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2 CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE
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12 Via Videoconference
July 27, 2023
13 Commencing at 10:04 a.m.
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Shana W. Spencer, RPR, CRR
25 Court Reporter

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1 **APPEARANCES**

2

3 ADVISORY COUNCIL MEMBERS:

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

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1 P R O C E E D I N G S
2 CHAIR PARTIN: I'll call the
3 meeting to order, and I'm going to take the
4 roll call.
5 MS. BICKERS: Did you need me to do
6 that today, or is Heather on?
7 CHAIR PARTIN: I don't know if we
8 have the secretary or not.
9 MS. BICKERS: Okay. I have got the
10 list ready so -- Beth?
11 CHAIR PARTIN: Here.
12 MS. BICKERS: Nina?
13 MS. EISNER: Here.
14 MS. BICKERS: Susan won't be here
15 today. She sent us an email.
16 Dr. Roberts?
17 (No response.)
18 MS. BICKERS: Heather Smith?
19 MS. SMITH: Here.
20 MS. BICKERS: Dr. Bobrowski?
21 (No response.)
22 MS. BICKERS: I thought I saw him
23 logged in. Maybe we lost him.
24 Dr. Compton?
25 DR. COMPTON: Here.

1 MS. BICKERS: Dr. Muller?
2 DR. MULLER: Here.
3 MS. BICKERS: Dr. Gupta is not
4 going to be with us today.
5 John Dadds?
6 (No response.)
7 MS. BICKERS: Dr. Hanna?
8 (No response.)
9 MS. BICKERS: Barry Martin?
10 MR. MARTIN: Here.
11 MS. BICKERS: Kent Gilbert?
12 (No response.)
13 MS. BICKERS: Mackenzie Wallace?
14 (No response.)
15 MS. BICKERS: Annissa Franklin?
16 (No response.)
17 MS. BICKERS: Dr. Schuster?
18 DR. SCHUSTER: Here.
19 MS. BICKERS: Bryan Proctor?
20 (No response.)
21 MS. BICKERS: Peggy Roark?
22 MS. ROARK: Here.
23 MS. BICKERS: Eric Wright?
24 DR. WRIGHT: I'm here. Thank you.
25 DR. BOBROWSKI: And I'm here,

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1 Bobrowski.

2 MS. BICKERS: Sorry. I lost count.

3 Give me one second. I'm sorry.

4 I counted ten, so we should have a

5 quorum. You're good to go.

6 CHAIR PARTIN: Okay. Great. Thank

7 you.

8 Next up is approval of the minutes.

9 Would somebody like to make a motion?

10 DR. SCHUSTER: I'll move for their

11 approval. This is Sheila Schuster.

12 DR. MULLER: Second. John Muller.

13 CHAIR PARTIN: Thank you.

14 Any discussion?

15 (No response.)

16 CHAIR PARTIN: All in favor, say

17 aye.

18 (Aye.)

19 CHAIR PARTIN: Any opposed?

20 (No response.)

21 CHAIR PARTIN: Okay. Thank you.

22 Minutes are approved.

23 Old business. What is the status of

24 Anthem MCO? And I guess this goes to the

25 commissioner.

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1 COMMISSIONER LEE: Good morning.
2 Still in litigation. No new updates on this
3 topic.
4 CHAIR PARTIN: Thank you. I'll put
5 that up for next meeting.
6 Has the letter to the governor on the
7 workforce study, has that been sent?
8 COMMISSIONER LEE: No. We did
9 discuss this with the secretary's office, and
10 we thought and believe that since we were in
11 the midst of a workforce study already, that
12 the letter should not be -- did not need to
13 go to the governor. So the secretary did
14 make that decision -- secretary's office did
15 make that decision.
16 So we do have -- and I can jump into C
17 because it's related to B. We do have a
18 preliminary workforce study report. I have
19 reviewed the report. I think it's got some
20 very good information in there.
21 We will be finalizing that next week and
22 will send that out to the MAC and the TACs
23 for review. And we can discuss it at the
24 next MAC if you all would like a presentation
25 on the report. We can definitely present on

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1 the report after you review and answer any
2 questions that you may have and talk about
3 some of the things that we're going to do
4 going forward.
5 For example, we do have a state
6 university partnership that is also going to
7 be looking at some access and some workforce
8 that we may be able to fold into this after
9 you look at the report and have your
10 questions.
11 CHAIR PARTIN: Okay. Thank you,
12 Commissioner. And that would be related
13 to C; right, the UK analytics study?
14 COMMISSIONER LEE: Yes. Yes.
15 CHAIR PARTIN: Okay. So let's put
16 that on the agenda for the next meeting.
17 COMMISSIONER LEE: Yes. We can --
18 we can definitely have a report out, a
19 presentation on the findings of the workforce
20 study.
21 CHAIR PARTIN: Okay. Sorry. I'm
22 making notes.
23 Okay. And then the next item is just a
24 reminder about the update on canceled
25 appointments, and that will be put for the

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1 September meeting.
2 And then the PDS legislative rate
3 increase and, Eric, if you would like to
4 speak to that.
5 DR. WRIGHT: Yeah. First, I want
6 to just thank Commissioner Lee and Pam Smith
7 for meeting with me on Wednesday, June the
8 21st. We had about an hour meeting to
9 discuss the PDS rate increase and some of the
10 communication that is being sent out to the
11 agencies that oversee PDS services for
12 individuals with intellectual and
13 developmental disabilities, primarily through
14 our 1915C waivers.
15 Commissioner Lee and Pam agreed that we
16 are working towards a goal of communicating
17 with consistency -- whether it be case
18 managers, support brokers, or however agency
19 described -- the individuals who help
20 families navigate PDS services with those
21 waivers.
22 I felt very positive about the meeting
23 and, obviously, there was a need to have this
24 discussion as it continues to be a little bit
25 of confusion within the community and social

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1 media related to how these rate increases are
2 being communicated to representatives across
3 the commonwealth.
4 In that, though, I do suggest that we
5 get a little bit of an update from
6 Commissioner Lee on any developments -- or
7 Pam -- if she would take a few minutes to
8 reflect upon the meeting and some of the
9 results of those discussions.
10 COMMISSIONER LEE: Thank you,
11 Dr. Wright. I think that the meeting went
12 well, too. I think always, you know, working
13 on our communications is a good strategy.
14 And, Pam -- is Pam on the call today?
15 And if she would like to provide any
16 additional comments or updates related to the
17 conversation we had with Dr. Wright.
18 MS. SMITH: I am. Thank you,
19 Commissioner. So we are working on a
20 communication that has -- in addition to,
21 Eric, some of the things that we talked about
22 as far as the timing and that families -- you
23 know, so the families weren't told you have
24 to wait till you re-cert, some direction
25 around that.

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1 That, you know, when a family reaches
2 out to you and they need to modify the plan
3 of care, then part of the responsibility of
4 the case manager/support broker/PDS
5 coordinator -- that's one of the things also
6 we're changing, to give everybody one name so
7 that we don't have, you know, 15 different
8 names for different programs -- that that
9 needs to be handled like any other plan of
10 care change in that it needs to be scheduled
11 timely.
12 So we are working on that communication
13 as well as the communication about the second
14 rate increase that just went in. It was
15 effective July 1st. It will actually go into
16 the system tomorrow night. We are going to
17 go back and mass adjust claims from July 1
18 until that goes in tomorrow night. But that
19 communication is going out hopefully this
20 afternoon. If not, it will be out tomorrow.
21 But we are working with -- with our
22 partners with the ADS and the CMHCs. And,
23 also, another exciting thing that we're doing
24 with, in particular, participant-directed
25 services is we have expanded the availability

1 of that so that it is similar to SCL and that
2 any certified case manager can perform those
3 functions.
4 So we're beginning to see some of our
5 other case managers start picking up
6 individuals for PDS that maybe were not in a
7 waiver they served before, or they may -- it
8 may be in the same waiver, but they did not
9 do participant direction before. So that is
10 growing and is expanding.
11 DR. WRIGHT: Thank you, Pam. Pam,
12 can you speak to a conversation that you and
13 Commissioner Lee and I had related to -- with
14 the rate increases, there was a discussion
15 about a request to CMS about -- and I guess
16 it was related to budget increases related to
17 the waivers as well and how that might be
18 addressed. I believe there's a plan that you
19 all have in place with CMS; is that correct?
20 MS. SMITH: So right now in
21 particular -- and I'm sorry. My dog has
22 decided he is going to talk right now, so I
23 apologize.
24 DR. WRIGHT: No. That's okay.
25 MS. SMITH: I apologize for the

1 noise in the background.
2 Right now, there are -- in Michelle P in
3 particular, there -- in the regulation, there
4 is a budget amount. There's a limit of
5 40,000 if a plan is only participant-directed
6 services and 63,000 if the plan has both
7 traditional and participant-directed
8 services.
9 So through Appendix K, we have waived --
10 there are a lot of actually -- we waived
11 several limitations, but one of them was that
12 budgetary limitation. Because, one, it does
13 not make sense that we're going to increase
14 the rates but then we're going to leave an
15 old budgetary cap in there, which would, you
16 know, result in individuals either not being
17 able to give their employees a pay increase;
18 or, B, them not getting the amount of
19 services that they needed.
20 So we -- as part of the initiatives
21 right now, with us modifying the waivers and
22 rewriting the regs to reflect the rate
23 increases, we are looking at that -- at all
24 limitations. And so that would be
25 limitations on the amount of service hours a

1 week as well as limitations -- those
2 budgetary limitations. But we are not
3 enforcing that 40,000 and 63,000-dollar
4 amount right now. So it allows the
5 individuals to have access to be able to pay
6 their employees a fair rate based on the rate
7 increases.
8 DR. WRIGHT: Thank you.
9 MS. SMITH: You're very welcome.
10 CHAIR PARTIN: Okay. Thank you
11 all.
12 Next up, we have a report from DMS about
13 community health workers and how they
14 function.
15 COMMISSIONER LEE: Yes. I think
16 Justin Dearinger is on the -- in the meeting,
17 and he will be providing an update on this.
18 Justin?
19 MR. DEARINGER: Hello. Thank you,
20 Commissioner.
21 Yes. We started July 1st providing
22 reimbursement for community health workers
23 for several provider types, and we'll go
24 through a little presentation now to talk
25 just a little bit about that.

1 So some of the qualifications for being
2 a community health worker, you have to be a
3 legal United States resident. You have to be
4 employed as a community health worker in the
5 state of Kentucky, to be at least 18 years
6 old, and meet and maintain the certification
7 or recertification requirements.
8 Those certification and recertification
9 requirements are put in administrative
10 regulation through the Department For Public
11 Health, and they are maintained there. Some
12 of the services that a CHW can provide: The
13 preventative services, health promotion and
14 education, facilitate provider communication,
15 patient education, and other approved DMS
16 services.
17 A couple of things that we as -- in the
18 Department For Medicaid Services, in meeting
19 with providers and provider groups, were able
20 to see is something that you had brought up
21 earlier, was no-show lists. One of the
22 things that continue -- that we continue to
23 strive and fight against are: What are the
24 causes of individuals that are Medicare (sic)
25 recipients not showing up or not cancelling

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1 appointments? And part of that process is
2 finding out exactly why they're not showing
3 up so that we can attack those different
4 areas.
5 Some of those things can be found out by
6 using community health worker services.
7 Community health workers provide services
8 that -- again, you'll see one of these says
9 facilitate provider communication. They
10 reach out to individuals to see if they've
11 changed phone numbers, changed email
12 addresses to make sure that they're getting
13 their notifications for their appointments,
14 to make sure they understand that they have
15 to cancel appointments and give
16 notifications.
17 In addition, we talk about other
18 approved services and patient education.
19 Those things are part of how to access
20 services such as transportation services,
21 nonemergency medical transportation, other
22 forms of assistance that they may need in
23 order to get to their appointments as well as
24 being able to find out -- reach out and find
25 out reasons why they may have missed an

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1 appointment, which the biggest percentage
2 of -- when that report comes out of no-shows,
3 the biggest percentage of no-shows is just --
4 there is no reason given. And so community
5 health workers can also help with that, to be
6 able to pinpoint reasons why individuals
7 weren't able to show up.
8 All right. Next slide. The health
9 navigation and resource coordination is vital
10 for community health workers to provide. It
11 helps them to find Medicaid providers to
12 receive covered services. A lot of times,
13 Medicaid recipients and individuals don't
14 know exactly which provider may provide the
15 best service to them. And then a lot of
16 times, they'll end up going to an emergency
17 room or to an improper provider for certain
18 services they need.
19 It helps them make appointments for
20 Medicaid-covered services. This also
21 encompasses helping them to cancel
22 appointments, change appointments for other
23 needed items, arrange appointments that are
24 together, arrange transportation to medical
25 appointments, attend an appointment with the

1 recipient for a covered service if they are
2 in need of understanding what's going on or
3 understanding certain -- having certain
4 communication barriers. Help a recipient
5 find other relevant community resources such
6 as support groups and other areas of support
7 for the recipient.
8 Health education and training.
9 Education and training for health issues such
10 as immunizations, managing blood pressure,
11 managing STDs, diabetes, accident prevention,
12 occupational safety, and control of toxic
13 agents or poison control all assist us with
14 promoting better health for individuals in
15 the long run and, at the same time, keeping
16 costs down to the medical community.
17 Health promotion and coaching.
18 Cessation of tobacco use, reductions in the
19 misuse of alcohol or drugs, improvement in
20 nutrition, improvement of physical fitness,
21 family planning, control of stress, pregnancy
22 and infant care, including prevention of
23 fetal alcohol syndrome.
24 I spoke with a physician yesterday over
25 the phone that talked about the multiple

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1 times he -- and the amount of time that he
2 spends with multiple individuals going over
3 cessation of tobacco use or improvement in
4 nutrition in his clients, when he discusses
5 nutrition and themselves and in the -- in
6 some of the younger patients that he sees.
7 These things can be done by a community
8 health worker who are trained in these
9 different things, and it allows clinicians
10 more time to see more patients and to be more
11 successful.
12 So providers -- what type of provider
13 can bill for community health workers? Right
14 now, we have alcohol and other drug treatment
15 entities, behavioral health service
16 organizations, community health mental --
17 community mental health centers, FQHCs, or
18 Federally Qualified Health Centers.
19 A health system consisting of a hospital
20 or at least a group of physicians or more
21 than one group of physicians, a hospital, a
22 local health department, primary care clinic,
23 a rural health clinic. And then there are
24 some other Medicaid providing --
25 participating providers such as dentists and

1 midwives that are also able to bill for
2 community health workers.
3 Some other requirements for community
4 health workers. They cannot enroll as
5 independent Medicaid-participating providers.
6 They have to be employed by one of the
7 current Medicaid-enrolled provider types.
8 They must be related -- the services they
9 provide must be related to medical
10 intervention outlined in the individual's
11 care plan.
12 There's no reimbursement for CHWs that
13 are already paid by federal funds through
14 grants or other means. If reimbursement is
15 already included in a per diem or cost
16 settlement type they're not reimbursed for or
17 for CHWs that are employed by Managed Care
18 Organizations, or MCOs. And CHWs are not
19 eligible for WRAP payments.
20 Those are some of our billing codes
21 currently, most up-to-date billing codes that
22 we use for CHWs. As you can see, there are
23 CPT98960 through 98962. And, basically,
24 they're the same CPT code that just deals
25 with how many individuals a CHW is working

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1 with at that moment. And they're in
2 30-minute increments.
3 So MCOs hire their own CHWs, and they
4 reimburse -- fee-for-service Medicaid
5 reimburses for CHWs for all different
6 providers.
7 So the other thing is that there are set
8 limits for some of the community health
9 workers that they can't exceed, but those are
10 broken down by provider type groups so that
11 the limits aren't strictly per individual.
12 So if an individual goes to a physician
13 today and sees a community health worker; and
14 then on Wednesday, they go to see their
15 dentist and a community health worker assists
16 them there; and then on Friday, they go to
17 see their therapist and a community health
18 worker sees them there, they're able to do
19 all those things within the same week. And
20 those limits don't reflect on each other
21 because they are different provider-type
22 groupings.
23 So that's all I had for that. I
24 appreciate you taking the time to listen to
25 me. Anybody have any questions or --

1 CHAIR PARTIN: Justin, I have a
2 question.
3 MR. DEARINGER: Sure.
4 CHAIR PARTIN: So community health
5 workers are not something that DMS provides.
6 These are people who are hired by providers
7 to provide services to different practices?
8 MR. DEARINGER: Yes, ma'am.
9 Absolutely. So all of our -- a lot of our
10 different provider types hire community
11 health workers to assist them in many
12 different avenues of what they do, and
13 community health workers are varied.
14 Currently, there are many types of grants
15 that are used to hire and provide community
16 health workers, and each grant is very
17 specific on what they may do.
18 Currently, managed -- some of the
19 Managed Care Organizations we have in our
20 state hire -- or have on staff community
21 health workers, and they do more of the
22 varied duties that our providers can use
23 these community health workers for.
24 So whether it's, you know, taking the
25 time that a physician would sit down and go

1 over nutritional needs or values with a
2 patient and freeing up the clinician that way
3 or if it's assisting an individual with
4 scheduling and learning transportation
5 services to make sure that the no-show --
6 their no-show rate goes down, all those
7 things can happen through the providers that
8 are hiring these community health workers.
9 CHAIR PARTIN: So I receive letters
10 from various MCOs saying that the participant
11 has been contacted, and they talk about their
12 blood pressure. They talk about smoking.
13 They -- you know, it goes through a whole
14 list of different things.
15 Are those community health workers that
16 are doing that?
17 MR. DEARINGER: It depends on the
18 Managed Care Organizations. But I would say
19 in a lot of cases, that -- or in some cases,
20 it definitely is a community health worker
21 that does that.
22 CHAIR PARTIN: Okay. Thank you.
23 Anybody --
24 MS. BICKERS: Dr. Bobrowski has his
25 hand raised. Oh, I'm sorry, Beth.

1 CHAIR PARTIN: I was just going to
2 say: Did anybody have any questions?
3 DR. BOBROWSKI: I've got one
4 question. Justin, can local health
5 departments hire -- I didn't see that. I may
6 have missed it on your list of different
7 provider types -- that could get community
8 health workers? So I didn't know if
9 health -- just local health departments
10 qualify to hire somebody there.
11 MR. DEARINGER: Yes, sir.
12 Absolutely. If -- as a matter of fact, on
13 the front page of our Kentucky Medicaid
14 website, if you will look on the right-hand
15 side, we have a -- two different links for
16 community health worker information.
17 One of them is the presentation that I
18 just went over, but the other one is a very
19 extensive fact sheet and FAQ sheet that
20 details exactly what provider types are
21 eligible to bill, the limitations, the CPT
22 codes, and many, many other questions that
23 providers have asked us. And we've added to
24 that list to help individuals understand, you
25 know, all the different ins and outs. It's a

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1 brand-new service, so there are a lot of
2 things that we're still working on as well.
3 DR. BOBROWSKI: Thank you.
4 DR. ROBERTS: Can we -- I'm sorry,
5 Eric. Can we get a copy of this presentation
6 emailed to us, or is it on the website?
7 MS. BICKERS: It'll be --
8 MR. DEARINGER: It's currently on
9 the website, yes.
10 DR. ROBERTS: Okay. Thank you.
11 MR. DEARINGER: But Erin can send
12 it out, too. And I believe that Deputy
13 Commissioner Veronica Cecil has already put
14 the FAQ link in the chat as well.
15 MS. BICKERS: All presentations are
16 emailed out to the MAC afterwards and then
17 uploaded to the website.
18 MS. RITTENHOUSE: This is Susan
19 Rittenhouse at Seven Counties. I have two
20 questions, please. The first one is: In
21 regards to the certification, with some
22 provider types, an individual can be hired
23 and has a certain amount of time that they
24 can work, say up to six months, while they're
25 getting that certification. Is there a time

1 frame for that with community health workers?
2 MR. DEARINGER: So that's governed
3 by the Department For Public Health Services.
4 And at this time, I don't think that there's
5 that grace period. I'd have to go back and
6 look at the administrative regulation. I
7 don't remember if there is -- if you're
8 allowed to bill for a community health
9 worker's services before they get that
10 training. I don't think so. I'd have to go
11 back and look to be a hundred percent sure,
12 but I can go back and look at that.
13 I know for sure in their administrative
14 regulation, that before you get your
15 certification, you have to complete a small
16 amount of training from them. But that
17 training, to my understanding, is always
18 available, so they can do that online at any
19 time. And it's not a large amount of
20 training so -- but I would have to go -- I
21 don't believe that right now it's
22 reimbursable, like you said, pre --
23 pre-certification.
24 But it's something that we're -- that's
25 one of the issues -- like I said, we've

1 started this July 1st, so it's a new service.
2 And there are a list of topics that we have
3 that we're meeting on currently or that we
4 have meetings set up to discuss, to come up
5 with some solutions and recommendations that
6 we've gotten feedback from providers.
7 And what you just mentioned is having
8 community health workers set up kind of like
9 peer support service workers. When they
10 start, they have a certain amount of time to
11 get their certification, and they're still
12 able to reimburse as long as they're under
13 supervision.
14 MS. RITTENHOUSE: Correct.
15 MR. DEARINGER: That's something
16 that we've discussed as well. So a lot of
17 different things that we've looked at. We're
18 trying to make the process for payment for
19 dental providers smoother and easier. We're
20 looking at limitations, all those things that
21 we're talking about and discussing so -- but
22 thank you for bringing that up. And I'll try
23 to find out exactly, but I'm pretty sure that
24 that's not correct.
25 COMMISSIONER LEE: Hi, Justin.

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1 This is Commissioner Lee. Yes. You are
2 correct, Justin, that the CHW, the community
3 health worker, does have to be certified in
4 order for the provider to bill for their
5 services. Now, providers can hire
6 individuals that they think -- or that are
7 working towards their certification and have
8 them in the office getting them familiar with
9 the services array and their members that
10 they serve, but they cannot bill for that
11 community health worker until the community
12 health worker receives their certification.
13 MS. RITTENHOUSE: Okay. Thank you.
14 My second question is a little more
15 complex, and you may not have an answer but
16 would like to at least put it on the radar.
17 I know that community mental health
18 centers are eligible for this provider type.
19 Four of the community mental health centers
20 in Kentucky currently are also CCBHCs, and I
21 understand that this code is not eligible for
22 WRAP payments.
23 My question is that the CMHCs have
24 received correspondence that we cannot bill
25 for outpatient CMHC services and for a CCBHC

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1 on the same day as a CCBHC service. Is this
2 code going to be exempt from that requirement
3 so that we could provide this service as a
4 CMHC on the same day that there's a CCBHC
5 service being provided?
6 MR. DEARINGER: That's a good
7 question, and it is an in-depth question. So
8 let me take that back and get an answer back
9 to you, so I'll give you an answer a hundred
10 percent.
11 MS. RITTENHOUSE: Thank you very
12 much.
13 MR. DEARINGER: Yep.
14 DR. WRIGHT: Hi. This is Eric. I
15 had a question, too. Two quick questions.
16 First off, when you look at this, Justin,
17 give me an example of about how much time and
18 training goes into this, you know. And as
19 you see people unfolding kind of this and,
20 you know, launching this into their agencies,
21 are they advertising these positions with,
22 you know, a certain salary range? And if so,
23 can you kind of give an average of what these
24 people are being paid?
25 MR. DEARINGER: So right now, the

1 average amount of training time just depends
2 on, you know, again, if they're certified.
3 If they're already certified, it's very
4 minimal, being able to describe exactly what
5 you are looking for for this CMH -- or the
6 community health worker.
7 Each provider type will -- and each
8 individual provider will have different needs
9 for that CHW's services. Some may need
10 individuals to strictly focus on no-shows and
11 reducing that no-show rate. Others will want
12 them working on nutritional education or
13 whatever their priority is for those
14 individuals.
15 I know I spoke with one provider last
16 week, and they have a lot of their office
17 staff that are constantly working on
18 assisting individuals with -- helping them
19 kind of go through different -- the paperwork
20 and the processes of just the visit itself.
21 And so they were getting backed up in their
22 office where a CHW would be able to assist an
23 individual with that type thing. So every
24 provider kind of will be different.
25 And as far as pay range, we don't have

1 that information yet. We have some
2 preliminary information from the MCOs, but
3 I'm not sure that that really correlates. So
4 I would hesitate to give any of that
5 information because we just started the
6 services July 1st.
7 I think toward the end of the year,
8 we'll have a better understanding of how much
9 these individuals are being paid and some of
10 their specific roles that providers have
11 hired them for. And we can -- we can kind of
12 give out some reports and look at some
13 assessments based on those things.
14 I don't know if you had any more,
15 Commissioner Lee, but...
16 DR. WRIGHT: One real quick
17 follow-up is: And can an individual start
18 this certification process without being --
19 like, you could say, hey, here's an
20 opportunity for someone to start this
21 certification process and become certified
22 without having an agreement to be hired?
23 MR. DEARINGER: Absolutely. So
24 someone can become a certified community
25 health worker. They just can't be reimbursed

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1 through Medicaid until they're employed by an
2 enrolled provider type.
3 CHAIR PARTIN: So is there an
4 educational program for these people to
5 attend? Is it a formal educational program?
6 MR. DEARINGER: There is. There
7 are a set standard of education that they
8 have to obtain from the Department For Public
9 Health.
10 CHAIR PARTIN: Okay. So that's
11 through the --
12 MR. DEARINGER: The Department of
13 Public Health has a program that they go
14 through, and they have educational
15 requirements that they -- that they approve
16 that has to be met in order for them to get
17 their certification through the Department
18 For Public Health.
19 CHAIR PARTIN: Okay. Okay. Thank
20 you.
21 Anything else?
22 DR. COMPTON: Madam Chairman, this
23 is Steve Compton. I do have a question. Why
24 are optometrists not listed on those that can
25 hire community health workers?

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1 MR. DEARINGER: So optometrists are
2 listed as -- are in -- in that services --
3 and I believe that they're lumped into the --
4 maybe the -- one of those groups. I can't
5 remember.
6 DR. COMPTON: CMS defines us as the
7 physicians. It could go under that.
8 MR. DEARINGER: That's where it's
9 at. I'm trying to --
10 DR. COMPTON: Okay.
11 MR. DEARINGER: I apologize. I'm
12 trying to pull up my FAQs, but I think
13 they're grouped into the physician group.
14 DR. COMPTON: I've got it in front
15 of me, so I just --
16 MR. DEARINGER: Okay. There you
17 go.
18 DR. COMPTON: Thanks for clearing
19 that up. Thank you.
20 MR. DEARINGER: Sure.
21 DR. COMPTON: Bye-bye.
22 CHAIR PARTIN: Okay. Any other
23 questions?
24 (No response.)
25 CHAIR PARTIN: Okay. Thank you,

1 Justin.
2 MR. DEARINGER: Thank you.
3 CHAIR PARTIN: Next up, we have an
4 update on maternal and child health.
5 DR. THERIOT: Hi. This is
6 Dr. Theriot. I'm not sure what screen you
7 guys are seeing. I hope you're seeing
8 slides.
9 CHAIR PARTIN: We are.
10 DR. THERIOT: Oh, good. All right.
11 I just wanted to give a little update on
12 maternal health. And this should not take
13 too long, but I wanted to talk first a little
14 bit about the dashboard that we've been
15 talking about. Just -- it's not ready yet.
16 It's still in production, but I wanted to
17 give you just a snippet about what we're
18 planning.
19 Whoops. I cannot advance. Hmm. Why
20 can I not advance? Well, anybody have any
21 ideas? It worked. Okay.
22 So the maternal health data -- (audio
23 glitch) contain maternal data but will have
24 some child data as well. Child data is going
25 to include, like, ER visits, well-child

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1 visits, immunizations. And the maternal data
2 will have types of deliveries, like,
3 C-sections versus vaginal deliveries, if the
4 baby was term, preterm, late term. And then
5 different categories of -- if mom received
6 certain screenings, if there was a doula
7 involved, the smoking status, NICU
8 admissions, things like that.
9 And so when you go into the dashboard,
10 you'll have a drop-down list, and you can
11 sort the data by year. And this is -- in
12 this example, it's sorted to 2020. You can
13 sort by Managed Care Organization. So you
14 can just look at data from all of the MCOs,
15 or you can look at specific MCO, or you can
16 look at fee for service. It's also broken
17 down by race and ethnicity. So that's the
18 main toggle that you can see.
19 And so these are just little examples.
20 So this is the example of the type of
21 delivery, and I picked one year and picked
22 all deliveries for that year. And so you can
23 see we had -- what? -- 16,000 or so vaginal
24 deliveries during that year and 9,286
25 C-sections.

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1 Then we broke the C-sections down a
2 little bit more. Was it a primary C-section,
3 meaning it's the mom's first C-section,
4 versus a repeat C-section? And you can see
5 how that breaks down.
6 Now, you can take this graph, and you
7 can break that down by race. You can
8 manipulate the graph a little bit.
9 This is an example when I just changed
10 it from all MCOs to one MCO, and so you can
11 see the difference there. Like, in this one
12 MCO, the primary C-sections were 25 percent
13 of the births versus -- what was it? -- 21
14 percent for everybody together.
15 And then again, you can do it for race
16 or whatever you happen to be looking at.
17 I -- so I broke it down by race. And on the
18 left, you see it's all MCOs for a year of
19 births for the black race. And you can see
20 the primary C-section rate was 20.64.
21 And then on the right side -- and let me
22 move this out of the way. The primary
23 C-section rate for the white women was 21.08,
24 so fairly close. But, again, you can just
25 break it down how you really want to look at

1 things.

2 This is an example -- again, this is one

3 year. And I keep moving our little pictures

4 around. This is one year of data, and you

5 can click on -- let's see -- November of

6 2020. And if I was in the interactive --

7 (audio glitch) this. Well, actually, this

8 red one. You can click on this, and I can

9 see that 25 percent of the moms that gave

10 birth during that month of that year smoked

11 cigarettes. And, again, you can break it

12 down by different -- the different things as

13 well.

14 Just a glance at the child data. You

15 can, you know, click on an age group and a

16 month and a year, and you can see how many

17 children had a well-child visit during that

18 time or a vaccination or an evening visit.

19 We're trying to add in the COVID vaccinations

20 as well. And then you can sort, just like we

21 talked about, the same categories of sorting.

22 Do you guys have any -- go ahead.

23 (Brief interruption.)

24 DR. THERIOT: I'm sorry? Does

25 anybody have any questions about the

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1 dashboard?

2 DR. SCHUSTER: Dr. Theriot, this is
3 Sheila Schuster. I guess I'm curious
4 about -- were you all curious about where
5 people were giving birth?

6 DR. THERIOT: Yes. What I didn't
7 show you --

8 DR. SCHUSTER: So home, hospital,
9 and if we ever get birthing centers and if
10 they're in Kentucky or elsewhere?

11 DR. THERIOT: Yes. We can do that.
12 We also have it broken down by county. And
13 then what I didn't show was also a list of
14 top ten diagnoses for women that were
15 admitted to the hospital postpartum and top
16 ten diagnoses for women that had an ER visit
17 postpartum.

18 And I couldn't show all of this. I
19 really would have liked to do it interactive.
20 No. 1, I was really worried that the Internet
21 wouldn't cooperate if I did that. But
22 because it's still in production, I really
23 couldn't show a lot of the detailed
24 information yet.

25 DR. SCHUSTER: Yeah.

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1 DR. THERIOT: And I think all of
2 those things are very important to look at.
3 Because, again, it'll show us a snapshot.
4 It'll show us trends. So if -- if we make a
5 big intervention, for example, the extending
6 care to 12 months' postpartum, we know the
7 day that went into effect and then we can
8 follow it out to see outcomes, you know, if
9 it had anything to do with our outcomes.
10 Or if an MCO makes a big change in --
11 you know, with doula care or something like
12 that, we know when that started. We can see
13 how that's helping our population. So I'm
14 really excited about it, and it should be --
15 it should be done soon.
16 DR. SCHUSTER: This is Sheila
17 again. It would also be helpful to have --
18 I'm so glad you're going to have the top ten
19 diagnoses for admission postpartum. Because
20 with Senate Bill 135 passing and our emphasis
21 on more education and maybe getting more
22 treatment providers out there for perinatal
23 mental health issues, it'll be interesting to
24 follow that data as well. Thank you.
25 DR. THERIOT: Yes. Thank you.

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1 And I didn't point it out. But in that
2 squiggly line graph, you can also look at if
3 mom was screened for substance use, if she
4 was screened for SDoH, if she was screened
5 for postpartum depression. So that will all
6 show up in that graph as well that you can
7 break down.
8 DR. SCHUSTER: Super. Thank you
9 very much.
10 DR. THERIOT: Thanks.
11 CHAIR PARTIN: And that will be on
12 the DMS website?
13 DR. THERIOT: Yes. That's our
14 plan.
15 CHAIR PARTIN: Great.
16 DR. THERIOT: And then I wanted
17 to -- real quick, the 2022 maternal mortality
18 review report came out this month. It's
19 always a little bit behind. And I wanted to
20 give you a few highlights from that report.
21 Our maternal deaths actually stayed
22 about the same as they were last year. We
23 had 63 maternal deaths in 2020. And, again,
24 we -- this report is produced from the work
25 of the Maternal Mortality Review Committee.

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1 And that committee takes a look at every
2 single maternal death or a death of a mom,
3 either while pregnant or within 365 days of
4 being pregnant, and really drills down and
5 looks at every single -- (audio glitch)
6 happened. Was it preventable? What were
7 risk factors leading up to the death, if any,
8 and then what can we do to change it?
9 And so it takes a lot of time to go
10 through these reviews, which is why, you
11 know, this is so kind of behind -- couple of
12 years behind. And I can tell you we had a
13 meeting earlier this week, and they're
14 usually six-hour meetings. (Audio glitch.)
15 Only got through ten cases for going into --
16 with each one of the cases.
17 So you can look in 2019, we had 61
18 deaths. And then 2020, we had 63 deaths.
19 Kind of holding steady. 2018 was a bad year
20 with the 76. When we look at the
21 pregnancy-related deaths -- and those are the
22 deaths that happen because of the pregnancy.
23 You know, it wouldn't have happened if the
24 mom hadn't been pregnant. Those are holding
25 steady as well. And our 2019 rate is 16.9.

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1 The 2019 United States rate -- national rate
2 was 20.1.
3 And so these are the ones I think of
4 as -- you know, it's a hemorrhage. It's a
5 heart problem. It could be eclampsia. You
6 know, these are the medical deaths that
7 happened. Now, not to say that they should
8 have happened or -- you know, because a lot
9 of them are preventable. But these are a
10 little bit different -- (audio glitch) that
11 big number of 61 that encompassed every death
12 that, obviously, most of them had nothing to
13 do with being pregnant.
14 They -- you know, it could have been an
15 overdose. It could have been a car accident
16 or natural that we looked at. And a good
17 number are accidental deaths and then you
18 have homicides and suicides.
19 A lot of those accidental deaths I can
20 tell you are overdose deaths. And when we
21 dive down and look at all the records, at
22 least the committee has questions that maybe
23 some of these ones that are deemed accidental
24 are actually suicide. But without an actual
25 note or something like that showing intent to

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1 commit suicide, you can't deem it suicide
2 legally.
3 So even though it's such a high number
4 of accidental deaths, if -- I really think
5 some of those really should move over to that
6 suicide category, and we need to do something
7 about that.
8 Speaking of drug overdose deaths, we
9 have about 50 percent of our moms in that
10 accidental maternal death category that die
11 because of overdoses. And that is a huge
12 number. That is why our maternal death rate
13 is so high in Kentucky, is overdose deaths,
14 and it's higher than the rest of the nation.
15 In case you're wondering about racial
16 disparities, we still have a huge racial
17 disparity. About half or twice as many
18 maternal deaths occur for black women
19 compared to white women, and we still have to
20 work on that.
21 And so really what we gleaned from that
22 2019 cohort is about 20 percent of the deaths
23 were pregnancy-related deaths at 16.9 deaths
24 per 100,000. Overall, deaths from all
25 causes, we were at 115.1 per 100,000. 54

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1 percent of the mortality cases had substance
2 use linked to their death, and almost 90
3 percent are preventable. And when you look
4 at the national deaths -- (audio glitch).
5 COMMISSIONER LEE: Dr. Theriot --
6 DR. THERIOT: In Kentucky, 89
7 percent are prevent --
8 COMMISSIONER LEE: -- you keep kind
9 of going --
10 DR. THERIOT: Oh, I'm sorry. Did
11 I --
12 COMMISSIONER LEE: -- in and out a
13 little bit, Dr. Theriot, yeah.
14 DR. THERIOT: Oh, okay. Should I
15 just repeat this slide?
16 I -- all I was saying was that the --
17 about half of our cases, 54 percent of our
18 mortality cases have substance use linked to
19 their death, and 89 percent of our cases are
20 deemed preventable of all of the cases.
21 And, nationally, the CDC says 60 percent
22 of the deaths are preventable. And our
23 number is so high because of substance use.
24 And so, really, if we wanted to make a
25 difference, we really need to focus on the

1 substance use and opioid epidemic.
2 And I think that's it. You guys have
3 any questions?
4 DR. SCHUSTER: Dr. Theriot, this is
5 Sheila Schuster. With the racial disparity
6 between the black moms and the white moms,
7 I'm a little surprised that that's not listed
8 as a key finding.
9 DR. THERIOT: Well, I guess it
10 is -- it's not different from the other
11 years, unfortunately. And it is a key
12 finding, like you said, that we didn't
13 mention.
14 The other interesting thing is when I
15 look at those deaths, those -- I mean, a few
16 of them might be overdose deaths, but those
17 deaths are not related to substance use.
18 Usually, those deaths are related to a
19 medical reason, you know, like a hemorrhage
20 or a cardiovascular reason, not a
21 pregnancy-related death.
22 DR. SCHUSTER: I think that is key
23 to point out because I think people that are
24 just going on whim or prejudice or whatever
25 would associate perhaps black deaths with

1 substance use disorder, and --

2 DR. THERIOT: You're right.

3 DR. SCHUSTER: -- I really think

4 that that's important to point out when we

5 discuss this data. I mean, I think we need

6 to keep focusing on the racial disparity.

7 And I will tell you, from presenting in

8 the legislature, that legislators are having

9 a hard time hearing that, that there is a

10 racial disparity. So the more that we can

11 delve into that and point out the things that

12 it's not related to, I think, is really,

13 really important. So I ask you to consider

14 that.

15 DR. THERIOT: Thank you. I will.

16 That's a very good point.

17 DR. SCHUSTER: Thank you very much.

18 CHAIR PARTIN: Any questions? Any

19 other questions?

20 (No response.)

21 CHAIR PARTIN: Okay. So our next

22 update on maternal/child will be in six

23 months. And, Dr. Theriot, would you -- when

24 you do that report, could you point out

25 that -- or pull out that data about the

1 reason for the mortality, increased mortality
2 with the black women versus the white women?
3 And maybe we need to look at Hispanic
4 women as well and see if there's a difference
5 there and look at the causes of the deaths,
6 not just say that it's not related to
7 substance abuse. But maybe we need to start
8 looking at some of the other reasons so that
9 we can zero in on what we can do to help
10 prevent that.
11 I'm not sure if Dr. Theriot heard that.
12 DR. THERIOT: I did. I'm sorry. I
13 didn't realize I was on mute. But I said
14 that was a great idea. I've written it down.
15 Thank you.
16 CHAIR PARTIN: Okay. We'll look
17 forward to hearing that in six months.
18 Okay. Any other questions?
19 (No response.)
20 CHAIR PARTIN: Thank you very much.
21 As always, your presentations are very
22 informative and helpful, and I appreciate it.
23 Okay. Commissioner, you're up next.
24 COMMISSIONER LEE: Good morning. A
25 couple of updates. I know that many of you

1 may have seen the press release that went out
2 related to our Mobile Crisis State Plan
3 Amendment being approved. We have an
4 implementation time of September 1 of 2023.
5 Leslie Hoffmann and her behavioral health
6 team have worked very hard on the behavioral
7 health Mobile Crisis State Plan Amendment.
8 And I know that we have an aggressive
9 agenda for the next MAC to include the -- the
10 workforce development report. But I think,
11 you know, it definitely would be beneficial
12 to have Leslie or her team on the meeting
13 next time to just give you an update on the
14 mobile crisis and go over some of the
15 provisions that are outlined in the state
16 plan.
17 Earlier this week, we also submitted --
18 or last week, July 14th, as part of an
19 Emergency Medical Transportation Task Force,
20 we submitted two state plan -- or a State
21 Plan Amendment that contains provisions in
22 there for ambulances or EMS -- EMTs, EMT
23 providers to treat in place.
24 Currently, our transportation -- our
25 ambulance transportation reg only allows an

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1 emergency ambulance to transport to a
2 hospital. So we're following along the lines
3 of other states who have submitted State Plan
4 Amendments to allow those EMT providers to
5 come and treat an individual in place without
6 transport.
7 Again, currently, those providers do not
8 receive -- do not receive reimbursement if
9 they don't transport. So we believe that may
10 help get some of those services that
11 individuals need and prevent -- get the
12 services they need in that location rather
13 than transporting them unnecessarily to a
14 hospital.
15 We are also looking at CMS to help us
16 with -- we have created a state plan for
17 treat, triage, and transport of individuals.
18 So this means that an EMT could go to -- or
19 an ambulance could go to a site of a 911
20 call, for example, assess the situation,
21 treat the individual in place, triage them,
22 and transport them to a location other than a
23 hospital.
24 Those locations could include actually a
25 physician's office. It could include an

1 urgent treatment center, for example, so that
2 that individual can get the most appropriate
3 care.
4 Now, this would not be a replacement for
5 a nonemergency medical transportation benefit
6 that we have in place already. And this --
7 these transportation State Plan Amendments
8 are designed to work in conjunction with our
9 Mobile Crisis State Plan Amendment because
10 the crisis -- Mobile Crisis State Plan
11 Amendment does have a provision in there that
12 allows two providers to go to a site and then
13 one of those individuals has to be a
14 behavioral health specialist.
15 So we are -- we believe that this
16 will -- these SPAs in combination will
17 definitely allow a greater flexibility with
18 transportation needs for our members. Again,
19 we have just submitted those to -- that state
20 plan to allow treat in place and treat,
21 triage, and transport.
22 We are -- definitely have some
23 priorities in the department, as you heard
24 with Dr. Wright's conversation that he had
25 with Pam and I related to PDS and certain

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1 things in the HCBS waivers. We still have a
2 large focus on our HCBS waivers.
3 As some of you may know, we do currently
4 have a waiting list in our HCB waiver
5 program, which we have never had before. The
6 good news is that waiver renewal year starts
7 on August 1st, so we do believe that we have
8 enough slots to clear up that waiting list
9 from the HCB waiver. However, we do
10 anticipate that we may have another waiting
11 list as we move forward. So, again, a lot of
12 focus on our HCBS programs.
13 The other main focus that -- a lot of
14 our work has been related to unwinding from
15 the Public Health Emergency. And we have
16 Veronica -- I think Deputy Commissioner
17 Veronica Cecil is on the call, and she can
18 give you an update about where we are with
19 unwinding.
20 Veronica?
21 DEPUTY COMMISSIONER CECIL: Thank
22 you, Commissioner. Good morning, everyone.
23 I am going to share my screen, and we will
24 provide these slides after the meeting to all
25 the MAC and TAC members and then it will also

1 be uploaded to the MAC website for anyone
2 else that would like to see them.
3 To really just -- I'm really going to
4 try to do my best to be quick through all
5 this but just a snapshot of what the
6 enrollment is looking like. We were
7 originally doing a graph that showed
8 pre-pandemic, but it's getting too big and
9 too weedy.
10 So we -- this is looking at from January
11 of 2022. You will see that there is a dip.
12 Medicaid renewals that were subject to
13 redetermination started in May, and so that's
14 why you are seeing a bit of decline.
15 Our current enrollment as of the date of
16 July 3rd, which is the data metric that was
17 used for this, was 1,642,210. So that is
18 below the -- you know, we were over -- a
19 little over 1.7 million prior to the start of
20 redeterminations.
21 We have four cohorts going on right now
22 so four months of redeterminations that are
23 somewhere in the pipeline. So our May
24 redeterminations, even though we started
25 those in -- initiated those in early April,

1 they're continuing. We're continuing to show
2 data on them. And the reason for that is
3 because we do have -- you know, members do
4 have the capability to request reinstatement
5 within 90 days of their termination. So for
6 May, that would have been May 31st.
7 So if somebody just missed a notice and
8 then discovers walking into a provider's
9 office that they no longer have coverage,
10 they can still provide information to us, and
11 we will retro that coverage back as if no
12 gap.
13 So keep in mind, providers, you know, we
14 are asking for you all to help us connect
15 those members to support and resources to
16 complete that application or that
17 redetermination.
18 So the numbers you will see will change.
19 In May, the numbers have, you know, increased
20 for approvals and/or terminations as a result
21 of people coming back in and completing those
22 redeterminations if they've received a
23 notice.
24 We did extend a group of individuals.
25 You'll see there on the left side, 6,669 were

1 extended. We did that. CMS is allowing
2 states to extend members for -- to conduct
3 additional outreach if they've not responded
4 to a notice. We're doing this specifically
5 for our long-term care and waiver providers,
6 you know, our really vulnerable individuals
7 of our program, to make sure that they do
8 have the opportunity to complete that
9 redetermination and not be procedurally
10 terminated as a result of not responding.
11 So we have asked CMS and have received
12 approval for Kentucky to be able to do an
13 additional 60 days, if needed, to provide
14 that additional outreach. So of those that
15 we extended for May, 4,100 have been
16 processed, so they might fall under approval
17 or the termination bucket depending on how
18 the redetermination was completed.
19 We did extend -- so the original
20 extension for these members were to June, and
21 we did extend another 2,500 through July.
22 The difficulty here, and certainly a priority
23 for us, is to make sure that all those folks
24 have responded to that notice because we
25 cannot extend them beyond the end of July.

1 So we are prioritizing those
2 individuals. We're working with facilities
3 and case managers to make sure that that
4 individual understands that they need to take
5 action and submits that notice.
6 The pending bucket is really those folks
7 who had a task when May 31st came, that there
8 was a task pending. And so those are also
9 prioritized, so we can make sure we can
10 complete that redetermination. We still have
11 85 left over from May.
12 But we're tracking -- I mentioned the
13 reinstatements, and the good news is that we
14 have been able to reinstate. So in the
15 approval bucket is around 3,500 -- a little
16 over 3,500 individuals. So it just shows
17 that people are coming back in, and that's a
18 good thing.
19 Here is June. Similar -- I'm not going
20 to go through all of the specific data points
21 because you all can have this. But, you
22 know, starting to, again, see -- we
23 extended -- just wanted to point out we did
24 extend additional folks that had a June 30th
25 end date so that we could continue to

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1 outreach to them and work with them to get
2 that redetermination response in.
3 We do have pending 1,396 from the June
4 renewal. Those tasks are being worked as
5 quickly as possible. You know, sometimes
6 those do result in an additional request for
7 information that has to be issued because
8 once the worker starts completing the
9 redetermination, there's information missing.
10 So an RFI might still go back out, but those
11 are still being worked.
12 And, again, from the June renewals,
13 we've got a little over 1,400 that have been
14 able to be reinstated because they did --
15 after their termination date did come back in
16 and provide the information that we needed.
17 So July and August, these look a little
18 different because they're still in process.
19 July 31st is approaching and so July
20 renewals. You know, we are working. We had
21 a larger amount of passive cases, and about
22 60 percent of those were -- we were able to
23 redetermine automatically, so that member did
24 not have to take any action to get
25 redetermined for Medicaid.

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1 Of the active renewals -- so they did
2 have to respond to a notice. Of those, we've
3 had a little over 3,500 that have turned in
4 their information, and we've determined 2,600
5 of those is eligible and 646 as ineligible.
6 That's an actual determination of an
7 eligibility.
8 We are tracking the number of
9 individuals who are also eligible for a
10 Qualified Health Plan and that advanced
11 premium tax credit, which, as you all may
12 remember, allows that Qualified Health Plan
13 premium to be really affordable; in some
14 cases, at zero cost.
15 We're tracking that because we want to
16 make sure that there's no gap in an
17 individual's coverage. If they're ending
18 Medicaid, we want them to immediately be able
19 to access coverage through the Qualified
20 Health Plan. So we're tracking these
21 individuals to ensure that they are making
22 that connection and they're signing up.
23 For August, again, you will see a large
24 number of cases that qualified -- or a larger
25 percentage of cases that qualified for

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1 passive. That's always great. And in that,
2 we almost had 90 -- excuse me, 70 percent
3 that were automatically redetermined. So
4 that number is coming up, which is always
5 great, because that means people don't have
6 to take action.
7 We've got 367 active renewals that have
8 been completed for August. 241 determined
9 eligible, 89 determined ineligible. So
10 continue to work on those cases as well.
11 Just a reminder. This is the rest of
12 the unwinding period. So we've already sent
13 out -- I'm sorry. We're about to -- in the
14 beginning of August, we'll be sending out
15 notices for September renewals, but here is
16 the distribution for the rest of the
17 unwinding.
18 Keep in mind -- and I mentioned this in
19 May -- that we did push a lot of cases that
20 have children to later in the unwinding
21 period because we are implementing continuous
22 coverage for children. And that system --
23 automated system change, it doesn't go into
24 effect until September.
25 So we wanted to make sure that if a

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1 child is determined eligible, they're granted
2 that 12 months' continuous coverage. For any
3 child that comes in, though, between April
4 and when the system goes into effect does
5 still get that continuous coverage. It's
6 just more of a manual process.
7 Wanted to show -- because a Qualified
8 Health Plan coverage is also very important
9 as we go through unwinding, but this is a
10 snapshot of what that enrollment looks like.
11 We're, you know, always happy to see it tick
12 up because that means people are moving off
13 of Medicaid who have been determined
14 ineligible and accessing that coverage.
15 Just also wanted to remind you that --
16 we've talked about this before. But the
17 Office of Civil Rights, when it comes to
18 telehealth, is requiring providers to return
19 to HIPAA-compliant platforms. That due date
20 is coming up August 9th, so this is just a
21 reminder to make sure that if you're doing
22 telehealth, you have to be in compliance with
23 a HIPAA-compliant platform.
24 Continue to always advocate to please
25 sign up for one of our social media accounts,

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1 like us or follow us, because it is the best
2 way to stay up to date on the most current
3 information on unwinding, get information out
4 when we hear scams or trends. We do have the
5 monthly stakeholder meeting. All of those
6 meetings are recorded and posted including
7 the presentations on our unwinding website.
8 We just had a -- this month a specific
9 stakeholder meeting for the 1915C waiver
10 members and providers. That information is
11 out there. So if you did not -- you were
12 able not able to join that, I encourage
13 waiver providers to go out and access that
14 and watch it and look at the presentation on
15 your -- at your convenience. It provides a
16 lot of really good information.
17 And then, you know, we're striving to
18 keep providers in the loop. The KLOCS
19 report, the Kentucky Level of Care Report,
20 that's accessible by our long-term care
21 waiver providers. It allows them to identify
22 the members that are subject to a
23 redetermination.
24 And then in KYHealth-Net -- don't
25 forget, providers -- you can see that

1 redetermination date. So as the member comes
2 into your office, if it's a date that has
3 passed and they've lost coverage, you know,
4 definitely connect them so that we can make
5 sure that loss of coverage, that they were
6 actually ineligible and then connect them to
7 a Qualified Health Plan if that's the case.
8 Or if it's in the month or the next month,
9 just ask them if they've checked to see if
10 they have a notice or have received a notice
11 from Medicaid.
12 Well, I -- that's the end. Happy to
13 take any questions that someone might have
14 about unwinding. And, Dr. Schuster, I see
15 you trying to raise your finger.
16 DR. SCHUSTER: I have never figured
17 out how to raise my hand on these Zoom
18 things.
19 DEPUTY COMMISSIONER CECIL: It's
20 okay. You can see fingers.
21 DR. SCHUSTER: Thank you very much,
22 Veronica. It's always good information. I'm
23 curious under your terminated, there was a
24 category that was actually the largest
25 percentage, and it said procedural reasons.

