CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

****

MAY 23, 2024
9:30 A.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

MAC Members:

Elizabeth Partin
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Heather Smith
Dr. Garth Bobrowski
Dr. Steve Compton
Dr. John Muller
Dr. Ashima Gupta
John Dadds
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace
Annissa Franklin
Sheila Schuster
Bryan Proctor
Peggy Roark
Eric Wright
Commissioner Lisa Lee

MS. BICKERS: Good morning. This is Erin with the Department of Medicaid. It's not quite 9:30 and we are still clearing out the waiting room so we will give it just a few more minutes before we get started.

Good morning. It is 9:30 and the waiting room is about clearing. I see a few more members popping in.

Dr. Schuster, did you sneak in under a different name this morning? Okay. She may not be on with us yet.

Good morning. There you are, Dr. Schuster.

DR. SCHUSTER: Yes. I'm traveling. I'm changing my name here. I guess everybody knows who I am, but there we go. All right.

MS. BICKERS: The waiting room is cleared if you would like to begin.

DR. SCHUSTER: Okay, thank you. I apologize for being late. I had trouble getting the Zoom to work and I got nervous. But anyway, good morning.

We will call the meeting to

order of the Medicaid Advisory Council for May 23rd. And Mackenzie Wallace is not going to be with us today, so Erin or Kelli, could you do the role call, please.

MS. BICKERS: There we go. Can you hear me? Sorry about that.

DR. SCHUSTER: Yes.

MS. BICKERS: Okay. So Beth?

(No response.)

Nina?

(No response.)

Susan?

MS. STEWART: I'm here.

MS. BICKERS: Jerry?

DR. ROBERTS: Here.

MS. BICKERS: Heather?

MS. SMITH: Here.

MS. BICKERS: Garth?

DR. BOBROWSKI: Here.

MS. BICKERS: Steve?

DR. COMPTON: Here.

MS. BICKERS: John? Either John? Okay.

(No response.)

Ashima?

DR. GUPTA: Here.

MS. BICKERS: Catherine?

DR. HANNA: Here.

DR. SCHUSTER: Barry?

(No response.)

MS. BICKERS: Kent?

DR. SCHUSTER: Kent can't be here. He had an emergency. He texted me this morning.

MS. BICKERS: Okay. And Annissa?

(No response.)

Sheila is here.

Bryan?

(No response.)

Peggy?

(No response.)

And Eric?

(No response.)

DR. SCHUSTER: We may not have a quorum yet; do we?

MS. BICKERS: You do not. I will keep an eye out for anyone who joins. Sometimes Peggy joins us a few minutes late. I will let you know.

DR. SCHUSTER: All right. And I talked to Eric yesterday, so I know that he is going to be on.

MS. BICKERS: Beth is joining us now.

DR. SCHUSTER: Okay, great.

MR. WRIGHT: And I am here.

DR. SCHUSTER: Ah, great. Okay. Are we at a quorum now?

MS. BICKERS: No, ma'am.

DR. SCHUSTER: Okay. All right. So we will skip the approval of the minutes of our last meeting and go on to old business.

And the perennial question that we ask is what is the status of Anthem MCO?

COMM. LEE: And that is still pending litigation so there is no update.

DR. SCHUSTER: Okay. We should just record this maybe, Commissioner Lee. I have an other category because I was trying to figure out some follow-up from the language access and we do have a suggestion that I would like to run by

you, Commissioner Lee.

COMM. LEE: Okay.

DR. SCHUSTER: And that is we have had presentations by the MCOs, each one individually to a number of the TACs and we have made those available to the MAC members, but the question that I'm hearing from a number of the MAC members, but also in the TAC meetings is: How can we easily and quickly get a translator on the phone when I have a patient in my exam room and realize that we need an interpreter?

What they are requesting, actually, is an easy to follow table, a one-pager that would have that information from each of the MCOs on one sheet. Is that something that's doable?

COMM. LEE: Yes, I do think that is a reasonable request. I believe, so we will take that back and make sure that we get the appropriate information, because if it's -- we don't -- I would think that it would be easier to have one language line rather than utilizing six different

options depending on who the individual is enrolled with, so let us take that back and see what we can get and get that to you.

DR. SCHUSTER: That would be great. And I'm guessing -- I'm no longer in clinical practice -- but I'm guessing, that if there were a single line, that that would be so much easier. I don't know how that would work, and the MCOs each have lines available, or have that service available, but I think for the practitioner, Commissioner, they may know that someone, you know, speaks a different language, but they may not know that until they get into the exam room if it's a new patient, and so it's that kind of immediacy that we need. So that would be great. We would appreciate that very much.

COMM. LEE: All right. We will definitely take that back and get something to you. We can also check with other states and how that is operated in other states.

DR. SCHUSTER: All right. That would be fantastic. I think you would have universal gratitude from all of your providers if we could ease that, and I think it would be certainly in the patient's best interest, the members' best interest, too. Thank you very much. We are off to a great start here.

So we threw a couple of kind of biggies at you this morning. One is, and I've shared this with the MAC, but many of the people that are on the meeting may not be aware, that CMS is sending out new guidance on how MACs and TACs should operate, and also the creation of Beneficiary Advisory Councils. So this looks to me -- and this is a 2025 goal of theirs as I understand -- so this looks to me like something that we will need to be working closely with you all from the MAC perspective and the TAC perspective. So I am going to toss that big ball over in your court and let you go with it.

COMM. LEE: Yeah. So the Center for Medicare and Medicaid Services, CMS,

did drop some final rules. We are still digesting all of those rules. There is a lot of information in there and a lot of things that we have to come into compliance with in various time frames. As far as the Medicaid Advisory Committee is concerned, they have stated that all states have to establish a Medicaid Advisory Committee and a Beneficiary Advisory Council, which, you know, MAC and BAC by July of 2025 and eventually -- and this is where we are going to need a little bit more guidance -- eventually representation of the BAC transitions over into the MAC, so by, again, a lot of information. So in July 9th of 2025, we have to have our Medicaid Advisory Committee and our BAC established and, you know, this council is in statute, so we do believe that we are going to have to change based on the new federal guidelines, we are going to have to change our statute that covers the MAC. We are going to have to change that up. So the percentage of the MAC members that are

transitioned over on to the MAC or representation on to the MAC. For example, it has to be 10 percent by July 9th of 2025, and then 20 percent, by July 9th of 2026, and 25 percent have to cross over, July 26th and on into '27.

The CMS has said that they will also provide some 50 percent administrative match, which we get that right now, anyway, for some of our Medicaid Advisory Council meetings at -- let's see, what else is it -- currently, in statute, the MAC members are appointed by the governor and other bodies, but the federal rule states that the director of the single state agency of the Medicaid program has to select the members for the MAC and the BAC. So, again, that is where we will have to change that state statute.

They also state that the terms has to be the terms of the members will be set by the state and that terms may not be followed immediately by consecutive term of the same member, so there has to be rotation. You know, they want to ensure

that members are rotated regularly and provide -- get that fresh perspective.

They also are pretty prescriptive about the topics of categories that the BAC and the MAC will discuss. For example, it includes pediatric care, behavioral healthcare -- or, I'm sorry, this is the representation, is somebody from pediatric care; behavioral health; reproductive health services; services specifically pertaining to individuals over age 65; health services pertaining to individuals with disability; and also having, you know, the member of either the managed-care organization or the association that represents the managed-care organization; so we would think that would be the Kentucky Association of Health Plans, would also be on the MAC.

They also state that we shall include other state agencies serving Medicaid members, so that would be our Department for Community-Based Services, behavioral health, DALE, but those

individuals are not voting members, so we would have to have some of our sister agencies in there, and they do clarify that the topics and the role of the BAC is to advise the state regarding their experience with the Medicaid program on matters of concern related to policy development, in matters related to effective administration of the Medicaid program.

So still a lot to learn and to digest. Again, they talk about topics for consideration of the meetings, include addition and changes to services; coordination of care; quality of services, eligibility, enrollment and renewal processes; and beneficiary and provider communications by that state agency and MCOs.

Also, they state that the state agency should, you know, help prep members for meaningful contribution, and that at least one state agency executive staff member should attend all MAC and BAC meetings.

I think we are pretty good. Our MAC is almost aligned with some of these measures. We are going to have to do a little bit of tweaking, but again, we have, I think, a good structure and we need to, you know, continue to dig in and get a little bit more guidance from CMS about the transition of those BAC members over into the MAC, and I think Dr. Partin had her hand up, and then Dr. Bobrowski.

DR. SCHUSTER: Yes. And then Dr. Bobrowski.

Beth?

COMM. LEE: You are on mute, Beth.

DR. SCHUSTER: Can you hear us, Beth? Yeah. We can't hear you. We are not getting any sound. We are still not. Do you want to put your question in the chat? Because we are not getting any sound from you. Put your question in the chat and then you may want to turn off your computer and log back on.

Let me go to Garth for a question while you are doing that, Beth.

Thank you. Garth?

DR. BOBROWSKI: Okay. Question -- and I may have misheard you or maybe didn't hear you. There was -- I didn't hear you mention dental and some of the other TAC representation on our MAC, but is this -- I know you said we were close to having our MAC match this new entity, but is our MAC, as it is now, is that different from the other Medicaid Advisory Committee? I may have missed what you said.

COMM. LEE: So, you know, we will have dental representation, Dr. Bobrowski. Thank you for bringing that up. We do have -- we are almost aligned, we're just -- the main thing we are going to have to focus on is definitely our members, the membership, so that we have beneficiaries more widely represented on our MAC. And so the final roles have, you know, they call for a Beneficiary Advisory Council, which is BAC, and then a Medicaid Advisory Council, and those individuals on that BAC will

eventually transition over to the MAC to make up 25 percent of the members. So 25 percent of the members on the MAC will have to be beneficiaries or individuals who have, who live with a beneficiary, who take care of a beneficiary, in some way are related to or are in the life of that beneficiary so they know how the Medicaid program impacts that individual's life so they can have input into the program.

DR. BOBROWSKI: Okay. Thank you.

DR. SCHUSTER: And Beth's question, Commissioner, is she didn't hear any mention about the TACs. Does this new guidance touch on the TACs as well?

COMM. LEE: No. It doesn't touch on the TACs, and that is, you know, something that we can continue. I mean, with the TACs the way they are. I think it does provide us with an opportunity to look at the TACs and the MAC and see, you know, what sort of efficiencies we can provide. I know that several of the TACs are focusing on the same topic, for

example, so there is some duplication. So I think that is of the MAC, that newly formed MAC, should have some input and some guidance on the way that the TACs are formed and how they operate. We do want to work with some individuals, and get some recommendations as we go forward with how we best implement all of this stuff. Again, July 2025 is coming up right on us, so we have a little bit of work to do to get everything lined up before. And if we have to change statute, that is going to have to be done January, February when the legislators are in town, so that's something we really need to be thinking about.

DR. SCHUSTER: And that is a short session coming up so we know that things have to move quickly, so we really need to be on top of that, and all of those TACs are also set in statute, so there's going to be some changes.

And just to be clear the makeup of the BAC, the Beneficiary Advisory Council, is 100 percent members are people

who are caretakers for members, essentially.

COMM. LEE: They can either be members themselves or individuals who take care of individuals who are on Medicaid.

DR. SCHUSTER: Right.

COMM. LEE: So because there is a concern that it's a little bit difficult sometimes to try to find members to serve, but knowing that we can pay for their, you know, their transportation and lodging if we have in person meetings, for example. We also, you know, have to make it an option, for example. There is a requirement in one section of the rule that says there is a requirement for states to, that we have to publicly post the MAC and BAC bylaws and structures, and in the final rule, the CMS does clarify that BAC members must have the option to include their name on the membership list and publicly posted minutes. So for example, if we do have members and they do not want their names published, then they have that option not to publish their

names.

DR. SCHUSTER: And does it say anything about what the size of the BAC should be?

COMM. LEE: No.

DR. SCHUSTER: You know, a minimum of 10 members or 20 members; is there anything?

COMM. LEE: I haven't seen that yet, again, still looking and evaluating. We have, again, a lot of work to do by July. And that's just one little section of the final rules. You know, there are other requirements related to access to care; to HCBS; documentation of access of care and service payments; in lieu of services; state-directed payments; quality assessment and performance improvements; managed-care quality rating systems; so there is a lot in these final rules that we haven't digested yet. I mean, I've got a summary of the rules and the summary itself is over a hundred pages. So lots, lots of information in those new rules.

DR. SCHUSTER: Yeah. So there's

a question in the chat, Commissioner, about when would you be taking applications for persons or caregivers to be on the MAC, and how many do you have as of today?

COMM. LEE: And --

DR. SCHUSTER: Go ahead.

COMM. LEE: I was just going to say I wouldn't even hazard a guess yet until we digest all of the information. Going back to your original question, Dr. Schuster, about how many -- how big is the BAC supposed to be? And currently, we do have Peggy Roark is our Member Services Representative that is on there right now, and as far as on our TACs, I'm not sure if we have any representation on the TACs of our members.

DR. SCHUSTER: We do have the Behavioral Health TAC. We have a designated spot for a consumer and Valerie Mudd has filled that deposition. We actually have several of us on the MAC that are representing populations of members. Eric Wright is one, I'm one,

Kent Gilbert is one, Mackenzie Wallace are all, you know, appointed to represent persons with disabilities or, you know, the elderly or parts of the population of Medicaid.

COMM. LEE: Yeah, and I think the final rule pretty clear is it has to be actual members.

DR. SCHUSTER: Has to be an actual member, yeah.

COMM. LEE: Or caregivers. So, you know, just again, a lot in there and once we get more guidance from CMS we will know how best to move forward, and we hope that guidance will come pretty soon, because the other thing we are concerned about is there is a lot of reporting that we have asked, and when I say we, the Medicaid directors, and particularly, the National Association Medicaid Directors Board, have asked CMS for templates so we can have those reporting requirements sooner rather than later, because there is a lot. One of the things that, as I read through these summaries, was all of the

reporting that we have to do, and not just on, you know, like our MAC meetings. We have to do an annual report, which is fine, we have, you know, our minutes and we can do those annual reports, I think rather quickly, but there are a lot of reporting requirements for rates, for example. We have to publish every one of our fee schedules online, which we do that anyway, but there's a few other requirements for us related to reporting, lots of reporting requirements around the HCBS services. Some information specific to Waitlist, and how we are handling Waitlist that has to be reported to CMS. So lots, lots of stuff in there.

I think Dr. Wright has had his hand up for a minute.

DR. SCHUSTER: Eric?

DR. WRIGHT: Yeah, I was kind of curious, the 25 percent, with what is kind of being defined or what we know at this point. What is our current percentage of representation by caregivers or members on the TAC at this point? Do we have a

percentage currently?

COMM. LEE: I don't know the percentage. I know Dr. Schuster had just referenced some of the individuals that are on there --

DR. WRIGHT: Okay.

COMM. LEE: -- that represent, but I'm not sure of the exact percentage.

MS. BICKERS: Commissioner, this is Erin. I don't have a percentage, but there are several TACs that do have members, themselves, or their representative's caretakers. I can pull a number together of how many we have as a whole, if you'd like, and send it out to the MAC. I know, I believe, the Consumer Rights, the IDD, Consumer Health, so there are several TACs that have -- Persons Returning -- that have members and their representatives or caregivers. So I can pull that together if you'd like.

COMM. LEE: Yes, that would be very helpful, Erin. Thank you.

DR. SCHUSTER: I think that would be very helpful, Erin. Thank you.

COMM. LEE: And of course, I need to read the final rule to get more questions. In this summary is well over 100 pages long, but there is that transition, you have to create a MAC and a BAC, and there's this transition of those members from the BAC to the MAC. So I don't understand, I'm still a little fuzzy of how all of that will work once we start transitioning members over from the BAC to the MAC.

DR. SCHUSTER: Yes, it sounds, logistically, like you'd have to start with your MAC membership having some percentage of consumers on it, or else you can keep growing the MAC and you are talking about term limits and nonconsecutive terms, so I guess you would set it up so people would serve a term and then rotate off and then other people would come off of the MAC, although you'd have to grow that percentage, I guess, from 10 percent to 25 percent, so lots to be done.

Let's keep this on our agenda.

COMM. LEE: Definitely.

DR. SCHUSTER: For our going forward and lets keep communicating, Commissioner, about particularly on things that are going to have to be changed in legislation. I think that is going to be a huge lift, just because of the new session will be upon us.

COMM. LEE: Yes.

DR. SCHUSTER: Given that it is a short session, and we have to get it done by then to meet the CMS requirement.

COMM. LEE: Yes, and we will have to start working on legislation now. As soon as we can get those sessions and parsing out and that work for all of the new rules to figure out exactly what all we will have to do, but the MAC and TAC, we definitely know that we have work to do there.

DR. SCHUSTER: Yeah. Any other questions of Commissioner on this?

Did you all have any idea this was coming, Commissioner, from CMS?

COMM. LEE: A little bit. They

had been talking about it for awhile, and I guess with my position on the board, I have served on the National Association of Medicaid Directors in some capacity. I was their finance chair before being elected president this year, so the NAMEC board did have some insight into some of the things that were coming down because CMS does have -- and the NAMEC board has a really good working relationship, and some of the things before they are put into rules, they are floated by the board members to see if this is something that would be well received. And in some other states, they don't have the structure that we have here in Kentucky. They are lacking in their MACs and some of them have legislators on their MAC, for example, and some of them don't even meet, so I think CMS really wants to make sure that there is outside input into the Medicaid program related to policies and, you know, recommendations, so I think that one of that our MAC was held up as an example of how it can work really well.

DR. SCHUSTER: And you are in a prime position to hear from other states how they are going about this so that's going to be incredibly helpful, I would guess, in the role as president of the National Association, so that's going to be very important. Well, the MAC stands ready to work with you in any way we can, Commissioner.

Beth, do you have another question? Your hand is still up. And we still can't hear you. I put an answer to your question in the chat. The TACs will continue and they are not touched on in the new rule by CMS. Okay.

All right. We will go on to the next, which is, can you give us kind of an overview of the impact on Medicaid on the new biennial budget and any new legislations specific to Medicaid's operations.

COMM. LEE: So our budget was funded, you know, there were a few things that we, you know, you know they didn't fund our Mobile Crisis, but overall, our

budget as we currently operate and we can continue to provide services. So we were funded.

There were a couple of new requirements that we have to implement. For example, House Bill 6 is non-codified budget instructions. It's nursing home, personal needs allowance.

House bill 274, of course, pharmacies can vaccinate children 5 and over now, it used to be 9 and over.

Senate Bill 280 was related to new professional services and their hospital reimbursement improvement program impacted that. Senate Bill 74, House Bill 10, lactation consultants, opportunity to increase FPL for pregnant recipients.

There were some new restrictions, House Bill 477, limits us on sepsis, you know, we had, currently hospitals use sepsis-2 criteria. We were trying to move to sepsis-3 criteria, which is what, I think, 47 or 48 other states currently use, but we are limited to sepsis-2 now we will be not be able to

move to sepsis-3.

House Bill 505 has some provisions related to case managers, peer support specialists, for example. We can't restrict hours for peer support services and we must allow peer support specialists to treat groups of 12 and allow temporary license.

Senate Bill 71 and Medicaid eligibilities and penalties for individuals who move into the state only for the purpose of receiving treatment. I think this is related to information, conversations that we heard that, maybe some providers or some individuals, were moving into Kentucky just to receive substance abuse treatment, and then they were moving out, or they were, you know, maybe some providers were actually recruiting individuals to come into the state to provide services to them, and then when those individuals, either were finished with services, or did not complete their treatment, they were in Kentucky, and some of them were homeless

and then trying to get them back to the state in which they were originally from became somewhat of an issue. So those are some of the major ones that we have been looking at and we will have to do a little bit of work on.

Also, House Bill 6 was a study related to 1915(c) waiting list.

DR. SCHUSTER: Yeah, I was going to say there is a lot of interest in that particular one, because of the incredible funding for 1,925 new slots, but it comes with a very tight turnaround for you all to report.

COMM. LEE: Yes.

DR. SCHUSTER: On how those waiting lists will be managed, and I believe that report is due, maybe, in October.

COMM. LEE: Yeah, it is due really soon.

DR. SCHUSTER: Yeah, so excellent rundown.

Does anybody have any questions of the Commissioner about the budget or

legislation?

(No response.)

All right. Thank you very much, Commissioner.

Our next question was, and I think this is an ongoing one, update on unwinding for Medicaid flexibilities and any change in approach.

COMM. LEE: And I don't -- is Senior Deputy Commissioner, Veronica Judy Cecil? I know that she was in a meeting, if not, I do have a -- I do have some information that I can pass along.

MS. BICKERS: I do not see her, Commissioner.

COMM. LEE: Let me see. I do have an update from her. And I do have a presentation, but I don't know if you want to see the presentation. It's the one that she typically gives when she updates on the public health emergency, but the main thing, I think, that I would like to pass along is all of the flexibilities that we had in place, we thought would expire in December of this year, but CMS

is allowing us to extend those to June 30th of 2025. So that is some really good news that all of those flexibilities.

We're still -- you know -- there was a report that was created -- I can't remember if it was Kaiser or whatever, Kentucky is one of the best states in retaining children in our unwinding services. We are getting ready to end, I guess, this month will be our last month of unwinding. We have made some enhancements to our system for members to make sure that they maintain eligibility and again, our whole purpose of unwinding, the one thing we wanted to do was retain those individuals who qualify for the Medicaid program, and help those who did not qualify, transition over. So I think we have done a really good job of doing that. So we had anticipated, I think, at the beginning of the unwinding period, where we had about 1.7 -- at the highest during COVID -- we had 1.7 million individuals, and we currently have 1.5. So we had anticipated we would lose about

maybe 200,000 individuals, so our projections were right on target, and we currently have 1.5 million individuals remain in the program. We have sent out Medicaid services related to unwinding, and so we are gathering that feedback.

And, again, just staying informed, we are continuing our meetings, our online meetings that we were having and informational sessions related to unwinding. We are going to continue those. And, I think, what we'll do is keep those on the books moving forward, and maybe start transitioning those informational sessions to be more Medicaid focused and not just unwinding. So happy to answer any questions on the unwinding.

DR. SCHUSTER: Very good. Any questions from any of the MAC members about unwinding? Do I remember that the children are being looked at starting in September; is that right?

COMM. LEE: Yeah, but now since the flexibilities have been pushed out to 2025, we are going to see if we can't

continue those and all of that enrollment until we have to start in 2025.

DR. SCHUSTER: Oh, okay. Yeah, so important to keep the kids in the house, so to speak.

Any questions for Commissioner Lee on that?

DR. WRIGHT: Commissioner Lee, can you, kind of, explain the difference between flexibilities and Appendix K?

COMM. LEE: Appendix K flexibilities are strictly related to the HCBS program. So those E14 or 14E, I always get those confused are a little bit different. They're a little bit more related to the eligibility, but the Appendix K is strictly for HCBS services.

DR. WRIGHT: And just to clarify, those flexibilities abilities have come to the conclusion; correct?

COMM. LEE: Yes. And I think Pam Smith is on the line. If she is on, she can --

MS. SMITH: I am.

COMM. LEE: -- can add a little

bit more to that.

MS. SMITH: They -- the ones that we -- and I can get links, I can put links to the presentation. There were some flexibilities that we continued and made permanent by modifying the waivers, so those are in place as of May 1st, for all of the waivers except Model 2, which was February the 1st, but I will get the link to that presentation and the recording to the presentation that is on the website, that lists all of those, has a document that lists everything and where to call with questions.

DR. SCHUSTER: Does that answer your question, Eric?

DR. WRIGHT: Yes, thank you.

DR. SCHUSTER: Yes. That would be very helpful, Pam, because I do think there are still questions about Appendix K, so that would be great to have that -- have those links. Thank you.

Any other questions on unwinding, flexibilities, and so forth? Well, good news that CMS is extending

those flexibilities until -- what did you say, July of 20 --

COMM. LEE: 2025.

DR. SCHUSTER: Yeah. Wonderful.

We'd like an update on Mobile Crisis delivery implementations since the last report.

COMM. LEE: So, you know, the legislators did not fund the Mobile Crisis delivery system that we had designed, you know, we do -- Medicaid covers Mobile Crisis. We have our municipalities that cover, the first responders respond to crisis. So there is a Mobile Crisis infrastructure in place. It's just somewhat, maybe, uncoordinated, so our vision was to build a Mobile Crisis continuum of care that served everyone, including, you know, individuals not enrolled in Medicaid. So since it was not funded, we had to take a step back and make sure that we are continuing our current Mobile Crisis services that are in place. So just had to take a step back from that right now, and we do have it on

our radar, but not something that we can implement at this time.

DR. SCHUSTER: So I know that Caroline was given a contract to coordinate all of that, Commissioner, with the RFP that you all put out, and so forth. Are they still working on this?

COMM. LEE: We are reevaluating based on what we can do in the current infrastructure, so we are really just reevaluating that. We had thought that maybe they would serve as the air traffic controller, if you will, for the 911 and 988, but we are just reevaluating right now.

DR. SCHUSTER: Okay. Because there was, I think, lots of, you know, this was a whole new system coming in and 988 was going to be involved and, obviously, 988 is still relatively new. I guess, we're coming up on the second anniversary of it in July so there's, from your perspective, there's, kind of, a hold on the new program, the new implementation.

COMM. LEE: Yes.

DR. SCHUSTER: Okay. Any other questions from any of the members on that? Thank you.

And then we've got a couple of exciting waivers that are out there, that we're waiting, I think they are in different stages of approval hopefully by CMS, so I'm wondering if we can have an update on the reentry waiver.

COMM. LEE: So we did have a conversation with CMS. CMS has a backlog of 1115 waivers, which is our -- reentry is 1115 waiver -- so what they have done is they have gotten states into cohorts based on various factors, and so Kentucky, really happy to report, is in Cohort 1. So we hope to have the reentry waiver approved by July. We are still continuing to work with them on our approval process, so we are hoping that that will be very soon. So the SUD/SMI anticipated approval by September 2024, and we'll have more discussions to follow on the approval.

DR. SCHUSTER: So that is the

1915(i)?

COMM. LEE: Mm-hmm. Well, no. I'm sorry. The SUD/SMI recuperative care pilot is part of, I think, the reentry, so I don't know if Ann or Leslie is on the line, or Angela, that would kind of -- Angela Sparrow -- to kind of provide that 1915(i).

MS. SMITH: I can provide -- Commissioner, I can provide it. We have submitted it to CMS and they were -- actually they followed up with one question, and have let us know, based on our early conversations with them and the prep, that we have we are skipping the 15-day call, and we were expecting at any point in time, the official, the IRAI which is just for us to respond to questions, so it is moving through quickly. So we are very excited, CMS is excited to receive that waivers, so I'm expecting in the next -- within June -- to get that request for additional information, the informal request for information. So it is moving through the

process quickly. They are reviewing it. The one question they had was a simple copy and paste error that was going to be an easy -- that was going to be an easy fix, so.

DR. SCHUSTER: And that's the 1115, Pam?

MS. SMITH: That's the 1915(i).

DR. SCHUSTER: Oh, the 1915(i) is what you're talking about.

MS. SMITH: Yeah.

DR. SCHUSTER: Oh, wow, that's, all right. I was still back on the 1115 that has the respite and extended hospitalizations. Is that the one that is part of the reentry?

MS. HOLLEN: No, ma'am. It is its own application.

DR. SCHUSTER: Okay.

MS. HOLLEN: So the SMI that has extended hospitalizations and the recuperative care pilot --

DR. SCHUSTER: Right.

MS. HOLLEN: -- that's in queue. That is next. We are focused on getting

our approval for the reentry, and then our overarching SUD 1115, is also in queue for this September with our SMI -- the SMI 1115 -- that has the extended hospitalization coverage and the recuperative care pilot.

DR. SCHUSTER: Okay. Because I think I got confused somewhere along the line, and thought that had been approved already.

MS. HOLLEN: No. You know, we submitted all our applications, and as Commissioner Lee said, CMS has a backlog, and they're trying to -- they put -- I don't know if they're going to do the SMI with the cohort, but definitely reentry in a cohort.

The other thing I wanted to add, is that Kentucky was selected as one of the five states to participate in the National Academy for State Health Policy, and with the health and reentry project state learning collaborative, it's an 18-month collaborative that will kick off in June, and so we have a work group for

reentry and the commissioners from the Department of Corrections, Department of Juvenile Justice, Department for Behavioral Health, Deputy Commissioner Leslie Hoffman, and Behavioral Health Supervisor, Angela Sparrow, will be the core team that do that collaborative, so it's just going to help feed with that implementation plan developing, once we get approval for our reentry pilots -- I mean our reentry waiver, 1115.

DR. SCHUSTER: Okay. That's good news. I think I heard someplace that it could take a year after final approval for the reentry to really be up and going.

MS. HOLLEN: Yeah, if you remember, when we got that original SUD 1115, it was ten months before they approved our implementation plan, and then another eight months before we got some things off of the ground, because you can't really -- you can think about and plan what you think the changes are going to be but until you get approval of your implementation plan, you can't really

start those changes. So, yes, we get -- they say, yes, here is your approval for the application and then let's see you're implementation plan and they have to approve that. So it's kind of a phase process.

DR. SCHUSTER: Yeah. It feels like we have been waiting for reentry to hit the ground for --

MS. HOLLEN: We have.

DR. SCHUSTER: Five years, six years.

MS. HOLLEN: You know, we were one of the first states to send it in; right? In 20 -- I don't know, I have lost it. Maybe three years ago. And basically, CMS wasn't ready for it. They, you know, were trying to catch up.

DR. SCHUSTER: Right. And they changed the guidance and we had to go back to the drawing boards.

MS. HOLLEN: Yeah. You are correct.

DR. SCHUSTER: And poor Steve Shannon has been chairing the Reentry TAC

for all that time, getting ready.

So pam, let me go back to the 1915(i) for a minute. So it has been sent in, and one question back, and you are expecting an official response in June?

MS. SMITH: We are. We are expecting to get the IRAI, so that informal request for additional information, we are expecting to get it in June.

DR. SCHUSTER: And that's --

MS. SMITH: The one question they had was a simple copy and paste error that was going to be an easy -- it was going to be an easy fix.

DR. SCHUSTER: And once that is finished, we move on to approval by CMS?

MS. SMITH: So what happens is they will send that to us, e will review all of that and provide responses, and then they will complete the waiver that stays on the clock for the entire time, so time is clicking down, so we will respond very quickly to that, and then we will expect either an approval or additional

questions from CMS, but everything -- all indications so far look very good. They have not had a lot of questions.

DR. SCHUSTER: Okay. Well, very good news. Thank you very much.

Any other questions from any of the other MAC members? These obviously have to do with behavioral health more so than anything else, but if you think about reentry, we have so many Kentuckians who are incarcerated, and a good number of them have a substance use disorder or behavioral health issue, and to be able to start treatment while they are still incarcerated, and then make that smooth transition into the community is going to be huge. I think it's going to be one of the most impactful things that we've done in a long time.

This next, I think, probably is for you, Pam. These questions came from Eric about legally responsible individuals, LRIs and the Medicaid waivers.

MS. SMITH: Yes. So I will

quickly -- if it's all right, I'll go through the questions real quick, and then if you have additional questions, if that's okay to do it that way.

So we delayed the implementation to start the review process until July 1st, and that is because we have actually added it into the system, so it is going to be in NWMA, so there's not going to be any more paper process, any forms, the case manager that is helping with if you choose Participant Directed Services to directly put that information into the system, so it will make for easier tracking. And also, for in the future, individuals that have already been approved, they won't all have to go through any preapproval process because we won't have to look for paper documents. We will have the actual review in the system.

Case managers and support brokers will have information to share. We are actually very quickly updating guides and reference sheets, as well as a

very extensive frequently asked questions list. We were working on it this morning right before this meeting, and then I am going to in the chat -- we actually have on June the 10th -- we have two sessions, we have a provider -- if I can get my computer to cooperate, I'm sorry. We have, in the morning, on June the 10th at 11 eastern, we have a provider training. At 3 o'clock that same day, we have a participant information session, and then on June the 20th, we are actually going to have to Q&A sessions. One at 2:30 eastern for providers, and one at 3:30 eastern for participants. All of these will be recorded and available on the website, but I will copy and paste these links in the chat as well. A communication went out, I believe, on Monday, that had the information on how to register for those and how to attend those. And I'm not sure -- yeah, I think I pasted all of that. So you should be able to follow those links. It not, if you reach out to the help desk, the number in the email I

put in the chat earlier, they can help with getting individuals linked up to the right meeting.

DR. WRIGHT: May I ask a couple of quick questions?

MS. SMITH: Absolutely.

DR. WRIGHT: On that notice that came out recently, too, it indicated that there are some prior reviews that have been done if you were approved before March of 2020.

MS. SMITH: Yeah.

DR. WRIGHT: I noticed that it mentioned specifically HCB or SEL. When you say HCB there, are you including the Michelle P. Waiver. As well?

MS. SMITH: No. That's only the Home and Community-Based waiver. The only two waivers that require approval of LRI as employees, or family members as employees, were the HCB Waiver, itself, and the SCL Waiver. I know it is so confusing because the group of them are Home and Committee-based Waivers, but someone a long time ago thought that that

would be a good name for a waiver, too. So I know it gets confusing, but it was specifically referring to the Home and Community-Based Waiver.

DR. WRIGHT: So can you clarify how Michelle P. Waiver plays into this role? Is it now under the LRI?

MS. SMITH: Yes. Every single waiver that has Participant Directed Services as an option, if the individual is an LRI, they are required to go through that formal review process, and that is part of our attestations to CMS is to how we -- that allows us to be able to pay LRIs for providing these services to individuals.

DR. WRIGHT: And when you say, formal review, can you give a little more detail on like, you say case managers and support brokers, are they going to be the --

MS. SMITH: No.

DR. WRIGHT: -- providing the guidance, or where does that come from?

MS. SMITH: They will be

providing the guidance. We will actually be providing, so we are doing the Q&A sessions and those informational sessions, and we will be putting out the direction, as far as the policy, and answering all of those questions. The case managers -- and we are actually going to get away from the term, support broker, and it is actually going to be case managers across the board -- but they will be the ones to answer questions to help fill out the -- to help request the information. The new criteria is much simpler than what it was before for individuals under the age of 18. It is, the individuals that have to be reviewed are parents, and that includes stepparents, foster parents, or adoptive parents, and anyone who is a court-appointed legal guardian. So grandparents do not have to be reviewed, siblings, so it's a much smaller group than in the past that had to be reviewed, and they have to meet two sets of criteria. So one is, I think -- I do not have it sitting here in front of me, but

one of them is, they have to show that they have extraordinary care needs, which most of these children, they meet institutional level of care, so they have extraordinary care needs. They can have a communication deficit that would keep them -- that would prevent them from being able to communicate their needs effectively. They also, they can qualify if they have a behavior problem where they may have a self-injurious behavior, or they may have behaviors that someone would need to be knowledgeable and know how to manage. That it would be a legally responsible individual that may be best suited to them.

The second portion is that they would have to demonstrate that they have not been able to find another caregiver, which that is -- we know we do not have very many providers in Kentucky, that accept pediatric patients or specialize in pediatric patients. Or they have to demonstrate that they have not been able to work due to frequent appointments or

frequent calls. And so that is not in any specific period of time. I think it says 12 months, or within the last 12 months or longer. So we did not want to exclude individuals that may be have not been working for more in the last year because they needed to stay home because they were the best caregiver for their child.

For adults, it is the two individuals that have to be reviewed are if you are a spouse or if you are a court-appointed legal guardian.

DR. SCHUSTER: Pam, I'm going to ask you to back up for those on the MAC that are not familiar with these waivers. Can you define LRI?

MS. SMITH: Yes. Legally responsible individual. So for a child, it is any parent, and that includes adoptive, foster, and stepparent, and any court-appointed legal guardian. For an adult, so anybody 18 and over. For a child, it is under 18, and 18 and over, it is a spouse or a court-appointed legal guardian.

DR. WRIGHT: Can I ask you a question? What about a parent of an adult child who is not a court-appointed legal guardian?

MS. SMITH: They would not have to go through the process, because it is not expected that a parent would still be providing those types of supports to an adult child. So they do not have to go through that process.

DR. WRIGHT: They don't have to, okay.

MS. SMITH: They do not have to.

DR. WRIGHT: They don't have to.

MS. SMITH: They do not have to. No. Parent is only for those individuals who are under the age of 18.

DR. WRIGHT: Eighteen. Thank you. All right. You've cleared up a lot of that.

MS. SMITH: That is a little different than what it was. We have narrowed the definition a lot for what the LRI is and, you know, we've been reviewing the individuals that are providing care

right now. I have talked to -- I have talked to several parents myself, looked at the cases with them, and been able to, hopefully, allieve some of the concern that they had, or the fears that they had. We are not anticipating that we are going to just come in and deny a bunch of parents. That is not what we believe is going to happen. But in order to offer this option, we have to fulfill that guarantee to CMS, which is that we have these guards in place.

DR. WRIGHT: I hear you.

MS. SMITH: Yes.

DR. WRIGHT: All right. You've answered a lot of my questions, and the document actually did as well, the other day. So thank you, Pam, for all your help. Appreciate it.

DR. SCHUSTER: Yeah. Thank you, Pam.

I think once people can get their hands on the information, my impression, from what Eric had said originally, maybe at the last MAC meeting,

was that all of this was blowing up on social media, as the word kind of spread from maybe caseworkers mentioning it, and then parents not knowing where to get the information.

MS. SMITH: Right. We do have a lot of helpful people on social media that like to share information and I like to always just repeat back, please direct people to us and to the different -- to DALE or BDID, to the source of the information, and then, hopefully, when we do these sessions in June -- we didn't want to do them too early, because since it is not starting until July 1st, we didn't want to do them earlier, because we wanted the information to be more fresh, and we are still also trying to work on updating all of those resource guides as well, so.

DR. SCHUSTER: Okay. Thank you very much.

Any other questions from any of the other MAC members?

Thank you, Pam.

Erin, do we have a quorum now we could go back and approve the minutes?

MS. BICKERS: As soon as Dr. Gupta to returns from her --

DR. SCHUSTER: Oh, yeah. She had to be gone for a couple of minutes.

MS. BICKERS: I was hoping to catch it before she left, but we were in the middle of something and I didn't want to interrupt. So I will remind you before we adjourn.

DR. SCHUSTER: Okay. Thank you very much.

So let's move on to the TAC reports. Let us know about your meetings. If you've had any requests for information from DMS or the MCOs, whether you are working on anything with, perhaps another TAC, and then if you have any recommendations.

We will start at the back end of the alphabet with the therapy services. And I think that's Dale; isn't it? Anybody on from the Therapy TAC?

(No response.)

All right. Primary care?

MS. MOORE: Good morning. This is Stephanie Moore. I am the chair of the Primary Care TAC. We have not met since the last meeting, so there is no report today.

DR. SCHUSTER: Okay. Thank you.

Physician Services? Is that usually Ashima Gupta?

MS. BICKERS: It is. I was looking to see if Cody Hunt was on. They met on Friday. I can tell you that. That was their first meeting of the year.

DR. SCHUSTER: Okay.

MS. BICKERS: I don't see Cody on either.

DR. SCHUSTER: All right. We will ask Ashima when she gets back. Thank you. This is graduation time, as you know, and I think her kids were having their awards ceremony, so she needed to go to that.

Pharmacy?

MS. HANNA: Yes. I'm actually reporting for their February 13th meeting.

I apologize that Ron could not be here today. They did cancel their last meeting, but I was reporting for their former one, because they didn't have a report at the time.

At this meeting, they continued their discussion on community health workers services, and, you know, just talked about the benefits that could come from pharmacies being able to provide these services with the community health worker pharmacy staff that they may have in place.

Mainly, because it can create a lot of access for these much-needed services into our communities.

And they continue to ask the Department of Medicaid services, you know, are they going to plan to add pharmacies and pharmacies to the list of providers who can order and/or provide these services, and if not, could the Department of Medicaid Services, you know, provide guidance on statutory, you know, language that would need to change to allow this to

happen. Mainly to benefit our services -- our patients -- and our services because of the access and, you know, the impact that we could have in that area.

Also, let's see, they continued their discussion on rebilling of the NADAC. That is where the price, you know, we had a price increase that takes into effect. It takes awhile for those to, you know, show up on the other end, but in the meantime the pharmacy is paying more for the product, so just in a nutshell, they are having a lot of challenges going to go back and look for these claims, because it is like finding a needle in a haystack in many situations, because of the complexity of the report. So they continue to ask if there is some way to get some type of interface to make it easier for pharmacies to search for these claims, so they are not being reimbursed underwater on those claims, if you will, below their cost. So that is causing some challenges in our communities.

As we all know, for those who

listen to this, a lot of pharmacies are closing in some communities, feel like this could really help. But the complexity, evidently, of these reports is hard for pharmacies to go back and look for these claims to try to go back and rebuild them appropriately. The two things -- that was an ongoing discussion point. The two newer items that they did discuss was a GoodRx Caremark goings on. So it appears that, you know, sometimes GoodRx is kicking in for these Medicaid's -- this is on our dual eligibles, just to make it clear. These may be kicking in, they could be dual eligibles, or they could be individuals who have, you know, commercial insurance, and then Medicaid pays on the back end. And so what is happening is, these are coming in with GoodRx with a higher co-pay than you might see normally for that patient under, you know, another plan or Medicare, typically, so therefore Medicaid is picking up this portion of it, but it does lead to Medicaid paying more, and the

pharmacies then being charged a fee back on those claims, and so it negatively impacts both Medicaid and the pharmacies in many situations; okay?

And they also did discuss Anthem dual eligibles, and this is primarily, I believe, and I will try to get clarification on their next meeting on their DME products such as their test strips and stuff that they are coming back with the co-pay, you know, due to a deductible. I guess it's not really a co-pay. It's co-pay with a deductible. And then when the pharmacies were trying to bill this to Medicaid, their claims were getting denied. Probably, I think I did talk about to Fatima about this some time ago, because of processing issues between the DME coming over to the pharmacy side, and also because these products maybe from what I remember non-formulary products under Medicaid, so that continues to be an issue that they did discuss.

They did not have any

recommendations at this time and their next meeting, I believe, is on June the 5th. And I thank you.

DR. SCHUSTER: Thank you very much, Kathy. So are they meeting with Medicaid during their TAC meetings? Do they have any staff there?

MS. HANNA: I do believe that Fatima is, or a representative from Medicaid is usually on the call whenever they are meeting.

DR. SCHUSTER: Okay.

MS. HANNA: As to my experience.

DR. SCHUSTER: Okay. And because I'm just wondering on some of these, if more dialogue directly with Medicaid about resolutions, the GoodRx, for instance, and also the Anthem issue. Those new items.

MS. HANNA: Yeah, I think --

MR. LAMOREAUX: Dr. Schuster and Kathy, this is Leon Lamoreaux. We did become aware that the Medicaid health plan did implement a DME deductible as part of the new benefit design, and we worked with

them for at least the DME or the test strips for diabetes. They will no longer be subject to the deductible. Other disposable medical equipment still will be, but we addressed that very, very quickly as soon as we became aware of it, so that we have been able to address that concern.

MS. HANNA: I thank you.

MR. LAMOREAUX: At least for the DME test strips.

MS. HANNA: Okay, good. Good, good, good. And, like I said, that may have been an old thing on there, but that came up at that meeting, but thank you for that. We appreciate it.

DR. SCHUSTER: Yes. We certainly want to have our diabetic members get those test strips without any problem or without anybody being having to pay extra. Thank you, Leon.

All right. Thank you very much, Kathy. Appreciate it.

Steve Shannon? Persons Returning to Society From Incarceration?

MR. SHANNON: Yes. Again, I'm Steve Shannon, chair of that TAC.

Our last meeting on May 9th, we had a great PowerPoint presentation about the waiver, and the status, and the benefits, and what it looks like. We meet for about an hour plus, and that was all we talked about at that meeting.

I would encourage, Dr. Schuster, that perhaps an abbreviated version of that be shared with the MAC at an upcoming meeting to really understand. We heard some of it from Commissioner Lee today, and Ms. Hollen, but Angela Sparrow just did a great job -- Medicaid staff and behavior health lead -- on laying out what it looks like, what is going to take place. And that is really all we did at our past meeting. No recommendations, but it was a great educational opportunity for all folks who participated and joined that meeting. I think it would just be valuable for the MAC to see that. It was a great way to lay it out and understand it.

We are looking forward that there is an advisory committee that has been formed that would help guide and shape this implementation, so we are excited about that as well, and I think we will all be a part of that, and we all have an opportunity for input. It was great to see it laid out before us for the first time in over two years. We have been talking about it, kind of, philosophically, and now we have something on paper that we can see and understand to grasp and unfold.

That's my report, but I think it would be beneficial for the whole MAC to see that information.

DR. SCHUSTER: Okay. Thank you for that suggestion. We would certainly talk about it, and since we are getting close to, perhaps we can celebrate CMS approval by having a presentation of the MAC after that. So I do think it is going to affect a large number of Kentuckians --

MR. SHANNON: Right.

DR. SCHUSTER: -- and really

move people into recovery, we hope. So thank you for that.

Optometric care?

DR. COMPTON: Yes. Steve Compton of the Optometric TAC. We actually canceled our April meeting so we have no report and we meet again in August.

DR. SCHUSTER: All right. Thank you, Steve.

DR. COMPTON: Thank you.

DR. SCHUSTER: Nursing services?

MS. BICKERS: I believe Lisa had a conflict and was not going to be able to be here today. She had patients. But that they did recently have a meeting last week. No recommendations that I recall.

DR. SCHUSTER: Okay. Thank you, Erin.

Nursing homes?

MS. BICKERS: They have canceled their meeting for next week. Terry said they had no agenda topics at this time.

DR. SCHUSTER: Wow. Does that mean everything is going 100 percent for

nursing homes? I'm sorry. It's hard to imagine that there aren't some issues.

MS. BICKERS: From my understanding, they have been working with some DMS staff on some more provider-specific issues versus like TAC issues.

DR. SCHUSTER: Okay. All right.

I see Rick Christman for the IDD TAC.

MR. CHRISTMAN: Yes. We met on April 2nd and we had a quorum. Among the items we discussed, again, were involuntary termination, specifically from the SEL program, which were residential services, and for example, as of that date, 65 people had been involuntary terminated in the past six months. We decided to gather more information. Seeing, for example, what the crisis units might do, the Mobile Crisis units. Beyond that, we talked about, tried to get some more information about the revised rates and regulations, but we were asked a little bit early on that, so maybe our

next meeting we can get into that in more depth. Beyond that we had no recommendations, and that's my report.

DR. SCHUSTER: Okay. Thank you very much, Rick.

Hospital care?

MR. RANALLO: This is Russ Ranallo, reporting for the Hospital Care. We had a meeting on April 23rd. We had a quorum. We had no recommendations. We discussed several topics just to highlight two of those out of the report.

We've had several issues on incarceration, but DMS worked with us to set up a meeting with the Department of Corrections and folks from DMS. We went through multiple questions and concerns and made some good headway and we will continue on there. We are appreciative of those efforts and DMS helping with that.

And looking at some, we have an issue with the nows and the emergency room where we have some MCOs are using a software and an algorithm to downgrade ED visits and reduce payments.

But we are not saying reasons why and there's a lot of lack of understanding about how the algorithm and the software works. So we are diving into this, but I expect that it's going to be, become a more heavy issue as we dive in. So that is all I have right now. Thank you.

DR. SCHUSTER: Russ, you mentioned an incarceration issue. Can you explain a little bit.

MR. RANALLO: We have got multiple, there is a whole host. There are probably about a dozen, it's about who is ultimately responsible for the bill, different situations. There are a lot of situations where we have somebody has presented to the hospital and they have been released and the website is not updated so the claim gets denied. There have been cases where people are brought in and they are either in custody, or not in custody, and who is responsible for that bill. There is a lot of not consistent process being applied across

the regions and what we're trying to get is some clarification on who is ultimately responsible for the bill, how do we get it streamlined. And I think the take home from the meeting was, we really need to have continued education that maybe an FAQ that is worked up and everybody can point to and follow. It was a very productive discussion. I was very pleased and appreciative of everybody who was on the call, but it's a lot of, just individual examples of cases where the hospitals feel like they are in the middle and both sides are telling us they are not responsible for the bill, whether it is for the jail or the MCO, and we are just trying to get clarification on who is responsible so we can have our processes correct.

DR. SCHUSTER: Good. Thank you very much. I was curious about and I can see where you all get caught because you have to treat whoever comes in the door, so you have and then you are looking for, as you say, who is the responsible person. Thank you for sharing that, Russ.

MR. RANALLO: Thank you.

DR. SCHUSTER: Home Health?

MR. REINHARDT: Hi, everyone. I'm Evan Reinhardt from the Kentucky Home Care Association, reporting for the Home Health TAC.

We met on April 9th and discussed some guidance and reimbursement for supplies, as well as coding, and also requested each MCO to supply their type of bill requirements, and then we received some electronic visit verification updates, and we did not have any recommendations.

DR. SCHUSTER: Okay. Thank you, Evan.

Health Disparities?

(No response.)

Anybody on for Health Disparities?

MS. BICKERS: I do not see anyone. They did move to quarterly. I do not believe they've had a meeting since the last MAC.

DR. SCHUSTER: Okay. Thank you,

Erin.

EMS?

(No response.)

MS. BICKERS: I believe it's the same with EMS.

DR. SCHUSTER: Okay. Dental?

DR. BOBROWSKI: Yes. This is Dr. Bobrowski. We did meet a couple of weeks ago. We did have a quorum. We are working with Commissioner Lee and DMS on some data issues.

The Kentucky Dental Association and myself and Commissioner Lee met with the representatives of the Primary Care Association, and we kind of talked, preliminary talks, about dental care and dental access, so that is going to be an ongoing meeting that kind of ties in with the TAC. But we did meet with the Primary Care Association, and we've been working with Commissioner Lee to make some certain items of care just easier to do.

And I want to do a public apology to Commissioner Lee and Justin Dearinger and some of the other -- Erin,

and some of the other members of the DMS, that on the last TAC meeting I put something on the agenda, and I was complaining that, we've got to do this to get this done, you know some things have to go in sequence. Well, I don't get on the website every day, so before I got on these committees, I probably didn't get on them once a quarter, once a year. But I do, anyway, want to apologize to them that they had fixed the issue probably two or three months before I even knew about it. So it is a heartfelt apology to you all, and at this time, there is no recommendations from the MAC from the Dental.

DR. SCHUSTER: Okay. Thank you very much, Garth.

Consumer rights and Client Needs?

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

Before I talk about our last

meeting and give our report, I just wanted to just really follow up on what the Hospital TAC was discussing at their last meeting related to people who are incarcerated and are released and then have a suspension on their coverage and, you know, aren't able to use their Medicaid coverage because of that suspension not being lifted. That's been an issue for many, many years now, and I do think that the reentry waiver, when it is approved and, of course, implemented, could greatly help in that situation because people should be getting enrolled and have their coverage activated before they are released, at least if they are in prison. That won't be happening in jails. But something that I think we could be doing, and I would love to see some efforts made toward doing this, is just to look at not having a suspension at all. We had talked a few years ago to Vikki Wachino, who used to be one of the top administrators at CMS, and has since started the health and reentry project. I

had to look that up to remind myself exactly what it was called. But she has really focused a lot of her efforts since leaving CMS in helping reentry. And we had, essentially, sought her advice on what we could do here in Kentucky, and while the suspension ensures that there aren't services being paid for by Medicaid while someone is actively incarcerated, I think there are other ways that we could ensure that whenever people are incarcerated and then upon release, there would be no suspension to have to worry about, I think putting it on the jails and prisons and providers to make sure that they are not billing when someone is incarcerated is really the better solution there, and I think drawing back anything that is intentionally or unintentionally get billed during incarceration, would be better than having that suspension in place. So I'm just going to put that out there. It's something that we had raised years ago and I think, maybe, should be revisited.

For our Consumer TAC, we met on April 16th. We met remotely using Zoom. We didn't have a quorum, which is pretty unusual for us, but we had some people out sick.

We did discuss a number of our usual topics. We discussed Medicaid renewals, network adequacy, and some quality initiatives that CMS -- or DMS is actively, kind of, putting in place related to health-related social needs, which is a new term that CMS is using for things like access to safe housing and nutritious food, that we more commonly refer to that as social determinants of health, but they are very interrelated.

So after a full year of processing Medicaid renewals for adults, and I know the Commissioner Lee gave us a great update just earlier in the meeting I just wanted to touch on a few things related to what we learned. Of course, it has been a challenging process. We've seen a number of Kentuckians lose their Medicaid coverage. Hopefully because they

were no longer eligible and not for administrative reasons, but we know that some of them were for administrative reasons, too many. But we've learned a lot of lessons. But what we want to say is that we really appreciate how much DMS has worked with connectors and advocates to identify and fix system issues that have probably been there for a long time, and we just didn't realize how common they were, how much they were, sort of, contributing to churn and to administrative, either denials or discontinuances, and so I think the process that we have gone through has actually improved our system in a number of ways. And with child renewals, you know, in our future, whether that is in September or maybe a little bit down the road now, I think that we will be in a much better position to do those renewals and have fewer children losing coverage, because of system fixes that have been made.

Two, in particular, that have

stood out to us that are pretty recent, are one that led people to lose Medicaid coverage after they lost SSI without first being considered for another type of eligibility, and those individuals should now be receiving prepopulated packets, and should have that opportunity to renew their coverage before they lose it and have to reapply, so that is a big improvement.

And I wonder if that gets to some of what we had heard earlier about people on the IDD TAC saying that some people had been terminated.

And the other big issue that we have identified that's been fixed or is being fixed, is about 29,000 -- well, it impacted about 29,000 Kentuckians who have had their coverage reinstated. Essentially because information that DMS had because of different data sources was used to determine that they weren't eligible, but that was passively determined, that individual didn't receive a request for information and that RFI to

ask them to verify that the information was correct and up-to-date. So that is a situation that, I think, is in our past and should no longer be affecting Kentuckians moving forward, and that really is a big improvement.

So we know that letters have been going out to these individuals. I assume that not everyone will be aware that their coverage was reinstated so it is important for connectors and providers to notify patients who were affected. But again, I just think that we are in a much better position now, to start child renewals whenever, that does start.

And of course, having coverage alone, does not mean that people who were getting needed care are, you know, getting the care that they need, so that's why we at the Consumer TAC, focus so intently on network adequacy over the past year.

At our last meeting, we reviewed a second draft of the form that they are calling, Access to Services, that something that DMS has been developing

with our input, and this is going to be a really helpful tool for DMS to identify Kentuckians that aren't able to access a provider in their MCO network, in the region, where they live, and to be able to really better understand where the gaps are in our network, so that we can start to focus more systemically on that, making improvements.

And we also learned in that meeting in April, that DMS should be getting their first report from the MCOs in May, so they may have already gotten it, regarding providers who haven't billed a claim in over a year, to determine if they are actually serving Medicaid members or not.

So the issue now is if you are an enrolled Medicaid provider, you get counted as active and available even if you are not seeing any patients or maybe just seeing just a few patients. And so, of course, that creates a type of shadow network, if you think about it, where we have providers, but they are not actually

accessible.

So to have a more accurate and meaningful network, we really need to make sure that we are basing that network on the variety of services being provided in the geographical area, so we know that people are actually able to get those services and in a timely manner.

And in our past meetings, we have explored new opportunities provided by CMS to redirect some Medicaid funds to cover health-related social needs, which like I mentioned, housing and food and, of course, we have been talking a lot about the SMI waiver with Sheila, and, you know, really looking at how we can provide those wraparound supports to certain individuals who are high risk and experiencing different health disparities.

I think it could go a long way in reducing those health disparities in managing chronic conditions like asthma and diabetes and also severe mental illness.

We have been learning a lot

about initiatives that the state is implementing to start screening for and tracking social determinants of health through hospitals, MCOs, and even now the Medicaid application. And so I think that's going to be, again, another good tool for us to understand where some of those gaps are, where people have basic needs that aren't being met, and hopefully we can then put together another really strong proposal to CMS to say: Hey, this is how we need to be spending our Medicaid money so that we be addressing some of these health-related social needs.

But back to this screening for social determinants of health and, of course, there's Connect Resources, which is a referral system, where you can actually make referrals to the different community providers, that is something that we discussed, as well. And while we think that there is a lot of opportunity here, of course, there is a lot of need in the community, and with Medicaid members in particular, but we know that CBOs,

community-based organizations, are often overwhelmed by the volume of referrals, and some of them are concerned about the volume of information and how it's being handled, particularly, for individuals experiencing personal violence. So that's something that we really need to put more attention and just thought towards as we are developing this and continue to make improvements to the system.

Following our last Consumer TAC meeting, we did have an opportunity to discuss some of those concerns with cabinet staff in more depth and they've agreed to meet with and CBOs in June and see how individuals are working and also consider what changes can be made to address some of those concerns. So that was a positive outcome of our last meeting.

And while we didn't have a quorum, we weren't able to make recommendations at that meeting, I did want to express appreciation for DMS. Their most recent responses to the

recommendations we made at the MAC meeting in March, those were regarding input on the Medicaid membership survey and accessibility through the use of video explainers, screen readers, closed captioning, subtitles, those sorts of things that improve accessibility for folks. In both of those cases, DMS expressed that they had already had plans in place, and they provided a timeline for completion within the next few months, so we were really pleased to hear that. We were able to give some input on that Medicaid survey before it went out, and that was also a really good opportunity.

So we are looking forward to seeing what the results are once that survey closes and DMS puts together a report.

That's it for me. I'm happy to answer any questions if you have any. Our next meeting is scheduled for June 18th at 1:30.

DR. SCHUSTER: Thank you, Emily. And thanks for, kind of, pulling in the

incarceration issue. I think one of the providers, Beth, put it in the chat that a lot of times providers don't know if someone was recently incarcerated and maybe in that suspension mode, and I do think that there are some issues there, as well. But I appreciate your report.

Children's Health TAC? Have they met, do you know, Erin?

MS. BICKERS: They met in April. I do not see anyone on and I do not believe they had any recommendations.

DR. SCHUSTER: Yeah, I don't think we've actually had a report from the Children's Health TAC in it feels like many, many meetings. I would have to go back and look. But it would be nice to hear what they were discussing. Thank you.

The Behavioral Health TAC met on May 1st. We welcomed a new member, Tara Hyde, representing par, and we had a quorum.

We had anticipated that we would get a report from the Office of Data

Analytics about comparing multistate comparison study of rates, but that has been delayed until the July meeting.

We had an excellent, excellent presentation by Jennifer Dudinskie about audits being conducted by the MCOs. Both pre-payment and post-payment audits and got a much better understanding of how all of that works and the role of DMS and that. We had forwarded a lot of questions prior to the meeting, and then Jennifer made an excellent PowerPoint available, and we are going to have a recommendation here in a minute about that.

We got waiver updates, and I won't go through that because we heard a lot of that.

The discussion around Behavioral Health Associates, that's the kind of reformulation of people that have a bachelor's degree and are working on a Masters in a profession, and what their role is going to be, and Jonathan Scott has been working on those regs, and I believe that they were not presented in

May but are being presented to the administrative right review subcommittee in June.

Justin Dearinger gave us a good report on no-shows. You might find this interesting, Garth, because the no-shows come up frequently, from your perspective with dentists.

89,941 -- so about 90,000 no-shows were reported in 2023. And of those -- 64,000, or 72 percent, had no reason stated. So not very helpful in terms of trying to address some of those social determinants of health and try to figure out why people are not keeping their appointments. Interestingly, the highest number of no-shows reported by provider type were from the occupational therapists. And the area of the state with the highest number of no-shows was Louisville Metro. Justin indicated that CHWs could possibly be of help in contacting individuals to get a better idea of the reason for people not keeping their appointment, which I think could be

really helpful information. And he emphasized, and I think we emphasized here at the MAC, that the importance of more providers using that portal and reporting their no-shows.

So that is something, and Garth, I am not picking on you, but, you know, you have brought this up many times, so the next time that your Dental TAC meets or you have meetings with your dental colleagues, I would sure encourage you to make those reports.

I am not sure that we have a good representation of behavioral health clients and they are not keeping their appointments either, so we will bring that up again at the BH TAC.

Under new business we have an MCO that sent a letter to several providers and made a blanket statement that they were reducing reimbursements by 20 percent, which has caused a great deal of consternation, as one might imagine. So Leslie Hoffman and Angie Parker pointed out that MCOs are required to give 30-days

notice in such cases. Providers can examine their contracts with the MCO to see if that is addressed or not. Those can be negotiated, and providers don't necessarily have to accept that cut-and-paste. They can decide they will no longer be a provider with that MCO any longer. It was pointed out by one of the attendees that if a number of providers do that, we can end up with a lack of access to behavioral health services, since that MCO has a large number of Medicaid members.

Our recommendation is that Kentucky Medicaid provide written guidance to providers about the pre- and post-payment audit procedures, and how each MCO is implementing those procedures. And I will send you that in writing, Erin, so that you have it for your records.

MS. BICKERS: Thank you.

DR. SCHUSTER: Yes. So that was our recommendation. The TAC will next meet on Monday, July 11th and that was our meeting.

Is Ashima back?

MS. BICKERS: Not yet.

DR. SCHUSTER: Not yet. Okay. So we don't have -- Physician TAC. So we don't have a quorum still; right?

MS. BICKERS: No, ma'am. Sorry. I was trying to read the chat really quick, as well.

DR. SCHUSTER: So we can't make a motion to accept the TAC recommendations. I think it was just that one from the BH TAC, if I remember that correctly. I don't think any of the other TACs --

MS. BICKERS: No. We only had the one recommendation this time. If you'd like to discuss your next 7 and 8, and as soon as she hops back on I can let you know.

DR. SCHUSTER: Okay. Thank you.

So Eric Wright brought up, initially, the issue of people having so much trouble accessing, figuring out how to access Medicaid, particularly the Medicaid waivers. And we discussed that

at the last meeting of the MAC and Pam Smith said that she had a number of documents that were available on the website, and so forth. Pam sent me those documents. I have since also talked with a couple of individuals who have reached out to Commissioner Lee with specific issues, both of them about children with significant healthcare and behavioral health care needs. Actually, heard from a number of other consumers and family members about this issue. So I took those documents that Pam sent, which were a variety of probably five or six different documents that discussed how to get into Medicaid a bit more specifically, discussed information about the waiver, and I sent that information to a number of our TACs and asked for their input. I sent it to the Children's Health TAC, the Consumer Rights TAC, the Health Disparities TAC, the IDD TAC, and that may have been all, but I am happy if any of the other members of the MAC would like to see that material. What we are trying to

do is get lots of input about, yeah, the Consumer TAC will discuss it at their next meeting. What are your recommendations, not only about the documents themselves, but one of the things that came up as Pam was telling us about this information, is you know, if people have no clue about how to access Medicaid, then documents that are on the Medicaid website may not be readily available to them, and we know, I did send that information also to some of the consumer and advocacy groups around disabilities and behavioral health to ask for their input, because I think the more that we have boots on the ground, let's call them the advocacy groups like the ARC or the Commonwealth Council on Developmental Disabilities, or the NAMI groups with this kind of information, the more likely that our family members and consumers are going to be able to access it. So we are looking, here, at both the documents themselves, and what kind of information is needed, and then what the process might be.

Pam also said that, internally, she has some work groups working on that, so I guess I would just like to keep this on the agenda. I do think that the MAC can play a very helpful role with all of the different perspectives that are represented on the MAC, in giving some recommendations on how to simplify this information, and how to simplify access both to Medicaid and to the Medicaid waivers. So I just wanted to give you all that update.

And again, if there are any questions, several of the TACs were going to talk about it in the upcoming months, so we will look at this again in July, and we will also ask Pam to report on how her internal work groups are operating. But if any of you would like for your TAC, to receive this information and give us some input on it, I'm happy to forward that information to you.

And I would ask, at this point, is there any new business that anyone on the MAC would like to bring forward?

Excuse me. I'm kind of froggy this morning. No new business? Okay.

So we have several ongoing, kind of, big picture things with this CMS requirement by July of 2025 to have in place; a BAC, Beneficiary Advisory Council is going to be a big lift in making whatever changes we need to make in statute around the MAC and the TACs.

One thing I would ask of the MAC members who also are representing groups that have TACs or attend those TAC meetings, is to take back that question to the TAC to look at your statutory reference in terms of who nominates members, for instance, for your TAC and to -- because, you know, if there's going to be any changes made in that, this is going to be the time to do it, to work on that legislation very soon. They will go back in session with a number of, I guess, already elected new members on the first Tuesday after the first Monday in January, and then this is a 30-day session, so they will meet that first week in January and

then they will go home for about a month. And then when they come back, it is hellfire to get something passed, because there is so much going on in a very, very short time. So just to alert you.

And our next meeting is Thursday July 25th at 9:30.

MS. BICKERS: Dr. Schuster, we still don't have a quorum, but you don't need a quorum to vote on your recommendations, just your minutes.

DR. SCHUSTER: Oh, okay.

MS. BICKERS: So we can move the recommendations forward, if you want.

DR. SCHUSTER: Yes.

MS. BICKERS: We can give it another moment if you'd like to wait. It is up to you.

DR. SCHUSTER: Let's go on. I didn't realize that. Thank you, Erin.

So the motion made by the Behavioral Health TAC is the only one that was put forward, so I would entertain a motion to accept that TAC recommendation and send it on to DMS.

DR. BOBROWSKI: So moved.

DR. SCHUSTER: Thank you, Garth. Is there a second?

MS. HANNA: Second. I think there were two of us.

DR. SCHUSTER: Kathy, thank you. All those in favor of forwarding the BH TAC recommendation to DMS signify by saying, "Aye."

MAC MEMBERS: Aye.

DR. SCHUSTER: And anyone opposed? And any extensions?

Thank you very much. And I appreciate that, Erin. I assumed that we needed to have a quorum.

Someone from Kentucky Medicaid says: I cannot hear anything. Did you see that, Erin, in the chat?

COMM. LEE: That may be Erin. I think that's, it's either her, or maybe Kelli.

DR. SCHUSTER: Oh.

COMM. LEE: Should I just tell her that you made a motion to --

DR. SCHUSTER: Yes, that we made

a motion to move the BH TAC recommendation on to DMS.

Did any of you all have trouble signing in this morning on the Zoom?

COMM. LEE: I did not.

DR. SCHUSTER: Okay.

DR. WRIGHT: I didn't either.

DR. SCHUSTER: Or maybe it was just me. I got nervous, because the last time we had a BH TAC, a few minutes before.

Peggy did you have problems?

MS. ROARK: Yes, I did.

DR. SCHUSTER: Okay. I wonder if --

MR. STUART: I did as well. It took a long time and just kind of spun on the clock for quite awhile, and then it finally popped up for me, but I had a little bit of trouble as well, so.

DR. SCHUSTER: Okay. Erin and Kelli have had to write on that and we had a terrible period of time there where all of a sudden the Zoom links weren't working for the MACs and the TACs, so we will pass

that along to them outside of the meeting.

I think we will go on and adjourn. I know that Ashima was going to try and get back, but I also know how school award ceremonies can go and they are very unpredictable in length, and you want to be there for your kids.

So we will approve the minutes at our July meeting and we will adjourn by acclamation. If no one has any objections, we will give you back quite a bit of time on your morning, early afternoon.

I wish you all a happy long weekend and let's remember those who have given their lives so that we have the freedoms that we have. We really need to cherish those freedoms and cherish those who gave the ultimate sacrifice to get that. So thank you very much, and have a great long weekend and I appreciate your service to the MAC.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 29th of May, 2024

/s/ Stefanie Sweet

Stefanie Sweet, CVR, RCP-M