

a little bit more here in a minute. And all the facilities receive an increase annually as -- based on the Medicare Economic Index. So once a PPS rate is established, each year, that rate is increased by an MEI.

So I want to go back to the one patient per day regardless of the intensity. So some FQHCs, RHCs may have a provider, you know, physical health, and some may have a dental office. So in operation, if an individual goes in and sees a physician and a dentist on the same day, that clinic would receive one PPS reimbursement.

But if an individual goes in to a clinic -- let's say they go into an FQHC or RHC and they have a service and then they leave that clinic and they fall or they cut themselves and they go back, they would receive a different reimbursement -- different PPS for that service because it was not part of the original reason that they went in to see that clinic. So it has to be vastly different, but there are some instances in which they could receive two PPS reimbursements per day.

So all of the facilities initially go through an interim rate setting. So, basically, what this is is the facilities -- and I'm probably going off script here, but you all can read what's on the screen and what's in the presentation when we get it. But, basically, a facility when they newly open, they submit information to the Department to determine how much it costs for them to do business for Medicaid members.

So we look at their interim information that they send, and we set this interim rate that they get paid for about a year. And basically, we consider, of course, the entity type, whether it's an FQHC or RHC, the geographic region, their operating hours, and any specialty services that they provide.

So then we set an interim rate that they receive for services. Once we set that final rate, after about a year or so, all of those claims that received an interim rate would be adjusted to their final rate.

This is why it's really important for us to look at the true cost of providing those services. Because in the event that we

artificially inflate or if we get an interim rate that is not very accurate -- let's say it's too much or too little. If it's too little, the provider is not going to get enough reimbursement to continue to provide the services. If it is inflated, when we do our retroactive adjustment, those providers will have to pay back any overpayment.

And in the past, we did have quite a few facilities that had an inflated rate. And when we went to set their final rate, it caused a real hardship for them to try to reimburse for the services that they had received that were not tied closely to their actual final rate. So, again, really important to set that interim rate as close to what we think the final rate will be as possible.

So then, when the final rate is established, we basically look at 100 percent of the reasonable cost of providing Medicaid services. So the reasonable cost of the facilities is determined, of course, based on a review of their base year universal cost report. And their base year is the first

full fiscal year after Medicaid enrollment that the clinic was operating at intended capacity, but it's not to exceed 24 months from their Medicaid enrollment date.

So, basically, in that final rate setting process, what we're doing is giving providers time to establish their practice so that we can see, when they are fully functional, what that practice looks like, what their cost is going to be, and we then complete their final rate setting.

And it's determined by the ratio of Medicaid-apportioned total costs divided by the total number of Medicaid daily visits. So, basically, what we do is we look at how many Medicaid members they have, and there's a form that I'll show you here in just a minute that we look at.

And then if a facility changes its scope of services after the base year, we can adjust the PPS rate if the CIS, the change in scope, qualifies using a MAP form. So, basically, what that means, if there's an addition or deletion of services and it dramatically impacts the cost of that

facility's rate, we can do an adjustment for that change in scope.

This is just an example of a cost report for Medicaid cost allocation. And you can see this Title XIX is Medicaid, and we look at the number of units of service. We look at cost, and we come up -- for example, here's -- this is a very simple explanation. This would be the total cost for the facility. But then when we factor in how much of that cost was allocated to Medicaid, then we come up with a total cost that would be Medicaid eligible.

Then we just go in and look at the rate sheets. Here's just an example of a rate sheet to calculate the PPS rate, and we come up with the PPS rate and the effective date. So the effective date, for example, and this is 7/1 of 2022. It was 166.30. So the PPS rate that was effective in 2020 was 163, but it looks like the interim was 159.

So in this case, this is pretty close to what the interim was. It's a little bit more, so this provider would receive additional funds when we adjusted those

claims. Now, had this PPS rate been $180, the facility would have owed the Department back money when we developed that final rate.

So we talked about change in scopes of service, and that allows us to adjust that PPS rate. A change in scope can occur when adding or deleting a covered service or increasing or decreasing the intensity of a covered service.

And so some items that are not -- that would not be a change in scope or a change in service would just be just a general decrease or increase in the cost of existing services and, you know, wage increases, renovation or capital expenditures, change in ownership. So those sorts of things would not constitute a change in scope. It would not allow us to change the PPS rate for a facility.

Again, this is just an example in a change-in-scope form that a provider would complete in order to see if they qualify for an adjustment in their PPS rate based on a change in scope.

So in Kentucky, again, we have 29 in-state FQHCs. Their final rates range from

$103.52 to $409.27. We have 32 out-of-state FQHCs, and we just pay those providers their medical visit rate based on their home state. We do not look for a Kentucky-specific rate -- PPS rate for those facilities.

Rural health clinics, we have 193 in-state rural health clinics whose rates range from $65.46 to $337.28. And of these, 34 have rates below $99.75 and have requested the average payment rate of $99.75. Again, we have 14 out-of-state rural health clinics, and we pay those providers based on their rate established by their home state.

Now we get into the certified community behavioral health clinics. Again, this is a fairly new provider type. They are in a demonstration program. In 2014, Congress enacted a program to test a model to improve behavioral health access and integration to care, and one of the reimbursement methodologies that states could use was the PPS rate that was allowed for rural health clinics and FQHCs.

So Kentucky, in 2020, we were selected to participate in a demonstration program,

and we went live in January of 2022. So in 2022, also, the Safer Communities Act came out and extended or expands the demonstration project to run through 2028.

Currently, we are in the demonstration phase of implementing the CCBHC program, and we are currently in -- demonstration year one ended in 12/31 of 2022, and cost reports are now being completed for demonstration year two rates. We have -- four community mental health centers were chosen to participate in the demonstration, and cost reports were submitted in 2022 for demonstration year one.

And thinking back to how that PPS rate is established, again, they have to be in operation for quite some time to kind of see how their services will be established and the rates that would be most applicable to delivering those services once they are fully established.

Total costs, again, are allocated to direct services using statistical data. And then the PPS rate is only paid for Medicaid-covered services, and the rate is adjusted by the Medicare Economic Index to

arrive at the payment rate. So each year -- so the CCBHCs are, again, reimbursed that PPS rate as the RHCs and FQHCs, and the rate is adjusted each year.

And then the rate setting process. This is just an example of the rate sheet, how we calculate the PPS rate for a CCBHC and, again, very similar to the FQHC process.

So I'll stop there, and I will stop sharing my screen and see if there are any questions that we can -- we can answer.

CHAIR PARTIN: I have a question, Commissioner. You said that Kentucky has out-of-state rural health clinics and FQHCs.

COMMISSIONER LEE: Yes, we do.

CHAIR PARTIN: How does that happen, that we're paying for -- Kentucky is paying for services in another state?

COMMISSIONER LEE: So it's -- typically, it's our border states so Tennessee, Ohio. And we have some FQHCs and RHCs that are right on the border of our state. And so we do have some individuals in Kentucky who it's closer for them to go to that facility, or they have an established

relationship with that facility. So they will go to those facilities. And in that case, again, we just enroll them and reimburse them what their state had established that their PPS rate was.

