CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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Via Videoconference
November 30, 2023
Commencing at 10:00 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

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

P R O C E E D I N G S

CHAIR SCHUSTER: So let's go on and call the meeting to order and welcome. This is my first meeting as chair of the MAC, and I appreciate the confidence expressed by you all in electing me to this position, or handing it to me and allowing me to do it. And so glad to have Garth Bobrowski as the vice chair and Mackenzie Wallace as our secretary.

So, Mackenzie, if you could do the roll call, that would be great. Thank you.

MS. WALLACE: Yes, ma'am. And so sorry I had to not be able to call roll at our last meeting, everyone. And, Sheila, congratulations, Dr. Schuster, on your appointment. Very exciting.

All right. So Beth Partin?

(No response.)

MS. WALLACE: Nina Eisner?

MS. EISNER: I'm here.

MS. WALLACE: Susan Stewart?

(No response.)

MS. WALLACE: Dr. Jerry Roberts?

MR. ROBERTS: I'm here.

MS. WALLACE: Heather Smith?
MS. SMITH: Here.
MS. WALLACE: Dr. Bobrowski?
DR. BOBROWSKI: Here.
MS. WALLACE: Dr. Compton?
DR. COMPTON: Here.
MS. WALLACE: Dr. Muller?
(No response.)
MS. WALLACE: Dr. Gupta?
DR. GUPTA: Here.
MS. WALLACE: John Dadds?
(No response.)
MS. WALLACE: Dr. Hanna?
DR. HANNA: Here.
MS. WALLACE: Barry Martin?
MR. MARTIN: Here.
MS. WALLACE: Kent Gilbert?
MR. GILBERT: Present and accounted for.
MS. WALLACE: Mackenzie. I am here.
Annissa Franklin?
(No response.)
MS. WALLACE: Dr. Schuster, you are here.

CHAIR SCHUSTER: I am here.

MS. WALLACE: Bryan Proctor?

(No response.)

MS. WALLACE: Peggy Roark?

(No response.)

MS. WALLACE: Eric Wright?

DR. WRIGHT: Here.

MS. WALLACE: And Commissioner Lee and/or her designee?

CHAIR SCHUSTER: And I believe that's Leslie Hoffmann. I think both Commissioner Lee and Senior Deputy Commissioner Judy-Cecil are out of town at a meeting. Is Leslie --

MS. HOFFMANN: I'm on.

CHAIR SCHUSTER: I see you on. Thank you very much.

MS. HOFFMANN: Yes, ma'am. I'm sorry. I couldn't get off mute.

CHAIR SCHUSTER: That's --

MS. WALLACE: All right. And it looks like we have quorum and are good to go.

CHAIR SCHUSTER: All right. Thank you very much. And we may have some people joining us late, so Erin will watch for them.

Or, Mackenzie, you might watch for them coming in and marking them as present.

MS. BICKERS: Beth is coming in right now.

CHAIR SCHUSTER: Okay. Great. I feel better with Beth on, the experienced hand here.

So our first order of business is the approval of the minutes of September 28th. You should all have gotten the court reporter's report, and I would entertain a motion for approval of those minutes.

MS. EISNER: This is Nina Eisner. I move approval.

CHAIR SCHUSTER: Thank you, Nina.

MR. GILBERT: And this is Kent Gilbert. I'll second.

CHAIR SCHUSTER: And Kent Gilbert, second. Thank you very much.

Were there any additions, omissions, corrections that anyone wanted to make?

(No response.)

CHAIR SCHUSTER: Seeing none, all who are in favor of approving the minutes, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: Or giving us a thumbs-up would work as well. Thank you very much.

Any opposed?

(No response.)

CHAIR SCHUSTER: Any abstentions?

(No response.)

CHAIR SCHUSTER: Okay. So I think, Leslie, you're on for our old business. Some of these are things that we've had on previous agendas. But if you could start with: What's the status of the Anthem MCO?

MS. HOFFMANN: Okay. And I've asked -- identified folks for the old business bullet, so I should have other staff on.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: But the first one, I think, was for Veronica, and she said as of two days ago, no status change and that she will update us as soon as changes occur.

CHAIR SCHUSTER: I heard a rumor. Of course, rumors are worth nothing in Frankfort. But I heard a rumor that the case

might actually come to trial in January.

MS. HOFFMANN: I have not heard that, but I don't think I would speak to it today without Veronica.

CHAIR SCHUSTER: Sure.

MS. HOFFMANN: I'll let you know as soon as Veronica gets more information, if that's okay.

CHAIR SCHUSTER: Okay. Sure. And I see where Peggy Roark has joined us. Welcome, Peggy. Thank you for letting us know.

How about the report from -- we're going to have a report in January on how the community health workers are trained, how they're used, and what they are paid. I know that the reg was out for comment, and I think that comment period has closed.

Leslie, have there been any changes, that you know of, in response to the comments?

MS. HOFFMANN: And is this regarding the community health workers?

CHAIR SCHUSTER: Yes.

MS. HOFFMANN: So is there somebody

from our team that was designated for this one, please?

MR. SCOTT: Hello, Leslie, and hello, Dr. Schuster. This is Jonathan Scott. I'm the DMS reg coordinator.

CHAIR SCHUSTER: Hi, Jonathan. How are you?

MR. SCOTT: Doing good. How are you? We have --

CHAIR SCHUSTER: I'm fine. Thank you.

MR. SCOTT: We have --

CHAIR SCHUSTER: We've been working on regs for a long time so...

MR. SCOTT: That's right. That's right. We have filed an amended after-comments version of the reg, and I can send that along to you if you'd like. But we did make some changes from the comments that we received.

CHAIR SCHUSTER: Can you briefly summarize those changes, Jonathan?

MR. SCOTT: Sure. Let me pull it up real quick while we're talking.

CHAIR SCHUSTER: Okay. Thank you.

There's been so much interest in the CHWs. We've all been anxious to get this rolling and appreciate the work that Representative Moser did on that bill -- that's two years ago now -- and the work that DMS has done and all of the CHW organizations as well.

MR. SCOTT: All right. I apologize for that. I had a couple of -- I had a couple of computer crashes that have --

CHAIR SCHUSTER: Oh.

MR. SCOTT: -- made my screen look a little differently here. So we are adding optometrists or other clinician types included by the Department as ordering providers. So we're making it a little bit more open-ended as to who could be included as an ordering provider. We're not making any guarantees, of course, but we are adding some flexibility into the reg going forward. So we don't have to go back and amend it.

We are also allowing sponsoring providers to be other providers or facilities that are approved under the regulation. And that's just a reference to the House Bill 124 language that allowed for additional

providers to be included.

CHAIR SCHUSTER: So those could be other community providers; right, Jonathan? Other non-profits?

MR. SCOTT: Eventually, yes. You know, it's still going to have to be an enrolled Medicaid provider.

CHAIR SCHUSTER: Right. Okay. Thank you.

MR. SCOTT: And then we have removed a reference to the community health worker reimbursement table and then we're just -- we are including CHWs on the physician fee schedule that will be updated, but we already have a process in place for that.

And then there was some language about grant-funded services, and we have modified that a little bit just to say if there's already a federal -- you know, it's just for the specific service involved. So you can have a little bit more braiding in place, I believe.

CHAIR SCHUSTER: That would be -- I think there were a lot of us that asked for

that, so that's an important change. We'll be anxious to see what that language looks like. Thank you.

MR. SCOTT: Sure. And I'll send you a copy of our SOC for you to post.

CHAIR SCHUSTER: Thank you. And I can -- we can have Erin send that out to the MAC members, then. Thank you, Jonathan. We really -- sorry to put you on the spot --

MR. SCOTT: Anytime.

CHAIR SCHUSTER: -- so quickly there. But I figure you have all that stuff in your head anyway so...

MR. SCOTT: I wish.

CHAIR SCHUSTER: Thank you.

MR. SCOTT: Thank you.

CHAIR SCHUSTER: You do a great job, so we appreciate that. That's very good news. So we'll look forward to that report in January from DMS, then.

Also in January, we'll have our biannual maternal and child health update with Dr. Theriot. And, of course, we're always particularly interested in the inequities that we see unfortunately around morbidity

and mortality of black and brown moms and babies. But we look forward to that.

We had asked about PDS. I think that was Dr. Eric Wright. And we've asked for updates quarterly, and we should get that also in January. So we've got a packed agenda in January.

Did you have any other questions or input, Eric, on that issue?

MR. WRIGHT: No, not at this time. Thank you for keeping that on the agenda. We can revisit that again in January, if need be. It does appear things are starting to move forward within the agencies so with the rate increase notifications with case managers. So I'm seeing that as I monitor it through social media posts.

CHAIR SCHUSTER: Great. And for those of you on the MAC that are not that familiar with the 1915C home and community-based waivers -- I know that Eric lives in that world both personally and professionally, and a lot of us are doing work in that area because of the long waiting list. We have about 12,000 Kentuckians that

are waiting for waiver services in Michelle P and in the supports for community living, or the SCL waiver.

PDS is patient-directed services, so this is the opportunity for family members to be hired and other people within the network of the family to be hired to provide those very meaningful and necessary and sometimes very intimate services for family members.

So PDS is increasingly -- because of the shortage of workers, quite frankly, in the waiver world, has become increasingly an important issue. So we need to stay on top of that. I just wanted to alert you about what PDS was.

MS. BICKERS: Dr. Schuster?

CHAIR SCHUSTER: Yeah.

MS. BICKERS: Justin Dearinger has his hand raised.

CHAIR SCHUSTER: Oh, I'm sorry. Justin.

MR. DEARINGER: Good morning.

CHAIR SCHUSTER: Good morning.

MR. DEARINGER: Yeah. My computer got me on a little bit late, so I apologize

for that. But I got to hear Jonathan give a little bit of discussion on the CHW administrative regulation, the community health worker. And I just wanted to give the MAC a brief update.

We have recently put in place -- allowed the dentists to be able to bill community health workers through a D code that was made possible through CMS allowing and creating those D codes for them to be able to use. So we've already -- we've been able to implement that, put that into our system, and they're able to use that currently.

All providers have been able to use CPT codes, all other providers. But it did not work out that well for the dental providers because they can't use and bill CPT codes, so they use the D codes. So we were able to work with CMS and get a D code for them, so they're able to do that now. I just wanted to kind of give that brief update.

I think as of last week, we've had around 600 providers that have billed for CHW services. So we're excited about that, and it's going up each month. So just a little

update on CHW workers for you all.

CHAIR SCHUSTER: That's great, Justin, and very positive. And I'm excited, Garth, for the dentists to be able to use CHWs. It may be that this is part of the answer to your missed appointments in terms of people reaching out and addressing those social determinants of health that keep people from getting there, whether it's transportation or lack of child care or whatever. So hopefully the CHWs will be helpful.

So it sounds like, Justin, at this point, all of the providers that are listed in the reg have the appropriate codes and are able to bill for those CHWs.

MR. DEARINGER: That's correct. At this point, all provider types that are allowed to use community health workers are able to bill for those.

And we have started discussions with the Department For Public Health that certifies community health workers and with other institutions that train community health workers to make sure that no-shows and missed

appointments are an emphasis for training and teaching community health workers to be able to dig into why an individual didn't keep an appointment, the importance of keeping those appointments, assisting individuals with appointment management, making sure that they get reminders, that their emails and phone numbers are correct, that if they are going to miss an appointment for some reason, that they call and cancel within the time frame that the provider has selected.

All those different things as well as connecting individuals with transportation services, with child care resources, all those different things, too.

So we're really hoping that this puts a dent in the no-show missed appointment that we have.

CHAIR SCHUSTER: Thank you. And while I have you, let me deviate from the agenda for just a second to go back to something we've talked about at the MAC, and you're the guru of that. Tell us about the dashboard on missed appointments. I think you said that a letter had gone out to all

providers, but I'd love for you to emphasize to providers how important it is to use that dashboard.

MR. DEARINGER: Absolutely. I don't know if the letter has actually made it into their hands or not. It's been sent out, so I don't know at what date that was sent out.

CHAIR SCHUSTER: Okay.

MR. DEARINGER: But if they haven't received one, they'll receive one soon that just talks about the dashboard and where it's located and how to access it. It's extremely important for us. You know, it may not be a huge benefit to providers currently, but it's extremely important to us because we look at that dashboard and the responses that are given by providers on that dashboard as what to really invest our time and energy into the reasoning behind why individuals are missing those appointments so that we can try to reduce the number of individuals that miss appointments or that no-show their appointments.

It's something that, you know, tries to

drill down to the exact reason given by the individual. And we understand that, right now, a lot of clinicians don't -- their offices don't have time to really call individuals and expand on that. But we are -- hopefully, with the community health workers and being able to utilize them, that we can better get an idea of what the reasons are they're not making these appointments and at least cut those numbers.

CHAIR SCHUSTER: Yeah. Well, I know that you've worked mightily to get that done, so we'll urge the providers and the provider groups to be on the lookout for that letter. And please encourage your providers to take the few minutes to record that information.

Dr. Theriot, I think, has her hand up.

DR. THERIOT: Hello.

CHAIR SCHUSTER: Hello.

DR. THERIOT: I just wanted to remind everyone that when you're looking at the appointments, like in your own facilities, just keep in mind that the no-show rate -- look at it by appointment.

You know, so the 8:00 appointment might have a very high no-show rate because Mom is busy getting other kids to school -- you know, it just couldn't happen -- versus that 11:00 appointment which might have a very low no-show rate.

And so I -- when we're looking at this, I know, you know, there's -- no-show rates are high. But a lot of it might have to do with the available appointments, if the NEMT showed up on time or not, if they were able to transport other family members that suddenly were there and you can't leave alone or not.

People's work schedules change and -- you know, like, when I make my dentist appointment, you know, you make it for six months later, and I show up to that appointment. And I'm pretty sure I'm going to do that.

But, you know, when you have flexible schedules and you're an hourly worker, it's very difficult to keep an appointment that is two weeks out or even farther. And so sometimes having appointments available that

are one or two or three days out, you're going to have a lot higher show rate for those appointments versus, you know, the two-week appointments.

So it -- you know, it's not just if people showed up and what's the overall rate. There's a lot of nuances that go into it.

CHAIR SCHUSTER: Yeah. Thank you. Thank you very much, Dr. Theriot. That's a good thing to be looking at, to really do an analysis of your no-shows kind of across time frames and even days of the week.

Most of us are slow moving on Monday mornings. And if you've got a bunch of kids to get ready to go to school and you are relying on NEMT, which may or may not show up, which is another issue that we probably ought to talk about at the MAC level at some point.

But thank you all, and I'm sorry for the digression. But I thought it was appropriate since Justin was on, and we've talked so much about no-show rates.

So updates from the Department. Leslie, I think that's you again.

MS. HOFFMANN: Yeah. So we've got lots of things going on, and I can't tell you how busy of a time it has been for Team Medicaid and all of our divisions -- it's not just one area -- and our commissioner office as well.

So I'm going to give you -- I think we're going to have a tiered approach here. If Helen Dawson is on, our representative, I kind of wanted to have them go over the unwinding update and then I'll take over. And then I think Pam has got some updates for you, too, Dr. Schuster.

CHAIR SCHUSTER: Great. Thank you.

MS. HOFFMANN: And congratulations, by the way. I didn't say that earlier.

CHAIR SCHUSTER: Thank you. And welcome, Helen.

MS. DAWSON: Yes. Good morning. Thank you for having me.

I've got a presentation, so I'm going to go ahead and share my screen and run through it just for -- there's a lot of updates, of course. I think you guys can assume.

CHAIR SCHUSTER: Right.

MS. DAWSON: So just put it all in slides for you all. Just to confirm, you guys can see the slides; right?

CHAIR SCHUSTER: Yes, we can. Thank you.

MS. DAWSON: Okay. Great. So I'll run through and hopefully get through it quickly and painlessly. But thank you for allowing me the time to kind of present these updates.

As Leslie noted, my name is Helen Dawson. I am with Altarum Institute, and we've been working for a while now with Team Kentucky to prepare for and then operationalize the unwinding.

So these are just kind of updates as of this month. These change daily so keep that in mind. But we wanted to share sort of a lot about the strategies we're doing and what we're seeing on the ground and for members, what they're experiencing.

So to start, I wanted to highlight a few of some of the things that we're doing. These are flexibilities and strategies that we're leveraging with approval from CMS to

try to help get through the unwinding period. This includes helping the workforce with the huge workload of cases that is ongoing through this 12-month period and streamlining the renewal process for members to avoid unnecessary terminations and trying to avoid any gaps in coverage.

So since the start of the PHE and the resumption of renewals, we've leveraged a lot of flexibilities. That whole list is available on the flexibility tracker online on the PHE website. But we wanted to highlight a few that are newer, and so they're on this slide here.

First thing I'll mention is that we have implemented a suspension of child renewals. So starting in October and through April, if there is a child that is under -- meaning someone under the age of 19 who has a renewal, that we will be automatically extending them for 12 months to grant continuous coverage.

The only reason a child may terminate would be whether -- if they turned 19, they moved out of state, they had a parent or

guardian request that they be disenrolled from the program or, of course, if they pass away. So those would be the only four reasons why a child might lose coverage during this continuous coverage period with this flexibility. If there's a change in circumstance like income or a change to their categorical eligibility, we wouldn't process that, and they'd continue to be enrolled for the entire 12-month period.

You'll also see on the slide that we're going to be redistributing December renewals. So members who had a December 31st renewal date are going to be redistributed across the remainder of the unwinding period, primarily February, March, and April with some in January. But this is designed to help with the workload and allowing our Medicaid workforce to work through a lot of the pending case actions.

There are some exceptions. If Medicaid renewals align with another program like SNAP or TANF, they are going to be processed in December, so there might be approvals or terminations. And then we will be processing

cases for which they can be passively approved. So if they would be approved through ex parte, we have the information in the system and are able to confirm eligibility.

And then we'll be processing cases that if they go through this path of renewal process and we're able to verify that their income level qualifies them to be eligible for a Qualified Health Plan with APTC, we'll go ahead and transition that person to the exchange to choose a Qualified Health Plan so that those activities can still occur.

We also wanted to mention that we are working -- we have expanded the extensions that we're allowing for populations to all populations. Previously, we had just had these for long-term care and waiver members. So they had previously had a two-month extension. This means that if they did not respond by the renewal date, they received another two months to do so.

But we have moved forward to extend all nonlong-term care and non-waiver members -- so everyone -- an additional one-month

time -- or time window to respond. If we get to the end of their renewal due date and they haven't responded, we will grant them that one-month extension. And then we've also increased the extension for long-term care and waiver populations to three months to give additional time for outreach and try to get members to respond.

So, again, more information is available online, and I encourage you to check that out. I'll put links to a lot of these things in the chat following my presentation, but I'll just keep moving through right now.

We wanted to also note for Appendix K waiver flexibilities, these were scheduled to expire about two weeks ago, two and a half weeks ago, six months after the end of the PHE. But we heard in August that CMS was going to be allowing states to extend the flexibilities if they took action by November 11th.

So we took action to incorporate all of the Appendix K policies into -- to incorporate certain Appendix K policies into the waivers by submitting those amendments.

Those are now under review. So as they're being reviewed, CMS is allowing us to continue to keep those flexibilities in place. So all Appendix K flexibilities remain in place until that updated waiver is reviewed and approved and we have an effective date.

Those on the screen now, I'm just showing sort of the list of the Appendix K flexibilities that we plan to make permanent. I'm not going to read these out to you. You can see them on the screen.

But another link I will put into the chat will be the -- we've developed sort of a one-pager on this update that we've put out onto the website. And it really provides a great sort of walk-through of what is going on, why, and what you can expect. So we'll share that and encourage you all to look at that following this call.

So we always want to share numbers. At this point, we're seven months into renewals. This last month that has -- is active is November. Those close today, so we'll be reporting on those numbers in the week to

come.

But the numbers on the slide reflect the CMS monthly reports which we submit. We submit those on the 8th of each month for the previous reporting period. So for November 8th when we filed the -- when we submitted the report to CMS, it reflected all activities that happened for those that had an October renewal. So all activities from October 1st to October 31st.

So all of these reports are available on our website but wanted to kind of just highlight here the reports break down terminations, approvals. And of those approvals, what were handled ex parte or through that passive renewal process I mentioned and then others that have been determined ineligible and those that are pending in extended.

In looking at October, our most recent month that we've reported on, we had a little over 155,000 individuals go through renewal. We approved almost 90,000, which is an automatically approved or -- and through active processing 89,854. That's a

significant percent. And we only -- we terminated a very low percent, just around 12,000.

There's about 3,000 cases pending, which means there's still ongoing processing for that case. Basically, somebody responded to the notice, and the State hasn't taken action on it. That renewal date comes, and we extend that coverage as pending until their review can be completed.

And then we are extending cases, as we kind of alleged to earlier, for members. And so this number is increasing month over month as we've utilizing -- you know, as we've been utilizing more of those flexibilities I mentioned and extending -- and providing extensions to more and more of the population.

So, then, we also are leveraging a reinstatement period flexibility. So this means that -- so if someone is procedurally terminated, which means they are terminated because they did not respond, they have 90 days to -- past their termination to respond to those notices and provide information for

us to be able to make that determination of eligibility. If they are approved, they can be reinstated back to their date of termination automatically.

So we want to make sure that our eligibility workers and providers sort of understand this opportunity. So if somebody walks into the doctor's office and has just been terminated within the last 90 days from their Medicaid coverage, you all can encourage individuals to try and go and respond to their notice so that it can be reinstated, if eligible.

The numbers on the screen continually increase, you know, daily because we're having people respond and then come back. So these change, but this is just a snapshot as of the date you can see on the slide there for each month.

So we also have been developing demographic reports starting with September. The full reports are available on the Kentucky PHE website, but they -- but you can see here they break down approvals and terminations by county, race, gender,

ethnicity, and age group. So it's a snapshot in a moment in time, so these numbers change as people are reinstated and pending cases are processed.

And also, you'll note on here there are child terminations here but just note that due to a system issue discovered with this report and the October report when it was run, we have been manually reinstating children. But to be reflective of this moment in time, this is what it is. But we are reviewing each case for a child to confirm that it was only terminated on one of those reasons.

October numbers are also up on the website. This is really helping us to see what's happening on the ground and focus attention to specific populations or regions. And, again, we have child terminations, but we're reviewing each case manually to make sure that only true terminations are happening based on the reasons that I mentioned earlier.

So both of these reports are on the website, encourage you to check them out.

And I can put the link -- again, I'll be putting it in the chat after I finish.

Another thing that we're looking into is the -- we really understand that, you know, it's about more than Medicaid across the state. You know, what is coverage across -- for all Kentuckians. And so we've been able to work within our system and our MCO partners to understand which members have third-party liability coverage at the time of their termination. So those are on the screen here.

We've seen that this information -- sort of this snapshot of understanding is really helpful. So we're looking into additional options across the state in various systems to see more visibility into employee-sponsored insurance as long as continuing to look at these TPL numbers that we can access.

We wanted to also flag that we're seeing a trend go up in Qualified Health Plan enrollment. So as individuals are determined ineligible for Medicaid based on income but they have an income that makes them eligible

for a Qualified Health Plan enrollment, with APTC, we want to make -- we want to see them move over and to choose a plan and get that coverage started as soon as possible so -- to avoid any gap in coverage.

We're seeing this tick up, as you can tell with the graph on the slide. And so we're really happy to see that, especially now that we are in the open enrollment period for QHP.

These are the unique numbers that -- as of November 22nd for enrollment. Again, we're seeing a large number of Medicaid members that are renewing or just members that are renewing, and we've even seen more growth since this point since this also increases day over day.

So these are just really promising numbers and appreciate sort of all the help that's going into helping members transition, communicate this information, and ensure that we have as many Kentuckians covered as possible.

The next slide, I just wanted to note that it is open enrollment, like I mentioned.

Medicaid allows continuous open enrollment, meaning that you can apply at any time. But for QHP, there is this window for enrollment. It's now open through January 16th. But after that QHP enrollment, you would need a qualifying health event for a special enrollment but -- so just keep these windows in mind. And then there's an unwinding special enrollment window that extends through July 2024.

The contact center has -- you know, working around the clock to support open enrollment for members, and so their hours are here on the screen. But really just wanting to frame these windows and time periods for all audiences to make sure everybody is aware.

Part of our main goal is to continue conducting high touch outreach. We have ongoing outreach to try to continue to increase the number of individuals who respond to notices. We have a lot of the communication materials available on the website.

This one might look familiar to you, but

we love to promote it. We have a lot of flyers and other materials for various stakeholders on the website, but this example is one that could be, you know, shared in an office or in your building to understand -- to just highlight or to flag the renewals that are happening for members as they're coming in. We also have information about how to reinstate and working continually on updating those materials.

So if there's ever something else that's needed, if you think there's a tweak that we could make or, you know, additional information that could be helpful to members or to providers, just let us know. We're open to feedback, and we really want to know what would be most useful on the ground.

To wrap up, I just want to say, you know, we do have all things unwinding on the PHE website, so that's one of the best ways to stay up-to-date and informed. The link's on the screen. I'll put it in the chat. It has all of the reports that we submit, including those demographic reports. It's got updated information on the unwinding and

all the flyers, communication materials, and connection to our social media links.

So encourage you to follow those social media links for the Cabinet. That's where you're going to have very up-to-date information, but you could probably just pick one. Don't need to do all three.

And then we host monthly stakeholder meetings, and we have all -- we have multiple reports available for providers and eligibility workers. And there's information about accessing those on the website as well.

So with that, I can stop presenting and take any questions, if there's time, or turn it back over to you, Leslie, whatever -- whatever works.

MS. BICKERS: Helen, we have a couple hand raised.

MS. DAWSON: Okay.

MS. BICKERS: We had Eric first and then someone on an iPhone -- I think it -- oh, it's Nina, now that she's turned her camera on. So Eric was first and then Nina.

MS. DAWSON: Okay. Great.

DR. WRIGHT: Hi. First, I want to

just commend you for the work that you guys are doing to try to continue to help Kentuckians maintain their coverage through these transitions.

My question related to waiver services. When -- the process of waivers, when a child is on a waiver or -- you know, and they're going through the renewal process with their agency such as KIPDA or Seven Counties, in that regard, explain to me. Is there something else that would need to be done beyond what is done at those annual renewals to ensure that they're maintaining their coverage for Medicaid?

That's one of my questions. And then the other question remains something -- I think Emily and her team with that TAC, the -- it's the Consumer Rights and Clients' Needs, related to this transitional period for guardianship that seems to be kind of an ongoing issue. I see that you've given a three-month situation, and if they're moving into an adult age, they're going through guardianship process.

Is it still -- you know, I think they've

described it as an en carta provision that could be placed into ensuring that those individuals do not lose coverage. And that's all.

MS. DAWSON: Yeah. Thank you, Dr. Wright. Appreciate those questions. I think for those -- my understanding is that there is not necessarily anything different, for the first question you had, that there wouldn't be additional work with that renewal because it would be in the system. But I can take that back and confirm.

And then specifically on the guardianship, I would have to loop in our DAIL team members, I believe, to just confirm the answer there. So can take those back and try to get, you know, the right answers for you.

DR. WRIGHT: There used to be --

MS. SMITH: I want to add on to that. Sorry.

MS. DAWSON: Yes. Wonderful. Pam is on.

MS. SMITH: I wanted to add on to that, that -- to remember that there's the

two separate renewals. So there's the eligibility renewal that they have to go through but then there's also their annual waiver level of care reviews that they have to do, that those are two separate reviews.

DR. WRIGHT: One of them is -- we used to call it MRT, medical review team. Is that correct?

MS. SMITH: So that may be part of the eligibility process. So when individuals reach a certain age, they have to go through that. They have to have that MRT or a disability determination as part of their financial eligibility determination.

DR. WRIGHT: Okay. All right. Thank you.

MS. SMITH: You're welcome.

MS. DAWSON: Thank you, Pam. Appreciate that.

CHAIR SCHUSTER: Thank you. And, Nina, you had a question.

MS. EISNER: I did. Thanks for the update, Helen. My question has to do with the slide that you had that had permanent flexibilities, and I believe the language

under telehealth was that it included counseling and case management. My question is: Does that permanent flexibility for telehealth also apply to partial hospital and intensive outpatient services?

MS. DAWSON: Thank you. That question is specific to that Appendix K flexibility. So for the details on that, they might be in that one-pager.

But, Pam, would you have the answer?

MS. SMITH: Yes. That slide is specific to the 1915C waiver services.

CHAIR SCHUSTER: So it would only cover, Nina, the people that are in Michelle P waiver, supports for community living, the home and community-based waiver, or the acquired brain injury acute long-term or the ventilator dependent. So not for the general Medicaid population.

Would that be correct, Pam?

MS. SMITH: Yeah. There has been -- and I don't know if Jonathan is still on, if he can speak to the expansion and what was done in the telehealth reg on just the fee-for-service side. But for that

particular -- addressing that particular slide, it was -- you're correct, Dr. Schuster. It was specific to those waivers.

And I'm impressed. You got all of them so...

CHAIR SCHUSTER: I've been living in that world for a while.

Nina, does that answer your question?

MS. EISNER: It answers the question with regards to the slide, but I'm still curious to find out and confirm whether or not there are any restrictions on telehealth for partial hospital and intensive outpatient services related to the Public Health Emergency end.

Because there have been some communications from the Cabinet, and we, in the provider community, remain a little bit confused about that.

CHAIR SCHUSTER: Let's -- if we can't answer that right now, let's put that on the January agenda, Nina, to have a report. This is something Jonathan --

MS. EISNER: Thank you very much.

CHAIR SCHUSTER: On what the current -- oh, there's Jonathan. Can you answer that quickly, Jonathan, or do you need a little more time?

MS. DAWSON: I also will add that I just put the link to the full flexibility tracker on there that has some information about the regulations that were put in place. They -- I believe it was the 907 KAR 3:170 which -- that means nothing, I'm sure. But that regulation had a lot to do with telehealth and approaches that Kentucky implemented.

So encourage you to look at that and then I think putting it on the agenda for the next meeting would be wonderful. But I just wanted to flag that.

And, Jonathan, if you want to add anything, please feel free.

MR. SCOTT: Sure. When we were drafting 907 KAR 3:170, we put a restriction about state and federal law changes. And so there have been some communications from the Federal Government about partial hospitalization and intensive outpatient

services. So I do want to defer to our behavioral health team on that and let them -- you know, they have been really watching some of the developments in this area.

So, you know, at this point, it's looking like that you're going to have to be able to articulate an exception to some of the recent federal guidelines that have come out. We do feel that the telehealth regulation is flexible enough but, you know, there are licensure board restrictions and some federal restrictions that are coming into play with partial hospitalization.

And so that's some of the issue that's going on right there, right now. We -- you know, we, as always, are wanting to continue the spirit of expanding telehealth as proudly as possible. Just there are some other players in the game on this one right now.

MS. HOFFMANN: Dr. Schuster, this is Leslie. So it is on the radar with behavioral health. I actually just had a conversation this morning, so it is on the radar, though. But if you want to put that

on January agenda, on the January's agenda, I think that would be fine.

CHAIR SCHUSTER: Yeah. We will do that, Nina. And if you have a very specific question or can share a communication you've gotten that you want to bring up for that meeting, let me know. But we will put it on the January agenda. Thank you.

We had a question in the chat about making the slides available that Helen provided, and I assume that those would be, Erin, I guess, posted on the website and then we send them --

MS. BICKERS: Yes, ma'am. As always, I will email them out to the MAC, and they will be posted on the website as well --

CHAIR SCHUSTER: Okay.

MS. BICKERS: -- which is being revamped. So please bear with me while I fix it. I know it's not very user-friendly right now, so I do apologize. I am working on it.

CHAIR SCHUSTER: Well, thank you. Also a question about FFS, which is fee-for-service, and those are people that are in waiver services meaning that they

are -- the providers are paid directly from Medicaid and not through an MCO.

So when you saw that chart, you saw all the MCOs listed and then it had a category for FFS. That means that those are lives, members who are covered directly by Medicaid and not through the MCOs.

So there's a lot of jargon and alphabet soup for sure. Any other questions -- and we appreciate your detailed presentation, Helen. Any other questions for Helen while we have her here?

(No response.)

CHAIR SCHUSTER: Okay. Thank you very much.

MS. DAWSON: Thank you.

CHAIR SCHUSTER: And what do you have next, Leslie?

MS. HOFFMANN: I'm going to give you just a couple of updates and then I'm going to turn it over to Pam just for a little while. So our mobile crisis, which, I think, was listed in the old business, is -- still continues through the procurement process. We're very close. Sorry for the

delay. It's just that time of the year, so it's just taken a little bit longer.

As far as our Team Kentucky 1115 authority, if you remember, we're renaming our old Kentucky Health, that most of it was rescinded. There was a couple things that were kept including the SUD 1115 under that.

So CMS extended our Team Kentucky. Now -- the name has officially been changed with the extension of 9/2024. They asked to extend it so they could review the SMI waiver that we submitted in May and that we have a reentry waiver, yay, being completed and submitted at the end of this year. So very exciting.

A little bit more on the reentry waiver. It's currently out right now for public comment. Although I can't answer a lot of questions, we do want you to follow the public comment process. And I'll have Erin to send you that one-pager out, Sheila, right after this that tells you where the next forums are, which we have one tomorrow that's virtual and if you want to participate and how to send your public comments in. And I

think public comment runs through December the 9th, if I remember correctly. So that's all very exciting.

We're hoping to have that completed by the end of this year and ready to submit as soon as we come back from the holidays January the 2nd, I believe, somewhere around there. Our SMI waiver, remember, is a companion to our SMI -- let me back up, so I can say that correctly. Our SMI 1115, that's a companion to the SMI 1915(i) State Plan Amendment.

So I was going to turn it over to Pam just to mention our progress as to where we are with the 1915(i) and the waiver redesign and anything else that you might have related to PDS, Pam, or anything else that you might want to share.

CHAIR SCHUSTER: Leslie, let me ask you --

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: -- before we shift over. I know you had a public forum on the reentry waiver. Is that recorded anywhere? Is that posted anyplace?

MS. HOFFMANN: Yes. It should be posted. I can find that for you.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: Now, remember what --

CHAIR SCHUSTER: So that would be a waiver --

MS. HOFFMANN: Yeah. Remember what Erin said. They might be having a little bit of trouble on the web, but I'll double-check that.

CHAIR SCHUSTER: Okay.

MS. BICKERS: Leslie, is that posted --

MS. HOFFMANN: Yes.

MS. BICKERS: Is that a recorded meeting on YouTube?

MS. HOFFMANN: I need to look because I've not looked at the recording on this one. Is that okay?

MS. BICKERS: No. That's perfectly fine.

MS. HOFFMANN: I need to double-check.

MS. HOLLEN: I was just going to

send the link in their meeting invite.

MS. HOFFMANN: It might just be -- I'll try to find --

MS. HOLLEN: Leslie, it's Ann Hollen. We also have another one that's going to be Friday, December 1st. It's, like, 2:00 in the morning, I think, 2:00, 2:30 virtual. I don't know that the first one is posted yet, but I would say it's going to be posted after our --

MS. HOFFMANN: After the second one.

MS. HOLLEN: Yeah.

CHAIR SCHUSTER: And there's a question in the chat, Leslie, about why jails were removed from the reentry waiver?

MS. HOFFMANN: It was -- to get us started, that we had to come up with a baseline that we thought CMS was going to approve. We can add additional services later. But we also have to show that we can build capacity and that we are ready to go once the implementation plan is ready.

Does that make sense? So we need some time to get ready to add things. So we used

the most recent guidance for reentry demonstrations. And if you remember, we also included the DJJ population in this one. So we've got -- it's a little bit different than the old one. It is now a subsection or a subcomponent -- I hate to say that because it's confusing -- under our Team Kentucky 1115 rather than SUD because it's going to serve more than just that population.

CHAIR SCHUSTER: So you're starting, if I recall, with the state prisons.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: And there are 14, I think, state prisons or something like that.

MS. HOFFMANN: Let me see. I was going to try to look that up.

CHAIR SCHUSTER: I think that's the number.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: So you're starting there, but your plan is to extend out to the jails because we know that a lot of people end up in their local jails.

MS. HOFFMANN: Yeah. If all the stars align, Sheila, we've got lots of plans for that waiver. We've got to get something approved, though, to get started. But yes, we are hoping to add on additional services. I don't want to speak to anything right now because we have to go through budget neutrality for additional services and all those things that we normally do, implementation plans, monitoring protocols, and things like that. So we've got to get something started.

Just a reminder to everybody that the Federal Government may also add another 30-day federal public comment like they did before. So that's a second opportunity that you can federally, on the federal world, make public comments again.

And then after that, even once -- that CMS says, you know, this is in a state that we can get started, we really can't. We have to do an implementation plan, monitoring protocols, and all the metrics that they'll require us to do. They usually give us about 90 days to complete that implementation plan.

I have noticed, just because this is different, other states have requested a little bit longer than 90 days to complete those but just wanted to throw that out there. It's not -- even after CMS says this is approved, it's not really ready to go, if that makes sense. It'll still take us a while.

And also remember that this will be part of that extension review that goes through 9/20 of '24, I believe.

CHAIR SCHUSTER: Okay. I think we've confused everyone with all of these waivers.

MS. HOFFMANN: I'm sorry.

CHAIR SCHUSTER: No, no. It's not your -- there's just so many balls in the air.

MS. HOFFMANN: I'm going to send to -- there is. And it's hard to understand all these pieces. I come from 1915C world, and I had a learning curve when I came to the 1115 because the 1115 waivers are a little bit different. It's kind of a play on words in population.

I'm going to send out just a little grid that kind of shows you our tentative plan. As you know, CMS can change it at any time, but I know it's very hard. So I'll send that to you, Sheila, so you can see what our plan is right now; okay?

CHAIR SCHUSTER: Great. And I'll share that out. Thank you, Leslie.

And, Pam, you want to give us an update, please?

MS. SMITH: So next week, we begin the 1915(i) SMI/SUD information sessions. So we start -- next week, we'll be in Morehead and Richmond. And this schedule is being posted on the website, and I'll put a link in the chat. The Richmond session will also have a virtual option.

And then the following week, we go on Monday to northern Kentucky and then we'll be in Louisville on Wednesday and Owensboro on Thursday. And the Louisville session will also have a virtual option.

So I'll -- Kelli is getting that posted. It's been shared on social media and through all of our distribution lists and through

everyone we can think of to get it out to individuals to encourage attendance to that.

We're going to go through and talk about the services and talk about the waiver ahead of the actual state -- State Plan Amendment. See, I go back to calling it a waiver, too. It's so hard because you're so used to waiver, but this is a State Plan Amendment.

But ahead of us putting that document out for public comment just to help people understand -- because those documents are so hard to read and get through. So -- but the comments that we take and any questions that we take during these sessions will be incorporated in finalizing that document as well as we will -- we will compile an FAQ document at the end that'll cover all of the questions that were asked at each session.

Very excited about making a progress on this. We have been working on it for a very long time.

The public comment has been posted for the 1915C waivers that were just submitted to CMS. We submitted all of them on the 9th of November, so they are in process of reviewing

them. I've actually received a couple questions from them, so I know that they are reviewing them actively right now. But our response to public comment has been posted, so I'll put a link in the chat to that as well.

That is the -- well, one other big thing with PDS is -- I'm glad to hear, Dr. Wright, that it seems like that the rates -- that that's resolving and that that's getting better. But we also have expanded the function of what's called either support broker or PDS coordinator, depending on the waiver that you're in -- you know, we've talked about this, how we like to have 15 different names for the same thing, and we're changing that.

But we've expanded that out to traditional providers to allow -- to hopefully open that up to allow more individuals that are wanting to participant direct their services, to allow them to have the opportunity to do that.

CHAIR SCHUSTER: Any questions? Yes. Dr. Bobrowski.

DR. BOBROWSKI: Let me get unmuted. I'm sorry.

CHAIR SCHUSTER: That's all right.

DR. BOBROWSKI: Would it be helpful -- and I guess I could -- and I do get on the website, you know, periodically. But would it be helpful to do kind of like a one-pager that would just show what the waiver program is, the number and, you know, maybe one or two sentences of what they do with that waiver? This would be information that we could pass on to our representative organizations. I just wondered if something like that would be helpful. A lot of folks, myself included, don't know what all these are for.

MS. SMITH: Right.

DR. BOBROWSKI: Because a lot of them don't involve me, so I haven't researched it.

MS. SMITH: Right. And we use a lot of acronyms, and so -- yeah. I think we actually have something similar to that, but we can absolutely share that. Absolutely. I think that is a very -- a very helpful idea.

We absolutely can do that.

MS. HOFFMANN: Dr. Bobrowski, we can include -- we want to make sure that we keep this separate because the -- I have to say this all the time. When we talk about a waiver on the 1915C side and a waiver on the 1115, it means something different. So we want to make sure that we can try to explain that. So we'll keep those documents very separated.

And then Pam also has a 1915(i) that is the first one that we've done here in Kentucky, so that's a little bit different, too. It's actually considered a State Plan Amendment. So I know that means -- it's very hard to understand because it's a bear to wrap your head around all these pieces. So we'll try to get that done. But I think Pam already has a one-pager that she keeps and --

CHAIR SCHUSTER: I was going to say, I think I've seen something, Pam, that you've already got. So it would be easy to build on that. And then I think, Leslie, adding a separate back page or something that talks about the 1115 side would make some

sense.

MS. HOFFMAN: Yeah.

CHAIR SCHUSTER: It's a great idea, Garth. Thank you for bringing that up.

DR. BOBROWSKI: Well, and that would be also helpful sometimes as, you know, the MAC gets new members. You know, it's just an informational kind of training, part of the folders, whatever you want to give out to folks just to help them get up to speed. But thank you very much.

CHAIR SCHUSTER: Yeah. Yeah. Thank you. And, Eric -- yeah. I see in the chat several people are saying that would really be helpful. Eric, you had a question?

DR. WRIGHT: Yeah. Pam, thank you for the updates here, and your team is truly amazing. Quick question I have is: With the case manager support brokers, you're indicating they'll allow more individuals to have PDS services. Are you suggesting more of the independent side of case management, or are you -- because I know that has been a difficulty with the -- particularly with KIPDA, is maintaining staffing to meet the

demand.

MS. SMITH: It is. So it is --

DR. WRIGHT: Talk to me -- what would that look like with the proposal?

MS. SMITH: It's similar to how SCL operates today.

DR. WRIGHT: Okay.

MS. SMITH: I mean, and it's truly -- so you would have the independent case manager and then you have the FMA that processes actually the payroll and does the -- you know, that the billing is going to go through. But we --

DR. WRIGHT: So you would -- you would separate those out like SCL?

MS. SMITH: Yes.

DR. WRIGHT: So it would just go to independent case management?

MS. SMITH: Yes.

DR. WRIGHT: Gotcha. Okay. That makes all the sense in the world. I think that's a great -- and that was included in the waiver renewal application?

MS. SMITH: It was, yes. It was.

DR. WRIGHT: Very good.

MS. SMITH: So in our existing ADS and CMHCs that are doing PDS, they still -- it remains the same. They still can continue to be a provider. But we've onboarded -- you know, our enrollment has increased so much that the demand has just outweighed the ability for the workforce to keep up with it.

DR. WRIGHT: Yeah.

MS. SMITH: So this will allow for more individuals to be able to select that option.

DR. WRIGHT: Is that, like, a contractual type of agreement? How are those -- I don't know much about the SCL independent case managers. Are they paid through the fiduciary agencies, or how are they --

MS. SMITH: No. They are Medicaid providers.

DR. WRIGHT: They are approved Medicaid providers.

MS. SMITH: Yes, they are. They are approved Medicaid providers.

DR. WRIGHT: Okay. All right. Thank you.

MS. SMITH: You're welcome.

CHAIR SCHUSTER: All right. Thank you very much, Pam, for your input.

MS. SMITH: You're welcome.

CHAIR SCHUSTER: Anything else, Leslie?

MS. HOFFMANN: I don't think so. A lot of moving parts, and we'll just keep coming and sharing each time we have a meeting.

CHAIR SCHUSTER: All right. Well, thank you very much.

We're going to get to the TAC reports. I moved them up in the agenda because I think the TACs get short shrift sometimes.

But before I do that, Erin would like to make a couple of comments about the website and other things. So Erin?

MS. BICKERS: Yes, ma'am. Thank you so much. Just a couple of quick minutes. I know we have a quick agenda.

Like I said a minute ago, we are updating our websites. They have moved some of the Zoom links all the way to the bottom of the page. I am working on them.

There's -- you know, between the MAC and all the TACs, there's 18 website pages. So I am working my way through those.

So if you do happen to be on there and you click on a presentation or a link, it's not working, please feel free to reach out to me. We are working on that the best we can. So I do apologize for any inconvenience that may have caused. I've had a couple of TACs since it's happened, and finding that Zoom link -- you know, we're used to it being right there at the top right. So I am working on that.

Also, too, since I have all the TACs in the same place mostly together, I just wanted to send a friendly reminder moving into 2024. If we could get your agendas, you know, the 10 days prior to the meeting is preferable. We completely understand that things happen. You guys are busy. You are working to provide for our members, and we appreciate you. The more in advance we can have our agendas, the better prepared DMS staff and our MCO partners can be.

The second I get your all's agendas, I

turn around, and I send them out to DMS staff, the MCOs, and get them out on the website. So that helps us better prepare and have the answers that you guys want on your agenda and can hopefully start moving some of the items off the agendas if we can be better prepared.

So -- and we do very much appreciate all of your all's partnership and hard work and the information you bring to the table while you're out in the community.

So thank you, Dr. Schuster.

CHAIR SCHUSTER: Yeah. Thank you, Erin. Good reminders to the TACs. And I know it sneaks up on you. You meet every other month or quarterly or whatever. And then, all of a sudden, it's time to get the agenda together and so forth.

I do want to, as we go through 2024, work more with the TACs to find out what you all need that would be helpful and to get a better idea in the reports maybe of some -- something that falls short of a recommendation but something that is -- would be a topic that the MAC might take up for

discussion. So be prepared, and you can certainly reach out to me at any time. My email is kyadvocacy@gmail.com.

So we'll go to the reports of the TACs. And the first one this month is behavioral health, so I'll give that report.

The BH TAC met on November 15th. We had a quorum. All six of the MCOs were represented. We spent most of our time talking about the waivers that you've just heard about.

I will tell you personally, and for many of the members of the BH TAC, that the SMI 1915(i) State Plan Amendment is really exciting. It's something that we've been working on for 20 years because it would have supported housing and supported employment for people with severe mental illness, also youth with severe emotional disturbance and people with SUD that need those services. So we are excited for these town hall meetings and hope to have a good turnout of consumers, family members, providers, and advocates of those meetings.

We're also very excited about the

reentry waiver. We've been -- as Leslie mentioned, we've been waiting for this. I think this is year four or three and a half. Yeah.

So we are very excited because I think it will be -- this will be the warm handoff, if you think of it, folks, for people coming out of prison and hopefully eventually jails and DJJ facilities, get them hooked up with an MCO to get their services -- treatment services lined up, to have them while they are incarcerated, actually the last 60 days before they're discharged, and then to have a seamless transition into the community. So we think it will help with recidivism and any number of things.

We had a very good discussion about rate setting and how that is done and the review of the rates, and Justin Dearinger did a really good job of talking about that process. We also -- a new agenda item was on behavioral health associates who are people with a master's degree but are in process of getting an advanced degree in a behavioral health field.

There was some concerns raised about whether these people should be allowed to provide psychotherapy services, which are a very -- a service that we think needs probably more education, certainly, than a bachelor's degree. And we're concerned about the lack of clinical supervision, so we had quite a robust discussion about that and recommended that DMS go to the licensure boards to ask some of those questions.

Pam Smith gave a good presentation on the 1915C waivers, and Deputy -- Senior Deputy Commissioner Judy-Cecil gave Medicaid unwinding.

The final thing that we talked about that I think is of importance, we want to be sure that there are no barriers to the school districts and the individual schools billing Medicaid for behavioral health services. As you all know, there's been since the pandemic a real emphasis on behavioral health among our students. We're seeing more youth suicides, unfortunately. We're seeing more kids really, really struggling with anxiety, depression; in some cases, PTSD. And so

there are lots of moving pieces here, but we will come back and revisit that.

And we had no recommendations for the MAC, and I've submitted a report to Erin to share with you.

How about the Children's Health TAC? Do we have anyone to give a report?

(No response.)

CHAIR SCHUSTER: Do you know if they met, Erin?

MS. BICKERS: They did meet. I believe they were not going to have anyone today due to clinicals or patients. They had a conflict.

CHAIR SCHUSTER: Okay.

MS. BICKERS: But they did meet.

CHAIR SCHUSTER: Okay. I know Emily is available. Consumer Rights and Client Needs. Emily Beauregard?

MS. BEAUREGARD: Good morning, everyone. I'm Emily Beauregard. I'm the chair of the Consumer TAC. We met on August 15th remotely, and we had a quorum present. We revisited a number of the topics that we typically discuss and that we've been

monitoring. I just wanted to touch on a few today: Medicaid renewals, network adequacy, and language access.

We continue to monitor Medicaid renewals really closely. We very much appreciate the efforts that DMS has made in fixing system issues and in getting so many flexibilities approved by CMS that Helen went over earlier in the call. That's really made the process easier and less onerous for a lot of Kentuckians.

Even so, we also know that there's still a number of Kentuckians who are struggling to either complete that renewal process, or they lose their coverage for some procedural reason. And we want to definitely be keeping an eye on that.

In particular, what we spent most of our time discussing was concerns related to the individuals participating in, you know, the home and community-based service waivers -- that's been discussed a lot today -- and also those in long-term care. And while we understand that, you know -- at least from DMS, we understand that caseworkers are

supposed to be helping people with that process, based on what we hear from folks on the ground, that seems really inconsistent. It may depend on the caseworker or the agency or the, you know, particular long-term care facility. But I'm not sure that we can assume that everyone is getting the kind of assistance that they need.

I really do hope that the -- you know, the flexibilities, the extension of coverage for children is going to take some of the pressure off of DCBS workers so that they can provide more one-on-one assistance to, you know, the folks who have waivers or are in long-term care. But that's an area where we still need to really be focusing time and attention.

And then the other topic that we discussed quite a bit was language access. This was not necessarily a new issue but one that we haven't discussed in a while brought by one of our TAC members who works very closely with the refugee and Latinx communities. And she's been hearing, I think more frequently, that providers are requiring

patients to work through their MCO to schedule an interpreter. That's been causing delays for some folks in their ability to get care.

You can imagine if you, you know, are trying to make an appointment and then you have to go to your MCO to get that interpreter and you have to make sure that you're sort of managing both of those appointments, that can be really tough for folks.

And we know that federal law clearly requires any provider participating in Medicaid or Medicare to provide interpretative services at no cost to patients. And they should be the ones -- providers should be the ones managing that process. And so we really appreciate and didn't know that MCOs were actually trying to provide interpretive services to kind of fill in gaps for providers who, you know, may be struggling to do that themselves or may not, you know, have -- may not be financially in a good place to cover those services.

But I think that it may also be

unintentionally causing some issues because providers, then, are expecting MCOs to do this and putting that extra work on the patient. So that's something that, now that we're aware of it, DMS is aware of it, we hope that there's going to be some more communication to providers to really reinforce what their responsibility is.

And we also discussed some ideas for how to better educate patients about their right to an interpreter, what they should expect from a provider, and then, you know, what they can do to report a violation or to get assistance when an interpreter isn't made available.

And Deputy Commissioner Veronica Judy-Cecil offered to create a visual decision tree that can be shared with Medicaid members, so we're really looking forward to working with them on that.

And then, finally, we have continued our deep dive into network adequacy with DMS, really looking at, you know, how we can make sure that Kentuckians with Medicaid coverage can get the care that they need, you know,

get those appointments, get the services that they need within the time and distance standards that are already set in statute.

And DMS provided us with a demo of some new maps that they've been working on, and the maps are based on the networks reported by MCOs and the claims data from providers. And right now, network adequacy is being measured on two things, whether the MCO is reporting having an adequate network and then looking at how many providers have billed within a particular quarter.

DMS is setting a threshold of 12 claims a quarter to count that as, you know, whether the participant -- or the provider is participating or not. I think that's really low given that we know, typically, a provider ratio to patients is, you know, one provider to a thousand patients or one provider to 3,000 patients, whatever it may be for a particular specialty. So I don't think we can consider 12 claims as an indication that, you know, a provider is participating and to their full extent in creating adequacy.

But all that said, I think that this is

a really good exercise, and I really appreciate the work that DMS has put into this because it's kind of a starting place for a discussion. There are some limitations in, you know, what data they have, and what they don't have is the demand that's unmet, you know. So we have billable claims data, but we don't have good data to show, you know, the people who have tried to get an appointment and can't.

So we suggested that DMS pull together, you know, a panel of beneficiaries, a panel of providers to walk through the maps and really think through ways that we can capture that missing data, and that's something else that I think could just really help us to fill in gaps.

And then we did make one recommendation related to network adequacy based on previous discussions, and that recommendation is that DMS create a process for beneficiaries to report when they are unable to access an in-network provider within time and distance standards. And if we had that kind of reporting mechanism, it would help to kind of

fill in that data gap that I just mentioned.

So that's the recommendation that we put forward. Our next meeting is going to be on December 14th at 1:00 p.m.

CHAIR SCHUSTER: Thank you, Emily, and we'll take note of that recommendation. Appreciate it.

The Dental TAC, please.

DR. BOBROWSKI: Yes. This is Dr. Bobrowski, chair of the Dental TAC. Just a comment. Ms. Emily, that was a really good report. And I know on a lot of times, we don't have a local interpreter for us in our area. Sometimes we call the guys down at the Mexican restaurant, and sometimes they've come up and helped us. But the -- you know, and sometimes, too, we've used an app on our phone that are -- there's multiple apps that are handy to do. But the -- go on to my report here.

We did meet on November the 3rd and had a quorum. We've been discussing the fee schedule and the revisions to that, also the qualifiers for certain codes. And, again, I want to thank you for -- DMS for all your

help and even adding in this new D code, I guess a D9994, I believe it is, for getting to work with the community health workers.

And I wanted to thank -- you know, sometimes you start naming names for people to thank, and you're going to leave somebody out. But, you know, many of the folks on this call today have been very involved with helping the Dental TAC. So thank you so much.

We've -- a couple of things that we've been working on is that we've been asking the MCOs on: What is the value paid out per year for 2022 and 2023 on their value-added benefits? We've asked for data on claims paid, and we've got that broken down. But we've been working with DMS on that.

Another thing we've discussed was the increase in costs, and we've gotten data from multiple, like, group offices that -- what's it costing now to run an office. Just a quick, for instance, was 2020, the increase in cost was 3.5 percent. 2021, it went up another 11.7 percent. 2022, the cost went up 22.48 percent. And the inflation and

workforce shortage issues are another topic that, boy, sometimes as an individual or even a group dental offices, what can we do about those things?

I did want to pass on a little information that -- you know, we had talked about the soda tax in the past. Right now, the dental association is putting that on hold. And at this time, we do not have any recommendations for the MAC or motions. Thank you.

CHAIR SCHUSTER: Thank you, Garth. A good report. Appreciate that.

EMS, please.

MR. WALKER: Yes, Dr. Schuster. Thank you. This is Troy Walker at Owensboro Health Muhlenberg EMS, and I help co-chair the Ambulance Service TAC. We're a newer TAC. We've hit the ground running.

And I know that Keith has talked a couple of times, and we've definitely -- one of our priorities is our nonemergency transports in the state and the difficulties that we have with those. One of those being, preauthorizations for the MCOs is a huge

burden on EMS. It's very difficult to get since we don't really have access to the patient until the ambulance gets there.

So we've had several meetings. And then when we had our meeting here on November 13th, we got a plan. And we had submitted a form -- or, actually, WellCare had submitted a form on behalf of all the MCOs, and that was approved.

So at our November 13th meeting, we are proceeding January 1st of '24 to get rid of the preauthorization process, and we will move to a -- it's a state form. It's a medical necessity form for nonemergency transports in the state of Kentucky that everyone will use. They'll fill that form out at the time of transport, or they have 20 -- I think 22 days afterwards for retro. And that will be what we will be using instead of that preauthorization process.

And the MCOs have worked great with us on this, all of them, with all great input and looking forward to getting that process started January 1st to help all the agencies -- or EMS agencies across the state.

So that's good news on behalf of the ambulance industry so -- and that's pretty much -- that's what I have to report this month. Thank you, Madam Chair.

CHAIR SCHUSTER: Well, thank you. And I'm so glad to hear that you're able to work with all of the MCOs. We've had some of that success in the BH TAC as well on bypass lists and so forth. So it sounds like you've got a solution to what had been a very difficult problem. So thank you for sharing that and thank you for your work and thanks to the MCOs for their participation.

Health Disparities.

DR. BURKE: Hey. I'm Dr. Burke. I'm the chair for the Disparity and Equity TAC. We did meet on November 1st, 2023. We did not have a quorum at that meeting. The MCOs provided us with some presentations. We're reviewing the grievance processes by MCOs as well as interpreter services, as talked about by some other TACs.

One of the most common topics of our recent meetings has been language access, the difficulty that a lot of different patient

populations have with that currently. As mentioned prior, you know, offices are supposed to provide a way for their patients to have those interpreter services available. But having the MCOs also aid in that does provide a much larger, I think, network to help out with. They have a lot more accesses and resources than, I think, a lot of offices do on their own.

So those are most of the things we've been reviewing recently. We've also been talking about the value-added benefits and, you know, ways that that might be able to help, you know, the groups with the most disparities in their health, if there's ways to maybe manipulate those to help improve access.

But we don't have any recommendations at this time.

CHAIR SCHUSTER: Thank you very much, Dr. Burke. I'm hearing language access is a potential topic for us to put on our agenda, obviously not in January because we have a very full agenda but perhaps at some other time. Because I do think that we have

an increasing number of non-English speaking or low-English-speaking folks coming into Kentucky.

Ashima, do you have a question?

DR. GUPTA: Yes. So just on that exact topic with the language. For example, in our office, we use languageline.com, which is about $3.95 a minute. So if I have more than one or two patients a day, first of all, those visits are extended by at least 10 to 15 minutes, and they are almost always Medicaid patients.

By the end of that visit, I have basically paid that patient to come to see me. It's a total wash. So if I have, you know, a handful of patients in one day, how am I paying my staff and the office to run when I've lost basically money on several patients?

And maybe this is something that we could bring up again, that the MCOs could take responsibility for reimbursing us if that could be a billable code or providing the translation services in the office.

Because those patients -- I mean, I have

so many -- just speaking from personal experience, I'm in the part of Louisville where we have so many refugees and people who don't speak English. And we do take advantage of family members when we have that opportunity. And if we were to be penalized, you know, for doing that, it would be difficult to continue.

CHAIR SCHUSTER: Thank you for sharing that, Ashima, and I think that is something that we're going to hear. We will certainly look at maybe March, and maybe we can put our heads together and think about some experts or maybe some other states that are doing it well. We can look to DMS also for some recommendations.

But let's have a discussion about language access so that we can be sure that the Medicaid recipients are getting the services that they need but not putting providers out of business or putting undue burdens on anyone. So thank you for sharing that.

Home Health Care?

MR. REINHARDT: Thanks, everyone.

Evan Reinhardt with the Kentucky Home Care Association and the Home Health TAC.

So we met on October 17th and had a quorum present. We continued our discussions on home health reimbursement rates and supply reimbursement rates as well as some policy considerations related to both of those topics and standardizing supply quantity limits.

The big topic for discussion was on electronic visit verification, which is set to launch January 1 of next year for home health. And we expressed concerns regarding provider readiness and just ability to coordinate with software providers, you know, getting providers ready to be able to comply on January 1. And also expressed our concern that there could be some impacts directly on consumers related to access, you know, if providers are not able to comply and wouldn't be reimbursed for services due to EVV noncompliance. So we had some robust discussion about that and continue to work with DMS on status updates there.

So we did have one recommendation, that

DMS and the Cabinet exercise any and all flexibility on the EVV requirements including the go-live date. So, you know, we continue to work with them on both of those things but, again, still have significant concerns about potential access issues for consumers.

And that's all we have.

CHAIR SCHUSTER: Thanks very much, Evan, and we will note that recommendation when we come back around.

Hospital Care, please.

MR. RANALLO: Hi. This is Russ Ranallo. The Hospital TAC did not meet. We next meet in December, so we don't have a report today.

CHAIR SCHUSTER: All right. Thank you.

Intellectual and Developmental Disabilities.

MR. CHRISTMAN: Good morning. Rick Christman. I chair the IDD TAC. We met on October 3rd and had a quorum. We spent a good -- and, of course, we come from the world of the 14 -- of 1519 (sic) waiver, both the Michelle P and SCL, which you've probably

heard mentioned before, and really appreciate Dr. Schuster's interest in this topic. She brings up those two waivers a lot.

I also want to thank -- working with Pam Smith has been very delightful. This is really a complicated issue, as you've already talked about. These two waivers are -- work with the same population but have very different ways of delivering what are basically the same services. So we're really hoping for that waiver redesign that Pam has mentioned and making the work of providers much easier.

I think we would -- I would also like to mention -- we talked about our waiting lists. In SCL, we have a waiting list at that time of 3,326. The -- Pam and the people there in Frankfort do a good job, I think, in managing this. Of all those people on the wait list, none are in emergency status. So I think we're doing a good job of keeping people who are really in crisis, they do get services.

Our Michelle P has a waiting list of 8,618. But as Pam pointed out, 55 percent of those people on the waiting list are getting

services from some other waiver or from -- through the state plan. So the State is doing a very good job of managing all of that, in our opinions.

The other thing that we're looking at, and we continue to gather information on this, is what -- how often does -- what are the statistics on participants who are involuntarily terminated by their provider, and how big of a problem is that? And how long do people stay in that status?

Other than that, we really had no recommendations, and that concludes my report.

CHAIR SCHUSTER: Thank you very much, Rick. Appreciate the work that you all are doing.

Nursing Services.

MS. BICKERS: They did meet. They did have a quorum, but I do not see anyone on.

CHAIR SCHUSTER: Okay. Thank you, Erin.

Optometric care, please.

DR. COMPTON: Yes. This is Steve

Compton. I'm a member of the TAC. We met on November the 9th. We had a quorum. We continue to discuss the implementation of the adult eyewear and medically necessary contact lens implementation. We're getting closer and closer to getting that finalized.

But we have no recommendations, so we meet again in February.

CHAIR SCHUSTER: Okay. Thank you very much.

Did I skip Nursing Home?

DR. MULLER: It's okay, Dr. Schuster. No problem.

CHAIR SCHUSTER: I'm sorry.

DR. COMPTON: It caught me off guard.

CHAIR SCHUSTER: I had a different list here, so I do apologize, John.

DR. MULLER: Well, we don't have -- it's John Muller. I'm the MAC representative for Nursing Home. Our TAC did not meet, so we do not have a report. Thank you.

CHAIR SCHUSTER: I must have known that. That's why I didn't have you on the list.

DR. MULLER: Right. Right.

CHAIR SCHUSTER: I apologize. Thank you.

DR. MULLER: No problem at all.

CHAIR SCHUSTER: Persons Returning to Society From Incarceration, which has the longest title of any TAC. Steve Shannon.

MR. SHANNON: Right. This is Steve Shannon. I chair that TAC. We met November 9th, got a lot of information about that pending 1115 waiver, reentry waiver. We're all very excited about that and how that's going to play out. Good conversations around that.

Update from MCOs. They're doing some work already with folks transitioning from state corrections facilities. I think they're doing more of that. And, hopefully, when the waiver happens, that will take right off.

We have no recommendations. We're just eagerly anticipating getting our hands dirty when this waiver is implemented.

CHAIR SCHUSTER: Thank you, Steve. You all have been waiting for a while, but we

appreciate it.

Pharmacy TAC, please?

DR. HANNA: Okay. I don't believe Ron is on, but I do have their report from the PTAC. They did meet on October the 26th, and they did have a quorum.

They did have three recommendations, you know, to put forward. The first one was to request that in order to drive an increase in childhood vaccination rates, that the Department of Medicaid Services send out a communication informing pharmacies to the rule change that no longer requires pharmacies to enroll in the Vaccine For Children program in order to be fully reimbursed for vaccines to children in Medicaid as long as that child, of course, meets the threshold under state pharmacy immunization statutes and rules. It seems to be an education thing that we just need to do here.

The second motion was passed to request that, you know, Department of Medicaid Services change their policy that would provide parity for patients in the

fee-for-service program by allowing access to vaccines at pharmacies and to ensure that pharmacists and pharmacies are reimbursed for the product and administration fee for these individuals. So this is in the -- of course, under the MCO area, they are reimbursed. But this is those fee-for-service individuals that are in that little carve-out area.

There was also a motion to ask that -- you know, Department of Medicaid Services create a statewide protocol for pharmacies to administer HPV vaccines to incentivize an increase in those numbers within that adolescent community. Because it was reported that those vaccination rates were low.

And, lastly, the PTAC, you know, wanted to let everybody know that the Department -- at Department of Medicaid Services they appreciate and thank the Department for working with them on these and other pharmacy issues. Greatly appreciated and then said thank you.

The next meeting is going to be on December the 13th at 1:00. Thank you.

CHAIR SCHUSTER: Thank you very much, Cathy, and we take note of those three recommendations. And we'll come back around to those. Given the low vaccination rates that we're hearing about all over the state, I would think that those would be excellent recommendations.

DR. HANNA: Yeah.

CHAIR SCHUSTER: So thank you for that.

DR. HANNA: Thank you.

MS. BICKERS: Cathy?

DR. HANNA: Yes, ma'am.

MS. BICKERS: This is Erin with the Department of Medicaid. Can you make sure those get sent to me in writing, please, so I get the exact wording?

DR. HANNA: Oh, absolutely. I will --

MS. BICKERS: Thank you.

DR. HANNA: -- do that. I didn't know that those hadn't been sent, so I appreciate that. Thank you.

MS. BICKERS: No worries. Thank you.

CHAIR SCHUSTER: Yeah. Thanks. Physician Services, please.

DR. GUPTA: This is Dr. Ashima Gupta. We -- the Physician Services TAC met on November 17th, 2023. We do have a recommendation.

The Physician's TAC would like to request DMS to do a cost estimate for what it would cost the State of Kentucky to implement the portion of the North Carolina State Plan Amendment that enhances the reimbursement for primary care physicians to 100 percent of the Medicare physician fee schedule and report the findings back to the MAC and the Physician's TAC.

This portion of the North Carolina State Plan Amendment reads as follows: That all evaluation and management codes ranging from 99201 to 99499 and new codes established within that range as defined in Section 1202 of the Affordable Care Act and paid to primary care physicians shall be reimbursed based on the Medicare resource-based relative value scale physician fee schedule. In addition to the ACA primary care

practitioners, obstetricians and gynecologists shall also be included as primary care physicians.

Reimbursement shall be based on the following methodologies: The Medicaid physician nonfacility rate shall be set at 100 percent of the Medicare physician nonfacility rate. The Medicaid physician facility rate shall be set at 100 percent of the Medicare physician facility rate when the Medicare physician facility rate and the Medicare physician nonfacility rate are different.

And we send that information, I think, to you, Erin. I'm sorry. That's a lot of wording, but I just had to state that.

Just a little bit of background on this. Over the course of the past two years, the Physician TAC has looked at several different options for improving outcomes and lowering costs. We know without a doubt that investing in primary care is where the greatest measurable return on investment is in health care, with recent studies showing that an increase in life expectancy has a

direct correlation to a community's number of primary care physicians.

Additionally, as the demand for primary care physicians continues to increase, we have to take the appropriate steps to ensure that we increase our supply of primary care physicians while also providing them with an incentive to maintain their practices.

We have heard DMS' request that any suggestive efforts be targeted and preventative in nature. Thus, we would encourage DMS to look at this part of the North Carolina model.

Any questions?

MS. BICKERS: I wanted to let you know I have all of that. And Cody was kind enough to also send me the SPA, so I didn't have to dig through North Carolina's SPA page. So you don't have to send me that.

DR. GUPTA: Thank you. Yes. He told me he sent you everything so...

CHAIR SCHUSTER: All right. Thank you. Good recommendation there.

Primary Care?

MR. MARTIN: Hey, Sheila.

CHAIR SCHUSTER: Hi, Barry.

MR. MARTIN: This is Barry. Since I'm the only member on here that is on the Primary Care TAC, I'll be reporting. We met on November 2nd, and we had no recommendations. We had a full quorum. And DMS and the MCOs reported on quality measures and priorities to us at that time.

And one other thing. In regards to translation services, the Kentucky Primary Care Association -- I'm going to put that in our messages -- has a preferred vendor agreement with a group called Voyce, V-o-y-c-e, and they have pretty reasonable rates. And they only charge if you use them. So I'll put that in the chat.

CHAIR SCHUSTER: Thank you, Barry, since that's a topic that we've talked about. And, obviously, that kind of information would be of use to everyone. Thank you. I appreciate your report.

MR. MARTIN: And congratulations.

CHAIR SCHUSTER: Yeah. Thank you.

And last, but certainly not least, the Therapy Services.

(No response.)

CHAIR SCHUSTER: Anyone here, Erin? Do you know if they met?

MS. BICKERS: I was scrolling. They did meet. I believe they did have a quorum, but I do not see anybody on.

CHAIR SCHUSTER: Okay. So I believe we have recommendations from the Consumer Rights and Client Needs TAC, from Home Health Care, from the Pharmacy TAC, and from the Physician's Services TAC.

So I would entertain a motion to accept the TAC recommendations to be sent to DMS.

DR. BOBROWSKI: Bobrowski. So moved.

MS. STEWART: Second.

CHAIR SCHUSTER: Thank you, Garth. And a second, please?

MS. STEWART: Susan --

DR. HANNA: Cathy. Oh, okay. Go ahead.

CHAIR SCHUSTER: Who was that?

DR. ROBERTS: Roberts will second, so I can get on the board here.

CHAIR SCHUSTER: Oh, all right.

Jerry, thank you. All in favor, signify by saying aye or raising a thumb or --

(Aye.)

CHAIR SCHUSTER: Good. Any opposed and any abstentions?

(No response.)

CHAIR SCHUSTER: All right. Thank you. And I thank all the TACs for your work. I think this is a good set of recommendations to be sending on to DMS.

So we will move now to the MCO reports. First of all, were there any questions for Anthem following its September report? Did anybody have any questions that they wanted to ask Anthem?

(No response.)

CHAIR SCHUSTER: All right. Then we'll go alphabetically, and I'm not sure who's going to -- who's reporting for Humana.

MR. DUKE: Yeah. Dr. Schuster, Jeb Duke here. I'll be reporting.

CHAIR SCHUSTER: Great.

MR. DUKE: Yep. First, I'd just like to thank you for the opportunity to come and share a little bit about Humana. Leslie,

the DMS team, it's great to have you here as well. We always appreciate your partnership.

We have 58 slides. Clearly, we're not going to share all of this content, but I would encourage the committee to just review the details. I can't spend a lot of time trying to be responsive to the ask, and there's a lot of insights in regards to our experience over 2022 and 2023.

I'm going to try to kind of bring some insights forward, spend a couple of minutes, and give Krista and Ryan with Molina and United an opportunity to share as well.

So let me attempt to share my screen here.

CHAIR SCHUSTER: And all those slides will be shared, Mr. Duke, afterwards with the MAC members and so forth, so we appreciate that.

MR. DUKE: Great. I don't know if I'm doing the best because I can see myself in the screen. So hopefully everyone can see my screen.

I just want to remind a little bit about who Humana is. Just a reminder, we are in

every county in Kentucky. If we think about who we serve, it's about half MAGI and half TANF. But we do proportionally, if you think of distribution of members in Kentucky, serve a higher number of MAGI members and a relatively high members with substance abuse.

From a market share perspective, if we go back to 2022 and we look forward, we went from 13 percent penetration of membership to around 11 percent. A lot of it has to do with the entry of a new health plan as well as the impacts of the Public Health Emergency on maintaining membership through redetermination. But in general, we serve around 165,000 lives in Kentucky, and that's what we anticipate as we move into 2024.

What is different about managed care and fee-for-service? A lot has to do with the discussions we've had today, is how we wrap benefits around the members, and we've done a lot. One thing we know about the priorities of Kentucky is we have generally a really low unemployment rate but really high -- or low workforce participation. So developing programs specifically to getting our

workforce retrained, retooled, and ready for employment is part of our programming and also services that wrap around that.

So child care for those seeking work and seeking interviews, preparations for those interviews and retooling. Also, members who have faced historical issues with criminal records, getting those expunged.

Basic needs. So we all know that -- and we talked a lot about helping members access care. What are the things that we can cover and care for so that they can focus on their health and health outcomes? A lot of our benefits are designed around that.

Just a couple of things I'm really proud of this year. For the first time, we're going to be offering $500 a year for members who need housing support for rental, utilities, or moving expenses.

Something I've mentioned every year that I'm excited about is haircuts for kids. So as our children are returning to school, to ensure they're ready to learn on day one and they're not worried about appearance, we offer free haircuts for kids as they return

to school.

Food has become a significant discussion point in this state, and a lot of our benefits are around that nutritional element. So we do offer fresh fruits and vegetables for our members and recipes, so they can begin to prepare healthy meals. As we think about the chronic needs and health needs of our members or habits, there's a lot of benefits around training for that.

So one of the things unique this year, we're going to be offering transportation as a pilot for members with behavioral health needs. We continue to work on innovation for diabetes and diabetes education with a partnership with Vida. And we continue our benefits around smoking cessation.

A lot of focus on pregnant women as well. Food, it's something new this year for us as well. So we're going to be offering 10 weeks of healthy food for moms who need that nutrition to not only support themselves but to support their unborn child.

Doula services, Humana has been unique in that, and we've offered it since 2020.

We'll continue to offer that unique service to our members who are seeking that type of support through pregnancy.

Our members, we've really focused around: How do we reward and incentivize members to do preventative care? And there's an even higher focus on that next year as we think about the new withhold. I think everyone is aware there's going to be a 2 percent withhold, so all the Managed Care Organizations are focused on really hitting those HEDIS metrics. So we redesigned our programs as we think about rewardable events and continuing the ones we've historically done but valuing at a higher rate and focusing on areas that are priorities of DMS.

Providers are critical and part of this as we think about education. You know, how do we know by MCO what's rewardable, and how do we link into those? So my team is really doing a lot to try to create materials and education directly to the member but also to providers around how we can reward patients who are seeking the care that will prevent long-term health issues and also getting back

to a routine of seeing that primary care physician and getting your care taken care of.

I'm really proud as we think about quality. I know that's a big discussion in Kentucky. But since Humana has directly taken on this contract since 2020, we've significantly increased our performance as we think about quality.

If we look at the state's score card from a HEDIS perspective, we've gone from a 3-star plan to a 4-star plan being one of the leaders as we think about managed care. If we look at NCQA, Humana in 2022 was rated a 3 1/2-star plan, which is great performance.

But we expect next year to be the first health plan at Humana and Medicaid, the first state to be a 4-star NCQA rated plan. My team has spent a lot from a case management perspective, a lot on data integration, to really drive this performance, and we're proud to be a national leader as we think about how Kentucky performs from a HEDIS and from a CAHPS perspective.

CAHPS are important, too, because it means: What do our members say about Humana? We've talked about access, but when we randomly sample our members and when he get our CAHPS scores, there is good news in regards to what they're saying. 5 star as we think about getting care easily. 4 stars on care quickly.

How do they rate you, the providers? They rate you really well. So you think about our network. Our members say we're a 5-star performing plan. And if we look across the rest of the deck -- we won't share them all -- I think it's really indicative of the performance improvement not only from Humana but from what you're doing as a provider within our network as a partner. So I want to thank you for that performance.

Some stats here. We won't go through them but also good news as we think about the last two years and improving HEDIS performance and metrics. Good details.

I think we want to talk about insights. What are we seeing from a utilization perspective? The trends have continued as we

think about '22 and into 2023. What we're seeing is lower utilization and inpatient care, which is good. You know, we want to keep our members outside the hospital by caring for them in appropriate settings.

I would say that some of that is the Public Health Emergency and the level of acuity of our members as membership has grown. So this trend may not move into 2024 as membership grows and the level of acuity grows.

We've seen an increase in outpatient hospital services. Some of the delayed services that didn't occur in COVID, we're starting to see those members seeking that care.

I would note, too, I think we need to understand the impact of HRIP on outpatient services and hospitals in place of treatment as you have a price differential between sites of care. We may see a higher propensity of members to utilize services in outpatient hospital settings.

We've talked about this at probably every TAC meeting and every MAC meeting. You

know, we're seeing significant increases in pharmacy costs. We're seeing a significant rise in both utilization and cost in behavioral health services. Some of that is okay; right? We want our members seeking care, especially seeking care for substance abuse and behavioral services. But we also want to manage the quality of that, and we're monitoring those services.

Pharmacy, the integration of generic utilization. So as we think about PDL and rebate strategies, you know, I think we've seen a good return on investment from the commonwealth, but that has corresponded to much higher costs in pharmacy.

Emerging trends. For the last two years, there's been an increase in para supports -- peer supports. So our members are utilizing those services in the community. And I think that's good. But we are still -- we need to monitor that utilization and make sure that those members are getting that care and coordination.

I think we're going to see a lot with community health workers as the trend for

peer supports has gone in the last 18 months. We may begin to see that with community health workers as well. And, again, that's not necessarily a bad thing; right? We want our care coordinated through managed care, through our providers, and through supports that those providers can give.

All right. Other -- other trends. And I know my other peers are eager to go here, but I encourage you to kind of look through some of our trends and insights, especially around hospitalization and behavioral health services. It's some good data.

What is Humana's strategy? So our strategy is to get as close to providers as possible. We believe once you have a part of the -- as we think about risk. The closer you are to the reward and closer you are to the risk of bad outcomes, the better performance we're going to have from a clinical perspective with our members.

So what we try to do is to directly coordinate with you to develop a relationship to move the path of risk. So what we do is we provide supports and incentives for you to

look at outcomes of members, not just fee-for-service care, and ultimately to bring you along that value-based continuum.

We do that initially with two different models. First is quality plus, and the second is model practice. 90 percent of our members who are assigned in our network are in value-based relationships; meaning, if they're assigned to your panel and you meet the expectations from a HEDIS perspective of the commonwealth, then you will get a reward.

And we're seeing significant increases in the number of providers getting rewards. We paid out close to two million dollars in 2022. We expect to see a significant increase in that in 2023.

Just in context. I care for 11 percent of the members in the state, and we pay over 2 million dollars. If you extrapolate that to a broader membership base, it's a big number that's rewardable for members. And I'd also say there's been a 300 percent increase in payments in quality plus and a 400 percent incase in model practice. And our model practice providers perform

significantly better than our fee-for-service providers.

Just to close. What I want to say also is Humana was founded in this community, and we still support this community. When we started in 2020, to date, we've provided over 56 million dollars in community contributions to our foundation and through our health plan. You may not see us out there with big checks, but we're omnipresent in the community developing relationships with community partners and developing long-term strategies for providers to improve the health care of Kentuckians.

So that's all I'm going to share today, Dr. Schuster. Again, thank you for the opportunity to share to this group. We'll provide all 58 slides and happy to answer any questions at a future date.

CHAIR SCHUSTER: Thank you very much, Mr. Duke. Appreciate your kind of zoning in on the things that we had asked you to report on particularly. But we will share those slides and follow up in January to see if there are any follow-up questions.

Appreciate it.

MR. DUKE: Thank you.

CHAIR SCHUSTER: And we turn to Passport, and I think it's -- is it Michelle Weikel who's presenting for Molina? I see Tom James on.

MR. SADLER: Hey, guys. Ryan Sadler here. I'm the plan president and CEO for Passport by Molina Healthcare.

CHAIR SCHUSTER: Okay.

MR. SADLER: Sheila, thanks for having us and congrats on the chairmanship. So good job today and welcome to the party. Congratulations and --

CHAIR SCHUSTER: Thank you.

MR. SADLER: -- I'm sorry all at the same time.

We've got Michelle that's going to be running the slide deck for us and, as you see here on the slide, myself, Michelle, and Dr. James will be presenting. So we'll get right into it.

The first is just, you know, a quick reminder about the Passport legacy. So Molina is the engine that runs Passport, but

we have fully integrated and are working hand and glove in terms of our Passport legacy.

So the Passport organization, as you guys know, have been here for more than 20 years. In fact, I've got some staff that have been associated with the business for more than 25 years at this point. So we still have quite the legacy in our team, and it's really helpful as we start thinking about the mission that we're all focused on delivering here. So it's been a great balance. And, of course, now powered by Molina helps us align to sort of national best practices, which is really a Molina sweet spot.

Next slide, please. I should mention we do have -- you see the picture there. It's got a little bit of a eastern Kentucky flavor. We -- we do have offices scattered throughout the state and throughout the commonwealth including Hazard on the east side and Covington on the north, Owensboro on the west and Bowling Green on the west as well.

So others in addition to that. But I want you to know we do have a footprint, and we're making a concerted effort to sort of diversify our presence, you know, outside of Louisville. While we do have a very meaningful presence locally in the Louisville area, we're committed to, you know, providing the same great quality service outside of Louisville across every county in the commonwealth. So hopefully you see more and more of us in your neck of the woods if you're outside of Louisville.

I did want to just make a quick plug, and I don't want to harp on the commercial side of this. But we're very honored to win Best Places to Work. I say that because it's important as we're merging our cultures of the legacy Passport and the Molina enterprise. So I'm proud of that.

But beyond that, we're committed to hiring staff in Kentucky, so all of our people are here. We've got hundreds and hundreds of employees that work not only on the Kentucky specific business but a handful of hundreds of employees in the Kentucky area

throughout the commonwealth who support the Molina enterprise across multiple states in the country. So we're hiring and continue to be hiring, and so we're just driving home the point that we are local and committed to being local.

Some of the fun things that we've done on the side to support the community are on the right, but we don't need to read all of those.

Next slide. Unfortunately, we are all too experienced in sort of disaster preparedness and our approach and what that means. It may not be intuitive to all of the people within our ecosystem, you know, the MCO role within, you know, disaster preparedness and emergency response. But there's a lot that goes on.

And this is, in some respects, what we do at Passport by Molina, but certainly all the MCOs do something like this. And so when things happen to our members and to our providers and to our sort of health ecosystem, all of us really are called to action. And whether it's a 6:00 a.m. phone

call or a middle-of-the-night phone call or middle of the day, there's a whole host of processes that are triggered, you know, not the least of which you see the things here but also include phone calls to all of our staff to make sure they're okay and to our provider partners and CBOs to figure out what are the actual needs on the ground.

We try to sometimes be present. Sometimes it's to get out of the way, whether it's, you know, lifting PA requirements or the like in case of emergency. There's a whole host of activities and, unfortunately, we have too much experience with that here in Kentucky.

But I want people in our provider community to know that we want to be that partner to you when disaster strikes. And we've got a history of doing it, but hopefully we don't have to experience that again. But if that comes up, certainly, we have a lot of experience there.

Quick snapshot on our membership. Just calling your attention to line 3 there, the Region 3. That's -- you know, roughly 65

percent of our Medicaid membership lives in the greater Louisville area. Not really a surprise. You see the smaller footprint outside of Region 3. And, of course, we're very interested in having a more meaningful presence outside of Louisville as well.

From my perspective, you know, whatever great services we provide in the Louisville area, I think it's our obligation to make sure that people in the far east and the far west of the state get just as much opportunity to be serviced by Passport as well.

The next two slides, these talk about the priority areas and the pillars in which we operate. So, essentially, every decision we make can be traced back to fitting in one of these priority areas and then further through one of the pillars that we focus on. So just to give you a little flavor of sort of our workflow and how we think about it, we bucket these priority areas into member engagement, health outcomes, health equity, and provider partnerships.

Provider partnerships is in the bottom

right quadrant, and I don't want that to appear as though it's somehow less relevant than the top left quadrant. It's really the foundation of everything that we do. Without our network, we are nothing. And, obviously, we rely heavily on our network partners to take care of our members.

And by the way, I should just say that that -- it's selfish in the sense that, you know, our economics work better, not only for our company but for our state, the better health that we take care of our members. So the healthier we keep our members, the better off all of us are.

And so, you know, when I say we're investing in certain things or we're delivering the big checks, as my buddy, Jeb, likes to say, it's because we believe we're investing in a healthier future for our members. And as a result, that helps all of us do better as well.

So the next slide is the five pillars. These are our focus areas; right? Wellness discovery, women and children health, social determinants of health, behavioral health.

And then, you know, it's really important to me that not only the providers but also the agency sees us and thinks of us as a valued partner. Our job is to help and to make sure we're connecting the dots. And if we're not, then we're failing at that job. So I take that personal responsibility to heart.

We're going to talk now in the next slides on some of the specifics to high quality and value-added benefits, and I think Michelle can take it from here.

MS. WEIKEL: There we go. I think I'm unmuted now. Okay. Great.

Hi. I'm Michelle Weikel. I am the AVP of quality improvement at Passport by Molina. So I'm going to spend a little bit of time talking about each of the pillars in detail and then our quality improvement results.

So as Ryan mentioned, wellness and prevention is a priority for everybody, and it's certainly supported in the new quality withhold value-based purchasing program that Jeb mentioned a little bit earlier. But you can see across here, when it comes to wellness activities, preventative screenings,

we just have consistent increases in our quality performance results and members engaging in kind of wellness behavior.

Sorry. My screen keeps freezing. There we go. Specifically for women and children's health, again, children's health being a predominant focus in the new quality withhold program. But you see a great 4 1/2 percent increase when you look at well-child visits for kiddos under three, the postpartum visit increased more than 2 percent, and the utilization of our healthy reward gift cards, a similar program again to Humana's program. It definitely has a positive impact on getting members to engage for these healthy behaviors.

SDoH is a significant focus for all of us across the board and making it a foundational item as opposed to its own specific, you know, activity. We're building SDoH into everything we do.

Calling out a couple things here. Certainly, the gift cards and the bus passes. We have rent and repair eviction to help avoid members losing stable housing. We have

unlimited cell phone texting and data, which I believe is a differentiator from us from the other MCOs. And then we're excited to share that Passport was awarded one of the Medicaid innovative collaborative awards, and we are using that funding as part of a diabetes food insecurity health education activity with FarmBox.

Behavioral health. The increase in members who go to the ED and then having a follow-up visit within seven days has significantly increased, 12 1/2 percentage points year over year. We've had a decrease in inpatient BH utilization and admits and a reduction in ED utilization for behavioral health provider -- behavioral health diagnoses overall.

Again, going to being a valued MCO partner in the state, we are executing agreements. The value-based care I'm going to talk a little bit more about in a minute. But that's, again, similar to what Humana was talking about with engaging providers in a -- a pay for performance, pay for quality kind of initiative, and really engaging something

on top of the fee-for-service fee schedule.

The Best Places to Work. We talked about disaster relief. Ryan mentioned briefly. We actually are hosting a RAM clinic in Mayfield, Kentucky. Setup is tomorrow, and that event is taking place on Saturday and Sunday. So, again, they were hit with a significant tornado, I guess, two years ago and -- but that -- the need in that rural community continues. And so that's just Passport engaging to continue to meet those members' needs.

MR. SADLER: Just a quick point while we're transitioning to the next slide. All of the MCOs are participating in the RAM event this weekend in Mayfield and through the association, KHP. So just a plug to all of our other partners there. Everyone is leaning in to support the Mayfield community.

MS. WEIKEL: Thanks, Ryan. When it comes to expungement clinics, we have partnered with the Department of Corrections offering expungement clinics. We've actually had 204 people who went through the expungement process, and that also works on

restoring their voting rights as well. So we're really proud of that opportunity, to try to meet those members where they are and get them reengaged in the community.

CAHPS, of course, is the member experience results. Our star scores for CAHPS are amazing. We've got a 5 star in the overall rating of the health plan, in the child survey, and then a 5 star of the rating of their personal doctor in the 2023 adult survey.

We met all of the goals across all of -- all the healthcare measures. And then we threw out some quotes here that just kind of share specific details members have shared with us about how Passport is making a difference in their lives.

HEDIS improvement. This is not at all representative of all the NCQA HEDIS measures. We just called out some highlights. When you look across the board from '21 to '22, almost 56 percent of our measures had an improvement year over year. We've called out a couple of specific ones here. Again, we talked about the ED

utilization follow-up for alcohol or substance use, bringing a member into the ED and how much there was an increase in the follow-up visits. That's actually one of the measures that is within the new quality withhold program.

So calling out some well-child activity, increasing in nutrition counseling, increasing in well-child visits year over year for kiddos under three, and breaking that out into different age ranges. So all of that activity is improving health outcomes for our members across the board.

This is laying out HEDIS year over year. You'll see, of course, the darkest teal line is incomplete. That's 2023 year-to-date. So when you look at the pattern and you see those 23 bars being lower, that's not something to be alarmed about because of the end of the year and all the activity that happens in collecting of data. But we are tracking those HEDIS measures as we progress and going into the quality withhold.

This shares a little bit about where we are in value-based contracts. Again,

engaging providers for pay for quality, pay for performance. We currently have 64 percent of our members assigned to a PCP that is part of a value-based contract. In 2023, 100 percent of our value-based providers' quality performance exceeded the providers who are still on a traditional fee-for-service kind of arrangement.

We will be adjusting our value-based contract in 2024 to make sure that we are representing all of the DMS value-based purchasing measures as well as some of the quality measures that, as a plan, we want to continue to focus on. And our goal is to get 75 percent of our members covered by a provider that is part of a value-based agreement.

I am going to turn it over now to Dr. James. He is our chief medical officer.

DR. JAMES: Good afternoon to everybody, and I want to be aware of the time. Sheila, can you give me any kind of a time check? And you're on mute so...

CHAIR SCHUSTER: I was going to josh you and say you had minus two minutes,

but if you could wrap up in about three to four minutes, Tom.

DR. JAMES: Okay.

CHAIR SCHUSTER: Thank you.

DR. JAMES: Just to go rather quickly, we're trying to be involved with being more than just a Louisville type of health plan. As Ryan said, two-thirds are in the Region 3. One-third are around the state. And there's different ways, through telemedicine, making sure we've got an adequate network, that we will be able to service the needs of our people.

The next slide is what we are doing in collaboration with the other health plans, but we're taking the lead on this. And this is with Project Sunshine. We're the first state to bring TelePlay to a Medicaid population across the state. So I'm proud of our work along that line and with all of the other MCOs.

Going on. And, Sheila, you and I can talk about that later.

Prior authorization is something that is always a hot topic. And what we are trying

to do is to reduce the need -- the burden, realizing that prior authorizations being done is a way of looking for those outliers that are inappropriate. And so as health care gets more and more standardized, the need reduces. And this result can be seen in this slide.

And going on. Sheila, I don't know whether you want me to go through these, because what we're doing is demonstrating: What are the kinds of conditions being seen on a behavioral health side? The next one is on a physical health side. And then: What are the types of hospitalizations? These are in the deck. And I could elaborate on these things, or we could move forward.

CHAIR SCHUSTER: Yeah. Why don't you go forward, Tom. I'd like to go back and look at them and maybe have some questions next month --

DR. JAMES: Okay.

CHAIR SCHUSTER: Or next --

DR. JAMES: That would be fine. I think that's an appropriate way. We can keep moving on.

I think I've got one last slide, and that's the effort between our case managers and our care connectors. We're meeting people not just on the telephone but getting out to the community or into the homes, and this gives us some of the numbers there.

And that is our presentation, and I thank --

CHAIR SCHUSTER: All right. I appreciate that very much and, you know, again, we'll distribute the slides. Thank you, Mr. Sadler and Ms. Weikel. We will distribute the slides. And then if you could have somebody at our January meeting, we'll have people come back around and see if there's some questions. So thank you for that.

MR. SADLER: Thanks again.

CHAIR SCHUSTER: And our final report is from UnitedHealthcare, and I think it's -- is it Greg Irby?

MS. HENSEL: Yeah. Greg is going to run the slides. I'll kick us off briefly. I think I've got about two minutes just to tee things up for my team. So for those that

don't know me yet, Krista Brinly-Hensel. I'm the CEO of the UnitedHealthcare Community Plan of Kentucky. I'm thrilled to have the opportunity to speak with everybody today.

We're the third in the row, so we'll try to make this -- and I think we're probably between you guys and the end of a very long meeting. So we'll try to respect that, keep it focused and to the point.

I think many of you are aware that we're the newest kids on the block, so to speak. I'm probably losing my right to say that shortly. But definitely, as you've heard some of the other presentations, we've been in the market -- it'll be three years here in January. And I continue to be amazed by what my team was able to do in the midst of a global pandemic and launching a health plan into a new market.

We've really been prioritizing flawless execution, making it very easy or as easy as we can be to work with. And relationships is key to us with both our providers and community partners. That was absolutely strained during our implementation. The back

half of 2020, as you can imagine, was not the time for us to be out asking providers to meet with us. They had more important things going on at the time.

But we are doing our best to create those relationships both virtually and, now that we are back out in the community, so to speak, trying to make up for lost time. So if you haven't seen me yet in your office and you would appreciate a visit, I'm happy to do that. I've been burning up the miles across the commonwealth, just getting to know things.

I did want to just highlight -- you know, there's plenty of information out, publicly available on the Web about UnitedHealth Group's cultural values. I think they're very pertinent. Hopefully you see us behaving that way on a day-to-day basis.

And on top of that, focusing my team on some guiding principles really aligns with what I was thinking about in terms of what I think is important. One is execution. Two is differentiation. Three is relationships.

What does that really mean?

Execution is understanding our contracts, both with our providers and with DMS, and executing against that. It's a point of integrity to do what we say we're going to do.

Differentiation, because we are the newest kids on the block, I believe that we were awarded a contract because there was a belief that the power of UnitedHealth Group could bring amazing things into the commonwealth and especially around addressing health outcomes.

In both of those things, in order to pull that off, relationships are really key to us. We recognize that we are one component of a complex healthcare ecosystem with all of you on the phone today, including the other MCOs in the market, to really make meaningful improvements. We've been focused on improving health outcomes, building truly distinctive provider relationships, and innovative community engagement.

Let's flip to the next slide really quickly here. Just to give you a sense of

timeline, what have we been up to the past three years or so? I would tell you 2021 was rocky for us. It was a rocky adventure.

A lot -- as you guys know, ongoing in your agenda is discussions about the status of Anthem. That has impacted us pretty significantly in terms of entering this market.

You see the membership is in the gray lines in the back of this chart. The first six months of 2021, we had a significant amount of presumptive eligible members granted to us from the fee-for-service population, most of which lost eligibility after their two, three months presumptive eligibility period.

So a quick and fast entry and then a settling in. Alongside that, I'll let my team address some of what that meant from a clinical perspective. But the growth of our plan has been primarily through members joining Medicaid for the first time. And, oftentimes, when folks first join Medicaid, they are in some pretty significant healthcare experiences.

All through that, while we're caring for members, we're also looking at the community and what the community needs are. I won't highlight all of these things. But the way in which we have engaged across the commonwealth, both where there are significant, urgent needs -- I know Ryan spoke about the tornados and the floods.

But also looking at long-term, sustainable, healthcare access issues, community health worker implementation, sponsoring and implementing some doula programs throughout the commonwealth. Really proud of my team for bringing things to the table that could make meaningful differences and figuring out a way to both fund and implement those things.

I just want to -- I'm probably over time. Greg is going to give me the shepherd's hook here in just a minute, but I'll give you a great example. Many of you may be aware there was a train derailment Wednesday night just north of London, Kentucky. And pretty quickly, my team engaged, alerting us that that had occurred.

Thursday morning, Suzanne Lewis, our health services director, was able to identify a member that was in our complex case management program, reach out to that member, have a conversation, make sure that they were safe. They were okay. They had everything they needed.

Greg Irby, who's going to speak next, did similar of all members in that impacted area, making sure to do outreach calls through our member services team and our local team, to make sure that folks were aware of what had occurred, aware of the resources available to them, and had everything they needed from the healthcare perspective.

So I am absolutely getting the shepherd hook via IM from my team, so I am going to shut it and let the team carry on the rest of the more detailed message. Greg, go ahead.

MR. IRBY: Appreciate it. So like Krista said, members are at the focus of all of our decisions. So this slide is going to tell you a little bit about who we have the opportunities to serve and how they're

distributed across the commonwealth and across different demographics.

A couple of things that I'll highlight here that may show up differently for us than other MCOs. We do have a large portion of our members who are pregnant currently or recently delivered. We try to take that population very seriously and offer as many benefits as possible to that group.

One of the other numbers you'll see on here is that eight percent of our members indicate that Spanish is their primary language. I bring that up just to talk about other options since we've talked about language access.

If you contact the members -- member services line, we are happy to connect you to a translation service. So if you have them in real time in your office and they want to call member services, we will happily connect you to a translator. That is a low-tech, no investment solution that we're happy just to have you utilize right now. So I really appreciate everyone's diligence to offer translation and your desire to do that, and

we want to be the best partner possible to you there.

Over the last several years, we have grown our network really significantly. Since this time in 2022, we've grown our access points by 8.3 percent, and we continue to look for new opportunities for network growth.

We are meeting our requirements for PCPs, hospitals, BH providers. And so we're trying to ensure that there's immediate access for members when they need it and where they need it.

Another thing that we're really focused on is improving our provider data. And so what that looks like, we are taking publicly available data sources, and we are comparing that to our data sources. And we're creating trust scores for all of our provider data. When we see something that needs attention, that gives us an opportunity to target in on that provider and ensure that we have the most up-to-date data. And so it's a really great way to target our collaboration with folks like you on this call to make sure that

we are maintaining good information for members.

The third thing that I'll talk about regarding access is that we want to ensure not only physical locations and accessible locations, but we also want to get creative and meet members right where they're at.

One of the things that we're going to do in 2024, which I'm really excited about, is we're going to hand out care tablets to a population of our members. So we've identified a certain group of members who do not have as much access to primary care as other people throughout the commonwealth, and we're going to equip their home with a care tablet that will enable them to connect directly with their providers, many of whom are on this call today.

Connect directly with their providers, have access directly to healthcare services all in the palm of their hand. And so we're hoping that that can increase their access without even adding a facility.

So we want to talk a little bit about our health equity lens. Jake Archibald is

going to talk to us a little bit about that and then we'll move into some of our clinical trends.

MR. ARCHIBALD: Thanks, Greg. I appreciate that. Can you all hear me?

MR. IRBY: Yes, sir.

MR. ARCHIBALD: As Greg said, my name is Greg Archibald. I'm the health equity consultant for the UnitedHealthcare community and state plan.

Wanted to give a couple quick examples -- or a few examples, rather, of how we are ensuring that each function, interaction, and decision that we make is seen through the health equity lens.

From an enterprise level, we launched the health equity university this year. That includes, of course, foundations of health equity that all UHC employees are required to take. It also involves a really robust course library full of courses that, you know, tell us all about best practices in health equity and how to apply that to our individual roles.

Locally, and the thing that I think I'm

most proud of this year, is we actually used one of our PIPs this year, our colorectal screening PIP, as our NCQA health equity accreditation submission. And as you all know, in July of this year, we were granted NCQA health equity accreditation, so something I'm extremely proud of.

This slide here kind of shows our approach to SDoH also through that health equity lens. This is our SDoH integrated service model that ensures our pop health quality and health equity strategies are aligned.

You know, we recognize there are multiple complex drivers to health and that no single program or solution can solve all of the barriers our members are facing in an attempt to live their healthiest lives. That's why we have this cross-functional member, provider, and community solutions working in concert to effectively drive population level change.

Since we are limited on time, I just wanted to give you that quick overview, and I'll pass it back to Greg.

DR. CANTOR: Hey, Jake, and thank you. I'll take the baton since we've got such little time left. Hi. I'm Dr. Cantor with UnitedHealthcare. And knowing that we are so limited, the next three slides basically say what you see here. Just like Humana, our inpatient admission rates have been reduced.

You can go to the next slide. Readmissions and then ER utilization. So we show that readmission rate has been decreasing, and our ER utilization for nonemergent has also been decreasing when we compare it year over year, with the highest utilization being with those that are in the high-severity, emergent categories.

And with that, these slides will be available to you. And there are more in the appendix. But for value of time, I'm going to pass it over to Suzanne for our highlight of a member story.

MS. LEWIS: Hi, everyone. My name is Suzanne Lewis. I'm the population health director and just wanted to highlight some of the great work that our community health

workers are doing out in the community. We have such a great opportunity to impact our members' lives. And so this is just but one example of many, and I won't read the slide to you.

But, essentially, you know, our community health workers, when they meet with our members, they meet in the homes. They go to the doctor's office with them. Many of you are aware of the value -- the great value of our community health workers.

But in this case, we had a very sick member who was at home, and when our community health worker went out to visit this member, found that the member was sleeping not in a bed but on two metal folding chairs and had been discharged home from the hospital. Didn't have a bed, didn't have home health, and some other equipment.

And she was able to work with this particular member and the provider office, and she also went to the provider appointment with him to make sure that the care that was needed for this particular member was received, that the member had transportation

to the appointments, that medications were ordered, that home health was engaged, and that the member was able to receive all of these things in addition to getting the member some, you know, again, DME equipment, a hospital bed, and assistance with food and other social determinants of health.

And so, again, just wanted to highlight the valuable work that our CHWs are doing and that we are partnering with the UK Center of Excellence in Rural Health, with their CHW program to send the rest of our community health workers through their program for certification through the state. And that should happen here in December. The rest of the team is going through the training. We've already sent a couple through the program.

So thank you all very much, and I'll send it on to the next presenter.

MR. IRBY: Perfect. In our last two minutes of time, we're just going to talk a little bit about what's coming in 2024.

So, Ashley, why don't you tell us a little bit about some of our benefits that

we're adding.

MS. HOBBS: Sure. Good afternoon. I'm Ashley Hobbs, our enrollee services director.

So we actively gathered feedback from members at our member advisory councils along with insights from providers and community partners to help form the foundations of our value-added benefits we're going to add for 2024.

So just quickly, this is a list of all the value-adds, but the ones that have the blue backgrounds are new for 2024. So we have transportation. It'll be 24 free one-way rides for community or medical services, car seats for moms who attend their postpartum visit.

Next slide, Greg. A hundred-dollar health and hygiene healthy foods card to members, a GED Works. That's testing -- helping the members find a testing site and prep for their GED, and then Greg mentioned our care tablets earlier.

MR. IRBY: Perfect. So as we round out these slides, we talk about our quality

initiatives, and you've heard about this from other MCOs. So I won't take a huge amount of time on this.

But what I will say is that we're trying to get innovative in the way that we partner with not only medical communities but also our community partners. We are working through a program called the catalyst program where we are launching in Owensboro right now.

We are partnering both with community and providers to impact deep relationships in that community, and we want to partner in a long-term way. And so this is a three-year partnership that we've established there, and we plan to do this in other places.

But I think the key message here is that we want you to be a part of this. We recognize that you are the trusted source of information for your patients, and so we are one piece of this equation. And we're really looking forward to partnering with you.

So we'll pause our slides here. There's several things that we've added into the appendix. But the final thing that I would

just say, on a personal note and from our team, is just a huge debt of gratitude to the work that you do. We understand that you are seeing our patients, and you're making these wonderful improvements in their lives. And so from a very sincere place, we are very appreciative of all that you do.

CHAIR SCHUSTER: Thank you very much. We appreciate that. And, again, we will distribute those slides to everyone.

You know, I do think it's important for us to hear from the MCOs. I think DMS always talks about the three-legged stool where we have the members, we have the providers, and we have the MCOs. And so I think it is important, and we appreciate the information that's been provided.

We have some MAC business to wrap up on. And, Erin, if you would share your screen with the proposed meeting dates for 2024.

MS. BICKERS: I added the times to the bottom. Give me just a second, and I'll read you guys off the dates here.

CHAIR SCHUSTER: Oh, okay.

MS. BICKERS: Anything I share I

have to post online, and they're getting a little --

CHAIR SCHUSTER: Oh, okay. Yes.

MS. BICKERS: I walk that fine line of what we want and what they'll let me have so...

CHAIR SCHUSTER: Well, basically, it's the third -- it's the fourth Thursday every other month starting in January except in November where the fourth Thursday is Thanksgiving. So it would be the third Thursday.

MS. BICKERS: Yes, ma'am. So I have January 25th --

CHAIR SCHUSTER: Right.

MS. BICKERS: -- March 28th, May 23rd, July 25th, September 26th, and then November 21st.

CHAIR SCHUSTER: Yeah. So can we get a quick motion to approve those meeting dates?

DR. BOBROWSKI: Bobrowski. So moved.

MS. PARTIN: I make a second.

CHAIR SCHUSTER: All right. Garth

and Beth with a second.

All in favor of approving those meeting dates, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: Okay. Great. The next one is that we talked last time about adding half an hour to our meeting time because it would give us a little bit less sense of being rushed here at the end. And there were three proposals.

One was that we add the half hour at the beginning, so we would go from 9:30 to 12:30 Eastern Time. The other was that we split the difference and go from 9:45 to 12:45, and the third was that we would add it at the end and go from 10:00 a.m. to 1:00 p.m.

I know that there was some discussion about the difficulty for people in the Central Time Zone if we had an in-person meeting. I'm going to assume that we're going to be meeting virtually in 2024. I think we can make other arrangements, and there were some excellent recommendations if we are going to have an in-person meeting, that we might shift the time to make it

worthwhile for people to make that drive coming and going.

So I would ask for your consideration of these times assuming that it's going to be a Zoom meeting. And I wonder if there's someone that wants to make a motion to pick one of these and see if we can get a majority agreement on a time change.

MS. STEWART: I'll make a motion for A.

DR. GUPTA: I'll second that motion. This is Dr. Gupta.

CHAIR SCHUSTER: 9:30 to 12:30. Okay. And seconded by Ashima. Thank you, Susan and Ashima.

Any discussion? Does anybody want to speak yea or nay on that?

(No response.)

CHAIR SCHUSTER: Okay. We have a motion and a second to move the time from 9:30 to 12:30, adding our half hour at the beginning of the meeting and assuming that these will be Zoom meetings.

All those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed?

(No response.)

CHAIR SCHUSTER: And abstentions?

(No response.)

CHAIR SCHUSTER: All right. Thank you.

I think we have one more --

MS. BICKERS: Dr. Schuster.

CHAIR SCHUSTER: Yeah. I know. The Therapy TAC person, Dale Lynn, was late to the party, but he does have a recommendation. So hang on, voting members, and let us hear from Dale.

MR. LYNN: Yeah. My apologies for being late to this meeting. I had another meeting that ran late.

We do have -- the Therapy TAC does have a recommendation for the MAC, and we have some concerns about the possibility that the MCOs may start implementing the MPPR edits. And we recommend that the MAC request Medicaid to revise regulations to prohibit that in the future.

The Medicaid rates are extremely low.

They're 63.75 percent of Medicare rates. And our neighbors across the border in Indiana, their Medicaid rates are full Medicare, 100 percent Medicare fee schedule. And with our lower rates, if MPPR is implemented, there's a lot of clinics that just could not possibly survive.

CHAIR SCHUSTER: Do you have that in writing, Dale, that you can send to Erin?

MR. LYNN: I will. Thank you very much.

CHAIR SCHUSTER: Okay. Could I entertain a motion from a voting member of the TAC that we approve that recommendation to be sent on to DMS?

DR. ROBERTS: Motion.

CHAIR SCHUSTER: Jerry. Thank you. And a second?

DR. BOBROWSKI: Second from Garth.

CHAIR SCHUSTER: Garth. All right. Thank you.

Any discussion?

(No response.)

CHAIR SCHUSTER: All those in favor of approving that recommendation to be added

to the ones we already previously approved, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed?

(No response.)

CHAIR SCHUSTER: And abstaining?

(No response.)

CHAIR SCHUSTER: Thank you very much. And thank you, Dale, for letting us know that you were available and had a recommendation.

MR. LYNN: Thank you.

CHAIR SCHUSTER: And with that, we're only five minutes over time. So I think we've sped along. I thank you all very, very much for your input. I have jotted down about eight things that have come up that we need to add to our agenda going forward. But, certainly, the language issue, we will look to put on our March agenda.

DR. ROBERTS: Hey, Sheila.

CHAIR SCHUSTER: But let me hear from you if you have other things.

Jerry?

DR. ROBERTS: I will be extremely

brief, but I have two issues under new business.

CHAIR SCHUSTER: Oh, I'm sorry. Yeah.

DR. ROBERTS: There's a new code that CMS is implementing next year, in '24. It's G2211. It's an add-on code for E/M. It's an ongoing care related to a single, serious, or complex condition. I would like to know if DMS will recognize that code.

The second is under a proposed -- and, again, this is Medicare. But under a proposed 2025 rule, Medicare Advantage plans that offer value-added benefits are likely to be required to send a mid-year essentially accounting of a covered entity's unused benefits. The idea is that, you know, the patients have access to these benefits under their plan, but most of them are not aware and don't know about them.

I know there is some outreach to patients from the MCOs regarding, you know, the benefits available to them. But if there was a formal, you know, mid-year -- similar to what Medicare is proposing. Send it out

to the Medicaid recipients saying, okay, look, you know, it's mid-year. Here are the benefits that you have access to that you have not used. I think it would be a benefit to the patient.

That's all I have.

CHAIR SCHUSTER: Oh, interesting. Can you send me a note on both of those, Jerry?

DR. ROBERTS: I will be happy to.

CHAIR SCHUSTER: Yeah. That would be great. Thank you. And I apologize that I didn't bring up --

Anybody else have any new business items?

(No response.)

CHAIR SCHUSTER: Seeing none, why don't we adjourn by acclimation. We won't even have a motion.

I appreciate all of you all, and we look forward to our meeting on January 25th. And set your alarm a little bit earlier because we'll start at 9:30.

And thank you, Erin and Kelli, for keeping us on track and rolling here.

I wish you all a happy holidays in whatever way you celebrate with you and your family and loved ones. And we will see you in 2024. Thank you.

(Meeting concluded at 12:39 p.m.)

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C E R T I F I C A T E

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

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

Dated this 14th day of December, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR