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2 CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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12 Via Videoconference
September 28, 2023

13 Commencing at 10:03 a.m.

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21 Shana W. Spencer, RPR, CRR
Court Reporter

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1 **APPEARANCES**

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3 ADVISORY COUNCIL MEMBERS:

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

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1 **P R O C E E D I N G S**

2 CHAIR PARTIN: We'll call the

3 meeting to order. Is our secretary on?

4 MS. BICKERS: I thought I saw her

5 log in. I'm scrolling. In the interest of

6 time, I'll just call roll instead of keep

7 scrolling. I have --

8 CHAIR PARTIN: Thanks, Erin.

9 MS. BICKERS: You're very welcome.

10 And I just wrote you guys down as you were

11 coming in. I have Catherine.

12 (No response.)

13 MS. BICKERS: Hanna. Did -- okay.

14 I have Beth.

15 CHAIR PARTIN: Here.

16 MS. BICKERS: Nina?

17 MS. EISNER: Here.

18 MS. BICKERS: Susan?

19 (No response.)

20 MS. BICKERS: I believe she said

21 her microphone was not working.

22 Jerry?

23 (No response.)

24 MS. BICKERS: Heather?

25 MS. SMITH: Here.

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1 MS. BICKERS: Garth?
2 DR. BOBROWSKI: Here.
3 MS. BICKERS: Steve?
4 DR. COMPTON: Here.
5 MS. BICKERS: John?
6 (No response.)
7 MS. BICKERS: Ishima?
8 DR. GUPTA: Ashima, yes. I'm here.
9 MS. BICKERS: Ashima. I'm so
10 sorry. I do that every time. My apologies.
11 John?
12 (No response.)
13 MS. BICKERS: Barry?
14 (No response.)
15 MS. BICKERS: Kent?
16 MR. GILBERT: Here.
17 MS. BICKERS: Mackenzie?
18 MR. GILBERT: Mackenzie --
19 MS. WALLACE: Here.
20 MR. GILBERT: Oh, okay.
21 MS. BICKERS: Annissa?
22 (No response.)
23 MS. BICKERS: Sheila?
24 DR. SCHUSTER: Here.
25 MS. BICKERS: Bryan?

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1 (No response.)

2 MS. BICKERS: Peggy?

3 (No response.)

4 MS. BICKERS: Eric?

5 DR. WRIGHT: Here.

6 MS. BICKERS: Okay.

7 DR. ROBERTS: Jerry Roberts just

8 came in.

9 MS. BICKERS: Oh, thank you.

10 DR. HANNA: This is Cathy Hanna,

11 too. I am here. I'm having some -- it's

12 like my Internet is -- something is wrong, so

13 I may -- I turned my camera off to see if

14 that would help. But if it doesn't, I may

15 have to jump in on my phone, but I'm here.

16 MS. BICKERS: Okay. Thank you.

17 CHAIR PARTIN: Okay. Do we have a

18 quorum?

19 MS. BICKERS: You have 11, yes,

20 ma'am. Sorry. I had to count. I have a

21 hard time calling names and counting at the

22 same time.

23 CHAIR PARTIN: Me, too. Thank you,

24 Erin.

25 Okay. Next up on the agenda is approval

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1 of the minutes. Would somebody like to make
2 a motion?
3 DR. SCHUSTER: I'll move their
4 approval. This is Sheila Schuster.
5 MS. EISNER: This is Nina. I'll
6 second that motion.
7 CHAIR PARTIN: Any discussion?
8 (No response.)
9 CHAIR PARTIN: All in favor, say
10 aye.
11 (Aye.)
12 CHAIR PARTIN: Any noes?
13 (No response.)
14 CHAIR PARTIN: Okay. The minutes
15 approved. Thank you.
16 Moving into old business, what is the
17 status of Anthem MCO?
18 MS. JUDY-CECIL: Good morning.
19 This is Veronica Judy-Cecil with Kentucky
20 Medicaid, and there is no change in the
21 status. The case is still pending.
22 CHAIR PARTIN: Still in the court?
23 MS. JUDY-CECIL: That's correct.
24 CHAIR PARTIN: Okay. Thank you.
25 I'll put that on for next meeting.

1 Okay. And then next up is the DMS
2 report on healthcare workforce, and thank you
3 for sending that out to us. It was very
4 interesting, but I think that maybe we
5 have -- need more explanation and maybe some
6 questions afterwards.
7 MS. JUDY-CECIL: Absolutely. And
8 we have invited -- Matthew Walton is here
9 from our sister agency, the Office of Data
10 Analytics, and I believe Matthew -- I did not
11 check to make sure he was on. But I believe
12 Matthew -- there he is -- is going to have a
13 short presentation to kind of go through the
14 high level of the report and then happy to
15 open it up for any questions.
16 CHAIR PARTIN: Thank you.
17 MS. JUDY-CECIL: And, Erin, if you
18 could make sure that Matthew is a cohost, so
19 he can share --
20 MS. BICKERS: I made him a cohost
21 when he logged in.
22 MS. JUDY-CECIL: Excellent.
23 MS. BICKERS: I try to grab all of
24 you guys in the beginning.
25 DR. WALTON: Yeah. I'm able to

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1 share screen, so thank you, Erin, and thank
2 you, Deputy Commissioner.
3 All right. So let me just -- thank you
4 for the introduction. My name is Dr. Matthew
5 Walton. I'm the lead researcher with the
6 Office of Data Analytics at the Cabinet. And
7 I have a short presentation for you all to --
8 just to highlight some of the things in the
9 report. I bet I can anticipate some of the
10 questions that you might have.
11 So the point here -- excuse me -- is to
12 show you all what we did, the challenges that
13 we faced. And then, really, the biggest
14 takeaway for our team was ways that we can
15 improve the quality of data available to
16 answer questions like this.
17 So, really, the title here is the
18 question: How many healthcare professionals
19 are practicing in Kentucky? It's a harder
20 question to answer than it may seem, and so
21 this is just a couple of slides to do a brief
22 discussion of our 2023 Healthcare Workforce
23 Capacity Report.
24 So three simple things that this report
25 does. You all are very familiar, I know,

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1 with the Deloitte report that was -- it's
2 about ten years old now. Our charge was to
3 update that report. And in the process, so
4 we read it very carefully. We noticed the
5 things that that team from Deloitte was
6 telling us or telling, you know, its readers
7 what needed to happen to improve the quality
8 of services in Kentucky and to show parts of
9 the state that were lower -- you know, a
10 lower saturation of healthcare workers
11 compared to others. So we updated that, so
12 we provide a count of credentialed healthcare
13 professionals.
14 What we did, we added 14 more provider
15 types. So we added -- for example, in the
16 2013 report, physical therapists,
17 occupational therapists, speech pathologists,
18 audiologists, there was a long list of
19 professionals that were not covered. We --
20 in our updated version, we added them.
21 The second is we really grapple -- we
22 know that the ultimate interest in this
23 report is to answer questions: Where are we
24 insufficient to meet the demand for the
25 state? That is a very hard question to

1 answer in a kind of empirically rigorous way.
2 I think a lot of people intuitively know when
3 they live in a community that they need
4 another dentist, or they need another
5 pediatrician or, you know, where they're
6 deficient.
7 At a 30,000-foot level when you're
8 looking at data, there -- we talked to
9 federal agencies. We talked to medical
10 schools. We talked to several experts. And
11 what we -- the best that we were able to
12 offer in terms of a simple and rigorous way
13 to compare Kentucky's ratios was to just
14 compare them to what the nation has.
15 So this is another departure from the
16 Deloitte report. Deloitte constructed
17 measures that said this is the ratio of
18 people in an area or county or
19 administrat- -- or an area development
20 district, and this is how many dentists they
21 have. And you should have this many if you
22 want to be sufficient.
23 Their method is sound. I'm not knocking
24 it, but we did not feel on our team that we
25 could support that. We didn't feel like we

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1 could defend it because we would prefer to
2 use something like a national association,
3 professional association's ratio that they
4 recommend. And there really aren't things we
5 could find that fit that description.
6 And the third thing I would offer is
7 where we feel the report adds the most value.
8 It's -- we obviously -- we're proud of the
9 work that we did in -- just in terms of
10 counting the professionals. We had to do
11 some data science that we can talk to you all
12 about if you're interested in terms of how to
13 make sure that the data we're using is the --
14 is accurate.
15 But the most important thing is -- for
16 what we feel like is where we can tell
17 stakeholders to aim in the future, where
18 future authors of a similar report could have
19 better tools to answer these kinds of
20 questions.
21 And so we rely really heavily on the
22 licensure boards. That's the backbone source
23 of data for all of the chapters in this
24 report. And in a supplement that we wrote
25 up, we offer fields -- data fields that if

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1 they were to be collected and populated by
2 providers, future authors who are doing the
3 same work that we have just completed will
4 have better tools and be able to answer more
5 interesting and useful questions than we were
6 able to do.
7 This is the last slide. I just chose
8 three provider types that I know are
9 represented on this call. We'll go through
10 just brief, high-level conclusions, and then
11 I think the best use of time would be for me
12 to be available to answer questions that you
13 all may have.
14 So, first of all, this is like what I
15 mentioned before. There are some criteria
16 out there in the literature. There's some
17 criteria that some other states use. Our
18 team did not feel like it was our place to
19 tell -- I mean, this is stepping into the
20 realm of policy, of policymaking.
21 What does it mean to have enough
22 dentists in a community, or what does it mean
23 to have enough physicians? What we felt like
24 we could do really well was give the
25 stakeholder group: Here are the ratios.

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1 Here's how many we can identify using
2 licensure board data. Here's how many people
3 the census says live in this area and then
4 here's how that compares to the country.
5 And we used Bureau of Labor Statistics
6 data for how many -- for example, how many
7 nurse practitioners there are in the U.S. and
8 how many Americans there are. So where you
9 see green in the report, that means the
10 ratios are at least as good or better than
11 the national ratios. Where you see red,
12 that's where the ratios -- and this is a
13 little confusing. That's actually where they
14 are higher.
15 If you think about this like
16 student/teacher ratios, generally speaking,
17 if your child can be in a lower
18 student/teacher ratio, you prefer that. The
19 same with the way that we're expressing
20 ratios here. This is where in these green
21 area development districts, there are fewer
22 people per dentist; or in Lexington and
23 Louisville area, fewer people per physician.
24 And I think a lot of this won't be very
25 surprising to the people on this call. I've

1 certainly heard this in many meetings around
2 state government spaces, that we know that
3 the area around northern Kentucky,
4 Louisville, and Lexington is where there's a
5 high concentration of healthcare
6 professionals. And much of the data that we
7 find supports that conclusion, that, you
8 know, if you live in Kentucky your whole
9 life, you tend to think that's how it is.
10 So we would offer that the discussion
11 and the debates about where there are --
12 where there need to be more supply of
13 providers are well-served by coming to kind
14 of a shared definition of what it means to
15 have enough or what a certain community
16 needs. What does it mean to be sufficiently
17 supplied?
18 More specifically, it's -- these are 30
19 provider types, so it's hard to say -- you
20 know, it's hard to speak very broadly or
21 generally. But a lot of these, Kentucky is
22 broadly in line with the country.
23 Now, the critical challenge to that is
24 if the whole country is undersupplied by,
25 say, nurse practitioners and we are green on

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1 these maps, that -- that is a limitation of
2 this method. And we offer that very freely,
3 that that goes back to this first point of if
4 our only unit of comparison is a whole
5 country that has a shortage of providers,
6 then maybe you will look better than what the
7 real, on-the-ground reality is.
8 But I picked three points to summarize
9 very simply and shortly. If you look at
10 dentists, you've got four area development
11 districts in eastern Kentucky that look like
12 they could use dentists. If you're looking
13 at mental health clinicians, probably need
14 them most across the whole state but
15 especially in western Kentucky.
16 And for those of you on this call that
17 are behavioral health professionals, we tried
18 to take a very careful description because we
19 heard the feedback on the previous report.
20 We do not aggregate professional types and
21 call them mental health counselors. Even
22 this title here is a little bit of a
23 generalization. We know that. That's not --
24 there's not a licensure type called mental
25 health counselor. This is a compromise we

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1 had to make because of the way the Bureau of
2 Labor Statistics collects data and calls
3 fields.
4 But we have clinical psychologists,
5 licensed clinical social workers, marriage
6 and family therapists. So we have -- you
7 know, we know that this is not a singular
8 field and that it's multiple different
9 disciplines who do slightly different things.
10 I myself am a social worker, so I'm sensitive
11 to that, you know, those distinctions that
12 need to be drawn.
13 And then we probably need physicians
14 everywhere that isn't Lexington or
15 Louisville. I think that was -- probably
16 didn't need to do a report to know that. But
17 what we can tell you with a little more
18 precision is that Buffalo Trace up in
19 northeastern Kentucky shows up. You can see
20 just in these three, the ratios are worse
21 than the country. So Pennyrile and Buffalo
22 Trace show up in a lot of these maps.
23 Pennyrile shows up in these two as well.
24 When you go through the whole 30 provider
25 types, you see this red show up several other

1 times.

2 And so, you know, to the extent that we

3 can tell you something that maybe wouldn't

4 have already been obvious, those are two area

5 development districts that appear to be -- if

6 there were to be, you know, an initiative to

7 attract more healthcare workers, we can say

8 that the ratios are the least favorable in

9 those two and then a few others that we talk

10 about in the report.

11 And the third thing, which would really

12 be -- I know this is also aligned with many

13 sentiments that have been articulated by this

14 group. If we want to do better analyses and

15 have more precise conclusions and answer

16 better questions, we have to ask for better

17 tools.

18 The group of analysts on the team that I

19 work on really did a -- you know, a very,

20 very strong effort of doing the very best

21 that we can to say: If Dr. Walton is in

22 Lexington in this dataset and there's another

23 Dr. Walton but Walton is spelled W-e-l-t-o-n

24 also in Fayette County, is that the same

25 person?

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1 Because what we do is -- I didn't talk
2 about this as much, but the -- where those
3 licensure board data have missing fields or
4 potentially incorrect data, we took data from
5 CMS, which is publicly available, and did a
6 linkage strategy to say let's validate this
7 information. So if it's missing, then we can
8 pull it from this other source, and that
9 dramatically improved the quality of data
10 available to us to write this report.
11 So I'll stop there and then I don't know
12 if we have much time for questions. But I'm
13 happy that you all were interested in this.
14 We feel like we learned a lot. Hopefully, we
15 give something to this group that's useful
16 and meaningful for your efforts.
17 CHAIR PARTIN: Okay. Thank you for
18 that report. I did have a question, and you
19 kind of answered that. But comparing the
20 numbers in Kentucky to national numbers, to
21 me, that didn't seem like it really told us
22 anything because we know nationally, there's
23 a problem.
24 So we were -- were you comparing knowing
25 that nationally the numbers were already bad?

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1 And so if we were bad in Kentucky, we were
2 even worse than what we recognize is bad
3 nationally? Is that a fair assessment?
4 DR. WALTON: That's not how I
5 would -- so I would answer your question
6 first with a question. Just forgive me. I'm
7 a former professor, and so I tend to do this.
8 I would ask: How do you know that the
9 quantity nationally is too low? I've read --
10 I'm sure we've read a lot of the same
11 articles, but can you give me evidence that
12 what we have nationally is too low?
13 CHAIR PARTIN: No, I can't. But
14 that's part of the problem, I guess, in my
15 mind, is that comparing it to national, are
16 we assuming that national is low and then
17 Kentucky is lower than -- than that shows,
18 that there's even a bigger problem? Or are
19 we to assume that nationally, it's good, and
20 comparing Kentucky to the national numbers
21 shows that Kentucky is deficit in areas that
22 nationally are good? I couldn't tell from
23 the report.
24 DR. WALTON: We make no assumption
25 about whether or not the national numbers are

1 good or bad. The only reason -- the reason
2 that they are the anchor is because they're
3 the one thing we can point to and say we can
4 be -- we can be most certain that this number
5 is true because we placed faith in the Bureau
6 of Labor Statistics and say that's the best
7 source of available information to say this
8 is how many -- I should say we trust the
9 Bureau of Labor Statistics and the census
10 bureau because those are the two numbers.
11 Think of it -- it's a division equation;
12 right? The numerator is the number of people
13 in the country, and the denominator is the
14 number of dentists. And those two numbers
15 were the best source of data for us to say if
16 you're going to compare two things --
17 right? -- a ratio in Kentucky and a ratio in
18 the nation, the best job you can do is pick
19 numbers you can have faith in.
20 And so this is where our report really
21 is not going to take the whole question all
22 the way to the finish line because
23 question -- debates about good or bad or
24 enough or not enough rely on work that just
25 hasn't been done yet, in my opinion. We need

1 to do better about making better, rigorous
2 definitions about what it means to have
3 enough.
4 CHAIR PARTIN: Okay. So, really,
5 it's a number that you can depend on, but we
6 don't know exactly what that number means.
7 Is that what you're saying?
8 DR. WALTON: We do know what it
9 means. It's a comparison -- you're making
10 some general assumption about the way that
11 people who hire healthcare workers supply
12 their areas. So in that sense, you can say
13 it's at least enough to meet a minimum
14 threshold that the people in the city are
15 comfortable enough with how many doctors they
16 have.
17 The issue is that you really -- you just
18 have to take what this report gives you and
19 elevate the discourse to the next step and
20 say -- because you have issues about not all
21 communities will need the same number of
22 dentists, you know. If you have a really
23 young population, they're not going to need
24 health care the same way that a population
25 where the median age is older.

1 And that gets very challenging, and I
2 think that's why the federal agencies have
3 kind of stopped short and not held out the
4 gold standard that all communities need to
5 hit.
6 CHAIR PARTIN: Okay. And then
7 follow-up to that question. In the report,
8 you were comparing different types of
9 healthcare providers to the total number in
10 the population. So how do we know, for
11 instance -- let me backtrack.
12 We know or have a pretty good idea about
13 what the ratio should be with physicians to
14 population. But we don't know what the ratio
15 should be per population for, say, LPNs, but
16 yet there was a comparison there.
17 So how do I get some meaning out of that
18 with the -- comparing the number of LPNs to
19 the total number of population or comparing
20 the number of marriage and family counselors
21 to the population? How do I -- how do I
22 derive some meaning from that?
23 DR. WALTON: Well, so what you
24 would -- what you would do is you could say
25 it's at least not worse than the nation, and

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1 that is -- I will agree, you know, it's not
2 the platonic ideal. But you can at least
3 start there. And then what you can do is
4 also derive meaning from saying: How does it
5 compare to the rest of Kentucky?
6 So a lot of what you -- how you derive
7 meaning is depending on the question that you
8 need to answer. And that's why we supply you
9 all of the area development districts, so you
10 can see how they compare to each other, which
11 may be the most meaningful. I can't say
12 because I'm not the one making the decisions
13 from this report. But you would -- meaning
14 you can compare to the country, and you can
15 compare to the other area development
16 districts.
17 So you can potentially assume that --
18 let's say that since we can't know for sure
19 if we have enough and let's assume we have a
20 deficient supply across the whole state, you
21 can at least know where you have the greatest
22 deficiency. And you can target resources
23 there.
24 MS. BICKERS: Beth, we have several
25 hands raised. I believe it was Dr. Gupta

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1 first, then J.P. Hamm. Then I believe it was
2 Dr. Schuster and then Dr. Bobrowski, in that
3 order.
4 CHAIR PARTIN: So go ahead with the
5 first person.
6 DR. GUPTA: Dr. Walton, this is
7 Ashima Gupta. Thank you very much for that
8 report.
9 MS. BICKERS: We're having a hard
10 time hearing you.
11 DR. GUPTA: Can you hear me, Beth?
12 DR. SCHUSTER: Yeah. That's a
13 little bit better.
14 DR. WALTON: It's very muffled.
15 DR. GUPTA: If you can't hear me,
16 just stop me, and I'll just write it down in
17 the chat. This has been a major topic in our
18 Physician Technical Advisory Committee.
19 MR. GILBERT: I think we should
20 probably move to the next person because we
21 can't hear Dr. Gupta.
22 MS. BICKERS: If you'd like to drop
23 it in the chat, I can read it off after
24 someone's next question. Thank you.
25 CHAIR PARTIN: Next up.

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1 MR. HAMM: Yeah. This is J.P. Hamm
2 with the Kentucky Hospital Association. Can
3 you all hear me okay?
4 CHAIR PARTIN: Yes.
5 MR. HAMM: So thank you very much
6 for the presentation, and I do want to
7 applaud you all on asking for better data
8 from all the different licensing boards
9 because that is vital for our workforce.
10 Where I'm confused is, for example, the
11 KBN, the Board of Nursing, has excellent
12 data. And they do a deeper dive, and they --
13 and your first slide showed practicing, and I
14 really focused on that.
15 Because if you do a deeper dive -- and
16 they publish this in their spring newsletter.
17 When you do that deeper dive, you all show
18 the total number of licenses at 70, but the
19 total number of people practicing is more
20 like 48,000. So that's a difference of
21 20,000 nurses about and, you know, that
22 difference is people who practice out of
23 state or working for insurance companies or
24 just taking time off.
25 So I'm concerned about the State showing

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1 green for nurses when we know that there's a
2 nursing shortage even if you compare
3 (audio glitch) -- going to Nina's question.
4 And I think it's a little bit misleading.
5 And so I'm trying to figure out, if we
6 want better data, why we didn't take
7 advantage of KBN's better data to show that
8 the number of licenses does not reflect the
9 number of people practicing.
10 DR. WALTON: Yeah. Thank you for
11 that question. So that was -- that was a --
12 one of the challenges of putting together a
13 report like this was to try and do justice to
14 the publicly available data that the boards
15 put out.
16 And the Kentucky Board of Nursing poses
17 a unique instance because I agree with what
18 you said. Their data is one of the better,
19 if not the best quality. And they have --
20 because they license so many people, my
21 assumption is they just built up a data
22 infrastructure to handle that much
23 information.
24 Whereas, some of the boards -- like, for
25 example, the board that licenses me is much

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1 smaller, and they probably don't have the
2 same budget to manage big datasets. That was
3 a judgment call that we had to make because
4 we didn't want to put data into a
5 public-facing report that counteracts.
6 They also have on their Web page just
7 the total number of licenses that they have
8 by county. And I -- you know, there's a
9 deeper debate that we could add that we could
10 potentially reflect that in two ways and
11 show -- because we did make an effort to do
12 practicing versus not practicing.
13 But not all boards do that. And so it
14 was an effort to try and align all of the
15 provider types with the publicly available
16 information and present it in a way that's
17 consistent.
18 So thank you for the question.
19 MS. BICKERS: Dr. Gupta's question,
20 Dr. Walton, says -- oh, sorry. I've got to
21 scroll up. The physician shortage has been a
22 major topic in our Physician's TAC over the
23 past couple of years. How will the data and
24 the recommendations from this report be
25 implemented?

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1 DR. WALTON: Well, I can -- I can
2 minimally respond to that because I'm not a
3 policy maker. So I -- you know, my job is to
4 give the information to policy makers.
5 But what I would -- what I would really
6 call attention to is -- there's a little bit
7 of reading between the lines that has to be
8 done. But in the report, we present that
9 medical school graduate degrees conferred in
10 Kentucky's three medical schools have been
11 going up over the time period that we
12 catalogued but then the number of those
13 graduates who go on to get a Kentucky medical
14 licensure is trending down.
15 And I can only imagine if you just think
16 about this, like, in a musical chairs
17 example. I -- we did not look at how many
18 residency spots there are in Kentucky's
19 training institutions for physicians. But I
20 assume that the number of graduates, degrees
21 conferred, is going up faster than the number
22 of residency spots. And we know from some
23 evidence that people will tend to practice in
24 the areas where they train, about half if you
25 look at the national numbers.

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1 And so what I imagine is that while
2 those medical colleges are growing the size
3 of their classes, just by the nature of the
4 way residency training works, they're having
5 to leave the state and then I would assume
6 many don't come back.
7 So we also replicated an analysis that
8 Deloitte did that showed the J-1 visa
9 program. It's not -- we don't know if a
10 physician has a J-1 visa from the data that
11 we have, but we do know if they graduated
12 from an international medical college.
13 So we took what Deloitte did and updated
14 it and found where a lot of the state's
15 underserved areas are being -- they're
16 practicing physicians that have graduated
17 from an international medical college. And
18 so that's -- that is one lever that can be
19 pulled to recruit physicians to parts of the
20 state that need doctors.
21 MS. BICKERS: I believe
22 Dr. Schuster was next.
23 DR. SCHUSTER: Yeah. Good morning,
24 Matthew. Sheila Schuster here. Thank you
25 for your presentation, and thank you for

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1 supporting something that I have testified on
2 to legislators and to the MAC, and that is
3 that our licensure boards don't have the data
4 that we need. And KBN comes as close as any.
5 So I'm particularly appreciative of the list
6 of data fields that you all suggest.
7 And I would say to every professional
8 group that's represented on the MAC, we need
9 to find a bill sponsor and require the boards
10 to literally ask those questions, and I
11 always use myself as an example.
12 I've been licensed for 100 years as a
13 psychologist but haven't practiced literally
14 since 2000. But I've kept my license and
15 done the CEs and so forth so that when I
16 testify and so forth, I can say I'm a
17 licensed psychologist. But I should not be
18 counted as practicing.
19 And that was an excellent question that
20 Mr. Hamm asked. So the county data is
21 helpful, but it doesn't really reflect the
22 practitioners.
23 I want to go back to the mental health
24 groups, and I appreciate your not having
25 lumped everything together because that was

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1 one of our big complaints about the Deloitte
2 report. And, of course, in the mental health
3 groups, you're also not including
4 psychiatrists and psychiatric mental health
5 APRNs who are a big part of the mental health
6 workforce. They're classified otherwise. So
7 that -- that makes it a little bit different.
8 But I'm concerned about your numbers,
9 and I'll tell you why. You list the licensed
10 psychologists, and my guess is that you
11 looked at just those, I think, 827 who have a
12 doctoral degree. But we have licensed
13 psychological practitioners who are
14 independent practitioners and practice with a
15 master's degree. And there's at least
16 another 800 or 1,000 that weren't counted at
17 all.
18 And that leads me to my next question,
19 which is you have groups of people listed who
20 require supervision. So you obviously didn't
21 use as your criteria completely independently
22 practicing people. And so if you go back and
23 look at psychology, social work, marriage and
24 family therapy, the alcohol and drug
25 counselors, all of them have people that are

1 practicing and that are providing services
2 who are working under supervision. And I
3 guess I'm curious about whether you all
4 thought about including those folks because,
5 otherwise, it's very uneven.
6 I mean, LPNs are not independently
7 practicing professionals. They work under
8 supervision and direction of other people.
9 And that's true of a number of other groups
10 that you have in here. So I just wonder if
11 you looked at the supervised people because
12 they really do provide services, and they
13 certainly are part of the workforce.
14 DR. WALTON: Yeah. Thank you for
15 the question. So the first -- in the first
16 point, LPCCs are featured in this report.
17 They are one unfortunate case where what we
18 call LPCCs does not exist in the Bureau of
19 Labor Statistics data.
20 DR. SCHUSTER: Statistics, right.
21 DR. WALTON: They put it together.
22 So in our report, licensed clinical alcohol
23 and drug counselors and LPCCs are put
24 together in a category, and that's a
25 compromise that just had to be made to make

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1 the comparisons with the national ratio. So
2 they are featured in this report. They're
3 just not -- we don't call them psychologists.
4 DR. SCHUSTER: But you don't
5 include the supervised folks in those fields.
6 DR. WALTON: No, we don't. And
7 I'll tell you -- I'll respond to that
8 question as well because that's -- we thought
9 hard about that. And the -- really, it's a
10 pragmatic reason, is that we thought we might
11 lose some parts of the audience if we went
12 really in depth about that.
13 We also know that if we -- I'll take
14 myself. I'm a CSW, so I could be under
15 supervision by an LCSW to sit for that. But
16 you end up with the same problem as if I were
17 retired. I don't see patients in my daily
18 work. And so if we were just to see the
19 licensures or the certificates of the CSWs,
20 we don't know which ones are under
21 supervision from our data. And so we end
22 up -- we could overcount the same way we
23 could undercount.
24 So I think this is one of the best
25 examples of -- that we need better tools to

1 be able to answer a question at that level of
2 sophistication. Because that's really taking
3 this and pushing it to the next level of
4 depth, and we did not feel like what we had
5 was able to do justice to that question.
6 DR. SCHUSTER: Well, I would
7 encourage you to go back and add to the
8 psychologists those who are licensed
9 psychological practitioners because they are
10 independent practitioners. They do not work
11 under supervision, and there's at least
12 another probably 1,000 of them. That's not
13 true of the CSWs, and it's not true of the
14 associates for the licensed professional
15 counselors or the LADCs but just -- just to
16 put that caveat in there.
17 Thank you.
18 MS. BICKERS: Beth, and I just had
19 a quick question. I'm sorry. This is Erin.
20 After Dr. Bobrowski's question, in the manner
21 of time for a full agenda, if anyone has any
22 other questions, they can drop them in the
23 chat. And I will catch them and send them
24 over to Dr. Walton, if that's okay with him.
25 I know we have a full agenda today.

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1 DR. WALTON: Yes. That would be
2 just fine. We would be happy to answer email
3 questions or however it is most appropriate
4 or useful for the group.
5 CHAIR PARTIN: Okay. And then when
6 we do that, would you share them with the
7 MAC, Erin?
8 MS. BICKERS: Absolutely. Yes,
9 ma'am.
10 CHAIR PARTIN: Thank you.
11 MS. BICKERS: Dr. B, I think, was
12 the last person with his hand up.
13 Dr. Bobrowski. I'm sorry.
14 DR. BOBROWSKI: That's fine.
15 That's all right. I'll try to be real quick.
16 I was hoping that maybe I could give some
17 information on the dentistry part of it, and
18 I'll try to be real brief and hopefully maybe
19 answer some of those questions.
20 But I know there was -- in dentistry,
21 there was provider type 60, 61 per DMS. And
22 I cannot remember how oral pathologists --
23 which provider type those are listed, but I
24 understand that even they have been -- are
25 not being paid by DMS. So those are a

1 specialty group of folks that may or may not
2 be included in those numbers.
3 Now, I know a lot of that data -- well,
4 Matthew, I want to thank you for your work on
5 that. That's a tough project to get into.
6 But I know some of those reports are based on
7 number of providers per population. Well,
8 the current studies -- well, even for the
9 last 40-some years show that 50 percent of
10 the population don't even go to the dentist.
11 So sometimes those numbers can be skewed.
12 One of the things we like to look at is
13 the number of paid claims per county or per
14 area, so that kind of gives you a little bit
15 more, I think, knowledge of who's doing the
16 work or where's the work being done.
17 But the -- the licensure boards, I don't
18 believe -- I used to be on our dental board,
19 but they typically don't list the provider
20 types. They have to get that information
21 from DMS. But the -- they just keep who's
22 licensed, who's actively licensed to do
23 dentistry.
24 They don't -- the problem, too, is that
25 the MCOs may show a dentist as a Medicaid

1 provider, but they may have quit seeing
2 Medicaid patients 20 years ago. So sometimes
3 those are tough ways to figure out who's
4 doing the work. Sometimes those paid claims,
5 you may have ten dentists in a county that
6 are listed as Medicaid providers, but only
7 one or two of them actually see the patients.
8 But, again, this is stuff that we've all
9 got to continue to work with our legislators
10 and DMS to help on this. But I've got more,
11 but I hope maybe that information might
12 answer some questions.
13 But thank you again, Matthew, for your
14 report.
15 DR. WALTON: Yes. Thank you,
16 Dr. Bobrowski. You illustrated another thing
17 that we thought very hard about, and if you
18 all -- I assume many of you all -- the Pareto
19 principle is something I think a lot about
20 when we do this kind of -- some of you all
21 may have heard of the 80/20 rule.
22 You know, if you look at a church and
23 you ask who are the volunteers in the church
24 and how much -- you know, the tithing and all
25 of that, 20 percent of the members of the

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1 church will do 80 percent of the volunteer
2 hours.
3 And you see that relationship consistent
4 in all kinds of ways. 20 percent of a
5 patient panel in an insurance pool will
6 consume 80 percent of the dollars spent.
7 We've actually seen similar
8 relationships happen -- because our team does
9 analyses of Medicaid claims as well. So
10 very, very sensitive to the point that you
11 make, Dr. Bobrowski, that we've seen similar
12 things, that -- I can't tell you because I've
13 done an analysis.
14 But if that rule is true and describes
15 the world reasonably well, something like 20
16 percent of the dentists will see 80 percent
17 of the claims or visits for dental patients,
18 and I bet you it's close. It may not be
19 exactly that, but it'll probably be close.
20 And so the remaining 80 percent of the
21 dentists who don't see very many are there,
22 and they're licensed. And it complicates
23 your -- a really thoughtful discussion about,
24 okay, here's our supply. Are we getting what
25 they can do to the people that need it? And

1 that is still a very hard question and --
2 which is why we offer this report with a
3 healthy dose of humility that we don't claim
4 to be able to answer that all-platonic
5 question.
6 We rely on all of the partners, and
7 what -- we hope what we can do is give a sort
8 of incremental step in that direction and
9 offer you a road map for the kinds of
10 questions to ask or to keep asking to get
11 closer to that sort of platonic ideal and --
12 and what kind of tools would you need to get
13 there.
14 And that's really where we think --
15 which is why I want to lean into. The fields
16 that the boards can collect would get us
17 closer and closer. Because we ask: How much
18 of your time in a typical week do you spend
19 with patients? Because we know that we have
20 researchers. We have administrators,
21 business leaders, people who are licensed but
22 do something else with their time versus see
23 patients.
24 And I know that a lot -- you were kind
25 of putting ideas out there as well as asking

1 questions, Dr. Bobrowski, but is that a
2 suitable response for you?
3 DR. BOBROWSKI: Yes. Thanks a lot.
4 Yes.
5 DR. WALTON: Yeah. Thank you all.
6 Thank you for your interest in this topic and
7 for the challenging questions. I mean, I
8 appreciate it. We wrestled with all of this
9 stuff as we wrote it. You all have found
10 parts that we could have probably explained a
11 little better in our narrative. We hope it's
12 useful for you all. And, you know, it was a
13 fun challenge to take on and to write, and
14 hopefully it gives you something that you can
15 use.
16 CHAIR PARTIN: Thank you, Matthew.
17 We appreciate you reporting to us, and we
18 look forward to hearing answers to more of
19 the questions.
20 DR. WALTON: Thank you.
21 CHAIR PARTIN: Okay. Moving on,
22 the next is an update on missed and cancelled
23 appointments, and how is reporting going?
24 And is there a common thread as to why
25 patients are not showing up for appointments?

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1 And this is the September update, and we have
2 an update every six months.
3 MR. DEARINGER: Hi. My name is
4 Justin Dearinger. I'm with the Department
5 For Medicaid Services, and I have a real
6 brief presentation to show you all. As you
7 all know, we've been working on a no-show or
8 missed appointments dashboard for a while,
9 and we've finally got that completed. We'll
10 have a provider letter sent out very soon.
11 And we have been, again, like I said, working
12 on this for quite some time.
13 We initially started out with -- with
14 the attempt of getting -- well, with the
15 attempt of this being an online presentation.
16 And the online version we struggled with
17 because we had some issues with -- well,
18 various technical issues.
19 So what we've done in the meantime is to
20 allow for this no-show dashboard to be
21 available for providers. So this is a
22 provider-based only at this time. If you're
23 not an active Kentucky Medicaid provider, you
24 won't have access to this dashboard. But we
25 are going to do our best to try to -- or we

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1 continue to work on trying to get this to
2 become an online dashboard for everybody to
3 be able to use and to view.
4 So to start, we will just kind of look
5 at -- the dashboard is currently available
6 for all providers. It's available in the
7 Kentucky MMIS system, which all Kentucky
8 Medicaid providers have access to. It's
9 under the KYHealth-Net part of the Kentucky
10 MMIS system, and it's under DMS reports.
11 There are multiple search parameters in
12 this provider dashboard, and there's a quick
13 chart example. This is all provider types
14 for the year, calendar year 2023. It allows
15 you to search for all provider types for
16 missed and cancelled appointments.
17 It allows you to search for any time
18 parameter that you set. You can search for
19 the week, the month, different years, other
20 different data ranges that can show different
21 missed and cancelled appointments.
22 You can break those down as far as
23 provider type. As you can see, these are
24 rural health clinics for the calendar year so
25 far in 2023 and all the missed appointments

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1 or cancelled appointments for rural health
2 clinics.
3 And then you can break that down even
4 further into reasons. So you can see here,
5 there's the no-show. No reason provided was
6 the top reason why appointments were missed
7 or cancelled, and you can see the number
8 there.
9 And then if you kind of look back and
10 compare the number of no-shows and the number
11 of no reason, that was primarily the only --
12 the only response that we got in this
13 category. So you can see that the biggest
14 gap that we found is no data, so there's no
15 data being entered for a reason.
16 There's just nothing being put there by
17 providers, and so that's probably one of the
18 biggest issues that we've found, is that
19 there is no data. And then the majority of
20 the data -- the majority of the reasons is
21 put in the "no reason" category. So that's
22 another issue that we've found.
23 As you can see, our goal with this
24 no-show dashboard was to capture accurate
25 no-show data, of course. We wanted it to be

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1 accessible to providers whenever they wanted
2 it, whenever they needed it. And then we
3 wanted it to be instantaneous. Prior to
4 that, any time we asked for reporting, it may
5 take a week or more to get those reports and
6 then you would only have the specific data
7 you were looking for. This allows providers
8 to be able to look at a variety of different
9 parameters, different time frames, and to be
10 able to have that instantly and to be able to
11 look that up instantly.
12 We see when we look at this data that we
13 need more accurate no-show reasons. That's
14 one of the biggest keys to trying to get this
15 done, is to hopefully show providers that we
16 need that information, that we don't have it
17 currently.
18 Again, the biggest number of no-show
19 data responses, there just wasn't a response.
20 There was nothing put in. The no-show was
21 put in there that there was an appointment
22 missed or cancelled, but there was no data,
23 no reason given as to why. And then the next
24 biggest reasoning for the no-shows was just
25 the -- the category "no reason."

1 So the goal really for us, for the
2 division of policy, is to find those areas
3 that are given for reasons for no-shows. So
4 when providers have staff reach out to those
5 individuals that have missed or cancelled
6 appointments or when those individuals come
7 in for their next appointment, really trying
8 to get them to describe what those issues
9 were that allowed them to not be at the
10 appointment.
11 And we realize that there will still be
12 a large number of no reason or no data.
13 There will still be a large number of just
14 simply forgot or couldn't come. But the goal
15 is to get those bottom categories, whether
16 they be child care, transportation, language
17 barriers, knowledge of appointment times,
18 whatever those things are, that we can figure
19 out exactly what those areas are that are
20 causing the most problems and then focus on
21 those areas, providing resources there,
22 providing training, providing member outreach
23 so that we can reduce those missed
24 appointments.
25 So that's all I have, and if anybody has

1 any questions, then I would be willing to
2 take those so...
3 CHAIR PARTIN: So for the missed
4 appointments, is it just a multiple choice
5 thing where the -- it's usually the staff
6 that's answering these rather than the
7 providers.
8 MR. DEARINGER: Sure.
9 CHAIR PARTIN: Is it a multiple
10 choice thing where they just choose an
11 answer?
12 MR. DEARINGER: It is. So there's
13 a list of different areas. There are some
14 that -- there are some un- -- you know, some
15 miscellaneous ones but a category that you
16 can put some notes. But there are a list of
17 different choices that you can pick from. No
18 reason or no response down to, again, child
19 care, transportation, communication,
20 language, all kinds of different choices
21 there.
22 And, again, like I said, what we found
23 is that the majority of those -- majority of
24 the time, none of those are selected.
25 CHAIR PARTIN: Okay. Because it --

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1 just anecdotally, for my practice, it seems
2 like the reasons are "forgot the appointment"
3 or "transportation" seems to be the two
4 biggest issues. But that doesn't seem to be
5 indicated by what's being reported; is that
6 correct?
7 MR. DEARINGER: Partially. So I
8 think the second biggest issue that we've
9 found on there is just kind of the "I forgot"
10 category, which we can, you know, start to
11 take -- we've already started a workgroup on
12 possible ways to kind of find some solutions
13 to that. But past that, we don't see that
14 there's a lot of information as far as
15 transportation, any other thing like that,
16 that's jumping out. There's just not much
17 data there.
18 So it's either really that there's no
19 reason given or that the reason given is --
20 there's no real reason, which is maybe I
21 forgot or just didn't feel like coming or
22 something like that. And we anticipate that
23 that will maybe be the biggest, you know,
24 reason moving forward, of course. But it's
25 those bottom reasons that we're really

1 looking to kind of focus in on to get some
2 proper data on so that we can attack those as
3 well.
4 CHAIR PARTIN: So maybe it's a
5 matter of staff not following up with the
6 patient as to why they didn't come in, and
7 maybe we need to be, as providers,
8 instructing our staff to follow up more
9 closely with patients to give a better
10 answer. So this can be something --
11 MR. DEARINGER: Right. Yes, ma'am.
12 And that's one of our goals, is to hopefully
13 get some better data so that we can really
14 pinpoint those exact reasons and causes. And
15 that way, we can spend some time developing
16 some solutions for those issues.
17 CHAIR PARTIN: Okay. Thank you.
18 Does anybody have any questions?
19 DR. SCHUSTER: Beth, this is --
20 MS. PARKER: This is Angie with
21 Medicaid. I was just going to add to this.
22 It's Angie Parker with Medicaid. I was just
23 going to add to this, that this data is
24 shared with the MCOs. So they do do some
25 reach-out to some of the patients if they

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1 see a --
2 CHAIR PARTIN: We maybe need --
3 maybe we need to be even at more of a
4 grassroots level, having providers instruct
5 their staff to contact the patients and ask
6 them specifically why and then reporting it,
7 and maybe that's not happening.
8 DR. SCHUSTER: Beth, this is Sheila
9 Schuster. And I was just going to say Justin
10 has been so good about reporting for months
11 now at the BH TAC meetings and working on
12 this. And while I'm disappointed that this
13 can't be public, I do think it's important
14 that it's available to providers.
15 So I think we're back to what you just
16 suggested, No. 1, that more providers use the
17 dashboard to report. And No. 2, that you get
18 your staff to really take that next step and
19 ask the question more specifically about the
20 reason why.
21 We know with the behavioral health
22 members of Medicaid, really important to
23 reach out and figure out why they haven't
24 kept those appointments. And I agree with
25 you, that a lot of times, it's

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1 transportation. Sometimes child care is the
2 other one that we hear.
3 So this has the potential to, I think,
4 be really helpful to make sure that we're
5 addressing those social determinants of
6 health. Thank you, Justin.
7 CHAIR PARTIN: Yes. Thank you.
8 Anybody else?
9 (No response.)
10 CHAIR PARTIN: Okay. Thank you.
11 Then we'll go ahead and move on.
12 The next item is just a reminder that in
13 January, we'll have a report on the community
14 health workers and what they're paid and how
15 they're being used in practices.
16 And, again, next up, Number E on the
17 agenda is just a reminder that we will have
18 another maternal/child update in January
19 2024.
20 Next on the agenda under old business is
21 PDS rate increases remains an item we should
22 get updates on as the process unfolds to case
23 managers, support brokers, and PDS agencies.
24 And this was something that Eric asked us to
25 continue to have on the agenda.

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1 And, Eric, do you have anything specific
2 that you would like to ask in this regard?
3 DR. WRIGHT: Well, there's been
4 much discussion amongst social media about
5 the rate increases and continued confusion a
6 little bit amongst parents/representatives in
7 relation to rate increases. And PDS stands
8 for person directed services, which is
9 offered through the waiver programs, most
10 1915C waivers.
11 Additionally, what we're seeing now is
12 that there's a letter that is going out and
13 some information related to the Appendix K
14 policies that were in place now. But it
15 appears -- correct me if I'm wrong, if I'm
16 stating this wrong -- that they're just going
17 to have a continuation of those current
18 policies until there is an update from --
19 well, actually, I guess it's CMS and DMS
20 working related to rate increases, which were
21 enacted in 2022 based upon the ARPA funds.
22 And I know that the Kentucky legislature
23 is going to take this up and continue to
24 review these. But in the interim, though, I
25 think there's still some questions. I have a

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1 couple that I'd like to just put out today.
2 On the notice, it says that all policies
3 that are currently approved and in place will
4 continue past November 11th, 2023, until the
5 effective date of the proposed waiver
6 amendment. And so upon CMS approval and
7 implementation of the revised waiver, only
8 Appendix K policies defined in the Michelle P
9 waiver or other waivers' amendment will be
10 continued.
11 I have questions related to that because
12 there seems to be information related to how
13 much -- how many hours a provider can be
14 offered at this time, particularly through
15 agencies like DAIL. You know, they're
16 suggesting now that things at the end --
17 October 1st need to be dialed back down to 40
18 hours if a parent maybe had been providing 60
19 hours during this ARPA funds period.
20 There seems to be some confusion whether
21 that's going to continue even until November
22 11th or past that. Now -- so if there could
23 be clarification to that today, that would be
24 great, which could be reflected in the
25 minutes. I think that would be very helpful.

1 MS. SMITH: So this is Pam with
2 Department For Medicaid Services. So that
3 was -- and I just found out that, last night,
4 the recording from the webinar that was held
5 on Monday and the slide deck has been posted
6 that goes through the updates for Appendix K
7 and what will be retained going forward
8 versus what will sunset once CMS has approved
9 the waivers. That is on the website.
10 We also are sending out -- we're working
11 on right now a participant version of the
12 information that has been shared. But one of
13 the things that is changing or that will be
14 going away is the overtime in PDS and in the
15 traditional services.
16 So -- but as of right now, as you
17 mentioned, Dr. Wright, it is -- it does
18 continue -- will continue until CMS approves
19 the waivers. The waivers are additionally
20 out for public comment as of last night, so
21 we're encouraging everyone to go and review
22 those waivers.
23 But the ability for the overtime, that
24 will be one of the changes that is not
25 continued, and we will be returning back to

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1 the traditional limits, which for individuals
2 in Michelle P, is 40 hours a week. And an
3 additional limit on that related to parents
4 in all of the waivers is that regardless of
5 the number of children that are on the
6 waiver, that a parent cannot provide more
7 than 40 hours a week in total split amongst
8 the children. The child can still get 40
9 hours a week, but it can't be a parent in
10 combination that provides more than 40 hours
11 a week.
12 The rates are something -- the existing
13 rates that are in place -- so there are
14 three -- the three changes, which was the 50
15 percent for residential and then the 20
16 percent over fiscal year '23 and '24 that
17 were included as part of the legislative
18 required rate increases that we were directed
19 to use the ARPA funds for, those will remain
20 in place as well as the 50 percent rate
21 increase for providers that send in an
22 attestation that 85 percent of that rate is
23 passed through to the direct care workers.
24 Those all will remain in place. They
25 are written into the waivers. They will

1 remain in place until the rates -- based on
2 the outcome of the rate methodology study.
3 Once those are determined, then we will do
4 another amendment to the waivers to update
5 the rates. But until that point in time,
6 they will continue to be in the waivers.
7 We're encouraging anybody that has
8 questions, to send them to the Medicaid
9 public comment box, and I can put that email
10 in the -- in the chat so that everybody has
11 it. We have found that while a lot of the
12 social media groups are well-intentioned,
13 there are some incorrect information that's
14 being shared.
15 But to clarify on some of the other
16 limits that I think were contributing to
17 questions about increasing rates for PDS
18 employees in particular, we removed the
19 40,000 and 63,000-dollar cap that was on
20 Michelle P services because it was not fair
21 to individuals to have an increased rate that
22 was going to limit the amount of services
23 they could get just because the rates
24 increased. So that limit is no longer in
25 place. The 40 hours a week is still in

1 place.

2 Similarly, in HCB, there was a limit of

3 $200 a day. We also have removed that limit

4 because, again, we've increased the rates.

5 It could result in individuals receiving less

6 services to have that dollar cap. But the 45

7 hours a week service limit is still in place.

8 And there was clarification that just

9 went out about that. And, again, we're

10 working on a letter for -- directly to the

11 participants to explain that a little bit

12 better.

13 But I do encourage everyone, please go

14 out and look at the waivers for public

15 comment. We're in the process of

16 notifying -- making sure that all of the TACs

17 and other individuals that requested that we

18 send separate notification when the waivers

19 were posted, Kelli is getting all of those

20 out. We did -- again, it was last night. It

21 was, I think, close to 6:00 that the waivers

22 did get posted. So we're in the process of

23 getting all the notifications out.

24 But we have already started receiving

25 public comment. I started looking at some of

1 them this morning. I think we've received 10
2 or 15 comments already between last night and
3 about 9:00 this morning. So that is
4 encouraging. We do want to hear from
5 everybody once those changes are reviewed and
6 encourage anybody that has questions, to ask
7 those as well so that we can help navigate.
8 We realize the waivers are not the
9 easiest thing to read. The format that they
10 are in is not -- not very user friendly, but
11 it is what we are required to use by CMS.
12 That is their format so...
13 DR. WRIGHT: Pam, can I ask a
14 follow-up question to clarify?
15 MS. SMITH: Absolutely.
16 DR. WRIGHT: With rates that are
17 currently enacted, is there a form or a
18 document in a PDF format that you could share
19 that shows what those rates should be at the
20 thresholds?
21 MS. SMITH: They actually are
22 posted on the website. So if you go to the
23 fee schedules on Medicaid's website, the HCB
24 rates are posted. And they have -- they
25 actually include what the rate was prior to

1 COVID, so what the rate was as of 2019, the
2 rate changes that were enacted through
3 Appendix K, what the rates were for state
4 fiscal year '23, and what the rates are now
5 as of July 1st of '23, so fiscal year '24.
6 DR. WRIGHT: So if you wouldn't
7 mind, if you could share that link maybe in
8 the chat, that would be a helpful thing for
9 us to be able to take a look at maybe during
10 the meeting.
11 MS. SMITH: I can do that. Yeah.
12 I'll go grab it. I'll put it out there.
13 DR. WRIGHT: That would be great.
14 The next question is --
15 MS. BICKERS: Pam?
16 MS. SMITH: Yes, ma'am.
17 MS. BICKERS: I was just going to
18 let you know I've already dropped that in
19 their follow-up email.
20 MS. SMITH: Thank you.
21 MS. BICKERS: You don't need to
22 drop it in the chat.
23 MS. SMITH: Thank you very much,
24 Erin.
25 DR. WRIGHT: Perfect. The next

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1 question is, you mentioned sunsetting and
2 time frame. I think the confusion is we've
3 had October 1st, November 11th, and until DMS
4 approves. Which one relates to the overtime
5 rule? And if you could help clarify that,
6 that would be great today.
7 MS. SMITH: For the overtime rule,
8 it is when CMS approves the waiver. And so
9 that will be -- we are still -- it's going to
10 be a prospective date, so it will be a future
11 date. We are working with CMS right now to
12 determine what the best date will be for all
13 of our waivers.
14 Because if you have worked with the
15 waivers at all, you know -- so each waiver is
16 on a waiver year, and all of our waiver years
17 were different. So, for example, Michelle P
18 just restarted on September 1st. HCB just
19 restarted on August 1st.
20 So we're working with CMS to determine
21 what that best future date will be. Once
22 that is determined, we will begin working
23 with the providers to make sure that there is
24 advanced notice, so it's not that everyone --
25 that it is decided that, okay, it's changing

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1 tomorrow. You need to change tomorrow. We
2 want everyone to have time to work with
3 participants to return back to what those
4 pre-overtime -- what those units were and to
5 have enough time to change those
6 person-centered plans.
7 DR. WRIGHT: Well, I have to
8 reference then -- I had someone from DAIL
9 yesterday, in KIPDA, reference that there's
10 something that was stated that it was going
11 to be -- I guess April maybe was included in
12 the conversation. A number of people at DMS
13 that stated it was starting the 1st.
14 And so we were speaking with a support
15 broker just yesterday, that at least with
16 KIPDA, they're suggesting that the dial-back
17 starts October 1st, and we were just
18 notified.
19 MS. SMITH: We are encouraging
20 individuals to go on and start having those
21 conversations.
22 DR. WRIGHT: But it's not -- it's
23 not mandated?
24 MS. SMITH: But it is not -- it is
25 not mandated October 1st. And if you have

1 that in writing or if you can send that to
2 me, I -- we -- my team has been working with
3 the providers and individuals to address any
4 miscommunications.
5 DR. WRIGHT: Yeah. That was
6 something that was miscommunicated yesterday.
7 So are you --
8 MS. SMITH: If you can send that to
9 me, then I can -- we can address that.
10 DR. WRIGHT: Okay.
11 MS. SMITH: But we are -- I will
12 say we are encouraging them -- we have not
13 given dates, and you'll see this in -- or
14 hear this in the recorded webinar. We are
15 encouraging providers to start having those
16 conversations with individuals about things
17 that will be -- that will be sunsetting once
18 that is over.
19 And there's still -- you know, as
20 always, there has to be the rationale behind,
21 you know, those person-centered service
22 plans. It has to be supported by the
23 participant's needs, and that has not changed
24 regardless of what the limits were so...
25 DR. WRIGHT: But just to clarify,

1 what I'm hearing today and just in summary is
2 that not October 1st, not October -- or not
3 November 11th. It's only when DMS
4 approves is when the --
5 MS. SMITH: When CMS, not DMS.
6 DR. WRIGHT: CMS.
7 MS. SMITH: CMS approves that
8 waiver. And so right now, they are out for
9 public comment until October the 27th, and we
10 will be submitting them to CMS for review on
11 November -- on or before November the 11th.
12 DR. WRIGHT: Okay. All right.
13 Thank you very much. You've clarified that.
14 That helps a whole lot.
15 MS. SMITH: Okay.
16 CHAIR PARTIN: Okay. Eric, you
17 indicated that you wanted this to be on the
18 agenda as an ongoing item. Would putting
19 this on the agenda, say, every six months be
20 sufficient, or do you need more -- more often
21 to be addressed?
22 DR. WRIGHT: I think if we put it
23 maybe on a quarterly basis until we get the
24 final -- you know, the -- once we get the
25 final approval, I think that would help, just

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1 to kind of keep the rate -- you know, the
2 topic out for discussion. Yeah.
3 CHAIR PARTIN: Okay. So --
4 DR. WRIGHT: Maybe quarterly.
5 CHAIR PARTIN: So that would be
6 January; right?
7 DR. WRIGHT: Yes.
8 CHAIR PARTIN: Okay. Thank you.
9 DR. WRIGHT: Thank you all.
10 CHAIR PARTIN: Okay. Next up is
11 updates from Commissioner Lee.
12 MS. JUDY-CECIL: Good morning. I
13 am not Commissioner Lee. I'm Veronica
14 Judy-Cecil with Medicaid. Commissioner Lee
15 is attending a provider association meeting
16 this morning and speaking to the group, so
17 you get me.
18 I know one of the things that
19 Commissioner Lee likes to share is our
20 enrollment numbers. So as of this week --
21 and, you know, this is only as good as the
22 date that it gets pulled. But we do have --
23 excuse me -- 1,626,029 members --
24 unduplicated members enrolled in Medicaid.
25 We -- of that, 142,930 are fee for service,

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1 and the rest, 1,483,099 are managed care.
2 Of that number of all Medicaid members,
3 the expansion population, which is -- for
4 those of you who are unsure what that means,
5 they are the ones that are part of the
6 expanded federal poverty level limit of 138
7 percent. That is -- 590,249 are part of our
8 expansion population.
9 I also want to give an update on
10 unwinding, and I'm going to share -- in the
11 interest of time, I'm only going to share a
12 couple of slides. We did have our
13 stakeholder meeting last week. It was last
14 Thursday, and that presentation is up on our
15 unwinding website.
16 But just for the folks on today, wanted
17 to provide some information about -- about
18 our current renewals and, you know, where
19 things stand and just chat a little bit about
20 kind of what we're seeing for renewals.
21 So there we go. This is looking at
22 enrollment across the unwinding period, and
23 you'll see that we are starting that decline.
24 The first set of renewals that were subject
25 to a potential termination was in May, so we

1 saw that on June 1st, the first initial dip.
2 And then as each month passes by, you know,
3 we see additional folks.
4 We knew there were going to be people
5 who were no longer eligible and were going to
6 drop off. I think what our biggest concern
7 is, we're seeing an increased number of
8 procedural terminations. And what that means
9 is that the individual has not responded to a
10 notice. There's something they have to do,
11 some action they have to take to respond to
12 us for us to be able to make that
13 determination. And if they don't do that by
14 their renewal date or by the due date, then
15 they -- they'll get terminated. So that's
16 what we're working on.
17 Just a quick glance at what our July
18 renewals -- since we did not present this at
19 the last MAC meeting, but we had 54,975 that
20 were in a July renewal. That means their
21 renewal date was July 31st. Of those, 27,044
22 were approved. This is just the snapshot at
23 the time of the July renewal. This aligns to
24 the CMS monthly report that we post every
25 month. So folks can go out and look at that

1 to see these numbers as well.
2 Of the approvals, we had about 82
3 percent that we were able to passively renew.
4 That means they had to take no action
5 whatsoever. We were able to go out and ping
6 all the databases, the trusted sources that
7 we have out on the federal hub and some state
8 data resources, and we can perform that
9 redetermination without them having to take
10 any action.
11 But of the terminations for our July
12 renewals, 20,344, there were 65 percent of
13 those that were those procedural
14 terminations. That does not mean that
15 everybody in that bucket is eligible. We
16 send a notice to someone. If we've gone out
17 and tried to verify their information and it
18 looks like they're no longer eligible, we'll
19 send them a notice. So even those
20 individuals that -- sorry about that -- that
21 are no longer eligible get put into that
22 bucket of procedural termination.
23 We do -- you'll see that we continue to
24 have a pending bucket, and the reason for
25 that is we are extending individuals, certain

1 individuals during the -- during this
2 unwinding period for long-term care and 1915C
3 waiver members. We're extending them up to
4 two months if they've not submitted a
5 response to a notice.
6 We also now have implemented this month
7 for anyone -- for anyone who hasn't responded
8 to a notice, we'll extend for one month. We
9 get two months for the long-term care 1915C
10 waiver members, only one month for the rest
11 of the population. So we may see that
12 pending number start to climb a little bit.
13 This is also if somebody has submitted
14 something and the State hasn't taken any
15 action on it, then they will be in pending
16 status.
17 So here are the numbers for August, and
18 we'll send these slides out. But like I
19 said, it is on our unwinding website. Again,
20 the different buckets. Just to note, so in
21 August of the approvals, 81 percent of those
22 were passively renewed. They didn't have to
23 take any action. We were able to just go
24 ahead and update their eligibility for
25 another 12 months and then the termination

1 bucket is -- about 65 percent are those
2 procedural terminations and then again the
3 pending.
4 So what a member can do if they're
5 terminated is, within a 90-day period after
6 their termination, they can respond to that
7 notice. And if we -- if they respond and
8 we're able to determine them eligible, we can
9 reinstate. It's an automatic process that
10 happens. They don't have to ask for
11 reinstatement.
12 So they come in, provide the
13 information. We determine them eligible.
14 They'll automatically get reinstated back to
15 their termination date if it's within that
16 90-day period.
17 So we're tracking those reinstatements,
18 too. So this -- you know, this is those
19 people that, for whatever reason, did not
20 respond prior to their end date but have
21 subsequently responded in some way.
22 So you'll see -- I'm not going to go
23 through all the numbers, but you can see May
24 renewals, the 90-day period has passed. So
25 that's -- we're not going to see necessarily

1 reinstatements for -- under that unwinding
2 flexibility, but folks should still be able
3 to reapply. And we're working through those.
4 June, July, and August, as you'll see,
5 you know, August being the most recent
6 renewal that we've closed, those numbers are
7 trickling in. But it's good to see that
8 people are at least possibly getting back in
9 if they've been terminated.
10 Couple of priorities I want to go over
11 just very quickly, and that is we're really
12 encouraging households with children that if
13 they receive a renewal notice, to respond.
14 Because the child eligibility federal poverty
15 limit is higher than it is for an adult. So
16 the adult may think, you know, oh, we're no
17 longer eligible. But really, we want to
18 encourage them definitely to send that in if
19 there's a child in the household.
20 The other is just to send it in anyway.
21 If we could make the determination -- you
22 know, perhaps they are eligible. Maybe
23 they're eligible in some other way. Without
24 that response, we just can't do that. So
25 we're just encouraging everybody to do that.

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1 And then, you know, our outreach is really
2 focused around if you're terminated, do what
3 you need to do in that 90 days, so we can get
4 you back in.
5 We released a new flyer on our website
6 and just encourage all of our providers and
7 stakeholders that if you have members, you
8 see members, they come into your offices or
9 you're communicating with them, please pull
10 those down. Maybe post them. Have them
11 available. Hand them out. You know, we
12 really want to continue to keep the word out
13 there about renewals are happening, so
14 certainly encourage you to do that.
15 Also, just want to remember -- remind
16 folks that if you're no longer eligible for
17 Medicaid, that member, that individual could
18 be eligible for a Qualified Health Plan and
19 premium tax credits that make that plan
20 either zero or very, very low premiums. So
21 just trying to encourage folks that if
22 they've been determined ineligible, to take
23 that next step. It is different because they
24 have to choose a plan and they have to pay
25 that premium, very different from Medicaid.

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1 So just encouraging folks to do that and
2 remind everyone that, you know, that's the
3 next step for somebody determined ineligible.
4 We're tracking QHP, Qualified Health
5 Plan, enrollment because when we see the
6 number -- the graph go down for Medicaid
7 eligibility enrollment, we want to see the
8 graph go up for QHP. Keeping people covered
9 is critically important.
10 Just a reminder, our website is out
11 there. Lots of information that we include
12 on a regular basis. Social media, if you're
13 not following us on one of the social media
14 platforms, we ask that you do. You don't
15 have to do all three.
16 We just recently -- just yesterday, late
17 yesterday, made aware of a scam. It's kind
18 of being recirculated, and we've been seeing
19 that throughout the unwinding. The current
20 one is a phone call. It has an 859 number,
21 and the person is really pushing for personal
22 information, bank information, very
23 aggressive.
24 So we're going to be posting something
25 on our social media today to just -- just to

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1 remind folks, you know, there are lots of
2 scams out there. Just try to be vigilant as
3 you do that. And it's really hard. They
4 really do just kind of prey on someone's
5 vulnerability.
6 And for providers, a reminder that you
7 can see the member's redetermination date in
8 KYHealth-Net. It's in there in red, and we
9 have the Kentucky Level of Care Report that
10 our 1915C and long-term care providers can
11 pull reports out of.
12 I think that -- the only other thing I
13 want to mention is that, you know, we pushed
14 a lot of the cases involving children to
15 later in the unwinding period. And we did
16 that because we were implementing continuous
17 coverage for children.
18 So we are -- we really are kind of
19 trying to look at additional flexibilities
20 and strategies that we can put into place to
21 make sure that someone otherwise eligible is
22 not getting terminated, that we're doing
23 whatever we can to make sure that we can
24 perform that redetermination. So, you know,
25 just doing our due diligence for that.

1 And we have exercised -- CMS has posted
2 June 2023 a list of the state strategies
3 available to states. We've elected 20 of
4 those strategies. Two of them are not
5 available to us, and we're in conversations
6 about whether or not we -- we elect one of
7 the other ones. So we're really trying to do
8 everything we can, take advantage of the
9 flexibilities and strategies that are out
10 there to, you know, get through this
11 unwinding period.
12 And then we fully acknowledge the wait
13 times are just -- you know, they're not good
14 on our hotline -- on our call center lines.
15 Again, we're trying to bring people on.
16 We're continually discussing what can we do
17 different. We are bringing more and more
18 people on and getting them trained, not just
19 for the call center but to do eligibility
20 determinations. So we're trying to work on
21 it.
22 I think there was a couple of questions.
23 DR. WRIGHT: Yeah. Veronica, I had
24 my hand up, and thank you for your
25 information today. So a concern that I've

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1 had posed to me a couple -- through a couple
2 platforms are individuals who are on waiver
3 services that have a child that's 17, and
4 they are going through the process of
5 guardianship. And they're also going through
6 the process of having to now, even if they
7 were medically deemed necessary, you know,
8 without the financial ability to meet the
9 criteria for Medicaid for waiver services
10 through the 1915C waivers, they have to
11 reapply for SSI. And in the interim, though,
12 they've been notified that they -- if they
13 don't get the approval, they're going to be
14 terminated for -- from the Medicaid waiver
15 program.
16 Someone who's gone through this myself
17 in the last couple of years with my daughter,
18 that process of SSI, you know, approval can
19 take three to four months. Can you explain
20 to me how you guys are going to address that
21 issue?
22 Because it sounds like that the timing
23 is a little off there. If SSI is not
24 responding within three to four months and
25 we're only having -- you know, we have to get

1 that SSI approval to meet the criteria at age
2 18, what's the solution?
3 MS. JUDY-CECIL: Right. It is --
4 sure. So one thing I would ask is that cases
5 that are complex like that, that there are
6 different impacts to the member and their
7 eligibility, is for those to be escalated, to
8 be quite honest with you. It's better for us
9 to be able to take a look at them and see
10 what are our options. We have some
11 discretion but not all discretion. So --
12 DR. WRIGHT: Well, the response is
13 that the ombudsman's office is getting very
14 busy with this, and so I don't know if y'all
15 are working hand in hand with the ombudsman
16 in the office there.
17 MS. JUDY-CECIL: We are.
18 DR. WRIGHT: Because, I mean, I
19 don't foresee that SSI, with their same
20 staffing issues, are going to see the process
21 being improved --
22 MS. JUDY-CECIL: Yep.
23 DR. WRIGHT: -- any quicker. So, I
24 mean, we're still going to see us being, you
25 know, three to four months.

1 MS. JUDY-CECIL: Right, right.
2 DR. WRIGHT: And, therefore, we're
3 not going to be able to see people. Because
4 we're seeing -- I'm getting a lot of
5 information about that, and all I can do is
6 say call the ombudsman or call Medicaid.
7 MS. JUDY-CECIL: Right. Yeah. And
8 let us take a look at it because we -- as I
9 mentioned, so we have some flexibilities in
10 being able to extend folks. There are what's
11 called ex parte periods of time where
12 somebody can continue to have that coverage
13 while the process is going.
14 I'm just going to be perfectly candid,
15 though. There are some times we have to
16 follow the rules. And if that rule forces
17 our, you know, ability to do something and it
18 comes to a termination, you know, we have to
19 move forward with that action.
20 I think -- and I note that, you know,
21 someone posted in the chat that -- about
22 appealing. And if someone appeals, it does
23 allow them to maintain that coverage as it
24 goes through the appeal process, so that's a
25 really good note.

1 But, you know, that's kind of where we
2 are, and we are certainly here to try to help
3 our members navigate this. Again, we don't
4 want to see members, especially our
5 vulnerable population who have great needs,
6 to go without that coverage. So the right
7 course is to try to get that up to us and
8 have us take a look at it to see what our
9 options are.
10 DR. WRIGHT: You mentioned
11 ex parte --
12 MS. SMITH: Veronica, I'll add that
13 we do not close the waiver slots in these
14 situations. We have a mechanism where we are
15 able to keep them open, so individuals are
16 not losing their waiver slots during that
17 time period where they're doing the SSI --
18 whatever, if it's the application or wherever
19 they are in that process. We do not close --
20 we keep that waiver slot open, and we've
21 worked with several -- with several
22 individuals through that process so...
23 DR. WRIGHT: You mentioned
24 ex parte. What is that again?
25 MS. JUDY-CECIL: So that is a

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1 period of time where the person is granted
2 eligibility. Even though maybe we have
3 something on our -- and this is different
4 than the passive renewal. But if we have
5 something -- if they're eligible even though
6 they're being terminated because we're not
7 seeing them, the reason for their eligibility
8 has ended, then we can give them a period of
9 time. It's, I think, three months -- two to
10 three months. They maintain coverage to give
11 them the opportunity to file for, for
12 example, SSI or for maybe another Medicaid.
13 They can file a Medicaid application for
14 another coverage.
15 So -- and a lot of times, again, we have
16 to look at the specific case to see does it
17 fall into something where we can utilize that
18 discretion or, you know, that they're
19 eligible for that extended period of coverage
20 while, you know, they try to get eligibility
21 in another category.
22 DR. WRIGHT: Okay. Great. Thank
23 you so much. You've answered my question.
24 MS. JUDY-CECIL: Okay. Great. I
25 think Dr. Gilbert, you were next.

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1 MR. GILBERT: Yes. This is Kent
2 Gilbert. Thanks, Veronica. Thanks for your
3 help.
4 Listen, I understand that Kentucky is on
5 the list of the 30 states that were required
6 to pause terminations because they got
7 procedural -- procedural terminations. So
8 what's the status of that right now, and how
9 does that affect the numbers that you've told
10 us that are clearly -- you're clearly
11 terminating people for procedural reasons?
12 So what's the mitigation, and what's going
13 on?
14 MS. JUDY-CECIL: Sure. So that --
15 on August 30th, CMS issued a letter to all
16 the states ensuring that states are
17 processing individuals in a household
18 separately and at that passive renewal rate.
19 So we go out. We check -- we verify income.
20 The income comes back and makes the adult in
21 the household not eligible, but the child is
22 likely still eligible.
23 Several states -- Kentucky is not one of
24 them. Several states would send the
25 household a notice and then if that notice

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1 wasn't responded to, terminate. In Kentucky,
2 we -- we do separate the eligibility. So if
3 someone is otherwise eligible, we will
4 separate them from that household notice, and
5 they'll continue their eligibility.
6 Kentucky was incorrectly included on
7 that list. We've been in communication with
8 CMS. Of course, with things like this, once
9 it's out there, it's hard to pull it back.
10 So you'll be seeing it get updated.
11 What we've done is, you know, a review
12 of all of our cases. We are going back and
13 just, in full disclosure, making sure that
14 nobody was inappropriately -- so we're going
15 back. We're looking at households with
16 multiple individuals and making sure that we
17 did appropriate -- the system did
18 appropriately separate them.
19 But, again, we have no evidence that
20 that has happened in Kentucky, so we are not
21 subject to that requirement to pause. And
22 it's not to pause all procedural
23 terminations. It's only the ones associated
24 with that particular issue.
25 MR. GILBERT: Gotcha. Thank you.

1 And I appreciate that you're taking that kind
2 of care because I think it does make a huge
3 difference. I also was glad to hear about
4 the 90-day -- you know, the ability to
5 reapply and get things going.
6 The fee-for-service folks, though,
7 they're -- how is that -- I mean, that's a
8 mess. What's going on with --
9 MS. JUDY-CECIL: Yeah. So, you
10 know, we continue to work on it. We -- we're
11 doing the extensions if they haven't
12 responded. I think the other challenge is,
13 you know, these can sometimes be a little
14 complicated because there's a resource or
15 asset test. And we're continuing to educate
16 our eligibility workers to make sure they
17 understand that we have some flexibilities
18 around that. So if something is pending or
19 being denied based on an asset or resource
20 requirement that, you know, we should -- we
21 should be moving those on along and not have
22 it hold up for that reason.
23 So, you know, we are -- I can assure
24 you -- just really concerned as well about
25 our long-term care and our 1915C members

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1 having to navigate this and make sure that
2 they're not terminated; which, if documents
3 are pending, if we've not processed those
4 documents, the member is supposed to be --
5 continue to be extended until that happens.
6 And we do not retro that termination. It is
7 always going forward and...
8 You know, but our system isn't perfect,
9 and so we just continue to ask that when our
10 providers are seeing this, to help escalate
11 those cases to us so that we can take a look
12 at it and see what's going on and reinstate
13 if we need to in the interim.
14 But we are -- one of the solutions for
15 this and for some of the other, again, more
16 complex cases is we're trying to bring up
17 staff, and we're redirecting staff from other
18 agencies that can kind of help form a team
19 that we can work on these and get them -- get
20 them through.
21 I know one of the other issues is
22 multiple requests for information. So
23 somebody submits something and then they get
24 another request and another request. And,
25 unfortunately, that is the difficulty of the

1 process because we, you know, have to make
2 the determination based on evidence, and I
3 promise you we get audited on this every
4 year. So we want to make sure that we have
5 the evidence in our system to -- that if
6 we're determining somebody eligible, that we
7 have the document to back that up.
8 So -- but we're looking at those cases,
9 too. We've gotten a lot of examples of where
10 that's happened, you know, multiple RFIs.
11 MR. GILBERT: Well, and it's twice
12 the rate. I mean, those fee-for-service
13 folks are losing coverage at twice the rate
14 as everybody else, and so they also require
15 probably more documentation, which makes it
16 complicated on both sides and --
17 MS. JUDY-CECIL: We --
18 MR. GILBERT: Just from
19 constituency side points, you know, it's
20 really -- you know, escalating a case,
21 it's -- I mean, I so appreciate what you're
22 saying. But escalating a case from a user
23 standpoint is not very easy. I mean, you
24 know, you call. You wait four or five hours
25 to get the wrong person who doesn't know what

1 you're talking about on the phone. You
2 finally get a number. You call that number,
3 and it's too late, or they can't take your
4 call.
5 I mean, escalating a case isn't a simple
6 matter. So if you have any advice that we
7 can pass back, I would sure appreciate it
8 because I know both --
9 MS. JUDY-CECIL: Yeah.
10 MR. GILBERT: -- providers and
11 clients who are having trouble with this.
12 MS. JUDY-CECIL: Yeah. We're
13 working on that. We're working on an
14 escalation path outside of our connectors and
15 agents for this particular reason, and so we
16 will be sharing that information very soon.
17 We're just -- we're getting our ducks in a
18 row so that we can be ready for when we
19 re-launch that. I fully understand.
20 We have -- I will say that we have dug
21 into the fee-for-service terminations, so we
22 know who they are. We know what category
23 they're under. We know whether it's been
24 appropriate.
25 We've also -- you know, we did front --

1 at the beginning of the unwinding through our
2 allocation of the cases across the 12 months,
3 we fronted -- there were a lot of
4 fee-for-service members. They were the ones
5 that were eligible for and should be applying
6 for Medicare, or we've gotten notice that
7 they're no longer eligible from our Social
8 Security file. So there were, you know,
9 definitely a larger number at the beginning.
10 You will see that it has completely --
11 it is completely tailoring off, though. Not
12 to say that there aren't fee-for-service
13 members in long-term care and 1915C members
14 being terminated. But, you know, we are
15 tracking it very closely.
16 MR. GILBERT: I appreciate it.
17 Thank you.
18 MS. JUDY-CECIL: Dr. Schuster?
19 DR. SCHUSTER: Yes. Thank you.
20 And I'm so glad that Dr. Wright and Reverend
21 Gilbert brought up some issues around the
22 people on the waivers because we have -- we
23 keep hearing this with people on waivers and
24 fee for service, Veronica. So we appreciate
25 that you're looking more closely.

1 Also, the scam -- and I will just say to
2 people -- because I brought this to your
3 attention last night. Several of our
4 behavioral health members were getting phone
5 calls, very aggressive, very, very
6 aggressive, demanding information, saying if
7 they didn't give it then, they would be
8 terminated.
9 In both these cases, the people were
10 wise enough to know they had already turned
11 in the information. But I worry because we
12 keep asking people to give their information,
13 and I'm concerned that -- if we're not
14 careful about how we get that out on social
15 media and so forth. But I appreciate that
16 you all are looking at that.
17 I have a question about passive renewals
18 and, I guess, are there passive terminations?
19 Because we're hearing from people that got a
20 notice that they're terminated, and they
21 never got a request for information. They
22 never got anything from you to say that they
23 need to submit information.
24 MS. JUDY-CECIL: No. The only --
25 if we've gone out and the trusted data source

1 tells us that their income is no longer
2 eligible for Medicaid, they will receive a
3 notice that is a prepopulated form to give
4 them the opportunity to verify that
5 information prior to -- it's not an automatic
6 termination.
7 The only instance and when somebody
8 might receive something different than that
9 is if we go out and ping the trusted source
10 and it tells us their income qualifies for
11 advanced premium tax credit for a Qualified
12 Health Plan, we want them to get kind of
13 moving in that direction.
14 So they'll get a notice that tells them
15 that. It clearly says your income says that
16 you're no longer eligible for Medicaid, but
17 you're eligible for APTC. If that
18 information is incorrect, they should
19 respond. Because we say in the notice, if
20 this isn't correct, contact us.
21 So the reason for that is because the
22 trusted data source is telling us -- or maybe
23 they've even reported it to us that they're
24 no longer eligible. It generates that notice
25 to get them moving to a Qualified Health Plan

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1 to get that process started, so there's no
2 gap in coverage.
3 But, you know, we're trying to maybe
4 educate more individuals along that line.
5 But otherwise, if the trusted data source
6 tells us they're no longer eligible, they get
7 a renewal notice to go and do that active
8 process before we will terminate them.
9 DR. SCHUSTER: Could you share that
10 notice with us or send us a link to that?
11 Because I think there's some confusion and
12 maybe because they see the first part. And
13 they see they're terminated, and the request
14 for information is not -- or the request to
15 verify, that they think they still are
16 Medicaid eligible, is not as clear as it
17 might be. Is that possible, to share that
18 notice with us?
19 MS. JUDY-CECIL: Absolutely. Yep.
20 Happy to do that.
21 DR. SCHUSTER: Yeah. I would
22 appreciate that because we're hearing that,
23 and we know that people get confused. And as
24 you say, there are multiple outreaches, and
25 they're hearing it from lots of different

1 people. But we really want to be sure that
2 people who, you know, inadvertently got
3 terminated and got a notice that they didn't
4 understand -- and I know you're trying to
5 keep those people in the loop. And we
6 particularly want to get them reinstated in
7 that 90-day period. So we're all focused --
8 MS. JUDY-CECIL: And they --
9 DR. SCHUSTER: We're looking at
10 close to 100,000 people in that 90-day period
11 right now.
12 MS. JUDY-CECIL: I will say that
13 they get outreached to as if they are going
14 through an active redetermination. So
15 they -- you know, we're calling them, and
16 their Managed Care Organization is calling
17 them to have that conversation.
18 So, oh, it looks like your income is no
19 longer eligible. You know, would you like to
20 sign up with a Qualified Health Plan? So the
21 outreach to them is similar to the outreach
22 we're doing for the rest of the population
23 going through an active renewal.
24 But yes, we're happy to share what that
25 notice looks like. And it's the notice that

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1 we used prior to the Public Health Emergency.
2 This is part of the normal eligibility and
3 enrollment processing, so that hasn't
4 changed.
5 DR. SCHUSTER: Yes. I guess my
6 only point is let's be sure that people know
7 that they have an opportunity to give you
8 different data or to give you some reason why
9 they shouldn't be terminated. Obviously, if
10 they are not eligible, they're not eligible.
11 We're not asking you to make them eligible
12 when they're not.
13 MS. JUDY-CECIL: Yeah.
14 DR. SCHUSTER: But let's be sure
15 that they understand that they have an
16 opportunity to give you that information.
17 Thank you.
18 MS. JUDY-CECIL: Yep.
19 MS. BICKERS: Veronica, there's a
20 question in the chat from Peggy. She says,
21 I'm curious how we're helping folks who don't
22 have access to cell phones or computers,
23 language barriers, or ones who don't
24 understand.
25 MS. JUDY-CECIL: So that's an

1 excellent question and, you know, one of the
2 challenges that we always face when we're
3 really communicating with our members in any
4 capacity. And that's why we do have multiple
5 modes of communication. So it's the written
6 notice, the phone call or text, or an email.
7 And if we have any of that on file, that
8 is -- you know, we ping all three modes of
9 communication.
10 For language, you know, we're continuing
11 to work on that and make sure that members
12 understand what the path is to navigate, how
13 to get help if there's a language barrier.
14 Probably could do better there as well. And,
15 you know, we have been working and,
16 unfortunately, it just is taking us some time
17 to try to translate the information into
18 multiple languages. We do a good job of
19 doing Spanish but not so good at doing other
20 languages and just continue to work on that.
21 So, you know, we heavily rely on our
22 partners in this area, and we're so grateful
23 for our community based organizations that
24 are out there in the communities that do help
25 individuals that might have a language

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1 barrier navigate the process. So I'm hoping
2 that those individuals are getting connected
3 in those communities with those resources.
4 And, you know, I will always say this.
5 If we can't prevent the termination, it's
6 what we do on day one after to try to get
7 them back in and make sure they understand.
8 And providers are just a great place for
9 that, not to add to the administrative burden
10 there.
11 But if the person comes in and you see
12 they're terminated, there are ways to get
13 them back on and, you know, we -- that's why
14 we've really been pushing the literature
15 that's on our website directed to providers
16 on what to do if somebody comes in and
17 they're no longer covered. So just trying to
18 continue to work on that.
19 CHAIR PARTIN: Okay. Anything
20 else?
21 (No response.)
22 CHAIR PARTIN: All right, then.
23 Let's move on to the update on the mobility
24 crisis.
25 MS. JUDY-CECIL: Yeah. And I think

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1 we have Leigh Ann.
2 MS. FITZPATRICK: Yes.
3 MS. JUDY-CECIL: There we go.
4 MS. FITZPATRICK: Hi. Good
5 morning. I'm Leigh Ann Fitzpatrick with the
6 Department For Behavioral -- no, I'm not,
7 with the Department For Medicaid Services.
8 I'm a behavioral health specialist. I
9 apologize.
10 I have just -- I'll be very quick. For
11 mobile crisis, our mobile crisis
12 implementation, for right now, we have our
13 SPAs that have been approved by CMS. Those
14 include a redefinition of mobile crisis
15 services that goes along with the CMS SHO
16 letter back in December of 2022.
17 We have created a new service of a
18 23-hour observation stabilization service
19 that goes along with our residential. So in
20 that case, if someone needs -- they don't
21 need to go somewhere overnight but need to be
22 somewhere away from a location or just a
23 stable environment. With that, there would
24 be a medical and a behavioral health
25 assessment to see what services that person

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1 needs.
2 With our residential crisis, we updated
3 the definition, updated crisis intervention.
4 Those were approved back in July 20 of this
5 year.
6 The last item is our behavioral health
7 crisis transports which was approved
8 September 11th. It's a new provider type.
9 This will be something -- it's two separate
10 situations that, say, if someone has called
11 988 and they determine that a mobile crisis
12 intervention services needs to be dispatched,
13 the team gets there and works on -- works
14 with that person, tries to deescalate.
15 And they see that that person -- it
16 can't be done there on scene, that they need
17 to go maybe to a 23-hour -- and sometimes,
18 unfortunately, maybe to the hospital or to
19 our most appropriate higher level of care.
20 At that point, a behavioral health crisis
21 transport provider can come and transport
22 that provider (sic).
23 The second situation is -- I know that
24 we have several -- this happens at several
25 locations around the state, that someone

1 walks into the ED or is sent to the ED. And
2 they need to go to either an inpatient
3 facility because that ED doesn't have --
4 within the hospital system has that
5 capability to treat them, and they need to go
6 to a higher level of care. And we can't call
7 911 because that's not an emergency service
8 or an ambulance or an EMS service.
9 So at that point, the ED somewhere
10 within that system can call the behavioral
11 health crisis transport provider and -- to be
12 able to provide that person to the next level
13 of care. And I will send this to Erin to
14 send out to everyone as well.
15 With the SPA changes, also, we have --
16 as you know, we're seeking an ASO to oversee
17 this model, provider capacity training, and
18 to oversee multiple levels of funds that have
19 been leveraged.
20 We do have our community crisis
21 co-response model, a new notice out for a
22 funding opportunity. And I'm going to put
23 that in the chat for you. We put that out
24 originally this summer. With increased
25 interest and other feedback from persons that

1 are interested in that, we have reissued that
2 NOFO out. Applications are due October 31st.
3 There is a webinar this afternoon to work
4 with folks that want to send an application
5 in or have further questions.
6 The last thing is, along with the
7 behavioral health crisis transportation, we
8 also -- we also have put in a SPA to CMS for
9 a treat/not transport that is still with CMS.
10 And, also, with that, CMS told us that some
11 of our -- some of Kentucky's regulations are
12 more stringent than the federal ones,
13 particularly on that EMS cannot get
14 reimbursed and must provide -- cannot be
15 reimbursed if they go somewhere else besides
16 a hospital. We are changing that regulation
17 to say that -- an alternative location,
18 taking out hospital and just putting in
19 alternative location.
20 And I know there are some questions, so
21 I'd be glad to take them. Anyone, go first.
22 MS. EISNER: Who? Me?
23 MS. FITZPATRICK: Go ahead, yes.
24 MS. EISNER: Yeah. Okay. Thank
25 you. Thanks, Leigh Ann. I'm pleased to hear

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1 about the BH crisis transport, but I'm
2 wondering if anybody is going to actually
3 start doing it. Do you have any ideas, or
4 are there additional providers coming on
5 board? Because there's such a --
6 MS. FITZPATRICK: So --
7 MS. EISNER: -- (inaudible)
8 resources.
9 MS. FITZPATRICK: So it is a new
10 provider type, and we have heard, like you
11 said, positive -- positive about it. So
12 let's say that an EMS -- you know, they have
13 the ambulance. If they have -- they could
14 enroll in that provider type as well if maybe
15 they have a van or car or something else. If
16 the NEMT providers, if they can, you know,
17 follow and meet the criteria, they can enroll
18 as that provider type as well.
19 So we're anxious, and we're hopeful that
20 we do have several that will be able to
21 enroll in that provider type.
22 MS. EISNER: Okay. Good. Thank
23 you. I'll remain cautiously optimistic.
24 MS. FITZPATRICK: Yes. Thank you.
25 MR. GILBERT: I'll echo that

1 cautious optimism as well. But I was just in
2 a meeting yesterday with house leadership
3 releasing a statement that they want to
4 introduce legislation to have sheriff's
5 offices, police officers, and various others
6 be eligible, too.
7 Is this part of your conversation? Have
8 you been in touch with them? We're curious
9 about this legislation that's going to move
10 in the new session, and I'm just not clear at
11 all how this -- how this interfaces. If
12 they're going to pass -- if they're going to
13 have something, it ought to dovetail.
14 MS. JUDY-CECIL: I can take that,
15 Leigh Ann.
16 MS. FITZPATRICK: Okay. Thank you
17 so much.
18 MS. JUDY-CECIL: Sure. So we
19 have -- based on previous legislation that
20 has come out that has directed some of the
21 work that underlies this new model, we --
22 there have been conversations with various
23 legislators. I can't tell you exactly, you
24 know, what leadership definitely, but yeah,
25 some conversations. Because they are aware

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1 of how we're implementing current legislation
2 and what, you know, the program is going to
3 look like.
4 And we do have, as part of this, a
5 community crisis response separate -- it's a
6 component of what we're doing in this model
7 that allows community -- communities to kind
8 of develop and leverage maybe some law
9 enforcement agencies.
10 The critical piece here is that we're
11 not -- you know, this is not to arrest more
12 people. It is to try to get the really
13 important behavioral health professionals in
14 the crisis response. And so that could be --
15 it could be a sheriff's office that has a
16 team that meets this definition.
17 So we look forward to seeing -- you
18 know, we've had to kind of create this just
19 from scratch based on lessons learned in
20 other states because states are doing this in
21 some form or fashion but not like Kentucky.
22 I mean, I think we really have developed a
23 comprehensive approach for the crisis
24 response.
25 So, you know, we'll certainly welcome if

1 there is -- and all that is having to be on
2 state dollars, by the way. So we can't --
3 you know, that grant program that we're
4 doing, that separate grant program is
5 separate from what we can do through
6 Medicaid.
7 MS. FITZPATRICK: Yes.
8 MS. JUDY-CECIL: So we would
9 welcome legislation that especially gives
10 funding, direct funding to a program like
11 that as long as -- and I --
12 MR. GILBERT: I wouldn't hold your
13 breath.
14 MS. JUDY-CECIL: Well, and as long
15 as it, you know, acknowledges and recognizes
16 that there has to be trained behavioral
17 health professionals --
18 MR. GILBERT: That's -- that is my
19 concern.
20 MS. JUDY-CECIL: -- as part of that
21 team.
22 MR. GILBERT: Yeah. My concern is
23 that they work very closely with you because
24 I think there are great opportunities, but
25 there are also great possibilities for either

1 misuse, abuse, or just plain ignorance
2 causing greater harm.
3 I think this is -- the proposal is, you
4 know, not -- we don't have legislative
5 language yet, but it has a number of very
6 concerning provisions including -- this
7 medical transportation piece comes under the
8 involuntary incarceration of the mentally
9 ill. That's the title, involuntary
10 incarceration.
11 I'm not real -- I am cautious. I want
12 there to be appropriate transportation, and I
13 want people to be able to get safely to and
14 from the care they need. I am wanting to
15 be -- I'm wanting all of us to be vigilant
16 about making sure that it's from trained
17 folks. Whether they're a driver or a sheriff
18 or a deputy or a constable or a clergy
19 person, they need to be meeting those
20 standards. And I hope you'll help keep the
21 legislative branch attuned to that.
22 MS. JUDY-CECIL: Thank you for
23 sharing that.
24 MS. FITZPATRICK: I'll also send to
25 Erin to send out our behavioral health crisis

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1 transport policy because in that, there is.
2 There's specific training that's involved.
3 There's specific vehicle recommendations,
4 requirements that are involved. It's
5 required to have a driver and another staff
6 person, so the driver can focus on driving in
7 those situations. So I think the policy does
8 outline some things.
9 MR. GILBERT: That's great. Thank
10 you.
11 MS. FITZPATRICK: You're welcome.
12 MS. JUDY-CECIL: Dr. Schuster.
13 DR. SCHUSTER: Yes. I'm glad that
14 Kent brought up this proposal from house
15 republicans. And they use the term
16 "confinement," involuntarily confinement of
17 the mentally ill, which is never what it's
18 been. KRS 202A is a voluntary
19 hospitalization. We're talking about
20 treatment here, folks. This is going the
21 opposite direction from treatment. It's
22 going into criminalizing mental illness, and
23 I am really, really concerned about it so...
24 And I hope it doesn't get all caught up
25 in what you all are trying to do, Veronica

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1 and Leigh Ann, over at Medicaid in terms of
2 getting these crisis teams and getting mobile
3 crisis and so forth.
4 I know that law enforcement has been
5 unhappy for a number of years about
6 transporting people after they've had a
7 mental inquest warrant sworn by the judge,
8 and we've had numerous pieces of legislation
9 and numerous discussions.
10 And I don't -- you know, there's a lot
11 of different issues here that could end up
12 getting together into a mess, so I just think
13 we really need to be on top of this.
14 Thank you.
15 MS. JUDY-CECIL: Yeah. That's why
16 we thought it was important that we can't
17 just do 988. We need to include 911, too,
18 and make sure that any -- anyone responding
19 to the crisis regardless of where it comes
20 from, there's a consistent response that's
21 appropriate for behavioral health, mental
22 health, you know, somebody with a behavioral
23 health or mental health issue and then
24 transporting them.
25 You know, what I think is really great

1 is the flexibility that's in our program, is
2 to be able to transport the person to an
3 appropriate setting. And so that -- you
4 know, in the past, transportation covered by
5 Medicaid was to the ER, and we're doing away
6 with that.
7 So, you know, we'll be able to assess
8 and get individuals to, you know, a
9 behavioral health treatment provider that we
10 never have been able to do before. So we're
11 really looking forward to the impact.
12 It is -- you know, we're rolling it out.
13 It's still very much in its infancy. It's
14 not even really been born yet. So, you know,
15 we're looking forward to the implementation
16 and working closely with providers on, you
17 know, making this successful.
18 DR. SCHUSTER: Thank you.
19 CHAIR PARTIN: Thank you,
20 everybody. I just want to note that we have
21 about 30 more minutes to the meeting, and we
22 have a lot more to cover. So this meeting is
23 probably going to run over, so I just want to
24 give everybody a heads-up about that.
25 Next up is MCOs report 98 to 99 percent

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1 adequacy of compliance for services, but
2 Kentucky's third-party quality contractor
3 (IPRO) "secret shopper" reports only 30 to 40
4 percent compliance. There is a concern that
5 this compliance does not address actual
6 accessibility services, so we had requested a
7 report to address the discrepancies between
8 the MCO report compliance versus the IPRO
9 report.
10 MS. PARKER: Good morning -- good
11 afternoon almost. I think we have one more
12 minute. But I am Angie Parker. I'm the
13 Director of Quality and Population Health
14 within the Department For Medicaid Services.
15 And I have with me today Chuck Merlino who is
16 our account manager for our external quality
17 review organization contract known as Island
18 Peer Review, also known as IPRO.
19 And we are -- I am going to go through
20 some of the high level of the -- what --
21 network adequacy access and availability and
22 what the secret shopper survey process is all
23 about.
24 So, first of all: What does -- what is
25 the definition of network adequacy? And what

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1 we have here is the state -- this is CMS'
2 definition, that we must ensure that Medicaid
3 and CHIP managed care plans maintain provider
4 networks that are sufficient to provide
5 timely and accessible care to our
6 beneficiaries across the continuum of
7 services.
8 The access and availability contract
9 requirements are as follows: For urban
10 areas, they have to be within 30 minutes or
11 30 miles of their place of residence or work,
12 to the extent that services are available.
13 In nonurban areas, PCP and hospital services
14 are to be within 30 minutes or 30 miles of
15 their place of residence or work, to the
16 extent services are available, and other
17 providers within 50 minutes or 50 miles of
18 their place of residence or work, to the
19 extent that they are available.
20 MCOs may request exceptions to network
21 requirements due to challenges meeting the
22 network adequacy such as workforce shortages.
23 As Dr. Walton went through earlier, I think
24 some of this can align to what he had
25 reported on. And they can also ask to

1 utilize telehealth as -- to meet network
2 adequacy per DMS approval.
3 Appointment wait times per contract, and
4 my -- and also with providers, MCOs'
5 contracts with providers -- is they are to --
6 you are to be able to see or get into -- see
7 a physician within 30 days for a routine, for
8 preventive services or, you know, just your
9 yearly checkup. If I were to call today, the
10 expectation would be to be able to get into
11 my doctor within 30 days of that request.
12 For 48 hours, urgent care for 48 hours.
13 And what I mean by urgent care is, like, sore
14 throat, pneumonia, or a cold. Hopefully,
15 people aren't going to see you for a cold,
16 but sometimes they do. And, of course, for
17 emergency and behavioral health services,
18 they're to be available 24/7 regardless if
19 they're in the network or not.
20 So what you had asked about is the
21 secret shopper survey. And, basically, what
22 this is, it's a telephone-based survey to
23 evaluate access to and availability of
24 providers participating in the MCO. It
25 assesses the ability to contact providers and

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1 make office-hour appointments using a secret
2 shopper survey methodology.
3 We change annually. We select different
4 provider types to review each year, and we do
5 a random sample. And eval- -- IPRO does all
6 this, evaluates availability of routine and
7 urgent appointments and after-hours access.
8 As I said, it's performed annually by IPRO.
9 The methodology, the IPRO -- the
10 surveyors are instructed to role play as an
11 MCO Medicaid member seeking care, and there
12 are scripts in which they are to follow
13 that -- based on routine or urgent-type
14 scenarios.
15 And they call providers in an attempt to
16 get appointments. They make at least four
17 attempts to contact an actual staff person to
18 complete the survey. In subsequent attempts,
19 they call on different days, different times,
20 just to make sure that -- to try to get in
21 touch with that provider if they haven't been
22 able to do that.
23 In the past ten years, these are the
24 secret shopper surveys that IPRO has done --
25 performed for the Department For Medicaid

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1 Services, and the last one was on
2 pediatricians. We've done dentists a couple
3 of times and, actually, we're doing them
4 again this coming fall. We're surveying
5 them.
6 So here are the results of the last
7 secret shopper survey -- say that three
8 times -- with a pediatrician. All MCOs sent
9 information to IPRO, and they excluded
10 selected providers based on certain criteria.
11 There were 1,169 providers in the final
12 sample, and they attempted 491 routine calls
13 and 491 urgent calls and 187 after-hours
14 calls. The survey was conducted in December
15 '22 and January '23. Your offices may have
16 been contacted.
17 So what were the results? They were
18 able to contact 80 percent for a routine call
19 to get an appointment. And the reasons they
20 were not able to contact the provider was --
21 and the No. 1 was their answering machine or
22 voicemail system. That's what they were --
23 they got, and this was after four attempts.
24 And the second would be the telephone message
25 was out of order.

1 Now, if there's any specific questions
2 on what all these mean, Chuck can further
3 explain all that. Constant busy signal,
4 wrong telephone number, no answer, answering
5 service, number of resident or nondoctor
6 business, and put on hold for greater than
7 ten minutes. That just occurred once.
8 So urgent call contact. They were able
9 to make contact 83 percent of the time but,
10 again, the reasons they were not able to
11 contact certain providers were basically the
12 same reasons as routine.
13 The appointments made -- and this is
14 where the concern comes into play, is only
15 31.7 percent was -- an appointment was made
16 for a routine call. And for urgent calls,
17 only 29.5 percent when they were able to get
18 through and make an appointment.
19 And the reasons appointments were not
20 made, provider was not on site or no
21 alternative provider available was the main
22 reason provided for routine. Provider
23 practice restricted to specialty. Those were
24 the top two. And then they kind of drop down
25 to provider not accepting new patients to not

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1 a plan participant.
2 Also, for nonurgent/urgent calls, the
3 main reason was provider practice restricted
4 to specialty. So in this case, for a
5 pediatrician, they may have been a
6 pediatrician that specializes in hematology
7 or something like that.
8 MR. MERLINO: Yep.
9 MS. PARKER: So we do have these
10 reports along with all the quality reports
11 that IPRO works on with us and for us on our
12 website, and here is the link. And if you
13 would like to go in and look at the entire
14 report, it is available here. You can do a
15 drop-down and pick the year.
16 And I'm not sure -- we have a few of the
17 access availability surveys, but I'm not sure
18 all 11 years are on there. But if there's a
19 particular year or service that you would
20 like to see, we can certainly get that for
21 you.
22 Like I said, we contract with IPRO to do
23 a lot of reports for us and help us with
24 focus studies on different diagnosis and
25 issues with -- that address our Medicaid

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1 population.

2 We also -- Medicaid also performs other

3 network adequacy reports that are reviewed

4 internally by Medicaid's expert, I guess you

5 would say. But we have a geo-mapping -- all

6 the MCOs report quarterly a geo-mapping and

7 access report. They are to submit a monthly

8 provider network status report, quarterly and

9 timely access report, and quarterly provider

10 network adequacy exceptions report. These

11 are all being reviewed by DMS' subject matter

12 expert on a monthly or quarterly basis.

13 That was it, very quick. If there's any

14 questions, or, Chuck, if you would like to

15 add anything to this, the information

16 regarding secret survey.

17 MR. MERLINO: Yeah. No. You did a

18 good job explaining the process. The one

19 thing I want to point out is I think that the

20 purpose of this presentation was the

21 discrepancy between what the MCOs are

22 reporting and what IPRO is reporting. And I

23 think the big difference is we are truly

24 doing a secret shopper. We're calling on

25 behalf of a Medicaid member trying to get an

1 appointment.
2 And from what I understand, that the
3 MCOs, many of which use SPH Analytics, which
4 is a vendor, and it's not a true secret
5 shopper. They're calling, and they're -- the
6 scenario or their script says, I'm calling
7 from so-and-so health plan, and then they ask
8 several questions.
9 So you could get a different response
10 knowing that you're calling from one of the
11 plans versus it's -- you know, they think
12 it's a member calling. So I just wanted to
13 add that because I think that was one of the
14 things that you were trying to look at.
15 MS. PARKER: Yeah. It's not
16 exactly apples to apples in what the MCOs are
17 doing as far as a secret shopper versus what
18 we are doing, what IPRO is doing.
19 Dr. Schuster, you had a question.
20 DR. SCHUSTER: Yeah. Thank you,
21 Angie and Chuck. It looks like you only do a
22 secret shopper once a year for a designated
23 population of providers.
24 MS. PARKER: That is correct.
25 DR. SCHUSTER: Is that right?

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1 MS. PARKER: That is correct.
2 MR. MERLINO: That's correct.
3 DR. SCHUSTER: Okay. Because I saw
4 where behavioral health was 2014, so could I
5 hope that it might come back around in ten
6 years and, you know, how often -- because
7 you've got lots of providers.
8 MS. PARKER: We'll put that on the
9 list for next year. Right.
10 DR. SCHUSTER: You know --
11 MS. PARKER: Right.
12 DR. SCHUSTER: -- I'll put in a
13 motion that you come back and do behavioral
14 health at some point, but it could take you a
15 long time to get through all of the provider
16 types, I guess, is what I'm saying so...
17 MS. PARKER: I was thinking we --
18 we did it -- in 2021, we did behavioral
19 health providers, alcohol and substance use
20 disorder providers. I was thinking that we
21 had done something like that in the time that
22 I've been with Medicaid.
23 MR. MERLINO: Yeah.
24 DR. SCHUSTER: Well, it says --
25 2018, it just says alcohol and other drug

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1 providers. It doesn't say behavioral health.
2 MS. PARKER: Right here -- and we
3 have 2014. But right here in 2021, we did a
4 few different providers.
5 DR. SCHUSTER: Oh, you did a whole
6 bunch of providers.
7 MS. PARKER: We did a whole bunch.
8 DR. SCHUSTER: All right. Well,
9 let me go and look at 2021, then.
10 MS. PARKER: Okay.
11 DR. SCHUSTER: Thank you.
12 MS. PARKER: If it's not -- I'll
13 make sure -- if it's not on the website,
14 we'll send that to you.
15 DR. SCHUSTER: Okay. Thank you. I
16 appreciate it.
17 MS. PARKER: Uh-huh. Does anyone
18 else have any questions? I didn't know if
19 there's anything --
20 (No response.)
21 MS. PARKER: Okay. Well --
22 CHAIR PARTIN: Thank you, Angie.
23 MR. MERLINO: Okay. If anything
24 else comes up, you know, you can reach out to
25 Angie, and we'll get you an answer.

1 CHAIR PARTIN: Thank you.
2 MR. MERLINO: Okay.
3 CHAIR PARTIN: Okay. We have 20
4 minutes, and we have two things on the agenda
5 that -- where we have to have a quorum, and
6 we have some members who have to leave on
7 time. So I guess we need to go through the
8 TAC reports, but we'll have to do this
9 quickly and then we'll have to do the vote
10 for the election.
11 And then, following that, we will do the
12 reports from the MCOs so that we can have a
13 quorum to vote to approve the recommendations
14 from the TACs and to vote for the officers
15 for the MAC.
16 So having said that -- and, again, I
17 apologize to the TACs. We've had a very full
18 agenda this time. But when it comes up for
19 your report, if you would just give your
20 recommendations and, again, I apologize.
21 We'll try to do better next time to allow the
22 TACs more opportunity to give information
23 about what's going on with their TAC.
24 So having said that, we'll start with
25 Therapy Services.

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1 MS. BICKERS: I don't believe
2 anybody is on from Therapy, Children's TAC,
3 or the Hospital TAC.
4 CHAIR PARTIN: Okay. So I'll just
5 say it but then we'll move on.
6 Primary Care?
7 DR. MERRITT: Elizabeth, this is
8 Patrick with the Kentucky Primary Care
9 Association. Is this the correct TAC report?
10 CHAIR PARTIN: Yes. Yes.
11 DR. MERRITT: Yes. I apologize.
12 So we -- there are no recommendations at this
13 time.
14 CHAIR PARTIN: Okay. Thank you.
15 Physician's Services?
16 DR. GUPTA: We did not meet.
17 CHAIR PARTIN: Thank you.
18 Pharmacy?
19 (No response.)
20 CHAIR PARTIN: Persons Returning to
21 Society From Incarceration?
22 MR. SHANNON: This is Steve
23 Shannon. We met, and we have no
24 recommendations. Thank you.
25 CHAIR PARTIN: Thank you.

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1 Optometry?

2 DR. COMPTON: This is Steve

3 Compton. We met and have no recommendations.

4 CHAIR PARTIN: Thank you.

5 Nursing Services, they had no

6 recommendations. They posted in the chat.

7 Nursing Home?

8 (No response.)

9 CHAIR PARTIN: Home Health?

10 MS. BICKERS: They posted the

11 recommendation in the chat. I believe Evan

12 had to sign out.

13 CHAIR PARTIN: Okay. Thank you.

14 MS. BICKERS: It says -- my

15 apologies. I'm trying to scroll to it. They

16 request that Medicaid add code T4544 to the

17 supply fee schedule allowed codes.

18 CHAIR PARTIN: Okay. Thank you.

19 Health Disparities?

20 DR. BURKE: Yeah. This is Jordan

21 Burke. We met on September 6th. We have no

22 recommendations at this time.

23 CHAIR PARTIN: Thank you.

24 EMS?

25 MR. SMITH: This is Keith Smith.

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1 We've met several times. No recommendations.
2 But when we have the opportunity, I
3 would like to give some laudatory comments to
4 groups of individuals that have made a
5 significant change for EMS and Department of
6 Medicaid Services.
7 CHAIR PARTIN: Okay. Thank you.
8 If we have time at the end of the
9 meeting, we'll come back to you. If not,
10 we'll do it next time.
11 Dental?
12 DR. BOBROWSKI: Yes. This is
13 Dr. Bobrowski. The MAC -- to the MAC, the
14 TAC was wondering why the oral pathology
15 payments for adults has been removed. This
16 was a payable item. Now it's been removed.
17 And no one from DMS has contacted the TAC as
18 to -- about this or why, so we basically have
19 no knowledge of it, of this happening. So
20 we're wanting to know why this has happened.
21 And the other thing is that we are
22 working with DMS on the fees for the
23 expansion codes, but it continues to be that
24 the -- even though the codes, like for a
25 denture, for a partial denture were added, we

1 continue to have extremely low fee
2 reimbursements that don't even cover the lab
3 cost of doing the procedure.
4 So we're working on that, but that's all
5 I have to report. We did have a quorum at
6 our last meeting.
7 CHAIR PARTIN: Thank you.
8 Consumer Rights and Client Needs?
9 MS. BEAUREGARD: Good afternoon.
10 Emily Beauregard, chair of the Consumer TAC.
11 We met and had a quorum at our last meeting,
12 and I have two recommendations. The first,
13 that DMS should not send anyone with SSI,
14 Social Security income, a Medicaid renewal
15 packet or RFI, request for information, in
16 order to maintain their eligibility.
17 The second recommendation is that DMS
18 should provide anyone losing SSI with two
19 months of ex parte Medicaid coverage when SSI
20 ends to allow time for them to prepare and
21 apply for Medicaid. That's only happening
22 with certain people. And I shared the report
23 in the TAC. There are some other issues that
24 we discussed that -- about Medicaid renewals
25 that we have some concerns about.

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1 CHAIR PARTIN: Thank you.
2 Children's Health?
3 (No response.)
4 CHAIR PARTIN: Behavioral Health?
5 DR. SCHUSTER: Yes. We met on
6 September 14th and had a quorum, and we have
7 no recommendations. Thank you. I did submit
8 a written report to members of the MAC.
9 CHAIR PARTIN: Thank you. Okay.
10 And I appreciate everybody --
11 DR. HANNA: Dr. Partin, I'm sorry.
12 This is Cathy Hanna. I couldn't get off of
13 mute earlier. I just wanted to say that the
14 PTAC did meet August the 9th with a quorum.
15 I do not have any recommendations, and I'll
16 make sure the report is submitted. Thank
17 you.
18 CHAIR PARTIN: Thank you. I
19 appreciate everybody being --
20 MS. BICKERS: I think you skipped
21 the IDD TAC.
22 CHAIR PARTIN: Oh, is it on the
23 list?
24 MS. BICKERS: Did I not type it?
25 Oh, it's on the second page down there. I'm

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1 sorry.

2 CHAIR PARTIN: Okay. Intellectual

3 and Developmental Disabilities?

4 MR. CHRISTMAN: Yes. We met on

5 August the 1st with a quorum, and we have no

6 recommendations.

7 CHAIR PARTIN: Thank you.

8 And then Hospital?

9 (No response.)

10 CHAIR PARTIN: Okay. If the EMS

11 TAC, if you can -- if you have something that

12 you very briefly wanted to bring up, you can

13 go ahead now and do that.

14 MR. SMITH: Thank you, ma'am. This

15 is Keith Smith, the chair of the EMS TAC. I

16 just wanted to give a great thanks to all of

17 the MCOs along with our billing companies,

18 EMS folks that participated, and Department

19 of Medicaid Services.

20 We've been having a terrible difficulty

21 with pre-certification, preauthorization

22 approval for EMS to transport nonemergency

23 patients. In working with the MCOs, we have

24 changed to where there will no longer be a

25 preauthorization, pre-certification process.

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1 It will go to a system very similar to
2 the Medicare Physician Certification
3 Statement that will be obtained at the time
4 that the patient is being picked up and will
5 be submitted with the claim, which should
6 help financially with a great number of EMS
7 providers in the state of Kentucky.
8 And I just really want to throw out a
9 thanks to everybody, including the MCOs, for
10 being willing to work with us, understanding
11 the issues that our EMS providers have been
12 having for a while now, especially with the
13 pre-certifications and the work of everybody
14 coming together. It was fantastic to be able
15 to have the cooperation and everyone doing so
16 in good spirit.
17 So that's all I wanted to bring up.
18 CHAIR PARTIN: Okay. Thank you,
19 Keith.
20 Okay. So next, we'll move to vote for
21 election of the officers, and I believe we
22 just --
23 DR. SCHUSTER: Beth, did you need
24 to make a motion to accept the
25 recommendations from the TACs?

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1 CHAIR PARTIN: Yes, I did. Thank
2 you, Sheila. I'm trying to --
3 DR. SCHUSTER: You're welcome.
4 MS. EISNER: I'll second that
5 motion. Nina.
6 CHAIR PARTIN: Any discussion?
7 (No response.)
8 CHAIR PARTIN: All in favor, say
9 aye.
10 (Aye.)
11 CHAIR PARTIN: Anybody, no?
12 (No response.)
13 CHAIR PARTIN: Okay. The motion is
14 moved to accept the recommendations.
15 And now we need to go to the vote for
16 the MAC officers. And I believe we have
17 three nominees, and we have three positions;
18 is that correct, Erin?
19 MS. BICKERS: Yes, ma'am.
20 CHAIR PARTIN: Okay.
21 MS. BICKERS: I have written down
22 Dr. Schuster for chair, Dr. Bobrowski for
23 vice-chair, and then I still have -- I wrote
24 Ms. Franklin -- I didn't write her first name
25 down -- as our secretary because no one else

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1 stepped up to say they would like to hold
2 that position.
3 CHAIR PARTIN: Okay.
4 DR. SCHUSTER: Yeah. Mackenzie has
5 indicated that she would be willing to
6 continue as secretary.
7 MS. BICKERS: Why did I write down
8 Wallace, then? I apologize. Mackenzie. I
9 wrote down the wrong name.
10 DR. SCHUSTER: Yeah. Mackenzie
11 Wallace, isn't it?
12 MS. BICKERS: Yes, ma'am. I've got
13 her and Ms. Annissa Franklin right next to
14 each other, and I think I just jotted down
15 the wrong name.
16 DR. SCHUSTER: Yeah. Yeah. She
17 said that -- I think she had to get off, but
18 she said she was willing to continue as
19 secretary.
20 CHAIR PARTIN: Okay. Thank you.
21 So would somebody like to make a motion
22 to accept these three nominees for these
23 positions?
24 MS. EISNER: This is Nina. I would
25 make the recommendation that we accept the

1 nominees as submitted.

2 MR. GILBERT: And this is Kent

3 Gilbert. I'll second.

4 CHAIR PARTIN: Okay. Thank you.

5 Any discussion?

6 DR. SCHUSTER: Do we need to make

7 speeches or anything?

8 CHAIR PARTIN: No.

9 MR. GILBERT: No. But now is when

10 you distribute the lavish gifts to secure the

11 vote. This is the time. This is the time.

12 Gift cards are totally acceptable so...

13 CHAIR PARTIN: No speeches today,

14 Sheila.

15 Okay. So all in favor?

16 (Aye.)

17 CHAIR PARTIN: Any dissent?

18 (No response.)

19 CHAIR PARTIN: Okay. So we have

20 our new officers. Thank you, everybody, for

21 your vote and for the nominees who have

22 stepped forward.

23 DR. WRIGHT: Beth --

24 DR. SCHUSTER: I am going to make a

25 brief speech and say we all owe you a huge

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1 round of applause.

2 DR. WRIGHT: I was getting ready to

3 say the same thing.

4 MS. EISNER: Yes.

5 DR. SCHUSTER: Yeah. To Beth for

6 her incredible service to the MAC and her

7 incredible leadership as chair, so let's all

8 give a round of applause.

9 DR. WRIGHT: I'll echo that.

10 DR. SCHUSTER: Yay.

11 DR. WRIGHT: Beth, your service to

12 the commonwealth of Kentucky and always

13 following up, particularly with those needs

14 of the vulnerable citizens that are

15 represented on the 1915C waiver, is greatly

16 appreciated as a parent who has two daughters

17 on the 1915C waiver.

18 So thank you, Beth, for your time.

19 MS. JUDY-CECIL: And, Dr. Partin,

20 just from -- representing Medicaid,

21 Department For Medicaid Services, we

22 appreciate all your service on the MAC, look

23 forward to your continued, you know,

24 hopefully involvement in -- you've been just

25 amazing to work with. You were always

1 available and accessible to us and were
2 willing to have conversations about, you
3 know, the programs and the agenda. So just
4 thank you again from the Department.
5 CHAIR PARTIN: Well, thank you,
6 everybody. It's been a privilege and an
7 honor to serve on the MAC and to serve as the
8 chair, I think, for the past 11 years. So
9 thank you, everybody. It really means a lot.
10 DR. WRIGHT: Is that three
11 governors, Beth; is that right?
12 CHAIR PARTIN: Yes.
13 DR. WRIGHT: Three governors that
14 you've served under. That's pretty amazing.
15 DR. SCHUSTER: I don't plan to
16 match that. I'm just telling you all.
17 DR. WRIGHT: Sheila, you'll be
18 around for as long as there is. I know you
19 well. You'll be around for a long time,
20 young lady.
21 CHAIR PARTIN: Okay. Well, thank
22 you, everybody.
23 We do have reports from two of the MCOs.
24 And before we do that, anybody have any
25 questions for the previous reports from Aetna

1 or WellCare?
2 MS. EISNER: No. But I just do
3 want to propose something for consideration
4 before we get into the MCO reports because I
5 fear some folks might start to drop off. I'm
6 just wondering if two and a half hours is
7 sufficient time for this meeting.
8 And I don't know that it's always been
9 that long, but it seems that, on a regular
10 basis, through no fault of anyone's, just
11 robust discussion and some great
12 presentations, that we tend to run hurried
13 and sometimes over.
14 So I didn't know if there was a reason
15 why it is exactly from 10:00 to 12:30 or if
16 there's any interest in extending that time.
17 CHAIR PARTIN: It's just always
18 been that way, Nina. I don't think that
19 there was any reason except that those were
20 the hours that were chosen. I think the MAC
21 can choose to change that if we so desire.
22 Would the MAC be in favor of extending
23 the time frame of the meeting?
24 DR. SCHUSTER: I -- I would for
25 sure because I think we're short-changing our

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1 TACs all the time, and there is robust
2 discussion beyond the recommendations. The
3 recommendations are few but don't reflect the
4 range of discussion and issues that are
5 raised.
6 And I think if we want more interplay,
7 which I think is appropriate between and
8 among the TACs, the only way to do that is to
9 be able to give more time for those TAC
10 reports.
11 And we're -- you know, the MAC is
12 bigger. We've added a couple of TACs, and
13 we're delving into issues. Each of the
14 presentations given today was excellent and
15 worthy of the discussion that we had.
16 But I agree with Nina that we keep
17 running into a time crunch. I think that --
18 CHAIR PARTIN: So would it be the
19 pleasure of the MAC to maybe extend the time
20 by a half an hour?
21 MR. GILBERT: I would be in favor
22 of such a move, but I would -- I know it's
23 very difficult for the folk -- maybe more
24 difficult for the folks in western part of
25 our state. But it is increasingly

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1 challenging to move further into the noon and
2 afternoon. It's easier to move earlier on my
3 end of things. That's just a personal
4 preference.
5 CHAIR PARTIN: Yeah. It's -- since
6 our state is divided on Central and Eastern
7 Time, especially if we go to in-person
8 meetings, it makes it very difficult for
9 people coming from a Central Time Zone to
10 make it to the meeting. Dr. --
11 MR. GILBERT: An in-person meeting,
12 if I'm going to drive, you know, an hour and
13 a half or two hours to get somewhere, then
14 I -- I'd as soon camp there. So if we go to
15 in-person meetings, a longer meeting is going
16 to be, in some ways, easier to schedule
17 around because it'll automatically take the
18 whole day so...
19 CHAIR PARTIN: Dr. Bobrowski, you
20 had your hand raised.
21 DR. BOBROWSKI: Yeah. I just
22 wanted to agree with the other folks that
23 have said -- responded on the time. To add
24 half an hour is fine. It might be -- I'm in
25 the Central Time Zone, but if you're going to

1 take an in-person meeting, it almost winds up
2 being a whole-day event in terms of
3 scheduling things.
4 But I agree with Dr. Schuster that I
5 really feel like that the TACs ought to be
6 able to get a little bit more time other than
7 just their recommendations. It's good to
8 kind of know what they're talking about, what
9 they're working on, even though it might
10 extend that, you know, two minutes, five
11 minutes.
12 You know, we're all in this to provide
13 health care, you know, to the citizens of
14 Kentucky. And in a lot of situations, our
15 efforts, our expertise overlaps with each
16 other. And I just think it would be good to
17 have opportunity to give the TACs a little
18 bit more time.
19 CHAIR PARTIN: I absolutely agree.
20 The TACs have been short-changed a lot, and
21 that's unfortunate. And we do need input
22 from them.
23 So speaking for somebody from Central
24 Time, I would -- I would be more in favor of
25 adding a half an hour at the end of the

1 meeting and going until 1:00 rather than
2 starting earlier.
3 Anybody else have any thoughts or
4 comments on that?
5 DR. SCHUSTER: Beth, I wonder if we
6 might just -- I'll move that the MAC time
7 frame be extended to three hours with the
8 exact time to be settled on at our next
9 meeting, maybe.
10 CHAIR PARTIN: Okay. Is that
11 agreeable to everybody else?
12 DR. BOBROWSKI: I'll second that.
13 Garth Bobrowski.
14 CHAIR PARTIN: Any further
15 discussion?
16 (No response.)
17 CHAIR PARTIN: All in favor, say
18 aye.
19 (Aye.)
20 CHAIR PARTIN: Anybody opposed?
21 (No response.)
22 CHAIR PARTIN: Okay. Thank you.
23 DR. WRIGHT: Sorry. I was muted.
24 Aye.
25 CHAIR PARTIN: Thank you.

1 DR. SCHUSTER: Yeah. Ashima has
2 put something in. Maybe start 15 minutes
3 early and end 15 minutes later to kind of
4 split the difference, so that's something to
5 consider.
6 CHAIR PARTIN: Okay. So we can put
7 that on the next agenda.
8 All right. The MCO reports. We didn't
9 have any questions for Aetna and WellCare, so
10 Anthem is up first.
11 MR. LAMOREAUX: Okay. Can you hear
12 me well?
13 CHAIR PARTIN: Yes.
14 MR. LAMOREAUX: Okay. Excellent.
15 Now, we have an individual that's going to be
16 helping us with the deck. Has he been given
17 the control? All right. Here we go.
18 So -- well, members of the Medicaid
19 Advisory Council, it's a pleasure for me to
20 be here with you today. I'm Leon Lamoreaux.
21 I'm the plan president for Anthem BlueCross
22 BlueShield here in Kentucky. And with me
23 here is Dr. Daniel Brunner, our medical
24 director, and Jeremy Randall, our director of
25 operations.

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1 I want to give each of them just a brief
2 moment to introduce themselves since many of
3 you may have not met them yet.
4 So Dr. Brunner?
5 DR. BRUNNER: Yes. Hello. I'm
6 Dr. Daniel Brunner. By training, I'm an
7 emergency medicine physician. I've practiced
8 in northern Kentucky my entire career for
9 over 22 years. I entered the managed care
10 realm in 2019 and became a full-time medical
11 director two and a half years ago here.
12 Jeremy?
13 MR. LAMOREAUX: Jeremy?
14 MR. RANDALL: Hi. My name is
15 Jeremy Randall. As Leon said, I'm the
16 director of operations, and I've been in the
17 industry for over 25 years and here in the
18 Anthem Kentucky Medicaid plan for the last
19 eight.
20 MR. LAMOREAUX: Well, given that
21 we've been asked to limit our remarks to 15
22 minutes but there were 19 original questions
23 that came, we're going to have to keep this
24 at a fairly high level. But within the deck,
25 we've made it a point to answer all 19 of the

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1 original questions.
2 To help organize the flow, we're going
3 to address this in basically these six
4 different agenda items: Anthem's whole
5 health and health equity business model, an
6 overview of Anthem's membership demographics,
7 the Anthem provider network and network
8 adequacy reports, which will have to be at a
9 very high level. We'll talk a little about
10 our operations excellence metrics and profile
11 our member services. And then if time
12 permits, we'll talk just briefly about
13 quality and quality improvement.
14 I may not get a chance to go all the way
15 into the material that is in the appendix,
16 but that is -- I'll bring that to your
17 attention as we move.
18 So as we go into slide No. 3, the vision
19 of Anthem BlueCross BlueShield Medicaid is to
20 improve the health of humanity. Our primary
21 way to do that here in Kentucky is through a
22 process we call "whole health." For me,
23 whole health has evolved over time. It used
24 to mean the combination of physical health
25 and behavioral health. But more recently,

1 we've recognized that the concepts of
2 health-related social needs, otherwise known
3 as social determinants of health, also need
4 to be taken into consideration.
5 For Anthem Medicaid, whole health
6 requires whole teams, and whole teams include
7 our care provider community and the community
8 at large. Our model places the member in the
9 center of our thinking. It integrates all of
10 the disciplines within the health plan, and
11 our local business partners and communities
12 are an active part.
13 An ultimate goal is to identify and
14 eliminate disparities and achieve health
15 equity with purposeful actions and dedicated
16 strategies. Whole health takes the whole
17 health ecosystem working together to achieve
18 positive results.
19 As depicted in the visual to the far
20 right, Anthem whole health starts with
21 analyzing data, determining our customer
22 needs, and then we work with customers and
23 other community members to see where we can
24 make a positive difference.
25 Another element of our business model is

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1 the purposeful efforts to achieve health
2 equity for each of our subpopulations, trying
3 to eliminate the inequities that do exist.
4 Our planning and strategic process focuses
5 our efforts in areas most needed by our
6 membership.
7 And as we can see from slide No. 4,
8 beginning in 2019, our planning cycle, Anthem
9 reinvented itself using elevate whole health
10 approach of strategic planning. The results
11 of this detailed process have identified
12 eight major areas of focus.
13 Those areas of focus are listed on the
14 right-hand side of this slide, and it's no
15 accident that we begin with decreasing crisis
16 events from behavioral health and substance
17 use since that is the area of greatest need
18 for our specific population.
19 You can see other key terms here:
20 Cancer, preventive care, chronic disease,
21 diabetes, hypertension, dental visits, birth
22 outcomes, mortality -- mortality and
23 morbidity rates, and food and housing.
24 For a couple of years now, Anthem
25 Medicaid has been producing what we call our

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1 insights dashboard. This -- the numbers that
2 you see displayed on this slide are for the
3 year-to-date September 2023 results.
4 Since there's a lot to unpack here, let
5 me orient you to the slide. Beginning in the
6 top left, you can see Anthem has paid over
7 three million claims for $488,000,000. These
8 claims on average are paid in 12.7 days with
9 96.4 percent of them processed within 30
10 days.
11 The top right outlines our call centers
12 statistics in which we have answered 88,000
13 provider calls at an average of 17 seconds
14 and answered 122,000 member calls at an
15 average of 13 seconds.
16 Anthem Medicaid has paid nearly two
17 million in prescriptions in 2023. 35 percent
18 of our membership utilizes the pharmacy
19 benefit, and 87 percent of the time, it is
20 with a generic drug.
21 The top five prescriptions by
22 utilization are those prescriptions for
23 cardiovascular disease and hypertension,
24 antidepressants, other behavioral health
25 topics, allergy, and pain management

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1 analgesics.
2 In the center of the page, one can
3 observe from our quality measures, 2022
4 measures are highlighted in blue. '23
5 measures are highlighted in orange, and the
6 year-over-year change is highlighted in
7 green.
8 Just to the right of the quality
9 measures is a couple of clinical utilization
10 statistics you might find of interest. In
11 2023, admits per thousand is 46, down from
12 last year's 53. Days per thousand is 260,
13 also down from last year's 287. ER visits
14 per thousand, 645, is up from last year, 623.
15 And telehealth per thousand is 966, down from
16 1,651 in 2022.
17 At the far right side of the page is our
18 membership and community outreach events, and
19 one of the most intriguing statistics on this
20 dashboard on the bottom, right-hand side are
21 the top five diagnoses. The left column is
22 based on claims paid amounts, and the right
23 column is based on count of claims.
24 It may surprise you to see that Anthem
25 Medicaid, our top one and two from both lists

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1 are opioid dependence and other stimulant
2 dependence. No. 3 is either sepsis in one
3 venue or alcohol dependence in the other, and
4 then rounding out the top five that are
5 mentioned in either category, chemotherapy,
6 hypertension, and generalized anxiety
7 disorder.
8 Let's turn to our membership slide on
9 slide No. 8 because Anthem, when it came --
10 let's move on to this -- keep moving, Brad.
11 Slide No. 8, we're going to give you a little
12 bit of a profile about the Anthem membership.
13 As you can see, Anthem serves about 180,000
14 Medicaid members.
15 But one thing may be less obvious, is
16 the mix of members that we serve. 49 percent
17 of our membership is the TANF expansion
18 membership; in other words, those childless
19 adults or the working poor that came into
20 Medicaid eligibility back in 2014.
21 One can also notice from this slide that
22 Anthem's membership is evenly spread
23 throughout the entire state, with 6 percent
24 in Region 1, 9 percent in Region 2, 21
25 percent in Region 3, 16 in Region 4, 23 in

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1 Region 5, and so on.
2 We also have a pretty good age
3 distribution. In addition to our
4 continual -- as we think about where we are
5 right now, in addition to the material on
6 this slide, it's important for us to focus on
7 our network adequacy.
8 And as we think about this, Anthem
9 Medicaid has an extensive and comprehensive
10 network because our Medicaid network is
11 derived from our commercial network, which
12 has been being built for the past 85 years.
13 The contractual access requirements for
14 MCOs, as we heard from Angie just a little
15 bit ago, are threefold. The first
16 requirement is providers within a certain
17 mile range for urban or rural settings.
18 Slide 10 here outlines some of Anthem's
19 access results. The first column outlines
20 the provider category. The second column,
21 the accessibility standards. The third are
22 the unique count of providers of each one of
23 those provider categories and then the
24 percent of membership with that access, and
25 the last column is the average distance to

1 one provider based on member zip codes.
2 So as you can see here, as a for
3 instance, 110 hospitals, 6,229 primary care
4 providers. And we can just kind of go all
5 the way down through each of the rest of
6 these specialty types.
7 Slide 11 outlines Anthem's compliance
8 for use -- provider types for each region of
9 the state. And as you can see, 100 percent
10 compliance for each of these areas as
11 outlined by the time and distance
12 requirements.
13 When we look at slide 12, the second
14 compulsory requirement for a provider is a
15 member ratio requirement. You can see the
16 fourth column over, the accessibility
17 standards. Ratio of a PCP to members is 1 to
18 15. You can look in 2020, our results; '21,
19 our results; '22, our results. And you can
20 see that where the ratio is 1 to 1,500, our
21 ratio is 1 to 16. So, in essence, Anthem
22 dramatically meets any and all of these
23 goals.
24 Slide No. 13, the third compulsory
25 requirement for providers is to make care

1 available within certain time frames, and
2 this slide outlines the last five quarters of
3 appointment availability standards based on
4 our quarterly survey results.
5 I do want to point out the staffing
6 shortages in our post-COVID environment are
7 placing significant pressures on offices to
8 meet some of these access standards. Some of
9 the things that we're trying to do, in
10 addition to our continual network recruiting,
11 is to promote digital technologies and
12 telephonic technology solutions to provide
13 increased access to Medicaid membership.
14 And then the last point that I would
15 like to make is that, in addition, we have
16 made strategic investments to try and help
17 train up the next generation of healthcare
18 providers. Over the course of the last three
19 years, we've invested over $700,000 in local
20 colleges and universities to provide
21 scholarships for individuals who agree to
22 practice in rural settings here within
23 Kentucky.
24 Slide No. 17, to briefly discuss some of
25 our other questions, Anthem has approved 355

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1 member requests for out-of-network providers.
2 And slide 18 talks about our 12-month
3 rolling average where we have had to execute
4 45 single case agreements where services were
5 simply not available in the state of
6 Kentucky. That is a little bit less than we
7 experienced last year.
8 I'm now going to turn the time over to
9 Dr. Brunner, our medical director, to talk
10 about some of our clinical insights from his
11 perspective.
12 Dr. Brunner.
13 DR. BRUNNER: Thank you, Leon. You
14 can go to the next slide, Brad.
15 We've seen an overall decrease in
16 hospitalization rates since 2021 with a
17 slight increase in behavioral health
18 hospitalization rates the first quarter of
19 this year. Over this time, we've seen an
20 increase in electronic medical record access
21 to facilities. With this, we can see in
22 real-time the intensity of our members' needs
23 and offer observation care. We can also
24 coordinate post-discharge care through our
25 case management teams.

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1 The cost per admission has decreased
2 overall, but there's a slight increase in
3 behavioral health costs per admission from
4 2021 to 2022. And to date, it has returned
5 to that of -- close to that of 2021.
6 We've seen a fall in the hospital
7 readmissions. With the prior authorization
8 process in place for physical health, case
9 management and social determinant of health
10 teams can coordinate with providers.
11 Post-COVID, primary care physician offices
12 were able to see patients for disease
13 management and post-discharge care.
14 While the readmissions per thousand have
15 declined, the cost for readmissions has
16 increased steadily over the past two and a
17 half years.
18 The ER utilization overall has fallen
19 since 2021. There's an increase in
20 behavioral health emergency room visits, and
21 these are driven primarily by anxiety, major
22 depression, and substance abuse.
23 Despite the fall in the ER visits, the
24 cost per visit for ER utilization has
25 dramatically increased over the past two and

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1 a half years.
2 Post-pandemic, we've seen our top
3 diagnoses shift. Our top four expenditures
4 this year to date are largely
5 substance use-related including opiate,
6 stimulant, and alcohol use. And also added
7 to that is general anxiety.
8 And due to vaccine hesitancy, encounters
9 for immunizations have dropped but are still
10 in the top ten -- our top ten list, where
11 child well visits have remained stable.
12 Regarding our prior authorization
13 process, we are continually re-evaluating the
14 process. We strive to simplify and
15 streamline the process to ease the
16 administrative burden on providers and their
17 staff. The majority of prior auth requests
18 are turned around within 24 hours.
19 Our digital Availity and Epic Payer
20 platforms are tools used to help simplify
21 this process. We utilize Milliman care
22 guidelines and ASAM for utilization
23 management reviews, which are peer-reviewed,
24 evidence-based, nationally recognized
25 criteria.

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1 I will now hand it off to Jeremy.
2 MR. RANDALL: Thank you,
3 Dr. Brunner. Next slide, please, Brad.
4 So first, I'd like to talk about our
5 claim denial rates. On this slide, you can
6 see our overall denial rate as well as the
7 top ten denial reasons, both metrics going
8 back to 2021. And I'd like to note that if
9 circumstances change, Anthem will proactively
10 adjust certain of these denials, trying to
11 save the provider's office from making a
12 phone call or having to submit an appeal or
13 email the provider rep.
14 You know, so, for example, looking at
15 the second highest denial reason there, if
16 that registration changes at all after the
17 fact, we will, on a monthly basis, identify
18 all the denials impacted by that and have
19 them adjusted.
20 Next slide. Yeah. On this slide, you
21 will find a count of all the audit requests
22 going back to 2021. Anthem offers multiple
23 methods to fulfill these requests including
24 via the Availity provider portal. And on the
25 next slide, you will find the same volumes

1 broken out monthly. Thank you.
2 Next slide. And up next, you'll find a
3 snapshot of our value-added benefits, and we
4 would ask for the community's assistance in
5 educating members on our value-added
6 benefits. You know, it is our intent that we
7 want all members to be aware and
8 appropriately utilizing these benefits.
9 In addition, we offer multiple tools to
10 support members with their whole health. And
11 some of these are digital like a smartphone
12 app. Some are a vendor. But all are trying
13 to wrap around the care that is provided in
14 the community.
15 And we had mentioned social determinants
16 of health, and here you can find how our
17 members' needs are reflected in the SDOH
18 referrals we receive. You can see that 36.8
19 percent of the referrals are related to
20 housing as our No. 1. Thank you.
21 And with that, I'll turn it back to
22 Leon.
23 MR. LAMOREAUX: So I think in the
24 interest of time, first off, I want to thank
25 everyone on this call for your service to the

1 commonwealth, a special emphasis to those who
2 have served over the course of the last 11
3 years, Dr. Partin in particular.
4 I hope you will join me as we think
5 about this -- the challenges that we face as
6 a state today are going to require the entire
7 community to come together as we strive to
8 improve the lives of humanity here in
9 Kentucky. I want to thank you for the
10 opportunity we have to be able to continue to
11 serve.
12 I've got an amazing team here, and our
13 desire is to be able to help you, help our
14 members, and so there's many things we want
15 to address with this particular presentation.
16 There's a lot of material that we did not
17 cover that is in the balance of the deck.
18 But I think in the interest of time and out
19 of courtesy to others, we will surrender the
20 mic.
21 CHAIR PARTIN: Thank you very much.
22 Does anybody have any questions?
23 (No response.)
24 CHAIR PARTIN: Okay. We appreciate
25 the information, and we will go through it.

1 And then at the next meeting, we may have
2 questions as we've had more opportunity to go
3 through the slides. Thank you.
4 MR. LAMOREAUX: Thank you for the
5 opportunity.
6 DR. BRUNNER: Thank you.
7 CHAIR PARTIN: Okay. Next up,
8 UnitedHealthcare.
9 MS. BICKERS: Beth, United was
10 moved to November per Dr. Cantor's request
11 that you -- that we had agreed on.
12 CHAIR PARTIN: Okay. Okay. So are
13 we doing three in November?
14 MS. BICKERS: Yes, ma'am. You and
15 Dr. Schuster said that that was okay to move
16 it.
17 CHAIR PARTIN: Right. Right.
18 Okay. All right, then. Well, that's not too
19 bad. We're 21 minutes over, 22 minutes over.
20 Anybody have anything else that they'd
21 like to bring forward?
22 (No response.)
23 CHAIR PARTIN: Okay. I appreciate
24 everybody's time and willingness to stay with
25 the meeting. And I also appreciate all of

1 your comments. It really means a lot to me
2 to have the support from the MAC members.
3 And my -- my practice is made up of a lot of
4 Medicaid patients, and my heart is with them
5 and with providing the best health care we
6 can for them. So thank you, everybody.
7 Would somebody like to make a motion to
8 adjourn?
9 DR. SCHUSTER: I'll move that we
10 adjourn and thank you, again, Beth.
11 MS. EISNER: I'll second and thank
12 you, Beth.
13 CHAIR PARTIN: Thank you, Sheila
14 and Nina.
15 Any discussion?
16 MS. EISNER: No.
17 DR. HANNA: Just thanks, Beth.
18 Thank you.
19 DR. WRIGHT: Just gratitude.
20 CHAIR PARTIN: I'll probably be
21 here in November. I haven't heard -- I
22 haven't heard that I have a replacement yet.
23 So if I am, I'll look forward to seeing you
24 all. So all in favor, say aye.
25 (Aye.)

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1 CHAIR PARTIN: Anybody opposed?
2 (No response.)
3 CHAIR PARTIN: So moved. Thank
4 you.
5 DR. SCHUSTER: Bye, y'all.
6 (Meeting concluded at 12:57 p.m.)
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2 C E R T I F I C A T E

3

4 I, SHANA SPENCER, Certified

5 Realtime Reporter and Registered Professional

6 Reporter, do hereby certify that the foregoing

7 typewritten pages are a true and accurate transcript

8 of the proceedings to the best of my ability.

9

10 I further certify that I am not employed

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

12 herein, nor otherwise interested in the outcome of

13 this action.

14

15 Dated this 16th day of October, 2023.

16

17 *__/s/ Shana W. Spencer_*

18 Shana Spencer, RPR, CRR

19

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