CHAIR PARTIN: Okay. So their rate is just based on the services that they provide to Kentucky Medicaid patients?

COMMISSIONER LEE: Correct.

CHAIR PARTIN: Okay. I understand. Thank you.

COMMISSIONER LEE: Any other questions about the PPS rate?

(No response.)

CHAIR PARTIN: I guess not. Okay. Thank you.

COMMISSIONER LEE: Thank you.

CHAIR PARTIN: We had a question in the chat about letter E under old business. I don't have a letter E under old business on the agenda.

COMMISSIONER LEE: Oh, a report from DMS about deleted behavioral health extended service CPT codes.

CHAIR PARTIN: Okay.

COMMISSIONER LEE: So the AMA did delete some of those extended codes, and we have been having lots of internal discussions and trying to find out ways for providers to make up for those codes being deleted.

One of the things we did is we reached out to our partners at the National Association of Medicaid Directors, and they polled all states. And most states said this was not an issue for them for some reason.

We had -- for example, North Carolina stated they don't cover those codes in outpatient therapy. We had some other answers. For example, Oklahoma uses H codes. They find -- they feel that the HCPCS codes give them more flexibility than CPT codes.

So we're still examining and looking at what we can do to make up for those codes. Again, we know it's very important that we get a solution to this sooner rather than later, and we'll continue to look for a solution.

And I would ask if -- Deputy Commissioner Leslie Hoffmann is on the meeting, if she has anything to add to that.

MS. HOFFMANN: We are currently working on a draft communication and hoping to have that out in the next couple of days. Again, just to remind everybody that the delay was only for us to take some extra time to try to assist with this issue. So should have something out very soon, like, in a couple of days.

COMMISSIONER LEE: Thank you, Leslie.

DR. SCHUSTER: And I'd like to thank Leslie and you, Commissioner, because this came up at the January BH TAC meeting and was a huge surprise to all of us including DMS and to most providers. But I have continued to hear -- and I just want to speak up -- from providers that it is really creating a huge problem.

So what we're talking about here are codes for services that would run beyond the typical, you know, 50-minute, one hour. And there are situations -- there are types of therapy that are provided that do require longer periods of time than that. So we're hearing from providers about Medicaid

members, patients of theirs who are decompensating without the intensity of those codes.

So just a little extra nudge. I know you all know that, but I feel like as the chair of the TAC, that I need to bring that up because we keep hearing from folks about the problem. And, in fact, one of our folks are looking into, you know, submitting comment to the meeting that's coming up in May where they're going to look at this issue at a national level.

So just want to thank you for your efforts on this, and we are waiting with bated breath, as they say, Leslie, for your communication.

COMMISSIONER LEE: And, Dr. Schuster, we definitely understand the importance of it. And particularly for our children, I know we have had several individuals reaching out for us. You know, the Children's Alliance is definitely on top of this, also, and they have reached out to states and have given us some information that -- how other states are working around

some of this.

So, again, as Leslie said, we just want to make sure we get it right, and we will have a communication out in a few days and hopefully get a resolution for this.

DR. SCHUSTER: Wonderful. Thank you so much. We appreciate your work on it.

CHAIR PARTIN: Okay. And I will put that on the agenda for the next meeting.

Okay. Let's see. Next -- oh, next up is approval of the letter to the governor regarding a workforce study. At our last meeting, we voted to send a letter to the governor, and Sheila Schuster has -- gave us a report and has written a draft letter for us which I sent out last night.

And I apologize for sending it out so late. Yesterday was one of those days that there just was not enough hours in the day to get everything done.

But I have received some comments this morning from people about the letter, and so I would like to ask if we could have a motion to approve the letter to get that sent to the governor.

MS. ROARK: I make a motion to approve it. This is Peggy Roark.

MR. GILBERT: And I'll second it. I'm Kent Gilbert.

CHAIR PARTIN: Thank you. Any discussion?

MS. FRANKLIN: Yes, ma'am. I like the letter as it is, but I feel like it could be stronger if we talked about what having this assessment or this -- once we ask him for this work, what is the true benefit to Kentucky for having it? Like, what do we propose can be done with that information? I think something like that should be included in the letter.

CHAIR PARTIN: Okay. Any objection to that?

DR. SCHUSTER: Beth, I don't have an objection to it. This is Sheila Schuster, and I presented the information at the last meeting. And I sent the report -- I think Beth sent that out with the letter, the report that Deloitte did in 2013. I think I put a general statement in there that, you know, we need to know what our capacity is,

and it would give us the information to address those shortages, either in areas of the state or in types of providers.

I'm not sure that -- what outcome we had from the Deloitte study, quite frankly. You know, there were lots and lots of recommendations in there. But if you go back and look at the recommendations, I don't know how many of them were actually enacted or taken up.

I guess my feeling was that we really still don't know what our healthcare workforce capacity is, and it's been ten years. And it felt like we needed to get something going again maybe to give us the impetus to make something of it.

But I'm happy to -- I'm not real sure what we want to add in terms of what we think the outcome will be. I mean, I'm happy to add it.

MS. FRANKLIN: Yeah. I -- I like that, and that was my thought. Like, I know -- if we're going to ask him to do this, I feel like we just have to have the supporting information that says, well, with

this, we are equipped to do what within the school systems or whatever, to appoint more students to move into this field, or our goal is to increase minority participation in the healthcare field in more positions than entry-level or something to that effect.

Because otherwise, I mean, right now, I don't think it's strong enough for him to, like, okay, yes, I've got to do it. I think it's a good letter, but it's too easily -- in my mind, he can easily say, well, no. Nothing was done with the last one, so why am I going to spend the money to do it this time?

I think it's a point of we need to insert information -- and I don't know what that is -- that makes him say, yes, I absolutely have to do this because.

MR. MARTIN: Could we ask that someone from the MAC is part of this process, to make sure that our voices are heard?

DR. SCHUSTER: Well, I think, Barry, it would be done -- I'm sure it was done under Steve Beshear's administration with a contract bid-out, whether it was bid

out or what to Deloitte. Deloitte was doing a lot of, lot of work in the state at that time because of the Medicaid expansion and whether it was done as part of that or not.

I think the only involvement of providers -- well, actually, the provider involvement was extremely limited because they used most of the data from the licensure boards, which, as I pointed out in my presentation two months ago, is problematic because the licensure board other than the Board of Nursing doesn't really have great data on who is actually practicing and where they're practicing and whether they're practicing full-time or part-time.

So it was presented as a done deal, is my recollection. So your -- you know, maybe we want to make this a very different kind of process, which is a whole different thing. And the MAC seems to be a good place to -- because so many of the providers are here, maybe we want to restructure the ask, not only to do the study but to use the MAC as the forum for discussion, for recommendations going forward and not just leave it up to

whoever is gathering the data.

MS. EISNER: I would agree. Even if it's a statement as simple as MAC involvement and development and implementation of actions is also requested.

MR. MARTIN: Right.

DR. SCHUSTER: Okay. The other thing, back to Annissa's point, is that -- I started to put that in there, was that, you know, think about all the pieces of legislation even this session but certainly last session and all the discussion we've had about workforce shortages.