1 DEPUTY COMMISSIONER CECIL: Yes.
2 DR. SCHUSTER: So they are not
3 ineligible. So what's a procedural reason?
4 Can you give us an idea?
5 DEPUTY COMMISSIONER CECIL: Yeah.
6 Honestly, the biggest portion of that is they
7 did not respond to a notice.
8 DR. SCHUSTER: Okay.
9 DEPUTY COMMISSIONER CECIL: And
10 that's been challenging not just for Kentucky
11 but across the United States, for state
12 Medicaid agencies to get folks to actually
13 respond to the notice, so a determination can
14 be made based on the information that relates
15 to that case.
16 So, you know, we've been doing tons of
17 outreach. So by the time that somebody's
18 renewal end date comes up, they've heard
19 from -- (audio glitch) both when the notice
20 goes out, then a couple of weeks later. And
21 then on the 15th of the month --
22 I'm going to turn off my video because
23 I'm having trouble.
24 Then on the 15th of the month of their
25 renewal, if we've not received anything from

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1 them, they get another call. And then the
2 Managed Care Organizations separately are
3 also outreaching to their members.
4 So we really have tried to exhaust all
5 outreach efforts. But we're still learning,
6 and I think we have new opportunities to do
7 that. And, you know, for instance, with back
8 to school, we've got some plans on how to get
9 information to families through
10 back-to-school efforts.
11 So the biggest challenge really has been
12 just encouraging someone to return the
13 notice. Even if they're -- even if they
14 think they're no longer eligible, we'd still
15 like to be able to make that dual
16 redetermination.
17 But, you know, I think most folks, when
18 they get it, may think they're not eligible
19 because they do -- I mean, some do know their
20 income is above the Medicaid federal poverty
21 level, so they're not even responding.
22 DR. SCHUSTER: Okay. Thank you. I
23 wondered if that's what it was because that's
24 been the biggest bugaboo, I think --
25 DEPUTY COMMISSIONER CECIL: It has.

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1 DR. SCHUSTER: -- because everybody
2 is trying to figure out, with multiple
3 contacts, why people are not responding. So
4 thank you very much, Veronica.
5 DEPUTY COMMISSIONER CECIL: You're
6 welcome.
7 Nina, I think I saw your hand next.
8 MS. EISNER: Yes. I just want to
9 make sure that I'm clear on what
10 non-HIPAA-compliant platforms are excluded.
11 So, obviously, FaceTime. But what else?
12 Anything else?
13 DEPUTY COMMISSIONER CECIL: So I do
14 want to -- (audio glitch) disclose that I am
15 not the expert on HIPAA-compliant platforms.
16 But I would say -- so yes, FaceTime, our
17 understanding. Gosh. I apologize. I'm
18 blanking on -- there is one other that I
19 know.
20 CHAIR PARTIN: Facebook Messenger.
21 DEPUTY COMMISSIONER CECIL: Thank
22 you. Thank you, Dr. -- yeah, Dr. Partin.
23 Facebook Messenger is another one.
24 MS. EISNER: Okay.
25 DEPUTY COMMISSIONER CECIL: Now, I

1 highly recommend -- because there's been
2 acknowledgment by a lot of the
3 non-HIPAA-compliant platforms of the issue,
4 and I think they're trying to find ways to
5 become HIPAA-compliant. So definitely check
6 in with those platforms directly to see if
7 they've got, you know, things in place to
8 make them HIPAA-compliant.
9 MS. EISNER: Thank you.
10 CHAIR PARTIN: Doxy.me is compliant
11 and free. So I'm not advertising or
12 anything, but that's one option.
13 MS. EISNER: What is it?
14 CHAIR PARTIN: Doxy.me.
15 MS. EISNER: Doxy.me?
16 CHAIR PARTIN: It's d-o-x-y dot me,
17 m-e.
18 MS. EISNER: Okay. Thank you.
19 MS. BICKERS: Dr. Bobrowski has his
20 hand raised.
21 DEPUTY COMMISSIONER CECIL: Yes.
22 DR. BOBROWSKI: Yeah. Question on
23 the -- and I don't know if this is an
24 unforeseen problem or not. But just with the
25 unwinding, some of our procedures in the

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1 expansion codes are multi-appointment
2 procedures, like making a denture, doing a
3 root canal on an infected tooth. Of course,
4 dentists don't get paid until the procedure
5 is complete.
6 But we're getting some calls on folks
7 that are -- have been unwound and no
8 longer -- they got the procedure started, but
9 now they are no longer eligible for Medicaid,
10 leaving the dentist stuck with, well, what do
11 we do.
12 Can -- are they supposed to go back now
13 and charge the patient or -- because they
14 already have paid the expenses, you know,
15 from lab supplies, office supplies, time
16 paying for staff. And the critical thing is
17 that, technically, we're not supposed to bill
18 it until it's finished.
19 So I don't know. Have you all talked
20 about that or looked at that?
21 DEPUTY COMMISSIONER CECIL: We
22 have, Dr. Bobrowski, and thank you for
23 bringing that up. We, in fact, have a
24 meeting this afternoon with the Managed Care
25 Organization leadership, and this is an

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1 agenda item. We -- we do want to provide
2 guidance to providers.
3 I think it is certainly our intent not
4 to disrupt a service that's been initiated
5 and -- especially, you know, dentures. And
6 we know there's a whole host of services that
7 require that multi-appointment modality. So
8 we are discussing it and do plan to issue
9 guidance so that you all have that available
10 to you to rely on. You're welcome.
11 DR. BOBROWSKI: Thank you.
12 DEPUTY COMMISSIONER CECIL: Any
13 other questions?
14 (No response.)
15 DEPUTY COMMISSIONER CECIL: Okay.
16 Thank you.
17 CHAIR PARTIN: Thank you, Veronica.
18 Commissioner, would you send me an email
19 with the -- for the agenda item for the
20 mobile crisis health plan? I was trying to
21 take notes on what that was, but I couldn't
22 write fast enough. And if you could just
23 send me --
24 COMMISSIONER LEE: Yes.
25 CHAIR PARTIN: -- what that item

1 will be, I'll put it on the agenda for the
2 next meeting.
3 COMMISSIONER LEE: Yes. We will
4 send that to you, Dr. Partin.
5 CHAIR PARTIN: Thank you.
6 Okay. Next up are the reports from the
7 MCOs, and I would like to say that we are
8 now -- we've got about -- well, we're going
9 to run short on time, I think. So I'm just
10 kind of letting everybody know that we'll do
11 the best we can to end up on time, but we
12 might run over just a little bit because I
13 want to make sure that everybody gets the
14 information that they need and is able to ask
15 questions.
16 Okay. So next up is the reports from
17 the MCO, and Aetna and WellCare are going to
18 report today. Aetna, why don't you go ahead
19 and go first?
20 MS. MANKOVICH: Thank you. Can
21 everyone hear us okay and see our screen?
22 Lauren, I think it looks good from my vantage
23 point.
24 CHAIR PARTIN: Yes.
25 MS. MANKOVICH: Okay.

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1 DR. SCHUSTER: Looks good.
2 MS. MANKOVICH: We will jump in.
3 My name is Paige Mankovich. I'm the
4 market president for Aetna Better Health of
5 Kentucky. I have Dr. Madelyn Meyn here with
6 me today. She is our regional CMO.
7 We have a very extensive deck. And to
8 your point, Dr. Partin, we do not have time
9 to go through all of it. So we are going to
10 stick to our 10 to 15 minutes, leave a little
11 bit of time for questions. At the end,
12 please feel free to ask us questions.
13 And we did provide our email addresses
14 here on the screen. So if you don't have an
15 opportunity to get a question in or if you
16 spend some time looking through our deck --
17 they will be made public. I believe they
18 will be on the MAC's website. You can, you
19 know, take a look through there. And if you
20 have questions, please feel free to send us
21 an email, and we would be happy to engage
22 further based on the information that we have
23 in the deck and what we talk about today.
24 So moving on into our presentation. We
25 wanted to start by showing what the top areas

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1 of priority were that we set for 2023. So my
2 team met in the fall of 2022, had a very
3 intentional strategic planning session, and
4 really decided that the areas of specific
5 focus based on data that we had and what we
6 know is incredibly important. So I'm going
7 to hit on a couple of these. Dr. Meyn's
8 presentation will take us through the last
9 three.
10 But I'm going to start by addressing
11 member engagement. So we know that engaging
12 with the Medicaid membership and doing that
13 in a manner that is successful doesn't always
14 look exactly like what you might expect.
15 Traditional methods of outreach sometimes --
16 mailing, things like that -- is not how we're
17 able to actually reach our members in a
18 meaningful fashion.
19 So we're utilizing other methods of
20 outreach, text messaging, really focusing on
21 when a member calls in. Or if we're at an
22 event and we see one of our members and talk
23 with them, that we're updating their
24 telephone numbers. We've got email
25 addresses, things like that, because we know

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1 that that's how members engage better with
2 their healthcare company.
3 We also know that engaging community
4 partners who are neighbors of our members is
5 a really important way to make sure that we
6 are locating our members. We are engaging
7 with them. We know how to get in touch with
8 them. We know that's especially important --
9 and the deputy commissioner hit on that --
10 during this unwinding period.
11 You know, it's incredibly important that
12 we know how to get information in front of
13 our members to ensure that they maintain
14 their eligibility and then also that they're
15 able to access services that they need to be
16 able to access.
17 As you can see from this slide, our
18 membership is pretty evenly distributed
19 across the regions, also fairly evenly
20 distributed by gender and by age group as far
21 as adults and children. We have
22 approximately 250,000 members, 30,000 of
23 which are with our SKY program, which we'll
24 flip to the next slide, if you will, Lauren,
25 and we'll hit on SKY just briefly.

1 We spoke last year to this group at
2 length about SKY. And so I'm going to over
3 it pretty quickly, but I don't want that to
4 imply that it's not an incredibly important
5 part of our health plan. It absolutely is.
6 For those who may be unfamiliar, SKY is
7 our sole-source contract where we provide
8 Medicaid coverage for all children in
9 Kentucky who are system involved. So if
10 they're in foster care, if they are in
11 juvenile justice custody, if they have been
12 adopted from foster care, or if they've aged
13 out of the foster care system but are still
14 under the age of 26.
15 SKY is a high-touch care management
16 model with other ancillary services such as a
17 training collaborative, a lot of, you know,
18 behavioral health services, a lot of
19 interaction with the State. Dr. Meyn is
20 going to get into some of the outcomes that
21 we've had with SKY that we are incredibly
22 proud of.
23 And then Dr. Meyn will also get into
24 more specifics with actual health outcomes
25 but that health outcomes are a huge part of

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1 our priority area and will continue obviously
2 to be as we set our strategy for 2024. We
3 are particularly focused on members with SUD,
4 maternal and child health care, getting
5 kiddos caught up on vaccinations and
6 well-adult exams, and identifying and
7 resolving social need barriers.
8 But we also know that in order to have
9 good health outcomes, members have to have
10 appropriate and adequate access to care. And
11 I know that we have an adequate network but,
12 oftentimes, what appears on paper or on
13 reports may not tell the reality of the
14 situation. So because of that, we are very
15 engaged with our network of all provider
16 types, making sure that we have appropriate
17 coverage of providers in all areas, all
18 specialties, PCPs and beyond, statewide.
19 One area of focus that we have that I
20 know is of great importance to this TAC and
21 great -- or to this MAC, excuse me -- great
22 importance to us as a health plan is making
23 sure that we are engaged meaningfully with
24 our dental network and that we are growing
25 our dental network and that we're addressing

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1 the needs and concerns of providers there so
2 that our members have timely and appropriate
3 access to dental care.
4 So with that, I'm going to turn it over
5 to Dr. Meyn.
6 DR. MEYN: Thanks, Paige.
7 Good morning, everyone. I'm going to
8 get into now, you know, a lot of our
9 programming around physical and social
10 determinants of health and kind of how we
11 think about what we're doing and how it
12 affects our membership and what we're looking
13 for for outcomes.
14 So along with, you know, our standard
15 suite of services that includes case -- care
16 management and behavioral health services, we
17 really do try to look at, you know, health
18 equity and social determinants of health,
19 women's health, behavioral health, kind of
20 make them into separate populations that can
21 mix together but that we have programs and
22 strategies to identify the needs for these
23 populations.
24 Next slide, please. So when we talk
25 about social determinants of health, what

1 we're really talking about is getting
2 resources and solutions to members that have
3 issues with food, transportation, security
4 that may take precedent over them seeking
5 medical care. And so resolving social
6 determinants of health resolution issues
7 really do, then, help to reduce kind of
8 low-value care around admissions and
9 emergency room.
10 So when we talk about what we do, we --
11 you know, we have gift cards. We have meals
12 delivered. And those solutions then,
13 therefore, take people back into their homes.
14 They take them back to their outpatient
15 services and away from the unnecessary
16 utilization.
17 Next slide. Here's a long laundry list
18 of all the things that we do around social
19 determinants of health and where we are. The
20 things I wanted to call out were our
21 community investments around housing, our GED
22 certification, our over-the-counter
23 medication benefit, which all our members get
24 along with additional benefit for period
25 necessities to help with that health equity

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1 issue.

2 And then we do work with a vendor around

3 loneliness and isolation, to identify members

4 who may not come up on a claim but have other

5 issues that we can help resolve but just

6 finding them and knowing what their issues

7 are to get there first.

8 Next slide, please. Focusing on women's

9 health, the main issue here that we really

10 look at for our members is to drive them into

11 high-value care in their primary care offices

12 to get those screenings for cancer care

13 screenings as well as obstetrical care.

14 And, you know, our goal is to not just

15 get them into the office but to have that

16 continuum of care even after delivery for a

17 pregnant person. You can see that 182

18 perinatal and postpartum assessments were

19 completed by care management for quarter one

20 2023. And those engaged in care management

21 have a higher percentage of delivering after

22 37 weeks than those that are not.

23 Additionally, our focus with text

24 reminders has increased our mammogram and our

25 Pap smear rates, which continues to be on a

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1 positive trend.
2 Next slide. So lots of data. Just
3 trying to hit the highlights here because I
4 know that we're running short on time.
5 I know, you know, across the country,
6 behavioral health has really been a focus,
7 especially coming out of the pandemic and the
8 rise in anxiety and depression that we've
9 seen, and certainly that's not an isolated
10 incident for Kentucky. So we have a lot
11 focused on behavioral health including
12 behavior -- our change education, our
13 behavioral health crisis line.
14 And then we also have a focus on SUD
15 prevention and access to MAT therapy. So you
16 can see that over 8,000 members have been
17 outreached to educate around opioid
18 prevention that has also increased our usage
19 of MAT.
20 Next slide. A focus on chronic
21 condition management is certainly always one
22 of our focuses. You know, it's never
23 changed. These are our HEDIS metrics. These
24 are how we care for our members in making
25 sure that once a member has been diagnosed

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1 with a chronic disease, that they're
2 maintaining the standard of care that is
3 acceptable for those conditions.
4 And you can see that through additional
5 programming around screening reminders, free
6 blood pressure cuffs, and remote patient
7 monitoring, we've been able to increase all
8 of these metrics related to chronic
9 conditions including blood pressure control
10 rates, hemoglobin A1C testing, as well as
11 diabetes testing rates.
12 Next slide. Population health and
13 prevention wellness is also kind of the other
14 end of our spectrum where we have chronic
15 disease and then the prevention. And,
16 typically, you know, we do a very good job
17 about prevention and focus on children and
18 getting them into well checks but, you know,
19 recognizing that adults need these
20 preventative measures as well to prevent
21 those chronic diseases.
22 Through our HRAs and our digital
23 campaigns and our additional text messages as
24 well as our community outreach programs and
25 our member advisory committees, we do have an

1 increase in annual well visits for both
2 children and adults.
3 Next slide. So what does this all mean?
4 I mean, we have lots of programs, good
5 results. Everything is trending up. But
6 does it make a difference? And you can see
7 here that 92 percent of our members are
8 satisfied with our PHM programs as well as 82
9 percent, which I think is an astounding
10 number, have made changes in how member cares
11 for themselves since starting and being
12 involved in one of our programs.
13 The next two slides are very busy, and
14 I'm not going to bemoan the great work that
15 we've done. But you can see just from a
16 visual that all of our outcomes are trending
17 positive. So coming out of the pandemic,
18 recognizing that we need to have extra
19 effort, extra programs, extra ways that --
20 you know, that people are engaging in their
21 health care through their phones, through
22 remote patient monitoring, through texting.
23 You can see that we have positive trends
24 for our HEDIS MY 2022 both in our health plan
25 and then the next slide will show you the

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1 positive trends that we have for our SKY
2 program.
3 All of this in all says that, you know,
4 we are a three-and-a-half star rated program,
5 and we look forward to our future years to
6 continuing those upwards trends. This is all
7 very -- I think that a lot of the next slides
8 are kind of standardized. Some of the other
9 presenters will probably have similar slides,
10 and so I won't, you know, kind of go into a
11 lot of that data that's to come.
12 But I did want to focus on this slide to
13 say, you know, in the last few years, we've
14 seen an increase in the amount of
15 authorizations that have been requested, but
16 our denial rate has stayed somewhat stable.
17 So that just means that we are getting more
18 authorizations and approving more services
19 for the members in Kentucky.
20 A list of, you know, why prior
21 authorizations may be denied. I know this is
22 always a contentious issue. And, you know,
23 things do get denied. That is part of the
24 managed care process. And, really, the main
25 reason for denials are lack of medical

1 necessity.
2 We decide as an organization how to --
3 you know, what needs an authorization. We
4 look at low-value care. We look at expensive
5 care. We look at care that has a lot of
6 potential risks involved to assure that those
7 members that are needing the services are the
8 ones that are actually getting the services
9 and that they are being performed by
10 providers that are credentialed and have
11 quality outcomes related to those services.
12 So, you know, a denial is not always an
13 easy thing to receive, but there is, you
14 know, evidence supporting that. And we do
15 follow our criteria in order to make those
16 determinations.
17 A lot of these denials, too, when
18 there's lack of information or -- you know,
19 there's an opportunity to have a discussion
20 with peer-to-peer. They can be turned over,
21 whether on a peer-to-peer or in appeal. So
22 there's always that opportunity.
23 Next slide. So the next four slides
24 really are just the diagnosis and trends
25 around behavioral health, physical health,

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1 ED, and inpatient utilization. And we can
2 kind of just flip through these slides quite
3 quickly because of time knowing that, you
4 know, what we're really seeing -- and I just
5 want to stop here, is this behavioral health
6 inpatient trend. You know, we're really
7 monitoring this.
8 This, again, is a trend across the
9 country, recognizing that people are having a
10 lot of behavioral health -- there is an
11 increase in the predominance and prevalence
12 of the behavioral health issues. But I think
13 also the pandemic has allowed us to have
14 greater access; right?
15 So we're accessing -- members are
16 accessing care that they normally wouldn't
17 with, you know -- like I said, with digital,
18 with phones, with our behavioral health
19 crisis lines, with the mobile crisis
20 implementation that's, you know, going to be
21 occurring in the fall.
22 So while this trend may be going up, I
23 think that it's a trend that we just are --
24 is new to us because of all the increased
25 services and opportunities to engage with

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1 those services.
2 This is just the physical health
3 inpatient. And I'll stop here real quick,
4 the readmissions. We can see the readmission
5 trends are pretty stable throughout the
6 years, both for behavioral health and
7 physical health. And, you know, that is
8 something that we're always working on.
9 With all these programs, with the
10 increase in network that Paige referred to,
11 with our case management, with, you know,
12 outreaching members for SDoH resolutions. So
13 this is something that's always, you know, in
14 the back of our mind.
15 And the last slide that I'll comment on
16 is our primary expenditure for -- primary
17 drivers of expenditure. And, you know,
18 again, it's the mental health non-inpatient,
19 so that's all those outpatient services.
20 You know, having people receive those
21 services when they are medically necessary is
22 a good thing. So seeing that volume, again,
23 I think it's just a testament that we're
24 providing more services, and more people are
25 accessing them.

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1 But the real story around cost is retail
2 Rx, so the number of scrips has increased as
3 well as the cost.
4 And that's the end of our presentation.
5 Very quick, I know, trying to be cognizant of
6 the time. So we'll take any questions. I'm
7 happy to have this opportunity to present.
8 Thank you so much.
9 MS. MANKOVICH: Nina, I see your
10 hand there.
11 MS. EISNER: Yes. Thank you.
12 Thank you so much for your presentation.
13 Under the prior authorization issue, I was
14 pleased to see that the number of denials was
15 staying flat relatively.
16 But I did note that the slide showed
17 that the total requirements for prior
18 authorizations are on a real upward trend,
19 and it's concerning at a time that it
20 requires additional burden of providers when
21 there's such a workforce shortage. So just a
22 comment.
23 MS. MANKOVICH: So -- sure. And I
24 appreciate that, and I thought that might
25 come up. And I can actually explain, I

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1 think, that a little bit more specifically.
2 So in 2020 and 2021, we had a relaxation
3 of prior authorizations, so I think what
4 you're seeing in that uptick is as things
5 were able to be turned back on for prior
6 authorization, there was a natural increase.
7 We also had an increase in membership
8 because of the Public Health Emergency and
9 members not going through a redetermination.
10 So you've just got -- we've got a bigger pool
11 of members that were subject to or receiving
12 treatment that might require a prior
13 authorization.
14 But to your point, you know, we do have
15 a UM steering committee that pays attention
16 to the number of services that -- we're, you
17 know, having very high approval rates on
18 prior authorization, to say: Do we really
19 need to have a prior authorization on that?
20 And we will remove prior authorizations.
21 So that work is ongoing on a regular
22 basis. It's not an annual review. It's a
23 quarterly review, I believe. So I think -- I
24 think there's several factors that are
25 playing into that increase, but your point is

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1 well-taken.
2 DR. MEYN: In fact -- and we work
3 with providers around prior authorization and
4 removing prior authorizations. In fact,
5 right now, we're working on -- you know, with
6 a provider that didn't see the necessity for
7 a 90-day but would -- I mean, for a 60-day
8 but needed -- wanted 90-day.
9 So we looked at: What are the denial
10 rates for the provider? What are the denial
11 rates for the procedure? And, you know,
12 changed that requirement to make it the 90
13 days instead of the 60 days.
14 So it is a collaboration. But, again,
15 you know, just to stress the point of, you
16 know, making sure that our members are
17 getting evidenced care and that -- not
18 wanting people to undergo services --
19 procedures when they aren't evidence-based is
20 kind of -- you know, and making sure that
21 quality outcomes are happening are our
22 primary focus.
23 MS. EISNER: Thank you for your
24 ongoing attention to this matter.
25 MS. MANKOVICH: Sure.

1 DR. ROBERTS: Yeah. Your point
2 about PAs being retracted -- requirement
3 being retracted and then re-implemented is
4 noted. You know, a more detailed PA
5 breakdown may be beyond the scope of this
6 presentation. The -- looking at how many --
7 how many of your codes require PAs over --
8 you know, over a period of years is something
9 that, Beth, we may look at -- when we set
10 forth the criteria for the MCO presentations,
11 that may be something to look at next year,
12 is, you know, the number of -- number of
13 codes that require PA over time.
14 You know, your denial rate stays, you
15 know, pretty consistent, but it is concerning
16 with the -- you know, at the comment that was
17 made. You know, if you're denying the same
18 amount but you're requiring a significantly
19 increased number of PAs -- you know, and,
20 again, these numbers are a bit skewed because
21 of coming out of COVID.
22 But that's -- I can tell you that is one
23 of the greatest obstacles that my colleagues
24 have with seeing Medicaid patients, either
25 enrolling in Medicaid to begin with or in

1 capping the number of Medicaid patients that
2 they see is -- you know, the reimbursement
3 rates are what they are. We all have, you
4 know, a program that we're working within.
5 But when it requires a significantly
6 increased administrative burden or profound
7 amounts of bundling within, you know, groups
8 of procedures performed, you know, the same
9 day or PAs for things that -- you know, that
10 are just not -- you know, they historically
11 haven't required PAs.
12 I do appreciate the fact that you're
13 looking at evidence-based care. That's
14 great. The, you know, transparency on why an
15 item or service was -- now requires a PA
16 would probably help it, you know, go over
17 better, a little bit better with physicians.
18 But that would also provide an opportunity to
19 say, okay, look, well, here is the evidence.
20 Let's remove the PA if we can find an
21 evidence-based consensus but the -- yeah.
22 That's my comment.
23 MS. MANKOVICH: Thank you.
24 CHAIR PARTIN: Any other questions?
25 (No response.)

1 CHAIR PARTIN: Okay. I had a -- I
2 had a couple questions. One, where you
3 listed the primary care providers at the very
4 beginning, you listed physician. You did not
5 list nurse practitioners or certified nurse
6 midwives.
7 Are they included in that physician
8 count, or did you just leave them out?
9 MS. MANKOVICH: We have a lot of
10 additional information in the appendix. I'm
11 looking at it right now. So participating
12 providers by region, we do have physicians
13 and nurse practitioners listed on page 34 of
14 our deck. So it's in the appendix.
15 I do not see that we have nurse midwives
16 on here. I may be speaking out of turn. So
17 I apologize, and I will go correct myself if
18 I am. I'm not sure if that's -- I apologize.
19 I don't know if that's a Medicaid-covered
20 service at this very moment, but I will take
21 that back and double-check.
22 CHAIR PARTIN: It is.
23 MS. MANKOVICH: Okay.
24 CHAIR PARTIN: Nurse midwives
25 are -- services are covered. Okay. So --

1 MS. MANKOVICH: So we can -- we can
2 supplement with that.
3 CHAIR PARTIN: Okay. And then my
4 next question is related to the -- sorry
5 about my dog -- related to the gift cards.
6 Do the recipients -- or the participants
7 automatically receive the gift card? For
8 instance, if they had a hemoglobin A1C, you
9 know that because of the lab billing. So do
10 they just automatically receive the gift
11 card, or do we --
12 MS. MANKOVICH: We have -- we have
13 a member of our HEDIS team or a group within
14 our HEDIS team that does outreach the member
15 to confirm where they live, what phone
16 number, what mailing address to send it to.
17 Because, often, the mailing address that we
18 have on file is not where they live anymore.
19 So we do have to validate that with the
20 member.
21 We would love to get to a point where it
22 could be instantaneous, but these often
23 are -- whether they're electronic or hard
24 copy gift cards, we want to make sure that
25 they're actually making it to the hands of

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1 the member.

2 CHAIR PARTIN: Okay. But you

3 automatically do that --

4 MS. MANKOVICH: Yes.

5 CHAIR PARTIN: -- based on the

6 billing codes and that sort of thing?

7 MS. MANKOVICH: Yes.

8 CHAIR PARTIN: Okay. I just wanted

9 to make sure that the provider didn't have to

10 do something.

11 MS. MANKOVICH: No.

12 CHAIR PARTIN: Okay. That's the

13 only questions I had. Thank you.

14 MS. MANKOVICH: Okay. Thank you.

15 Yep.

16 CHAIR PARTIN: Anything else?

17 (No response.)

18 CHAIR PARTIN: Okay. I would just

19 like to add that because there is so much

20 information here, probably members of the MAC

21 will want to look at these presentations.

22 And so I'll add to the agenda for the next

23 meeting that if people have questions after

24 they've looked at them, that they can ask

25 questions to each of the MCOs at the next

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1 meeting. So you may or may not receive
2 questions at the September meeting.
3 MS. MANKOVICH: We will be
4 prepared.
5 DR. MEYN: We love them.
6 MS. MANKOVICH: Yeah.
7 CHAIR PARTIN: Thank you.
8 MS. MANKOVICH: Thank you.
9 CHAIR PARTIN: Okay. Next up is
10 WellCare.
11 MR. EWING: Okay. Good morning.
12 I'm Corey Ewing, plan president here at
13 WellCare. Just wanted to say thanks for the
14 opportunity to present to you guys today.
15 I'll be pretty brief in my comments, and
16 we'll toss it over to my team and let them
17 get into the meat of the deck.
18 But a little bit about WellCare. Most
19 of you know who we are, but we've been here
20 since day one, 2011, when managed care came
21 into the state. We're fortunate to currently
22 hold the largest market share in the Medicaid
23 space with 32 percent of the market share
24 with primarily the majority of our members
25 being in Regions 7 and 8.

1 We see quite a bit of acuity coming out
2 of that region, and the reason I point that
3 out is you'll get to hear a little bit about
4 the work we're doing around social
5 determinants of health because it's a lot of
6 those things that lead to those higher
7 acuities. But you'll get to hear the team
8 speak to that in great depth here shortly.
9 With that, I will toss it over to Marc
10 Nyarko. He's our chief operating officer, so
11 I will let Marc go.
12 MR. NYARKO: Hey. Thanks, Corey.
13 MR. EWING: Okay. There we go.
14 MR. NYARKO: All right. Awesome.
15 So we build a robust provider network to
16 support our membership base, and we've met
17 accessibility standards for all provider
18 categories. Thinking about the accessibility
19 standards, we're supposed to -- and for urban
20 members, one provider within 30 miles; and
21 for rural members, provide one provider
22 within 50 miles. We are 100 percent adequate
23 for 33 of 37 categories, and our lowest
24 rating is 95 percent for endocrinologists.
25 We continue to assess our network

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1 adequacy looking for potential gaps. We also
2 have a comprehensive review on a quarterly
3 basis when we're looking at our network. And
4 when we identify potential shortages, we
5 launch a targeted improvement initiative.
6 An example of that is with applied
7 behavioral analysts. In 2020, we realized we
8 had a gap, and we launched recruitment then.
9 We went from 74 ABAs to 225 and are currently
10 100 percent adequate with that.
11 In addition to that, you know, when
12 members are in-network -- when an in-network
13 provider is unavailable and a member needs an
14 out-of-network provider, we're very quick to
15 negotiate with that provider, and we can
16 engage with a single case agreement within 8
17 to 24 hours.
18 Next slide. This slide outlines the
19 out-of-network requests that we received in
20 2022 by quarter. The majority of the
21 out-of-network scenarios, remember, was out
22 of state. And so that's when we would engage
23 with those providers to do a single case
24 agreement.
25 And, you know, we do take a look at

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1 patterns in our out-of-network claims, the
2 utilization. And we'll reach out to
3 negotiate with a provider with a network
4 agreement if we feel like there's, you know,
5 an opportunity there.
6 Telehealth is a very important tool that
7 we use to ensure access. We've actually paid
8 claims to over 12,000 distinct provider IDs
9 and 89 unique provider types. Looking at the
10 graph on the left, you'll see our spending
11 from 2020 to current has been very robust.
12 Now, I'd like to turn it over to Paula
13 McFall who -- our senior director of
14 behavioral services. Paula?
15 MS. MCFALL: I'm on mute. I'm
16 sorry.
17 I'm here to talk about our primary
18 drivers for spend, and much of it is
19 behavioral health. So just giving you some
20 information on that. Of course, the trend
21 began during the pandemic, and it continues.
22 Overall, behavioral health's per member
23 per month spend rose 12.8 percent in calendar
24 year 2022 compared to 2021. Lower level,
25 including non-BH services, are key drivers

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1 here. Data shows that there are some members
2 that only receive BH services that are peer
3 support or community support rather than
4 clinically-based treatment by a licensed
5 provider.
6 So here's two examples of peer support.
7 PMPM --
8 (Brief audio interruption.)
9 MS. MCFALL: I'm sorry. PMPM rose
10 135 percent from 2019 to first quarter of
11 2023. And the units per thousand also surged
12 to 198 percent. Prior to that, in 2020, peer
13 support was our 11th PMPM ranking, and now
14 it's 4th.
15 Community support services rose 114
16 percent in the same time period and also
17 jumped per K -- units per K 115 percent over
18 time. And community support was 16th in 2020
19 for PMPM ranking, and now they're 6th.
20 Next slide. A couple more examples.
21 Therapeutic behavioral health, the PMPM
22 jumped 213 percent during that same time
23 frame as did the units per thousand. And
24 psychoeducation units per thousand jumped 222
25 percent from 2019.

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1 Next slide, please. This is a slide
2 that compares a couple other states that
3 Centene have a Medicaid business, Ohio and
4 Indiana. And it looks at community-based
5 services, which includes your peer support,
6 comprehensive community support, and then
7 your outpatient services, which is provided
8 by a licensed clinician or physician, nurse
9 practitioner.
10 So Kentucky has 37 percent fewer members
11 per thousand of community-based services than
12 Ohio, but they are 125 percent higher in
13 units per utilizing member. Similarly, the
14 units per thousand for members in Kentucky
15 are 43 percent higher than Ohio for the
16 community-based services despite 37 percent
17 fewer members per thousand.
18 And as you can see from these slides,
19 the -- in contrast, we are much lower for
20 outpatient clinical services than Ohio and a
21 little bit lower than Indiana there.
22 On the table to the right, for 2021 to
23 2022, we had a 24 percent increase in PMPM
24 for community-based services. Units per
25 thousand were 11.6 increase. Units per

1 utilizing member were 26.6 percent increase
2 and then units per K were a 41.3 percent
3 increase, so just showing trends.
4 This is the last slide. We just wanted
5 to show a couple more examples of the trend
6 going up. For partial hospitalization, our
7 PMPM has gone up, from '21 to '22, 42
8 point -- 42 percent. Users per K, 21.5
9 percent; units per utilizing member, 30
10 percent; and units per thousand, 58 percent.
11 Also, applied behavioral analysis, which
12 we expected to increase since we did increase
13 our provider -- providers across the state.
14 So this is actually a trend we wanted to see.
15 The PMPM is 56.5 percent increase. Users per
16 K, 59.2 percent increase. The utilizing
17 members decreased very small, 1.2 percent,
18 and then units per K increased 57.3 percent.
19 And I will now have Dr. Patel talk to
20 you about denials and approvals.
21 DR. PATEL: Thank you, Paula.
22 MS. MCFALL: Yep.
23 DR. PATEL: So our goal for
24 selecting services for prior authorization is
25 to ensure that the members get access to the

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1 most appropriate clinical care, and so we
2 want to have member-centric care.
3 And, for example, pre-pandemic, before
4 PA was suspended, BH providers would often
5 submit authorization requests for pediatric
6 members but then subsequently call our
7 medical affairs team, which we do have some
8 child psychiatrists on board, for the best
9 advice of what the next best clinical service
10 should be. Should it be psychotherapy?
11 Should it be ABA, or should it, you know, be
12 short duration of stimulant?
13 And so what I'd like to say to that is
14 there's a broad spectrum of inputs when a PA
15 is determined chiefly driven by clinicians
16 who are regularly viewing the published
17 evidence-based literature and guidelines
18 along with support from data analytics,
19 certified coders, and with a broad review for
20 fraud, waste, and abuse.
21 Next slide, please. And so as you can
22 see here, our service categories for top ten
23 authorizations by volume for '22, most of our
24 things are fully approved greater than 90
25 percent with the lowest being radiology and

1 consultation and treatment.
2 The top denial reason, similar to the
3 previous MCO, is medical necessity. And then
4 a distant second is denied for no prior
5 authorization. And so, typically, the most
6 common reason is there's not enough
7 information in the prior authorization.
8 And we understand it's a delicate
9 balance of reducing the burden on the
10 provider and encouraging expeditious care in
11 an evidence-based fashion for our members.
12 It's a dance.
13 Next slide, please. And so what we will
14 say about ER utilization with physical health
15 and behavorial health is -- top ten
16 diagnosis, upper respiratory infection is
17 No. 1 along with cardiac chest pain and other
18 chest pain. COVID-19 has fallen down, but
19 it's still on the list and then you will see
20 some things that are not surprising to you.
21 But you will see distinct BH ER claims
22 is increasing year over year from 332,000
23 back in 2020 up to 359,000 and change in
24 2022, and physical medicine ER claims from
25 344,000 to 370,000 as well.

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1 And we also acknowledge, as the pandemic
2 has subsided and utilization is increasing as
3 people are looking to get the care that may
4 have been avoided in that time, some of this
5 is expected. But I do think some of it is
6 unexpected.
7 Next slide, please. With that ER
8 utilization in mind, what we do know is when
9 we are able to have members who have not
10 churned out or members who are not suffering
11 redetermination, members who we can
12 continuously have enrolled in our plan for at
13 least six years, which is 156,000 and change
14 members, you will see that our ER visits for
15 that cohort has extensively fallen from 2017
16 to 2022. I'd like to highlight that number,
17 from 128,000 and change to 90,000.
18 But the number that I would like to
19 highlight the most is our ratio of PCP visits
20 to ER visits increasing. So for that cohort,
21 we are able to connect those members all the
22 way to their primary care physician at a
23 larger range. And that's because we have
24 care managers who establish relationships.
25 We have an analytics team who has an immense

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1 amount of ability to do prioritization and
2 quality work.
3 We do understand that there's a balance
4 between using technology and using a warm
5 handoff and warm touch. As Corey had
6 mentioned, our members out in eastern
7 Kentucky, they are not always adept to using
8 high-tech applications. And so we do use a
9 balance of both, and I think it's necessary
10 to have multiple tools in our toolkit.
11 Next slide, please. And we also let
12 data drive our care management initiatives
13 that we do. We don't have any pet projects.
14 And what we do talk about is food. Food
15 insecurity is a big issue. We believe that
16 food insecurity -- without having consistent
17 food, the correct food, and food for your
18 family can result in other SDoHs being
19 exacerbated, augmented, and decrease in the
20 management of chronic conditions.
21 And so we have a program with Good
22 Measures that is quite vast and deep, and you
23 will see the tremendous amount of results
24 here. Inpatient visits per 1,000, less than
25 21 percent, decreased by 21 percent. Non-ER

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1 inpatient by 7 percent, and total medical per
2 member per month spend by 6 percent.
3 How do we drive this outcome? We
4 continually assess the initiative. Our data
5 analytics team has developed a Kentucky
6 market tool for Kentucky members alone. We
7 don't use a corporate tool. We don't use a
8 United States tool. We use a
9 Kentucky-created and Kentucky-based tool
10 because we're serving Kentucky members.
11 Next slide, please. And, you know,
12 something that's near and dear to our heart
13 is substance use disorder and how we can
14 combat that. We have an opioid task force
15 that was started back in 2021. As I've
16 alluded to, we use data to drive our
17 decision-making along with our care
18 management team, which is out in the field,
19 along with the experts of our pharmacy team.
20 What we have seen is 68 percent of our
21 members taking an opioid disorder medication
22 have received therapy in conjunction with
23 that medication. And what I'd like to say
24 about that is we encourage and emphasize
25 higher-level therapy, clinically appropriate

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1 therapy, evidence-based therapy, and
2 appropriate duration of therapy. Because all
3 those things matter in terms of decreasing
4 recidivism in substance use disorder.
5 We have a member-facing and a
6 provider-facing report. Percent of members
7 compliant with pharmacotherapy, percentage of
8 members receiving counseling, and prescribed
9 Narcan. Our providers know this for their
10 panel, and we're able to use our care
11 management and our quality teams to help
12 providers reach the appropriate goals to
13 impact our members.
14 Next slide, please. I'd like to pass
15 the deck over to our senior director of
16 member experience, Darren Levitz.
17 MR. LEVITZ: Thank you, Dr. Patel.
18 To carry on what you said, at WellCare, we
19 rely on data rather than hunches to drive our
20 community involvement. While any social
21 determinant program has its merits, it's
22 essential to ask if it's the most relevant to
23 the needs of the community.
24 WellCare's process incorporates multiple
25 publicly-available data resources as well as

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1 our own proprietary data to calculate with
2 precision the most consequential needs of
3 each of Kentucky's 120 counties.
4 For example, we include data from the
5 Social Vulnerability Index to help identify
6 each community's susceptibility to adverse
7 impacts of natural hazards including
8 disproportionate death, injury, or loss of
9 livelihood. We look at other resources such
10 as the rural health hub to assess where food
11 deserts are, or are there maybe limits on
12 provider types such as dentists.
13 Another source of data is a compilation
14 of requests we receive from our Community
15 Connections Help Line, a free resource
16 available to all Kentuckians. Using the
17 CCHL's data, we're able to identify thousands
18 of requests we receive and target them to
19 specific cities, counties, and even zip
20 codes.
21 It's through these data sources and more
22 that we create tools such as the map that you
23 see. These maps are provided to WellCare's
24 community engagement team members that live
25 across the state and serve in the communities

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1 they each live in.
2 Taking a look at this example, Fulton
3 and Muhlenberg are two counties at the
4 highest risk for this region. Digging in
5 deeper, the data shows us that the three
6 biggest barriers to care are housing, crime,
7 and environmental conditions.
8 The community engagement coordinator is
9 then given contact info for hyper local,
10 community-based organizations that address
11 those needs. While nobody would turn down a
12 food insecurity program in these counties,
13 based on the data that we see, the best use
14 of resources is to invest in programs like
15 rent assistance, reentry initiatives, and
16 improving water quality. These analyses are
17 conducted for each of the eight Medicaid
18 regions in all 120 counties through the state
19 of Kentucky.
20 As mentioned previously, our Community
21 Connections Help Line is a heavily leveraged
22 resource by our members. In a given year, we
23 receive thousands of calls from people in
24 need. We listen to their concerns and dig
25 deeper to find where they may be struggling.

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1 Let's face it. When someone is food
2 insecure, they are also likely dealing with
3 other issues like housing instability, or
4 they are in need of utility assistance. In
5 fact, on average, we assess 2.4 needs for
6 each person that calls the CCHL.
7 WellCare does not rely on purchasing
8 data for the CCHL. We found, especially
9 after COVID, that the CBO info on external
10 resources is out of date, and several CBOs
11 aren't even listed as operating anymore.
12 Instead, the community engagement team is
13 responsible for gathering all federal, state,
14 and local resources. These must be entered
15 and/or reverified throughout the year.
16 Because of the stringent process, we
17 address literally 99 percent of the caller's
18 needs on the spot. For the 1 percent that we
19 don't, we take on average just four hours,
20 only half a day, to find a viable resource.
21 As a quick aside, our best practice used
22 to be two days. But we realized that when
23 people call the CCHL, they aren't calling for
24 rent that's due in three weeks or
25 refrigerators that may be empty next month.

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1 Their world is on fire, and getting back to
2 them as quickly as possible is critical.
3 There always used to be a supposition
4 that there's an ROI on SDoH programs, but the
5 results have always been tough to quantify,
6 but not now. We not only use our data to
7 help guide our grants but to demonstrate the
8 value they bring.
9 On this slide, I'll give three brief
10 examples. In Bowling Green, we've partnered
11 with HOTEL INC where we provided a grant to
12 help their clients provide safe and stable
13 homes. Based on the data, comparing six
14 months prior to the program and six months
15 after, we saw a dramatic 67 percent reduction
16 in inpatient visits, a 100 percent reduction
17 in readmissions, and a 23 percent reduction
18 in ER visits.
19 With Welcome House in northern Kentucky,
20 we help people as they transition from
21 housing uncertainty to housing stability.
22 Again, comparing six months' data prior to
23 the program and six months after, we saw with
24 these members a 43 percent reduction in
25 inpatient visits and a 33 percent reduction

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1 in ER visits.
2 And lastly, our example of Water Into
3 Wine, where we dealt with food insecurity.
4 After our grant, we saw a 50 percent
5 reduction in inpatient visits and an
6 incredible 61 percent reduction in ER visits.
7 Being sensitive on time at this point,
8 I'm going to turn this back over to Corey
9 Ewing, our plan president, to WRAP up.
10 MR. EWING: The majority of the
11 slides -- our deck is, as you can see, we're
12 only about halfway through it, so it'll be
13 available for you guys. I know we're short
14 on time, so we wanted to stop here and see if
15 there are any questions for any one of our
16 presenters today. And, again, we appreciate
17 the opportunity to present for you all today.
18 CHAIR PARTIN: I have a question
19 and a comment. On one slide on substance use
20 disorder treatment, I was curious because --
21 there was 68 percent of those patients
22 receiving treatment, and I'm assuming that's
23 with buprenorphine. Correct me if I'm wrong
24 on that. Are we talking about buprenorphine?
25 DR. PATEL: That is correct.

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1 CHAIR PARTIN: Okay. So both of
2 the -- the Kentucky Board of Nursing and the
3 Kentucky Board of Medical Licensure require
4 counseling as part of treatment with
5 buprenorphine. So I just found it kind of
6 interesting that 68 percent of members
7 received therapy in conjunction with the
8 medicine. So that's just a comment.
9 And then my question is that -- or
10 comment is that -- not related to your slides
11 but that, recently, Kentucky legislation was
12 passed to allow APRNs to prescribe controlled
13 substances and, in the past, noncontrolled
14 substances independently after having a
15 collaborative agreement for four years. And
16 so there are now many nurse practitioners who
17 do not have a collaborative agreement.
18 And I just got word that a psych mental
19 health practice was hiring a nurse
20 practitioner and wanted to credential with
21 WellCare, and they were not able to
22 credential because they didn't have a
23 collaborative agreement.
24 So I'm wondering if WellCare is going to
25 change their policy on that since there are

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1 going to be many nurse practitioners who no
2 longer have prescribing agreements.
3 MR. EWING: I would -- I would love
4 to get the specifics on that one because I
5 would love to see what happened with that.
6 CHAIR PARTIN: Specifics on the
7 denial?
8 MR. EWING: Of who actually the
9 case -- who it was, the provider was, because
10 that does not sound -- I want to make sure
11 that that was -- that doesn't sound like it
12 was handled correctly.
13 CHAIR PARTIN: Okay. So you do
14 know that there are --
15 MR. EWING: Absolutely.
16 CHAIR PARTIN: Okay. And that you
17 will credential --
18 MR. EWING: Uh-huh.
19 CHAIR PARTIN: Okay. I will -- I
20 will get that information to you. Can you
21 send me your email so that I can get that
22 information to you?
23 MR. EWING: Absolutely.
24 MR. OWEN: Dr. Partin, I just
25 put -- Stuart Owen. I just put my email in

1 the chat as well.

2 CHAIR PARTIN: Okay. So should I

3 email you?

4 MR. OWEN: Yes. Yes, please.

5 CHAIR PARTIN: Okay.

6 MR. OWEN: Thank you.

7 CHAIR PARTIN: Thank you.

8 MS. BICKERS: Dr. Bobrowski has his

9 hand raised.

10 DR. BOBROWSKI: I got a quick

11 question, and this might just be a typo. But

12 I think it was slide 16. It was in the list

13 there. It listed out rental. Was that

14 supposed to be dental?

15 MR. OWEN: Dr. Bobrowski, I think

16 that's DME, durable medical equipment rental

17 items.

18 DR. BOBROWSKI: Okay. Thank you.

19 MR. OWEN: Certainly.

20 CHAIR PARTIN: I don't see the

21 email in the chat.

22 MS. BICKERS: Beth, I can get you

23 Stuart's email.

24 CHAIR PARTIN: Okay. Great. Thank

25 you.

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1 Any other questions for WellCare?
2 (No response.)
3 CHAIR PARTIN: Okay. Thank you,
4 guys, very much, and I'm sorry that we didn't
5 have time to go through all the slides
6 because I know there's a lot of valuable
7 information there. So we will be looking at
8 that and maybe have questions at the next
9 meeting.
10 MR. EWING: Okay. Thank you.
11 CHAIR PARTIN: So at the September
12 meeting, Anthem and United will be
13 presenting.
14 So next up, we have reports and
15 recommendations from the TACs, and first up
16 is Behavioral Health.
17 DR. SCHUSTER: I'll go
18 lickety-split. Thank you. Sheila Schuster
19 reporting for the TAC. We met on July 13th
20 and had a quorum.
21 We got a report from Ann Hollen about
22 the unwinding. And I will tell you, and I
23 want Veronica to know that we made a big
24 pitch with not only our providers but also
25 with the peer-run, consumer-run centers to

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1 get the word out there for people to respond
2 to those inquiries from Medicaid.
3 We did have an issue involving pharmacy
4 that I wanted to bring to everyone's
5 attention because it's troubling. I had
6 gotten an email from someone who used to work
7 at an SUD treatment clinic, and they had
8 gotten a letter from about seven or eight
9 pharmacies in western Kentucky that they were
10 no longer going to fill prescriptions for
11 psychostimulants for any of their clients.
12 A neighboring clinic that does
13 full-service behavioral and physical health
14 got the same letter, and it took some time
15 for me to get that information to Medicaid.
16 And I was glad at the BH TAC meeting that
17 Dr. Prather said that it had been taken care
18 of, that they had called the pharmacies.
19 And the pharmacies had complained about
20 how the prescriptions were coming in, or
21 something like that, and then just had
22 decided that they weren't going to fill the
23 prescriptions. And they apparently are now
24 filling the prescriptions, although I've not
25 heard that confirmed back from the provider

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1 organizations.
2 I guess my concern is, that's an
3 instance where people were absolutely not
4 getting their prescribed medications, and I
5 heard about it really just via the grapevine.
6 So I don't know what kind of system we need,
7 but we really need to not have that kind of
8 thing happen. And I don't know if pharmacies
9 can just decide willy-nilly. Maybe it's
10 something I need to discuss with the pharmacy
11 TAC, or we need to put on their agenda but
12 really concerning.
13 We got an update on the 1915(i) SMI
14 waiver that will have supported housing from
15 Pam Smith, and we're looking for those town
16 hall meetings to take place hopefully in
17 September.
18 We have no new recommendations for the
19 MAC.
20 I want to end on a positive note, and
21 that is to thank all of the MCOs but
22 particularly Herb Ellis from Humana for
23 working together so well to get a bypass list
24 together for dual-eligible Medicaid members
25 who have Medicaid and a commercial insurer.

1 And Herb reported that it's been in
2 effect since May 1st and is working very
3 well, and there are no problems. So we've
4 had that on our agenda for -- you know, since
5 we've been in existence, which is about 12
6 years.
7 Our next meeting is September 14th.
8 Thank you.
9 CHAIR PARTIN: Thank you, Sheila.
10 DR. HANNA: Sheila, I would like
11 to -- this is Cathy, pharmacy up here. I
12 would like to, you know, maybe talk to you
13 offline to find out what in particular was
14 going on there. I mean, you know, you always
15 want to make sure you know what the situation
16 is.
17 And, also, just -- you know, pharmacists
18 do -- with their professional judgment can,
19 you know, not fill it. But, typically, it's
20 unusual to see a policy. You know, if it was
21 a policy, that's a little bit different so...
22 But we can talk about that, and I'll be
23 happy to, you know, help in any way I can.
24 DR. SCHUSTER: Thank you very much,
25 Cathy. I'll reach out to you for sure.

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1 CHAIR PARTIN: Okay. Next up,
2 Children's Health.
3 MS. WHATLEY: Hi. Alicia Whatley
4 here from the Children's Health TAC. We did
5 meet earlier this month on July the 12th, but
6 we do not have any formal recommendations at
7 this time. And we have our next meeting
8 scheduled on September 13th.
9 CHAIR PARTIN: Thank you.
10 Consumer Rights and Client Needs.
11 MS. BEAUREGARD: Hey, everyone.
12 Emily Beauregard with Kentucky Voices For
13 Health, and I'm the chair of the Consumer
14 TAC. We did meet in June, on June 7th. We
15 had a quorum. We met on Zoom.
16 We revisited a number of topics that we
17 typically discuss and monitor. I'll just
18 highlight a couple because of, you know, the
19 time here today. Earlier, there was a lot of
20 discussion around Medicaid renewals. Of
21 course, that's something that we are
22 monitoring very closely. And we're all, I
23 think, concerned about the low response rate
24 that Deputy Commissioner Veronica Judy-Cecil
25 mentioned, you know, with so many people

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1 receiving notices and not responding to them.
2 And, you know, just historically, I
3 think this MAC has probably discussed for
4 years, you know, response rates and also bad
5 addresses or people who, you know, don't have
6 an updated address. The mail gets returned
7 to Medicaid.
8 And we know that before the pandemic,
9 that returned mail rate was, like, between 30
10 and 40 percent on any given month. That was
11 pretty standard. The returned mail rate now
12 is so low, it is, one, I think partly a good
13 thing, a testament to the work that DMS and
14 the MCOs have done to collect better
15 addresses and more up-to-date addresses.
16 But we do wonder if there are some of
17 these notices being mailed to addresses where
18 people no longer live and just -- and being,
19 you know, actually left there, delivered, not
20 returned to sender. Because during the
21 pandemic, we understand that the postal
22 service did have some flexibilities as well
23 and didn't have to verify whether someone was
24 necessarily currently living in a
25 particular -- at a particular address.

1 So we're wondering if that is partly
2 to -- you know, at least would partly explain
3 the low response rate, that mail is being
4 delivered but not being delivered to, you
5 know, the actual person that was -- it was
6 addressed to because, you know, they no
7 longer live at a particular address.
8 That's something that I think we need to
9 keep really digging into to try to understand
10 more. And regardless of whether that's the
11 case or not, if we continue to see such a low
12 response rate, I think we really need to look
13 at what kind of community response we need to
14 kind of collectively be working on.
15 And providers, I think, play a huge role
16 in that. You know, if people are getting
17 notices and not understanding them or not
18 opening them because they're getting too many
19 notices and they just assume that maybe it's
20 junk, they don't understand that it's
21 important -- whatever the case may be.
22 The more providers we have who are
23 looking in KYHealth-Net, who are identifying
24 that renewal date, making sure that their
25 patient is aware of it and, you know,

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1 providing them with assistance or at least
2 connecting them with a connector, I think
3 that could go a long way in preventing people
4 from, you know, losing their coverage simply
5 for not responding.
6 You know, we understand this process.
7 There will be some people who are no longer
8 eligible. That's always the case. But I
9 just can't WRAP my head around that being
10 about half of people currently enrolled in
11 Medicaid. And I know that's going to be
12 incredibly disruptive to providers as well,
13 not just to the individuals who, you know,
14 are seeking care and finding out that they're
15 uninsured suddenly. So that part about
16 KYHealth-Net, I think, is just something I
17 hope providers are aware of and are doing.
18 And something else that we've noticed is
19 that, you know, presumptive eligibility
20 enrollment has been really low for many
21 months now, partly due to the fact that not
22 as many people need it. But, also, House
23 Bill 7 passed in 2022 which prohibited the
24 State from doing the determination of
25 presumptive eligibility.

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1 But hospitals and Federally Qualified
2 Health Centers can still use presumptive
3 eligibility. And I'm just wondering how many
4 are, you know, doing that when someone is
5 coming and finding out that they're
6 uninsured.
7 Because right now, going through
8 reconsideration or an appeals process or a
9 new application, that all takes time.
10 There's going to be a backlog because so many
11 people -- there's so much, you know, paper
12 being processed right now or so many new
13 applications and renewals being processed,
14 that I really feel like we need to revisit
15 presumptive eligibility and make sure that
16 people have that option if they suddenly find
17 out that they're uninsured. And it's
18 because, you know, they just didn't respond
19 to a notice in time. So I think that's
20 something that we all need to be keeping in
21 mind and reminding, you know, providers, that
22 that is an option.
23 And then, finally, I'm going to skip
24 over a few of the things that I put in the
25 report that you all should have. But we did

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1 discuss the new dental, vision, and hearing
2 services that are now covered by Medicaid and
3 have been, you know, for this calendar year.
4 And, you know, having talked with a
5 number of providers now, a lot of community
6 health workers, Medicaid beneficiaries, it's
7 becoming pretty clear to us that most people
8 don't think that these services are still
9 covered. Maybe weren't aware of them to
10 begin with because it's been a short period
11 of time.
12 But even those who were aware, whenever
13 the services started in January, assume that
14 because of Senate Bill 65 that was passed in
15 March and then the most recent administrative
16 reg review committee meeting in May where the
17 emergency regs were found deficient, I think
18 there's a lot of confusion. And the
19 assumption being that, you know, because of
20 that bill, because of the deficiency, that
21 the regs aren't in place and, you know,
22 active.
23 And I think we're really missing such an
24 important opportunity to get people access to
25 these services. So just want to really raise

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1 awareness of the fact that a lot of Medicaid
2 beneficiaries and probably even providers
3 aren't aware that these are still covered
4 services, should be covered for the remainder
5 of this year, and we hope will be permanently
6 covered, which is something we need to work
7 on with our legislators. But that's
8 something that has been concerning to us.
9 Now, we know that there are thousands of
10 Kentuckians getting access, especially to
11 glasses. You know, there are many thousands
12 also getting access to some sort of dental
13 care or hearing aids for the first time. But
14 I think many more would if they knew that
15 this was available to them.
16 And I understand that there's also
17 network adequacy issues there and providers,
18 you know, being a little reluctant to
19 participate because they don't know what's
20 going to happen with these services. But the
21 services are just so valuable and so
22 life-changing for people and to, you know,
23 health outcomes generally speaking, that I
24 think we really need to find ways to make
25 them work better for Kentuckians and work

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1 better for providers.
2 And then just to that end, we did make
3 one recommendation at our last meeting, and
4 that was that DMS provide communication to
5 providers and connectors about the status of
6 Medicaid dental, vision, and hearing services
7 so that more people are aware and have that
8 information.
9 And then our next meeting will be on
10 August 15th at 1:30 p.m. Thanks.
11 CHAIR PARTIN: Thank you, Emily.
12 Any questions?
13 (No response.)
14 CHAIR PARTIN: Okay. Next up is
15 Dental.
16 DR. BOBROWSKI: Yes. This is
17 Dr. Bobrowski, and we had -- our last TAC
18 meeting was on May the 12th, and we did have
19 a quorum.
20 And I'm going to tie this in with -- a
21 short report here with some of the phone
22 calls that the Kentucky dental office --
23 Kentucky Dental Association office is
24 receiving.
25 And one of them is that several dentists

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1 that -- even though we have pushed for and
2 are in favor of the expansion codes, several
3 dentists are calling and saying, well, they
4 feel like that the DMS has just ignored the
5 provider. Said we're small businesses out
6 here, and we can't keep providing services at
7 below cost when others -- grocery stores,
8 whatever, they get 100 percent of their costs
9 paid for. Dental gets about a third of our
10 costs paid. The dentists say we've got lab
11 bills, time invested. It's just below what
12 some of those expansion codes are paying for.
13 Nothing's being done to help stop these
14 failed appointments. For example, Monday
15 morning, I had three failed at 8:00.
16 Tuesday, I had two. Wednesday, I had two.
17 This morning, I had three that didn't show up
18 at 8:00. It's just hard to keep doing this.
19 But the other thing is that we just got
20 a call from a lady dentist over towards the
21 Richmond, middle of the state area, that
22 they're doing the dentures and the root
23 canals and stuff. But her comment was, is
24 that -- excuse my French and her French. But
25 she said she's breaking her back and losing

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1 her ass, you know, to provide these services.
2 Now, the next thing is, is that
3 hopefully on a brighter, more positive note,
4 at the Kentucky Dental Association meeting in
5 August, we are going to have a Medicaid
6 forum. The title of it is: Kentucky Oral
7 Health, 49th. A Road Map to Change. I'll be
8 the moderator for a panel discussion with
9 MCOs and interested parties, and Commissioner
10 Lee has agreed to be there.
11 But that will conclude my report. Thank
12 you.
13 CHAIR PARTIN: Thank you,
14 Dr. Bobrowski.
15 Any questions?
16 (No response.)
17 CHAIR PARTIN: Okay.
18 EMS?
19 MS. BICKERS: Keith is unable to be
20 on today. He got stranded in Maryland trying
21 to get a new ambulance.
22 CHAIR PARTIN: Oh, dear. Okay.
23 MS. BICKERS: But they did have a
24 meeting. They have no current
25 recommendations.

1 CHAIR PARTIN: Okay. Thank you.
2 Health Disparities?
3 DR. BURKE: Hey, this is Jordan
4 Burke. We were able to meet on July 5th,
5 earlier this month. We did have a quorum.
6 We had a great presentation of our
7 transportation services, looking at
8 value-added benefits. And all the different
9 MCOs, you know, are providing those and which
10 ones may be attracting people to actually use
11 those services more and get them involved
12 with it.
13 We also had some discussion looking at
14 interpreter services and, you know, how truly
15 accessible and feasible using those are right
16 now and what ways we can maybe make that a
17 little bit easier, specifically for urgent
18 care appointments, so you don't have to call
19 48 to 72 hours beforehand and how that can be
20 streamlined when those patients come in.
21 But no recommendations at this time.
22 CHAIR PARTIN: Thank you.
23 Home Health Care?
24 (No response.)
25 CHAIR PARTIN: Hospital Care?

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1 MR. RANALLO: This is Russ Ranallo,
2 the chair of the Hospital TAC. The Hospital
3 TAC met on June 23rd, and we had a quorum.
4 We had several -- we reviewed several items,
5 but we do have one recommendation.
6 Kind of a caveat. We have not had a
7 recommendation in a long time. We've had a
8 very collaborative relationship with the
9 Cabinet over the last few years, but we don't
10 see eye to eye on this one item.
11 In the middle of June, we got a letter
12 from DMS, a hospital provider letter that
13 told the hospitals that the Sepsis 3 criteria
14 would be adopted for sepsis coding and
15 replacing Sepsis 2.
16 I sent a report in to DMS -- or the MAC
17 for this. I'll go through some of the
18 highlights. Sepsis 2 is the currently
19 accepted and adopted coding, and it's a
20 disease process that -- it's an inflammatory
21 response to a known or suspected infection.
22 In 2016, the Critical Care Congress
23 adopted a new definition of sepsis, the third
24 international consensus definition for sepsis
25 and septic shock, so that's commonly called

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1 now Sepsis 3. And it narrowed the sepsis
2 definition and only described sepsis as a
3 life-threatening organ dysfunction.
4 And if you go forward, in 2018, WellCare
5 began to apply the Sepsis 3 definition in
6 their inpatient coding reviews and started to
7 adjust DRG assignment and change payments.
8 We brought the issue through the Hospital TAC
9 to DMS, and there was a series of meetings
10 that were held between the hospitals, DMS,
11 MCOs. And the outcome of those meetings was
12 there was a memo and -- at the end of 2019
13 from Dr. Theriot that instructed the MCOs
14 that DMS would follow Sepsis 2, the current
15 CMS and ICD-10 definition of sepsis until CMS
16 adopted Sepsis 3.
17 Fast forward to June 13th of '23 when
18 the hospitals got a provider letter informing
19 them that Sepsis 3 would be used replacing
20 Sepsis 2. I put those letters in my packet
21 to the MAC. The Hospital TAC was not
22 included in any of the meetings or discussion
23 of the change.
24 The current coding guidelines and coding
25 clinics -- so the current coding methodology

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1 is -- they're all written by four parties,
2 CMS, AHA, AHIMA, and NCHS. That's the
3 National Center For Health Stats in the CDC.
4 They currently -- the current coding
5 guidelines for ICD-10 and CMS coding are
6 Sepsis 2, not Sepsis 3.
7 And from a coding standpoint, in
8 Sepsis 3, there's no sepsis without organ
9 dysfunction. There's only severe sepsis. So
10 you would never see an account in Sepsis 3
11 coded to sepsis. You would either see severe
12 sepsis or no sepsis at all. And that's not,
13 again, consistent with current coding
14 guidelines, coding clinics, coding indexing.
15 So it -- CMS has not endorsed Sepsis 3 yet.
16 And so after the hospitals reviewed it,
17 there's numerous concerns moving to Sepsis 3.
18 Administrative costs and burdens. We will
19 need to code Medicaid cases differently than
20 Medicare. And with our EMRs -- I know
21 particularly with my EMR, our coders code
22 cases. They don't code by payer.
23 So myself and others will have to
24 reconfigure and adjust our EMR to separate
25 the groupings of patients due to the

1 different coding requirements, which will
2 cost us money and will make our coders less
3 efficient. It also will have an
4 inconsistency, again, with what CMS currently
5 does and recognizes as sepsis coding, which
6 is Sepsis 2.
7 We have concerns about crossover claims
8 where Medicaid is secondary and Medicare is
9 primary if Medicaid uses a different coding
10 requirement than Medicare and how those
11 claims will be adjudicated, denied, have to
12 be appealed, and that whole process.
13 We don't believe that the change is
14 consistent with the current regs. The
15 current regs for acute inpatient hospital
16 reimbursement define diagnosis codes as codes
17 maintained by CMS. CMS, again, uses
18 Sepsis 2, not Sepsis 3. The regulation also
19 assigns a DRG grouping to match with the CMS
20 Medicare groupings, which would not be able
21 to be done using just Sepsis 3.
22 Quality and mortality. There's some --
23 a blurb there. But, essentially, when you
24 change the coding, you will have different
25 DRG assignments for those with Sepsis 3 than

1 are in Sepsis 2. And depending on how you
2 compare outcomes between patient groups
3 across states between payers, you could
4 see -- I know when WellCare denied those back
5 in '18, we saw sepsis being regrouped to UTI.
6 So you have the potential to see mortality in
7 DRGs like UTI and then suggesting that the
8 hospitals are providing poor care to not very
9 sick patients.
10 There's payment impact. Lots of
11 organizations are pushing -- even DMS,
12 through the HRIP quality goals that we're
13 currently under, are pushing for recognition,
14 diagnosis, and early management of sepsis.
15 So one of our HRIP quality goals is
16 sepsis screening in the ED and the use of
17 sepsis bundles early in care. DRG payments
18 are supposed to match the payments for the
19 cost of care. And when you eliminate that
20 code for sepsis and only allow the coding for
21 severe sepsis, it's going to change the DRG
22 assignment and reduce payment. When we ran
23 into this in 2018, the sepsis denial showed
24 an average case impact of more than $4,000
25 per case.

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1 The hospital association also has voiced
2 numerous concerns, and I've attached that
3 letter in my packet to the MAC. The
4 recommendation is the Hospital TAC recommends
5 that the MAC advise DMS to repeal hospital
6 provider letter A263 dated June 13th, 2023,
7 and that letter changed hospital utilization
8 management and coding to Sepsis 3 criteria.
9 CHAIR PARTIN: Okay. Is that --
10 MR. RANALLO: That's the report.
11 Any questions I can answer?
12 CHAIR PARTIN: Any questions?
13 MS. EISNER: I have my hand raised.
14 CHAIR PARTIN: Go ahead, Nina.
15 MS. EISNER: Yeah. And not a
16 question but just to reinforce the very
17 significant importance of the Cabinet
18 responding to this request very quickly. The
19 guidance in that June 13th letter that Russ
20 talked about gave instruction to basically do
21 something that CMS and ICD code -- or ICD-10
22 coding is not consistent with, and so it's
23 very critical that this matter be addressed
24 quickly.
25 CHAIR PARTIN: Thank you.

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1 MS. EISNER: Thank you.
2 CHAIR PARTIN: Next, Intellectual
3 and Developmental Disabilities.
4 (No response.)
5 CHAIR PARTIN: Nursing Home?
6 MR. SKAGGS: This is Terry Skaggs.
7 I am chair of the Nursing Home TAC. We met
8 on June 14th. We heard details regarding our
9 July 1, 2023, rate setting. We heard a
10 report on the Medicaid unwinding and did ask
11 for a specific breakdown specific to
12 long-term care. And we should be able to see
13 that at our next meeting.
14 We discussed the transition of our
15 assessment methodology. The current system
16 sunsets September the 30th, and we're working
17 with Medicaid to assure that the transition
18 of the methodology, which actually sets our
19 rates, is case mix neutral.
20 We discussed scheduling of a rebasing
21 that is due July of '24, both in our price
22 and capital components of our rates. We're
23 working with Medicaid right now to assure
24 that there's adequate funding in the -- in
25 the budget for the next biennium to pay for

1 the rebasing. We're also working with them
2 to determine the timing of the capital
3 appraisals that'll be used in that rebasing.
4 And I actually have a call tomorrow with
5 Medicaid to discuss the methodology for that
6 rebasing. Medicaid rates have not been
7 rebased since 2008, so it's very important to
8 our provider group that this rebasing is done
9 correctly.
10 And unless there are questions, that's
11 the Medicaid TAC.
12 CHAIR PARTIN: Any questions?
13 (No response.)
14 CHAIR PARTIN: Okay. Thank you.
15 MS. BICKERS: Beth, Rick with the
16 IDD TAC just logged in if you wanted to go
17 back for a report.
18 CHAIR PARTIN: Okay. We'll go back
19 to Intellectual and Developmental --
20 MR. CHRISTMAN: Thank you. Thank
21 you for that. I've been dealing with a lot
22 of issues here.
23 Yes. We had a meeting, and there was a
24 quorum. I think probably the one thing of
25 note is we noted that there's another waiver

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1 being worked on, a children's waiver.
2 Basically, it's a feasibility study right now
3 that would serve children who have mental
4 illness, autism, or another developmental
5 disability.
6 And that concludes my report.
7 CHAIR PARTIN: Okay. Thank you.
8 Nursing Services?
9 (No response.)
10 CHAIR PARTIN: Optometry?
11 DR. COMPTON: Steve Compton, a
12 member of the Optometric TAC. We have not
13 met since the last MAC, so we have no
14 recommendations. We do meet next Thursday.
15 That's the end of my report.
16 CHAIR PARTIN: Thank you. Persons
17 Returning to Society From Incarceration?
18 MR. SHANNON: Yeah. This is Steve
19 Shannon, chair of the TAC giving the report.
20 We had a quorum. We received update from
21 Medicaid and our MCO partners, and we have no
22 recommendations. And we meet September 14th.
23 Thank you.
24 CHAIR PARTIN: Thank you.
25 Pharmacy?

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1 DR. HANNA: The Pharmacy TAC did
2 not meet since the last meeting. Their next
3 meeting will be on August 9th. Thank you.
4 CHAIR PARTIN: Thank you.
5 Physician's Services?
6 (No response.)
7 CHAIR PARTIN: Primary Care?
8 MR. MARTIN: Yeah. This is Barry
9 Martin. Thank you, Chair. We met on July
10 11th at 11:00 a.m. via teleconference. And I
11 sat in as chair for Patrick Merritt in his
12 absence. And we met, and we got an update
13 from DMS and the MCOs.
14 And one of the -- we did come out with a
15 recommendation. We've been working with DMS
16 and the MCOs about standardizing some quality
17 care measures. And the MCOs and DMS come
18 back with some. And we just wanted to make a
19 recommendation to the MAC that we have a
20 little more collaboration and input with
21 those standards of care, coming up with those
22 standards of care and having some mutually
23 acceptable standards. That's our
24 recommendation.
25 CHAIR PARTIN: Okay. Were you not

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1 satisfied with the standards?
2 MR. MARTIN: No. We -- we were
3 kind of given the standards. We just want to
4 have a little more input, and we would like
5 to have been involved in the discussion
6 before being given them. We'd like to have
7 some input on responding to them and -- is
8 all we're asking for.
9 CHAIR PARTIN: Okay. Thank you.
10 MS. BICKERS: Barry, this is Erin.
11 Do you mind to follow that recommendation up
12 to me in an email, please?
13 MR. MARTIN: I can.
14 MS. BICKERS: Thank you so much.
15 MR. MARTIN: Thank you.
16 CHAIR PARTIN: Any questions?
17 (No response.)
18 CHAIR PARTIN: Okay. Therapy
19 Services?
20 (No response.)
21 CHAIR PARTIN: Okay. That
22 concludes the reports and recommendations
23 from the TACs. Would somebody like to make a
24 recommendation to accept the reports and the
25 recommendations from the TACs?

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1 MS. EISNER: Beth, it's Nina
2 Eisner. Can I go back to the Hospital TAC,
3 the urgency of my recommendation of
4 supporting that? I would like to make a
5 motion that the MAC accept the TAC
6 recommendations.
7 CHAIR PARTIN: Okay. What we're
8 doing right now is accepting them in total.
9 MS. EISNER: Okay. So we don't
10 need -- we don't need to specifically state
11 why it's so critical to accept the TAC
12 recommendation for hospitals?
13 CHAIR PARTIN: Let's -- I think
14 that we need to note that. But, typically,
15 we just accept the recommendations in total
16 for --
17 MS. EISNER: All right.
18 CHAIR PARTIN: For the TACs.
19 MS. EISNER: Okay.
20 CHAIR PARTIN: Let's put a special
21 notation there about the urgency for a
22 response to the Hospital TAC.
23 MS. EISNER: Yes.
24 CHAIR PARTIN: Okay. Would
25 somebody like to make a second?

1 MR. MARTIN: Yeah. I'll second.
2 CHAIR PARTIN: Thank you, Barry.
3 MR. MARTIN: This is Barry.
4 CHAIR PARTIN: Any discussion?
5 (No response.)
6 CHAIR PARTIN: All in favor, say
7 aye.
8 (Aye.)
9 CHAIR PARTIN: Anybody opposed?
10 (No response.)
11 CHAIR PARTIN: Okay.
12 Recommendations are accepted.
13 Okay. And moving along here. The next
14 item is actually something to include on the
15 September meeting, and this has to do with
16 the MCO's report of 98 to 99 percent adequacy
17 and compliance for services by Kentucky's
18 third-party quality contractor. IPRO, our
19 secret shopper reports, show only a 30 to 40
20 percent compliance. So there's a concern
21 about adequacy of compliance that does not
22 address actual accessibility of services.
23 So the MAC requests a report from DMS at
24 the September meeting addressing the
25 discrepancy between the MCO reports of

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1 compliance versus the IPRO report.
2 And then next up is Item 9. Physician
3 locum tenens may bill under absent physician
4 provider number using a modifier. The locum
5 tenens position is not required to be
6 credentialed with Medicaid to do this.
7 Many nurse practitioners, nurse midwives
8 are establishing practices and require
9 coverage for their practices when they are on
10 vacation or absent due to illness. So we're
11 requesting that Medicaid regulations should
12 be amended to afford APRNs the same
13 opportunity as physician practice owners.
14 And that would be -- that would be a
15 recommendation coming from the MAC, so I
16 would ask if somebody would make a motion to
17 accept that recommendation and a second.
18 DR. SCHUSTER: I'll move that,
19 Beth. This is Sheila Schuster.
20 CHAIR PARTIN: Thanks, Sheila.
21 A second?
22 MR. MARTIN: This is Barry. I'll
23 second it.
24 CHAIR PARTIN: Thank you, Barry.
25 Any discussion?

1 MS. BICKERS: Beth, do you mind to
2 follow that up with me in an email, please?
3 This is Erin. Sorry.
4 CHAIR PARTIN: Yeah. Sure.
5 MS. BICKERS: Thank you.
6 CHAIR PARTIN: You want me just to
7 repeat this in an email?
8 MS. BICKERS: Yes, ma'am. I do my
9 best to capture everything while I'm taking
10 notes. But when it comes to recommendations,
11 I like to make sure I have them in writing,
12 so I know exactly the ask and I don't miss
13 any information.
14 CHAIR PARTIN: So the ask is
15 exactly what's written on the agenda.
16 MS. BICKERS: I'll -- then I'll
17 copy it from the agenda. Thank you.
18 CHAIR PARTIN: Okay. Thank you.
19 Any discussion?
20 (No response.)
21 CHAIR PARTIN: All in favor, say
22 aye.
23 (Aye.)
24 CHAIR PARTIN: Anybody opposed?
25 (No response.)

1 CHAIR PARTIN: Thank you. And next
2 up, Item No. 10, and let me find the
3 explanation. The -- are members who are
4 dually eligible for services, Medicaid and
5 Medicare or Medicaid and a commercial
6 insurance, going to be moved from MCO to FFS,
7 or fee-for-service status?
8 And the background on that is after
9 years of effort and urging by the behavioral
10 health community, we now have a solution that
11 is working to make sure that providers are
12 able to bill and get reimbursed by the MCOs
13 for services rendered to dual-eligible
14 individuals.
15 DMS worked to provide a bypass list for
16 those who had Medicaid and Medicare, but the
17 commercial insurers presented a much bigger
18 problem because they vary in which services
19 they provide coverage for and reimburse. The
20 MCOs worked well together to come up with a
21 separate bypass list for commercial insurers.
22 And while it has only been in effect for
23 about two months, it is working very well.
24 We thought the problem was solved, but
25 now we are hearing that DMS is thinking about

1 moving all of the individuals who are dually
2 eligible from MCO coverage to fee for
3 service. And we would like to know the
4 rationale for this, and it is strongly being
5 considered.
6 So, again, this would be a
7 recommendation coming from the MAC, and so we
8 need a motion and a second.
9 DR. SCHUSTER: Beth, this is
10 Sheila. It's a question first.
11 CHAIR PARTIN: Okay.
12 DR. SCHUSTER: I mean, I want to
13 know if it's being considered and then we
14 need to be able to make a response to it, I
15 guess, is my thinking about it, about putting
16 it on. And I don't know if anybody is on in
17 Medicaid and can respond to it or if it needs
18 to roll over to the September agenda.
19 CHAIR PARTIN: Is Commissioner --
20 COMMISSIONER LEE: Yes. Hi. This
21 is Lisa. Can you hear me?
22 CHAIR PARTIN: Yes.
23 COMMISSIONER LEE: Okay. Great.
24 Thank you. Yeah. We had been looking at
25 moving some eligibility who had third-party

1 liability over to the fee for service, but
2 that has been put on hold. We are not
3 looking at that right now. So no, it's not
4 being considered at this moment.
5 CHAIR PARTIN: Okay. So we don't
6 need to do anything about this right now?
7 COMMISSIONER LEE: No. Not right
8 now, no.
9 CHAIR PARTIN: Okay.
10 DR. SCHUSTER: Let me request,
11 then, Commissioner, that if it's being
12 considered again, that those of us who have
13 worked so hard on this issue, both from the
14 MCO perspective and the provider and the
15 consumer perspective, be included in those
16 discussions?
17 COMMISSIONER LEE: Yes. If that is
18 brought up again, if we are thinking about
19 moving those individuals with third-party
20 liability to fee for service, we will bring
21 that up before the MAC when the
22 discussions -- when and if the discussions
23 begin.
24 DR. SCHUSTER: Thank you. And I
25 would like for the BH TAC to particularly be

1 involved. Thank you.
2 CHAIR PARTIN: Okay. Thank you.
3 Any other business?
4 (No response.)
5 CHAIR PARTIN: Okay. The last
6 thing on our agenda are nominations for the
7 MAC chair, vice-chair, and secretary. My --
8 my term on the MAC has expired, and I will
9 continue to serve until I have a replacement.
10 But in all fairness to the MAC, I felt like I
11 should not run for chair.
12 So the positions -- we're taking
13 nominations for the MAC chair, vice-chair,
14 and secretary today and then we will vote at
15 our September meeting.
16 DR. SCHUSTER: I would like to put
17 my name in nomination to serve as the MAC
18 chair. This is Dr. Sheila Schuster.
19 CHAIR PARTIN: Okay.
20 Anybody else?
21 (No response.)
22 CHAIR PARTIN: Okay. Vice-chair?
23 DR. BOBROWSKI: This is Garth
24 Bobrowski. I'll put my name back in the hat
25 for vice-chair.

1 CHAIR PARTIN: Okay. Thank you.
2 Anybody else?
3 (No response.)
4 CHAIR PARTIN: Okay. And then
5 secretary? I think Mackenzie is not on the
6 call today, but she is our current secretary.
7 MR. MARTIN: I'll recommend her to
8 sustain in that.
9 MS. EISNER: I agree.
10 MR. MARTIN: That'll be her
11 punishment for missing today. This is Barry.
12 CHAIR PARTIN: Thank you, Barry.
13 Erin, would you let Mackenzie know?
14 MS. BICKERS: Yes, ma'am.
15 CHAIR PARTIN: Thank you.
16 MR. MARTIN: Madam Chair, I think
17 we ought to cease nominations now and approve
18 as submitted.
19 CHAIR PARTIN: Okay. Thank you.
20 Okay. So somebody want to make a motion
21 to adjourn? We're about 15 minutes overtime,
22 and I appreciate everybody staying on.
23 MR. MARTIN: Did we have --
24 MS. EISNER: Before our motion to
25 adjourn, I'd like to thank you for your

1 service as chair of the MAC. Really
2 appreciate it and your leadership, so thank
3 you. And now I'll make a motion to adjourn.
4 MR. MARTIN: Chair Partin, do we
5 need to vote on the nominations or --
6 CHAIR PARTIN: We'll just vote at
7 the next meeting.
8 MR. MARTIN: Okay.
9 CHAIR PARTIN: Thank you, Nina. I
10 appreciate that. As we all know, when our
11 terms expire on the MAC, we're just gone, and
12 we don't get a chance to say anything after
13 we leave. So I appreciate that. Thank you
14 very much.
15 MR. MARTIN: I'm sure our paths
16 will cross again, Chair Partin.
17 CHAIR PARTIN: Probably so.
18 DR. SCHUSTER: I think there is
19 unanimous appreciation, Beth, for the many,
20 many years that you've served as chair and
21 really moved the MAC into being, I think, a
22 much better functioning and more important
23 part of the policy determination for
24 Medicaid.
25 We have excellent communication with

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1 DMS, and I intend to build on everything that
2 you've done. You've left me difficult shoes
3 to fill, but we all appreciate everything
4 you've done for the MAC and for the people
5 that the MAC serves and for all the providers
6 of services.
7 CHAIR PARTIN: Thank you,
8 everybody.
9 So we have a motion to adjourn. Second?
10 DR. SCHUSTER: Second.
11 DR. BOBROWSKI: Second.
12 CHAIR PARTIN: Okay. No problems
13 with that one, huh?
14 All in favor?
15 (Aye.)
16 CHAIR PARTIN: Thank you,
17 everybody. See you in September.
18 (Meeting concluded at 12:52 p.m.)
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1 * * * * * * * * * * *

2 C E R T I F I C A T E

3

4 I, SHANA SPENCER, Certified

5 Realtime Reporter and Registered Professional

6 Reporter, do hereby certify that the foregoing

7 typewritten pages are a true and accurate transcript

8 of the proceedings to the best of my ability.

9

10 I further certify that I am not employed

11 by, related to, nor of counsel for any of the parties

12 herein, nor otherwise interested in the outcome of

13 this action.

14

15 Dated this 11th day of August, 2023.

16

17

18 *_/s/ Shana W. Spencer_*

19 Shana Spencer, RPR, CRR

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