So we're taking a piecemeal approach, and whoever gets to a legislator with an idea, you know, something happens. And it may be -- to your point, Annissa, it may be around a particular provider group.

Nursing has certainly had a lot of those. Ken Fleming, I think House Bill 200, that was just signed by the governor yesterday or the day before, you know, develops a scholarship fund and kind of concentrates on areas of Kentucky with unmet needs.

So there's lots of ways to slice the pie, and maybe we need to put a sentence in that says, you know, lots of initiatives are being undertaken, but without knowing that base information and without some coordination, which the MAC could provide, you know, the MAC involvement and -- you know. I need to get your wording from you, Nina. It was great. But anyway, maybe tying it in in that regard, too. I'm happy to rework it from that standpoint.

CHAIR PARTIN: Any other -- okay. So I would like to get this letter to the governor sooner rather than later. So would it be all right with the council if Sheila rewrites the letter, incorporates the suggestions that were just made, and then we can't -- we can't do any approval outside of this meeting.

So would it be all right to approve the letter now saying that we will incorporate those suggestions and then get it sent to the governor?

MS. EISNER: I did just put up on the chat box what I had said but added, based

on the other conversation, analysis. So MAC involvement and analysis, development, and implementation of actions is also requested.

DR. SCHUSTER: Yeah. That's great. And I would try to add something to Annissa's point in terms of outcomes.

MR. MARTIN: Is it within our purview to be able to do that, to just give Sheila the approval to write the letter and send it on? I'm fine with that.

CHAIR PARTIN: I think what we would do is give Sheila the approval to write the letter. And then as chair of the counsel, I could make sure that it was -- that it incorporated everything and give the final approval.

MR. MARTIN: Okay.

CHAIR PARTIN: Whoever wants to give me that authority and get the letter sent.

MR. MARTIN: I'll make that recommendation --

MS. EISNER: Beth.

CHAIR PARTIN: Yes.

MR. MARTIN: -- if that's something

we can do.

MS. EISNER: I'll make that motion.

MR. GILBERT: And I'll make that second.

CHAIR PARTIN: Okay. Thank you. Any further discussion?

(No response.)

CHAIR PARTIN: Okay. Well, then, Sheila, thank you for doing that for us and getting those amendments --

DR. SCHUSTER: You're giving me a lot of power, folks. No, not really. I won't say anything nasty in there. I've got your language, Nina. Thank you.

CHAIR PARTIN: Okay. And so then we'll get the letter sent to the governor, and perhaps we'll have a response by our next meeting.

Okay. Next up is recommendations for the MAC, and we have a request because the person from the Nursing Home TAC needs to leave for another appointment, if they could go first. So go ahead.

Oh, wait a minute. There's another comment. Is there -- lots of comments in the

chat. Just a second. Okay. There was another comment, Sheila.

DR. SCHUSTER: Yeah. I've got it. Thank you.

CHAIR PARTIN: Okay.

DR. SCHUSTER: Thank you all for your input.

CHAIR PARTIN: So Nursing Home TAC, would you like to go ahead?

MR. SKAGGS: Sure. Excuse me. Thanks for letting me go first, and I apologize for being hoarse. I'm Terry Skaggs, chair of the Nursing Facility TAC.

We did meet on March the 8th. DMS did a presentation regarding the Medicaid unwinding, a schedule for revalidation of coverage for our nursing facility residents, and also the expiration of all PHE-related waivers on May the 11th.

Two big items that we have on our agenda. The first one is the -- our MDS crosswalk, and what that is is the current methodology that is utilized to determine our case mix rates. The current methodology expires on September the 30th.

We are currently in ongoing discussions with Medicaid and Myers & Stauffer to develop a new methodology under our PDPM assessment system to set our rates on a go-forward basis. And, again, those discussions are ongoing, and we are very hopeful that we will be able to develop something very timely and be able to move this forward.

We've had an item on our agenda for some time. It's regarding guardianship inaccessible assets. Medicaid -- this is a Medicaid eligibility for some of our residents when guardianship cannot complete the Medicaid application due to them not being able to access all of the assets of the individual.

And we asked at the meeting that the Department For Aging and Department For Medicaid Services get together to discuss a process for basically loosening the approval process for a guardianship resident until guardianship can have full access to the assets necessary for that final approval. Again, it's been an ongoing issue, but we feel like that we are moving forward in the

right direction and hope to get that resolved soon.

And that's all I had unless there are questions.

CHAIR PARTIN: Okay. Thank you, Terry.

MR. SKAGGS: Thank you.

CHAIR PARTIN: Okay. We'll go back to our regular schedule, and Behavioral Health is first up.

DR. SCHUSTER: Thank you, Beth. The Behavioral Health TAC met on March 9th. All seven voting members were there as well as DMS and DBHDID. All six MCOs were represented.

I'm not going to go into detail, but we had an excellent presentation from Data Analytics on a study that the TAC started about two years ago and that they took up the data and expanded it and really added to it.

It's on targeted case management and health outcomes for individuals with serious mental illness and looked at people with SMI. About 6,000 were in the study who had targeted case management for at least six

months within an 18-month period and compared them with Medicaid members with similar demographics and diagnoses but who did not receive targeted case management.

So the expenditures were not great. They were less than one percent of all expenditures annually across all MCOs, so targeted case management is not expensive. It does have some real benefits.

The TCM group utilized more healthcare services than the non-TCM groups, which is what we'd like. They had more outpatient primary care and preventative visits and fewer hospitalizations. They also had more ER visits for both behavioral health and physical health.

Probably the most significant and one that we had not expected was that people that were -- that got the targeted case management were less likely to have died during the study period than those who did not. So we had 4.5 percent of the population actually passed away during that 18-month period, which is certainly a very sobering statistic. But the TCM folks constituted only 3.6

percent of that population.

So we want to thank the Medicaid staff who were wonderful and the Data Analytics people and certainly thank Commissioner Lee for encouraging us to look into the data. I think it will direct us to look at other -- look at some other things that will be very helpful to us going forward.

We talked about the extended service codes being deleted. Justin Dearinger talked about putting up the dashboard.

I do want to report a victory, something that we've had on our agenda for probably two years that we now can take off, and that's the difficulty in getting reimbursed for people who have dual coverage with Medicaid and a commercial insurer. And I want to compliment all of the MCOs for being willing to come together to work on this.

Herb Ellis from Humana reported on it. They have come up with a single bypass list which has 88 service codes and three modifiers. And there will be a process -- the provider still must bill the commercial insurer, but there will be a uniform

attestation form and then the bypass list will be extremely helpful. And we're looking forward to that going live on May 1st. We're also looking forward to being able to stop talking about this issue that we've talked about for so many years.

We had an update from Leslie on all of the various waivers. We know that the hospital association continues to work on having a provider credentialing system, and we hope that that will be up by the time we have -- they will report at our May meeting.

And we have no -- we have no recommendations for the MAC, so a very busy meeting but very productive. Thank you. And I'll be glad to answer any questions. Thank you.

CHAIR PARTIN: Thank you, Sheila. Children's Health?

(No response.)

CHAIR PARTIN: Consumer Rights and Client Needs?

MS. BEAUREGARD: Good morning, everyone. Emily Beauregard. I'm the chair of the Consumer TAC and director of Kentucky

Voices For Health.

And our Consumer TAC met on February 21st. We met remotely, and we had a quorum present. We also welcomed a new member, Brenda Mannino, to the TAC, and she's representing AARP Kentucky. So excited to have her on board with us.

I just want to say that I have really appreciated the conversation about workforce capacity that you all have been having today. We really can't improve network adequacy without knowing what our real capacity is. And network adequacy has been an issue that the Consumer TAC has been discussing for many months now, probably more than a year.

And so, you know, in thinking about having a workforce capacity study, I think there's a lot of value in it. But having that data, and updated data, could be really useful as we look at how to work with licensure boards to collect more accurate data, working with legislators to be more targeted and strategic and how we, you know, identify what those capacity issues are and then look at investments in other efforts to

address any shortages.

But, you know, from the consumer perspective, we know that a lot of Kentuckians enrolled in Medicaid aren't able to get appointments in a timely manner or somewhere near where they live without having to travel quite a ways. And that's true for things like dental, for behavioral health, and a lot of other specialties. And so this is important for all of those reasons, and I just really appreciate your work on that.

It was something that we discussed at our last TAC meeting, network adequacy. And we have appreciated, you know, DMS sharing more information about what their process is, what reports MCOs provide, what the requirements are. And MCOs have offered to share information about the out-of-network care that they approve when there isn't someone available in network for a particular service.

We still think there are quite a few gaps there, gaps in how a Medicaid member would know, you know, how to get the out-of-network care if they weren't able to

find an in-network provider, gaps in how that's approved or not approved, and what, you know, any -- what appeal process may be available to someone.

So we're still working through those issues and trying to better understand, you know, how the current process works and then where we need to make some recommendations. So we'll be working on that.

And as usual, during our last meeting, we revisited a number of topics that we've been monitoring pretty much ongoing. But we focused primarily on the Public Health Emergency, the PHE unwinding and Medicaid renewals.

And I have to also say that we have appreciated so much the information that DMS has been putting out publicly in recent months and the stakeholder meetings that have been held this month and are going to be held once a month throughout this unwinding period.

If you haven't attended one of those meetings, they really are very informative, and I just want to say thank you to Senior

Deputy Commissioner Veronica Judy-Cecil for the excellent information that's getting out there because there's just been a lot of anxiety, of course, and confusion. And being able to, you know, hear what the timeline is, being able to see what the notices are going to look like, all of that is really, really helpful. And I hope that providers will be sharing a lot of that information with their patients.

So with that, I will say we did not end up making any recommendations at our last meeting, so I'll wrap up my report here. But I'm happy to answer questions or share more information if y'all need it. Thank you.

CHAIR PARTIN: Thank you, Emily. Dental?

DR. BOBROWSKI: Yes. This is Dr. Garth Bobrowski, and I wanted to again thank Commissioner Lee and her staff for all the help that they've given the dental community and being patient with us or patience with -- on dealing with issues. And we have to just keep working together on a lot of things.

But we had a TAC meeting on February the 10th, had a quorum. Won't take long but just many of our concerns were rebuilding the dental provider network. You know, like Ms. Emily was talking about, was just build workforce capacity.

One of the things we had done a few years ago was to look at -- there's quite a few dentists that are on the Medicaid rolls, but they see a very limited number of patients. So what we're -- we did this a few years ago, and we're going to try to do this again here coming up, was to do a report on the numbers of dentists based on a claims paid format. So we're going to look at this again.

But another thing we've been working with, and the commissioner has been very helpful on this, was developing a reimbursement level for basic dental services. And another thing is a level that the MCOs cannot go below. And either that's going to have to change by contract or legislation. We've discussed medical loss ratios.

And a tidbit of information is, like, this is one of the things we've been -- through the TAC and dentistry is working on, is getting patients ready to get back into the workforce. I mean, I can't imagine going to work with a front tooth missing, you know. Even though we wear masks, it would just still bug me. You know, so it's like a lot of our patients -- like, we want to get them where they feel confident about their smile, not having to hold their hand over their mouth when they talk.

So we -- there was a rumor going around that the Kentucky Dental Association was not in favor of these expansion codes, but we've been in favor of this for years. But hopefully we have expressed that to Commissioner Lee and her staff there, that we're working on this with them.

For example, since January 2nd of this year, there's been over four million dollars worth of dentures, crowns, broken smiles that have been fixed already. And we've been working through the KDA with the -- and with Commissioner Lee on Senate Bill 65. I think

it was House Bill 436, was the -- whatever is going on with the legislators and the governor, you know, it all could end in a week or two.

But if they're going -- we've been working with them as if they're going to end it or at least temporarily till 2024, is to at least extend it till July 1st so that patients that are in the process of getting a denture or partial denture or a root canal, well, that they can get this finished and the provider get paid for it in a timely manner. So we've been pushing for an extension, so we are contacting our dentists to contact their legislators to be in favor of this.

The other item was some of the reports that we are looking at getting, our DMS staff is able to get some of these without having to go through the MAC, so that's what we're working on. So at this time, there's no recommendations from the Dental TAC, and I just wanted to thank everybody again.

But another thing that I want to help -- I need help with is that the Dental TAC is looking at ideas of how do we move Kentucky

from being 49th in the nation in oral health upwards. So, you know, Behavioral Health TAC, Ms. Emily, other TACs, we're looking for some help and ideas on moving our oral health upwards. So we're tired of being 49th in the nation. We've got to do something. Thank you. That's my report.

MR. MARTIN: It would be nice if our in-state universities would take more in-state dental students. That would help a whole lot.

DR. BOBROWSKI: You're right. I know they take quite a few from Utah and a few other states around, and I don't know if that's a budgetary thing that they do but --

MR. MARTIN: Of course it is. 40 out of 120 on both schools are in-state. That was the last number I heard, so let's change that to 80 out of 120, and maybe that'll help us in the near future.

DR. BOBROWSKI: Okay.

CHAIR PARTIN: Good idea. Okay. Thank you.

Let's move on to Disparity and Equity.

(No response.)

CHAIR PARTIN: Okay. EMS?

MR. SMITH: Yes, ma'am. This is Keith Smith. I'm the chair of the EMS TAC committee. We last met on February 27th. We have several very large issues that we are having to deal with at the moment.

First off is a new preauthorization certification form that we are now required -- all EMS providers are required to submit for any nonemergency patient transfer we have to do. These new forms are really extremely difficult for our people to be able to complete because some of the information is information hospitals have to provide, and some of the information is information that the EMS provider has to find. But there's no way one entity can complete both sides of the form.

So at the TAC meeting, we did ask all of those insurance companies that were involved, if they would consider allowing EMS to use the Medicare PCS form which we've all been using for well over 10 to 15 years. It's a very easy form to complete. It's one that can be completed at the patient's bedside,

and it gives the information that the insurance companies need in order to make the determination of whether or not they're going to reimburse us for the transport or not.

We had two of our insurance companies agree on the spot that they would like to do that as opposed to using the new preauthorization form. However, we asked that all insurance companies look at accepting the Medicare PCS form in lieu of the new form in order to make it easier for our EMS providers to get reimbursed.

As of right now, it's not uncommon for our EMS vendors to be waiting on anywhere between 50 to 100,000 dollars in reimbursement simply because these precertification forms are not getting done and approved in a timely manner. So it's created a serious barrier.

To further rain on the parade a little bit here -- and I apologize for having such negative news. But we received word last week that Knott County EMS is going out of business in June because they can't afford to provide service any longer.

I also serve on the Kentucky Board of EMS, and we are trying to find ways now to see if, through mutual aide or some other way, we can get EMS coverage for Knott County. But we know of two other counties that are very close to having to throw in the towel and get out of the EMS business because they can no longer afford it because they -- the money is just not there.

We are in dire need of getting our reimbursement rates increased so that the cost that the inflation has pushed upon us are getting covered, so we can stay in business.

As an example. Some of our providers doing ABLS transport get reimbursed at the T2005 rate, which is actually a stretcher van rate, but that's what we've been instructed to bill it as. And it's a 55-dollar reimbursement.

Now, keep in mind, on an average EMS transport, we're committing about 125 to 130 dollars on every transport we send out the door by the time you figure in the fuel cost, the cost of the crew, the medical equipment,

everything that goes along with that. And when you're getting a 55-dollar reimbursement plus two dollars for mileage, that doesn't cover our costs.

We've got to do something, and we've got to do something quickly, or the EMS issue that we have in Kentucky is about to grow exponentially that we don't have a fix for.

Typically, on some issues, we can work things out. We can come to an agreement, and we can cover each other to a point. But given how bad the economy has taken a dive with people not being able to afford all the taxes that they pay for those systems that are tax-based, we are getting to a very dire point in EMS in Kentucky.

So these are all items that are being discussed during our TAC meetings. These are items that we have relayed to the legislators during the legislative session. They have been very open to hearing what we have to say.

The commissioner -- Commissioner Lee has been very open to understand what we're saying except we're getting to a point we've

got to have action, or we are going to be in deep trouble across the state of Kentucky when it comes time to transportation of our patients, out of hospitals to follow-on care, and, in some cases, just getting them to the hospital in general.

So, again, sorry to rain on everybody's day, but our situation is a little dire at the moment.

MS. EISNER: Nina Eisner. Is that a DMS form that requires the new authorization procedure for nonemergent?

MR. SMITH: Each individual insurance company is allowed to basically have their own variant of the form. And what gets us -- what causes our issues is where it's asking for such information as the NPI numbers for the hospitals, the ICD-10 codes for the patients. It's asking for technical information that EMS is not going to have access to.

Whereas, if we use the Medicare PCS form, we can identify by what the actual code -- or by what the actual cause is. So if they have contractures, we can mark

contractures. If they're a stroke patient, we can mark stroke patient. Basically, it's easy peasy to where we can mark what the issue is, and we're not having to hunt for codes.

And for those of you that have ever had to deal with the ICD-10 codes, you know, what I may think is an F91, to somebody else is going to be a different code altogether, simply because there are so many different variants to the codes. And we cannot expect our EMS folks to understand specifically what each patient has been coded as depending on what the physician that saw them last coded them as, so it's a challenge.

CHAIR PARTIN: Keith, does that --

MS. EISNER: We're talking about a delay in transportation, and we have all been talking about the adverse impact of that for all patients but most specifically for behavioral health who often require a nonemergent transport. So thank you, Keith, for the efforts of your TAC. It's a huge issue.

COMMISSIONER LEE: And this is

Lisa, and I apologize. I should probably know the answer to this question. But when you talk about insurance companies, are you talking about all insurance companies or just the Medicaid Managed Care Organizations with the form?

MR. SMITH: Great question, ma'am. Right now, it's the insurance companies that have Medicaid products. However, we have started noticing that more and more of the commercial insurance providers are requiring the same exact form to be completed.

COMMISSIONER LEE: Thank you. We'll have some internal discussions about this and see what we can do as far as the Medicaid portion of that is concerned to see if we can alleviate some of those burdens.

MR. SMITH: Thank you, ma'am, very much. I greatly appreciate that.

CHAIR PARTIN: Keith, does the TAC have any specific recommendation regarding the issue for reimbursement, or is it just generally you need higher reimbursement?

MR. SMITH: No. We have two basic recommendations. The first recommendation --

I'm sorry for all the noise. We're having new siding put on the side of our house today.

The issue that we have right now is the PCS form. If we can do away with the new preauthorization form that the insurance providers gave us and said that needed to be completed and we can rely simply on the Medicare PCS form, which is accepted widely by all insurance providers on the Medicare side, that will make it much, much easier for our providers to be able to get the reimbursement that they are due for the transports they are providing.

The second step is we need to work in order to get the reimbursement rates increased to be able to reflect what's been going on with the economy. It's just -- it's not just the Medicaid reimbursement that's low. We've run into other areas as well, especially when you have a specialty care transport where you've got a very sick patient that we have to put respiratory therapists, physicians, or even nurses on board to be able to do the transport. And

we're obligating upwards to 5 to 10,000 dollars on a transport with the people we're putting on the truck. And we're getting an 800-dollar reimbursement.

So there's a lot of things that we really need to do a deep dive on on how EMS gets reimbursed in Kentucky and nationwide from that perspective. It's not just a Kentucky issue. EMS nationwide is not in a good position right now.

CHAIR PARTIN: Okay. Thank you.

MR. SMITH: Thank you. And that's the end of my report for EMS.

CHAIR PARTIN: Any other questions?

(No response.)

CHAIR PARTIN: Okay. Next up, Home Health.

MR. REINHARDT: Hi, everyone. This is Evan Reinhardt with Kentucky Home Care Association. The Home Health TAC did not meet in February. Our next meeting is in April.

CHAIR PARTIN: Thank you.

Hospital?

MR. RANALLO: This is Russ Ranallo,

the Hospital TAC chair. We met on February 28th. We introduced a new member to the TAC. We had a quorum.

We just had follow-up items. Incarceration data, we continue to have hospitals that have issues with patients that in the system are still being listed as incarcerated and getting denials from the Medicaid plan. DMS is continuing to work on cleaning up and making that better, but we still have issues.

Molina emergency department claims policy. This is on there for a second time. There is a -- Molina has prepay and post-pay review policy for emergency departments that's been approved by DMS. They are still -- we are still waiting on the criteria around the policy to be shared with the hospitals. And this is the second meeting that we've asked for that criteria, and no updates are available.

We got an update on the HRIP. You guys heard earlier in this meeting. And then we talked -- had a good discussion about DSH finalizations for state fiscal years 2019 to

2021. We do not have any recommendations, and our next meeting is scheduled for April 25th.

CHAIR PARTIN: Okay. Thank you. Intellectual and Developmental Disabilities?

(No response.)

CHAIR PARTIN: Do we have a report from Intellectual and Developmental Disabilities?

(No response.)

CHAIR PARTIN: Okay.

MR. MARTIN: Chair Partin?

CHAIR PARTIN: Yes.

MR. MARTIN: I have a question for EMS. Is one of the issues -- are EMS services still under CON restrictions, guidelines?

MR. SMITH: Yes, sir, they are. However, House Bill 777 that was passed during the last legislative session has given some relief to the point that you can file for an immediate license using the provisions that were set up in 777. But by and large, that is for a restrictive license.

So let's say you wanted to go in and start a brand-new EMS service in, let's say, Jefferson County. You would have to go through the full CON process in order to get a license if you wanted to do everything that the license would allow you to do, to be able to do hospital transports, to be able to do nonemergency transports, emergency transports.

Otherwise, if you're looking for a specialized category such as what we've done for our hospitals, you can get a license under 777 that will allow you to take patients out and to take them to specialty care facilities. But it will not allow you to go out and do 911 emergency work in your community. That still has to go through the traditional CON process.

MR. MARTIN: So are some of these counties encountering whoever owns the CON, they're going under, but they just don't want to sell their CON?

MR. SMITH: It's -- in, I think, at least two -- if I'm not mistaken, in two of the situations, the counties own the CONs,

and they are contracting with companies because the county doesn't want to do EMS themselves. They don't want to hire employees themselves and incur the costs, so they've contracted out EMS.

And those two particular counties are the ones where the companies that were doing it have said we can't do it anymore. We've got to get out. So the county will still have the CON, but they won't have a service to provide because they have no equipment, and they have no employees.

MR. MARTIN: Okay. I was just curious if that was one of the hindrances.

MR. SMITH: Yes, sir. There's -- honestly, there's a whole lot that goes into this issue. This has taken years of issues occurring to get us to the point that we're in. This didn't just get created because of the turn in the economy. Unfortunately, though, the economy doing what it did has kind of been the death knell, though, for a lot of these areas.

MR. MARTIN: Okay. Thank you.

MR. SMITH: You're quite welcome.

CHAIR PARTIN: Okay. Nursing Services?

(No response.)

CHAIR PARTIN: Optometry?

DR. COMPTON: Yes, Chairman Partin. This is Steve Compton with the Optometric TAC. We met on February 2nd. We had a quorum.

The majority of our discussion was limited to the enhanced vision benefits that DMS has proposed. And we applaud those efforts, and we applaud the work that's taken place to date. However, we've got some concerns. And I will have five recommendations today. I'll try to make them brief.

The first comment is one of the enhanced benefits is for contact lenses for all adult and children who have Medicaid. And as proposed, it's either contact lenses or glasses. Our TAC recommends that contact lenses should be only available when they're medically necessary.

So the recommendation there is DMS should amend the Kentucky Medicaid vision fee

schedule 2023 to state: Adults and children receive a material benefit of one pair of eyeglasses per year and medically necessary contact lenses for one year. This is consistent with the proper standard of care and 907 KAR 1:362 and E, Section 5.

Our second concern is that the plan sheets that the MCOs sent out do not cover the provider cost, and providers cannot offer the intended benefit. So our recommendation there is -- I've got five pages here, but I'm trying to make it as brief as possible.

Our recommendation is that the MCOs should be required to offer the same reimbursement provided by DMS in the State Plan Amendment. If the same reimbursement cannot be provided, the reimbursement must be reasonable and at least cover the provider material and labor costs.

Comment No. 3. The covered contact lenses as proposed are outdated and could actually result in patient harm. The current benefit includes one contact lens per eye for an entire year, and I'll be honest. That technology went out in the 1980s. So our

recommendation there is -- I've got to find it. The recommendation is to cover the current technology with the contact lenses which are typically planned replacement lenses, whether they be one day, one month, one week, two weeks, but certainly not one per year.

I got my papers out of order. Here we go. So the recommendation there is DMS should revise the proposed contact lens benefit and cover more contact lens options when medically necessary. DMS should cover a set amount towards the contact lenses with the provider having the ability to balance bill for the remainder. This was the process utilized by the MCOs in prior years when offering contact lenses as a value-added benefit, and it worked very well.

Concern No. 4 is the quality of the covered eyeglasses should be improved. Our recommendation is the reimbursement of glasses must increase so that the higher quality materials are available. In the alternative, the MCO should be required to have a quality frame kit for providers to

utilize if the reimbursements are too low for providers to make the glasses in house.

And our fifth concern is prior authorizations should not be required for children's replacement glasses. That sometimes, quite often, results in a delay in school-aged kids getting the needed eyewear so that they can see what they're doing in school.

And our recommendation is DMS should remove the prior authorization requirement for children's replacement glasses. If the prior authorization requirement remains in place, MCOs must provide clear direction on the replacement administrative process, and replacement glasses must be available within a reasonable time frame.

That's our five recommendations. I would also like to request that we get a report -- if you would add to the agenda a report on the enhanced benefits for the next meeting of the MAC, please.

CHAIR PARTIN: Okay.

DR. COMPTON: Or a report from DMS.

CHAIR PARTIN: Okay. Steve, could

you tell me specifically what you want me to say?

DR. COMPTON: Oh, for the agenda item?

CHAIR PARTIN: Yes.

DR. COMPTON: Let me phrase it. I had it typed out. Just add an enhanced benefits update from DMS for the next meeting.

But now that stuff is tied up in Senate Bill 65, and the governor may veto. Or the governor may sign it, and the legislator may veto. We're just all in limbo right now.

CHAIR PARTIN: Okay. So that's the enhanced benefit for dental and eye?

DR. COMPTON: Dental, vision, and hearing, yes.

DR. GUPTA: Dr. Compton?

DR. COMPTON: Yes.

DR. GUPTA: This is Ashima Gupta, Physician TAC. I agree with all your recommendations --

DR. COMPTON: Thank you.

DR. GUPTA: -- as an ophthalmologist.

DR. COMPTON: Yes.

CHAIR PARTIN: Okay. Any questions?

COMMISSIONER LEE: Hi. I don't have a question. This is Lisa again. I'd just like to reiterate the importance of reaching out to legislators as soon as possible to make sure that the language in Senate Bill 65 does not prohibit us from going forward with these new expanded services.

DR. COMPTON: Okay. And I have not read the senate bill. I need to familiarize myself with that.

CHAIR PARTIN: Yeah. The -- I think the professional organizations will need to reach out to their members to contact legislators about that issue.

Okay. Next up, Persons Returning to Society From Incarceration.

MR. SHANNON: This is Steve Shannon, chair of that TAC, and I'll give the report.

We had a quorum. We received updates from Deputy Commissioner Hoffmann and

Leigh Ann Fitzpatrick on Medicaid and the status of the 1115 waiver, which we're all eagerly anticipating. We also got report from the six MCOs. They had really good meetings with the Department of Corrections. That was the result of our previous meeting -- we met in January. That was a result of a November meeting. And they were -- those were beneficial to both corrections and the six MCOs.

We had a member round-robin update really discussing legislation.

And the final piece, we discussed the 1115 waiver for people returning to society that California got approved. And their language had services can start 90 days pre-release.

So we have one recommendation to make, and our recommendation is that, when provided the opportunity, Kentucky Medicaid discusses with CMS extending the time frame for activating Medicaid benefits for individuals returning to society from incarceration included in the pending 1115 waiver amendment to be extended up to 90 days prior to release

but no less than 30 days prior to release.

We believe this extended period of time will allow for a smoother transition back to society, will ensure supports are in place for individuals as they leave a facility and go to the community and just sufficient planning.

And, again, our recommendation is, if given the opportunity, have a discussion with CMS. I've submitted this in writing as well, so Medicaid has it.

And in another piece we talked about, not a formal recommendation, is we're going to invite DJJ, Department of Juvenile Justice, to participate in our meetings. Obviously, we can't appoint them as a TAC member but have them join us as well.

Our next meeting is May 11th. That's the report. Thank you.

CHAIR PARTIN: Thank you. Any questions?

(No response.)

CHAIR PARTIN: Okay. Pharmacy?

DR. HANNA: Ron Poole, the chair of the PTAC is not able to join, so I was going

to give his report for him. They did meet on February the 8th.

Let's see. The first topic they discussed was they talked about the savings report for Senate Bill 50 and asked what the status of that was. The DMS representative who was there reported that it would be ready in the next four weeks or so. I'm not sure what the status is of that, but I think they were requesting to see where that was. I haven't seen that report yet personally.

The second thing they talked about was payment of clinical services from pharmacists and, you know, they requested that -- you know, asked if there was going to be a process put in place to reimburse pharmacists for these services. From what I understand, DMS said they're still -- you know, it's in the hopper, something they might be thinking about in the future but no progress at this time. So I think that that was an ask, which I'll go over here in a little bit, too.

They also talked about reimbursement for vaccinations and, you know, above and beyond just the vaccine as well. We're all

struggling with reimbursement, I think, sounds like from everybody.

But they did, you know, highlight one area, which was the polio vaccine. And I want to thank, you know, the Department of Medicaid Services for making it -- the polio vaccine, the Kinrix, is now put on the formulary. So as a result of those discussions, that was a positive win, so thank you so much for that.

Also was some discussion, ongoing discussion about the brand name, you know, shortages and formulary changes. And I just want to make sure, you know, that -- I want to basically say thank you to the Department of Medicaid Services for, you know, increasing our communication around that. We just want to make sure there's not any shortages. Because at the time of the meeting, they still had some of the major wholesalers were not able to furnish or get their levels up for the brand-name products or the generic, depending on which category we're in there, and this was problematic. But we worked through that, and I want to

thank you all. I think everybody across the state does. Thank you so much to Medicaid for that.

Also just want to bring to light -- you know, a lot of people don't understand the -- I think this has been brought up before. The Medicaid brand rebate program has placed many pharmacies in financial burden due to them not being able to meet their metrics for their generic compliance rates with their wholesalers, and this does financially impact them as well.

So you know, many pharmacists are losing major dollars, which there's not a lot of room there, believe me, due to the preferred brand, you know, formularies that we're seeing. And we just want to make sure that everybody is aware of that, and we keep our thumb on that so that pharmacies can be, you know, viable in our communities.

The next topic was community health worker waivers. I understand that's out. And the ask here was to see if there -- you know, Medicaid -- you know, if pharmacies would have the ability to hire and be

reimbursed for these services, as many of these services that go on in these areas are already being provided by pharmacies in some way or other, or they could be instrumental in that because they'd like to be able to bill for those services.

Also -- and the last topic, I think, is one that we've heard before. But, again, they wanted to bring it up and see if it couldn't be discussed further. It's basically because of some of the savings that we did see from Senate Bill 50. You know, they would like to see if some of the clinical services for pharmacy could be reimbursed for that and that the Department of Medicaid Services would consider that in the future.

And I believe that was everything. Let me make sure. I think so, and I thank you.

CHAIR PARTIN: Thank you, Cathy. Any questions?

(No response.)

CHAIR PARTIN: Okay. Next up, Physician Services.

DR. GUPTA: This is Dr. Ashima

Gupta from the Physician TAC. We did not meet since the last MAC meeting, but I just want to mention that our major topic of discussion over our last several meetings have been, you know, the impending primary care physician shortage crisis.

And I know we're all talking about the same thing with reimbursement and things like that. But we do strongly feel that, in the end, if we can invest in our primary care physicians, keeping our medical students going into primary care in Kentucky, that will improve overall health care and decrease healthcare costs.

It's a very long-term investment when we invest in any kind of preventative service. But, you know, we're seeing, you know, EMS, all these services that have to take care of patients that end up having poor health care and pouring money into those services. But we do need to try to improve preventative services.

And we appreciate Commissioner Lee meeting, you know, with us for serious conversations regarding the primary care

physician shortage, and it's honestly been quite depressing as well because we know DMS, their hands are tied. So we are trying to figure out ways, creative ways to try to keep our doctors in Kentucky in rural areas to lead that charge. So I don't have any recommendations. We did not meet.

CHAIR PARTIN: Thank you.

Primary Care?

DR. CAUDILL: Thank you. Thank you for the opportunity to present today. I'm Mike Caudill. I'm chair -- or outgoing chair of the Primary Care TAC. We met on March 2nd, 2023, with a quorum being declared. There was no recommendations for the MAC. The next meeting of the Primary Care TAC is scheduled for May 4th, 2023.

The current board of Primary Care TAC is being replaced with the exception of Barry Martin who shall remain on the TAC. The new members are Stephanie Moore, who is the current chair of the KPCA; Patrick Merritt, who will be the new chair of the PC TAC; Michael Hill; and Dennis Stauch (phonetic). I did not have a bio to present to you on

those people.

Items that we discussed and which have not already been discussed by Commissioner Lee here, is we discussed the disparity between 907 KAR 3:005 and 907 KAR 1:082 which deals with the requirement of providers finishing their charts and dating and signing them. FQHCs under 3:005 are required to do it within 24 hours of seeing the patient, and RHCs under 1:082, it's supposed to be within 72 hours. That disparity has been addressed.

There is currently an amendment going in front of the Interim Joint Committee on Health Services, or at least was as of our March 2nd meeting date, that would correct that. But in the meantime, CMS -- or DMS has said that we can rely on the 72 hours as set out in 1082.

The next thing is the establishment of core quality indicators, and that deals with our efforts to get that simplified. Because with six different MCOs and each having their own list, when you multiply that out, it becomes very cumbersome and burdensome on us and RHCs, also.

And to that end, there's been some meetings going on. Angie Parker with DMS was to meet with the MCOs on March the 6th. I do not know the outcome of that meeting. But CMS has declared that, as core indicators, they're focusing on four measures: Childhood immunizations, diabetes, maternal health, and social determinants of health.

And also, we discussed the follow-up on the dental workforce recommendations. And I noticed on Item 8, the health services workforce letter to the governor may include this, but this was a separate thing which was presented and adopted by the MAC.

And at that time, Veronica Cecil advised us that there was an informal group consisting of Kentucky's three dental schools as well as other stakeholders who were discussing the problems with the dentist shortage in Kentucky and that they were leveraging this group to comply with the directions of the MAC.

To this end, one of our members felt like that was too informal and was not in compliance with the intent of the

recommendation of the PC TAC or the MAC, and the Department -- Veronica Cecil has said that that would be -- feelings would be presented, but that was not in a formal motion.

And that is all that I have, and thank you for being able to participate for these years or months or whatever it's been. Have a good day.

CHAIR PARTIN: Thank you, Mike, and wishing you all the best in the future.

Next up, Therapy Services?

(No response.)

CHAIR PARTIN: Okay. Well, that concludes the TAC reports. Would somebody make a motion to accept the recommendations?

DR. SCHUSTER: So moved. It's Sheila Schuster.

DR. BOBROWSKI: Second. Bobrowski.

CHAIR PARTIN: Thank you. Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Any opposed?

(No response.)

CHAIR PARTIN: Okay. Recommendations are accepted.

DR. COMPTON: Chairman Partin, I have one clarification. The Optometric TAC will get the written recommendations to the MAC staff. I don't think they have those right now, so we'll get those to you.

CHAIR PARTIN: Okay. Great. Thank you.

DR. COMPTON: All right.

CHAIR PARTIN: So next up, then, is any other business. Does anybody have anything else that they would like to bring up at the meeting?

DR. SCHUSTER: Beth, I would like to bring up something. This is Sheila Schuster. Most of us are licensed providers that participate in these meetings, or we work with licensed providers. And I just want to draw your attention to actions being taken by the legislature ostensibly to protect our children, but some of us see this as an attack on trans youth and LGBT and so

forth.

But putting all of that aside, what the legislature is proposing in House Bill 470 and now Senate Bill 150 is to dictate to providers what they think the standard of care should be for treating certain conditions. They are prohibiting providers from providing services that the national groups have recommended as the standard of care; and, furthermore, they are saying that if there is a violation of those prohibitions, that the licensure board shall conduct a hearing and shall revoke the license of those providers.

So think about this, folks. Those licensure boards, as we all know, are set up by the legislature, and they give providers in different areas of health care, whether mental health and -- or physical health including dentistry and most of us who are licensed. And they are overriding the due process of those licensure boards and deciding on their own knowledge base as legislators, certainly not on the basis of any medical or mental health education, what

those standards of care should be.

So I'd just alert you to that. Regardless of how you feel about trans kids or gender dysphoria or any of these things, it's a really dangerous situation. And I think it's -- you know, what it means is that the legislator can pick any kind of topic that they want and weigh in and tell us what we can and cannot do. It's incredible government overreach, to say nothing of abrogating parental rights.

And in this particular case, I will tell you as a mental health professional, we will see more suicides among our trans kids. We will see families move out of the state in order to get treatment for their children who have gender dysphoria.

So I just want to alert us that I think we're entering a very dangerous phase in terms of what the legislature has the power apparently to do, and it will affect access to care for people in Kentucky.

I think we're going to have a much harder time attracting providers to this state. I've already heard from mental health

providers.

We're technically out of the bill. We were in before with our services being very limited. I don't think that's true of psychiatry because KRS 311 is in the bill, and they are licensed under 311. I think we're going to have -- Kentucky will be a state that will have a very hard time attracting and retaining healthcare providers.

So I just bring those bills -- and right now, it's Senate Bill 150. It's on the governor's desk. We're hoping for a veto, and we're hoping that the legislature will come to its senses and not override the veto. Thank you very much.

DR. GUPTA: Sheila, what can we as constituents do right now? Would it be best for us to contact our legislators to tell them not to override the veto?

DR. SCHUSTER: Yes. I mean, we're going to assume that the governor is going to veto it, Ashima, and I think particularly the physicians. And I know the pediatricians and the family practice -- I started to speak up

when you were talking about the importance of primary care because we're talking about pediatricians, psychiatry, and family practice being the most affected by this because they're the most likely to see these kids and to be starting them on appropriate hormone therapies and so forth.

We've already heard that there are some physicians that have told their trans patients that they will no longer care for them because they're so afraid. Mackenzie put the other piece in this, of liability for civil penalties is until the child reaches the age of 30. Now, there were criminal penalties in an earlier version.

So, you know, legislators are saying to us, oh, well, this is a much -- this is much more reasonable. Well, it's not reasonable. They are telling physicians that they cannot follow the standards of care in treating this population. They're actually acting like gender dysphoria does not exist, that it's a made-up thing that's being foisted on children.

I mean, there's a whole backlog that we

don't need to get into. But I think I have a sign-on letter that's being circulated, and anybody can contact me if you want to sign your organization on or if you want to sign on as an individual. My email is kyadvocacy@gmail.com.

Yes, and contacting leadership in the house and senate. I don't think that they understand the far-reaching implications of what they are doing. I hope that they don't understand and that they're just in a fog and that we can bring them out of this fog. Thank you for --

DR. GUPTA: This is just another example. I mean, they started this last year with, you know, the whole abortion thing. It's just another example of Government interfering -- getting into the exam room.

Can you tell me -- it was Senate Bill 150, and what was the other one?

DR. SCHUSTER: No. It's all now wrapped up in Senate Bill 150. It started out as House Bill 470, and they combined the two bills. It also, you know, puts all kinds of restraints on what can be talked about in

schools. It tells the schools not to use the preferred name and pronouns even if they are requested by the parent of a trans child. It has a bathroom bill in there.

I mean, they are really -- this is all-out warfare as far as I'm concerned on a -- this is six-tenths of one percent of the population, folks. I mean, you're talking about a minuscule number of kids that are affected by this, and yet they are so vulnerable. Their suicide rate is four times more than any other population that we have.

So thank you for your questions, and I'm happy to have you all sign on to our letter that's going to the governor. But reach out to your legislators now, particularly those of you who are providers, and tell them that this is unacceptable overreach of government.

CHAIR PARTIN: I think Emily put a link to the letter in the chat.

MS. SHEETS: And just to let everyone know, I will copy the chat over to a Word document and send it out to all of you after the meeting.

CHAIR PARTIN: Thank you.

DR. SCHUSTER: Thanks, Kelli.

CHAIR PARTIN: Any other business? Any other questions?

(No response.)

CHAIR PARTIN: Okay. Well, we have quite a number of things to add to our next meeting that have come about through this meeting, and I appreciate everybody's comments. I hope that the professional organizations will reach out to legislators and that other organizations will also -- or individuals will reach out regarding the issues that we have discussed today because that's the only way that we're going to affect any change here.

So no other business. Then would somebody like to make a motion to adjourn?

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

DR. BOBROWSKI: Second.

CHAIR PARTIN: Thank you. I guess there's no discussion on that. All in favor, say aye?

(Aye.)

CHAIR PARTIN: Okay. Meeting

adjourned, then. Thank you, everybody, and see you next time.

MR. MARTIN: Thank you all.

(Meeting concluded at 12:12 p.m.)

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C E R T I F I C A T E

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

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

Dated this 31st day of March, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR