CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
July 28, 2022
Commencing at 10:00 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter
APPEARANCES

ADVISORY COUNCIL MEMBERS:

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

Commissioner Lisa Lee
Senior Deputy Commissioner Veronica Cecil
CHAIRMAN PARTIN: Let's go ahead and call the meeting to order. And, Teresa, are you on? Would you take the roll call?

(No response.)

CHAIRMAN PARTIN: So I guess she is not on. So, Veronica, I think you said that Dawna was the staff person today?

MS. CECIL: Yes. I don't know.

Dawna, do you have --

MS. CLARK: I'm here, and I can go ahead and do roll call.

CHAIRMAN PARTIN: Okay.

MS. CLARK: Okay. Elizabeth Partin.

CHAIRMAN PARTIN: Here.

MS. CLARK: Nina Eisner.

(No response.)

MS. CLARK: Susan Stewart.

(No response.)

MS. CLARK: Dr. Jerry Roberts?

MR. ROBERTS: Here.

MS. CLARK: Teresa Aldridge.

(No response.)

MS. CLARK: Dr. Garth Bobrowski.

DR. BOBROWSKI: Here.
MS. CLARK: Dr. Steve Compton.

DR. COMPTON: Here.

MS. CLARK: Dr. John Muller.

(No response.)

MS. CLARK: Dr. Ashima Gupta.

DR. GUPTA: Here.

MS. CLARK: John Dadds.

(No response.)

MS. CLARK: Dr. Catherine Hanna.

(No response.)

MS. CLARK: Barry Martin.

MR. MARTIN: Here.

MS. CLARK: Kent Gilbert.

MR. GILBERT: Here.

MS. CLARK: Mackenzie Wallace.

(No response.)

MS. CLARK: Annisa Franklin.

(No response.)

MS. CLARK: Sheila Schuster.

DR. SCHUSTER: Here.

MS. CLARK: Bryan Proctor.

MR. PROCTOR: Here.

MS. CLARK: Peggy Roark.

MS. ROARK: Here.

MS. CLARK: Eric Wright.
(No response.)

MS. CLARK: You have ten MAC members here.

MS. HANNA: I apologize. I am here. I apologize. I'm on -- my father's caregiver didn't show up, so I apologize. I had to jump away for a minute. Thank you. This is Kathy Hanna.

MS. CLARK: Okay. That brings us to 11 MAC members present.

CHAIRMAN PARTIN: Okay. So we do have a quorum, so we can go ahead and move forward.

Peggy, I saw that your hand was raised. Did you need to say something?

(No response.)

DR. SCHUSTER: I think she had it up originally, Beth, to indicate that she was here.

CHAIRMAN PARTIN: Okay. Thanks, Sheila.

DR. SCHUSTER: Yep.

CHAIRMAN PARTIN: Okay. So next on the agenda is approval of the minutes for May. Would somebody like to make a motion?
DR. SCHUSTER: I'll move their approval. This is Sheila Schuster.

DR. BOBROWSKI: Garth Bobrowski

seconds.

CHAIRMAN PARTIN: Okay. Any discussion?

(No response.)

CHAIRMAN PARTIN: All in favor, say aye?

(Aye.)

CHAIRMAN PARTIN: Anybody opposed?

(No response.)

CHAIRMAN PARTIN: Okay. Minutes are approved. Next, we'll move on to old business. And, first of all, I would like to extend a thanks to the Department of Medicaid Services and the commissioner for updating the Rural Health Clinic Reg, 907 KAR 1:082. I think those updates to that regulation are good and important, and I thank you for moving forward on that.

So having said that, we'll just move into the old business. First up is: When will Medicaid regulations promulgate -- I'm sorry. When will Medicaid promulgate
regulations to reimburse Certified Professional Midwives?

MS. LEE: Good morning, this is Lisa Lee, commissioner for the Department For Medicaid Services. At this time, we have several projects that we're working on, and many of them from legislation that was passed in this session and last session. And so while we understand the request for -- to include Certified Professional Midwives, at this time, we are not considering adding it and nor will we be doing that in the near future.

But as you know, Dr. Partin, just from the conversation and just acknowledgment of the rural health clinic changes, you know, we do continue to listen to the MAC recommendations, and we'll work with you all to make sure that we're making policy changes that are very pertinent to the program and that will enable our members to be seen and receive the services that they need.

But right now, at this time, given our workload and the stretching of our staff based on all of the projects we have that
we're working on, we are not going to move forward with reimbursement -- regulations to reimburse Certified Professional Midwives at this time.

CHAIRMAN PARTIN: Okay. Thank you. And just as I continue to do, I'll continue to keep that on the agenda, and maybe one of these days, it'll be a yes.

MR. GILBERT: Madam Chair, may I raise a question? I'm new to the MAC, of course, so I'm trying to gain my feet here, and perhaps Ms. Lee can help me.

So though it has been enacted in law that it's okay, what's the consequence of not promulgating regulations? Does this mean that nurse midwives will not be paid or reimbursed?

CHAIRMAN PARTIN: No. Nurse midwives are currently reimbursed. This is a new category. They're Certified Professional Midwives. They are not nurses. They are regulated by the Board of Nursing, and they must pass national certification exams in order to be certified and be able to practice under the regulation of the Board of Nursing.
But they're not reimbursed for their services by Medicaid.

MR. GILBERT: But I thought the -- wasn't there legislation this year that enacted their reimbursements?

CHAIRMAN PARTIN: No.

MR. GILBERT: Isn't that what 575 did?

CHAIRMAN PARTIN: No. They're not reimbursed for their services. They are recognized, and they are able to practice. They're just not able to be reimbursed by Medicaid.

MR. GILBERT: I see.

DR. SCHUSTER: Madam Chair, I think Kent is thinking about the community health workers which was House Bill 525. And that was --

MR. GILBERT: Yeah. Thank you.

DR. SCHUSTER: And that was in legislation, Kent.

MR. GILBERT: Thank you, Sheila.

DR. SCHUSTER: Yep.

CHAIRMAN PARTIN: Okay. Next item is continuing Zoom meetings. We had talked
in the past about meeting in person in September. And so I just wanted to bring this up again with the group to see if you are comfortable meeting in person in September, or do you want to meet by Zoom? So any -- any discussion on that? Any thoughts?

MR. GILBERT: I would likely think it would have to do with where we are numbers-wise which are not currently good. I know that it would be lovely to see everyone in person, but I think maybe if we are not out of the red, as a substantial number of our counties are, I'm not sure that both travel or meeting in person is as wise as it might be otherwise.

CHAIRMAN PARTIN: Thank you, Kent. Anybody else have any thoughts on that?

MR. MARTIN: Yeah. If we don't do it in September, as the year progresses and the winter hits, we might as well just postpone it until next summer.

CHAIRMAN PARTIN: So are you in favor of meeting in person or by Zoom, Barry?

MR. MARTIN: If we can't meet in
September, we probably should just put it off until spring or attempt to do it in the spring.

CHAIRMAN PARTIN: Okay. Any other thoughts?

DR. BOBROWSKI: This is Garth Bobrowski. I would recommend just going with the Zoom for our September meeting. And just like Kent said, just maybe wait and see what the numbers are looking as the year goes along for the in-person meeting. I know we had agreed to go to once a year to try to do an in-person. But I think this September might be too early.

CHAIRMAN PARTIN: Okay. So I -- as much as I would love to meet in person with everybody -- because I miss seeing you and I miss that interaction. I miss our little side conversations before and after the meeting. But I'm inclined to also agree that since we've got counties in the red, that it might be wiser to meet by Zoom.

So we haven't heard from all the MAC members. So if there's any MAC member who would like to meet in person, please speak
up.

MS. ROARK: I think the Zoom meetings are the best for our gas prices, and I'm trying to work and with the COVID. And I just feel like it's the best for me.

CHAIRMAN PARTIN: Okay. Thanks, Peggy. Well, then, I don't hear any objections, so I think we'll go ahead and meet by Zoom in September.

MR. MARTIN: Sounds good. I still think that we should have it as a goal for us to meet in person once a year but find an opportune time to do that.

CHAIRMAN PARTIN: Yes. Yes. I agree. And we can -- we can revisit that again in September if you like. We should -- November should still be okay for travel. If COVID numbers are down and people are feeling comfortable, we could change our mind. But for now, let's just say that we will continue Zoom meetings until next spring.

MR. MARTIN: Okay.

CHAIRMAN PARTIN: Okay. Next up -- and I see myself on the screen now. I just got a little hesitant. Okay. Anyways.
Okay.

Update on missed and cancelled appointments. How is the reporting going, and is there a common thread as to why patients are not showing up for appointments?

I guess this would go to commissioner or somebody from DMS.

MS. LEE: Yes. Thank you. Lisa Lee again. We have been monitoring reports. For example, we pulled up the latest quarterly report in this last quarter ending in June. We do show 10,640 logged missed appointments in the system. And, again, our information is only as accurate as the provider's report.

Of those 10,640, a little over 7,000, or 67 percent of those, were just a no-show, no reason provided. We also are showing that about 11 percent, or a little over 1,000, individuals rescheduled their appointments.

Transportation issues are low on the list. Only 73 of those 10,000 reported as transportation issues, 12 childcare issues. But, again, the biggest was the no-show and the no reason provided at 67 percent.
And I believe that the MCOs that are presenting today, they may have more information on some of the no-shows specific to their population.

CHAIRMAN PARTIN: Okay. That's kind of concerning, that they're -- and it's kind of what we thought, too. People are just not showing up. They're just not showing up. There's no reason.

MS. LEE: And I think we could put it into perspective, too. But, again, though all we know are those no-shows that are logged. But we could also go back, and for this same quarter, we could run a report showing the actual total number of individuals who didn't show up to get a percentage of Medicaid population that's not showing up for their visits.

Because when we look at the 10,000, you know, in a quarter, that does sound like a lot. But when we compare that to the, you know, the claims and the individuals who did show up, you know, we'll see what the actual percentage is per quarter. And we may need to start looking at it in that lens, also.
CHAIRMAN PARTIN: Okay.

MR. COMPTON: Madam Chairman, Steve Compton. I think the no-show is probably underreported, though. So when we start looking at those percentages, we need to keep that in mind. We know who showed up, but the no-shows are not -- not every practitioner is reporting.

MR. MARTIN: Not only that, but if you use overall utilization, that will include walk-ins.

MR. COMPTON: Good point.

MS. LEE: Yeah. And thank you, Mr. Compton, for that observation. We do know that the information is only as accurate as we have in our system and if it is logged. So something that we, you know, still want to keep an eye on.

And I think at the last one -- at the last MAC meeting, Dr. Bobrowski, you may have even mentioned somebody who had missed 11 appointments. And if we can find those individuals and reach out to them just to see what we can do to help get them into the office, to their appointments.
Because that's going to be -- that's the overall arching goal of this project, is to try to identify those individuals, particularly those that miss one or more appointments, so that we can find out why they're missing, help them get in to their appointments, and make sure that they're adhering to their medication protocol and other measures to make sure that their health -- that they're taking care of their healthcare needs.

MR. MARTIN: I think we also need to stress to the providers that that's there, and they need to use it. And if they don't use it, then it doesn't give you good numbers to -- to leverage.

DR. SCHUSTER: Yeah. I'd like to follow up on that. We discussed this at the behavioral health TAC, and we were going to ask for a report on who is it that is reporting.

I know that you all can break that down, Commissioner, by behavioral health versus, you know, different specialties and so forth. And I think it would be really helpful to
have that information as well. We'd sure
like to get after our behavioral health
providers to make sure that they're using the
portal. Thank you.

MS. LEE: And I think keeping in
mind the overarching goal of we're trying to,
No. 1, reduce the number of no-shows but,
No. 2, make sure that individuals are getting
to their healthcare appointments and taking
care of their healthcare needs.

So I think -- I don't know that we have
had enough information about the no-shows
out. I know we have trained providers it's
in the system, but I don't know that we have
communicated widely enough the importance of
logging those no-shows.

So maybe we can do something in the
department to kind of help get the providers
to go ahead and start logging those no-shows
so that we can help them bring their members
into their offices for treatment.

DR. GUPTA: This is Dr. Ashima
Gupta. I know that our office, for example,
we've had so much turnover since COVID that I
know that reporting is not happening at my
office. It's just with the turnover, it just gets -- you know, that's like the least on the priority list to take care of. So maybe even just like a quarterly email that's sent out to the providers, I think, will really help.

MS. LEE: Thank you for that recommendation.

CHAIRMAN PARTIN: I think, also, it will be good to look at the overall patients that are showing up comparing to the ones that don't. But I also would want to temper that by saying that even if it's just two patients a day, for a practice, that's a lot. Because that's two slots that could be filled by somebody else who wants an appointment that day and who's put off because there's, you know, an appointment scheduled.

So looking at that, I think, is important. But, also, I think we need to keep in mind that it may not get to the crux of the problem.

DR. SCHUSTER: Madam Chair, I think Dr. Theriot has her hand up.

DR. THERIOT: Thank you,
Dr. Schuster. I was just wondering -- well, it would be nice to know what the providers are doing when a patient no-shows or misses an appointment. Because that's the point in time that it would be nice to intervene, you know.

And I wonder if there's some best practices out there, you know. So if a patient doesn't show, reaching out to that patient right away to, you know, see what's going on to try and get them in. And, again, it might be a reminder, but it also might be a car problem, you know, whatever else.

But I'm just wondering what the providers themselves are doing at -- you know, on that day to help patients attend their appointments.

CHAIRMAN PARTIN: That's a good idea.

MR. MARTIN: Well, we're finding across the board -- dental, behavior, and medical -- that a lot of it is just common offenders, the same offenders with multiple no-shows. And then you spatter in a few that doesn't do that on an ongoing basis. But
across the board, it seems like there's a
constant population that does that.

DR. THERIOT: Well, that's even
better. So knowing that ahead of time, you
know, what's being done to reach out to those
patients in particular to help?

MR. MARTIN: I think we're all
trying to call, confirm appointments. And
even when you confirm them, they still don't
show up. And even our registration clerks,
it's gotten to the point where they already
know, okay, we're scheduling them, but
they've not showed the last three or four
visits. They're not going to show again.

So that's where we need help from the
MCOs and Medicaid and other insurance
companies to help target those that we know
that we're wasting time on. And the ones
that doesn't show because of whatever
sporadic reasons, then those are ones that
may have legitimate reasons or not. I think
it's a targeted population we're looking for.

DR. THERIOT: Thank you.

CHAIRMAN PARTIN: Yes. I would
agree with that. At our clinic, we've
purchased a reminder, a text reminder through our EHR which added quite a bit of expense. So far, I can't say that it's made a whole lot of difference.

We do call people when they miss their appointment and try to reschedule. Sometimes they will schedule another appointment. Sometimes they just tell us they'll call back.

DR. BOBROWSKI: Sometimes at our office, if they miss several appointments like Commissioner Lee alluded to, we finally just get to the point and say, on a day you can come, you call us first thing in the morning. And if we get an opening, we'll call you. Otherwise, you can call on another day.

Because at some point as a business, we just -- and these are adults. Enough is enough. Act like an adult and be responsible for these appointments. I hate to be -- we don't mean to be mean or crude. But, you know, some offices, you miss a couple appointments, and you're just dismissed. Now, we haven't done that.
But it's just like last Thursday night about 7:30, I got a phone call. A lady called. I don't know how she got my personal cell phone number but called my personal cell phone number and said -- well, she messaged me on Messenger first. Then she called me five minutes later. Oh, I'm in pain.

Well, she's already missed four appointments this spring and summer. Well, you know, I didn't come in on that night. I already was into something else and then she -- and she didn't call Friday to be seen. We had to call her Tuesday to be seen, and we got her in and took care of her.

But, you know, these are adults, and I just think we just need to sometimes just quit spoon-feeding them and just say, well, this is the reality of you missing your appointments.

You know, yes, it's just like Dr. Partin says, we've got that text reminder system, and that adds an expense to your office running. And I think a lot of these ideas are good. But at the same time, you've got to be really careful of all the
administrative burden that we put on our
front office staff or assistants and nurses
and whoever helps to keep up with this
paperwork.

Because that's kind of one of the common
things that we hear, is that the
administrative burden is just getting
unsustainable for some of these programs.

DR. GUPTA: This is Dr. Ashima
Gupta. I totally agree. I mean, on
Monday -- we're in a private practice,
totally independent. I had ten no-shows on
Monday. And with decreasing reimbursement
from insurance companies, it just -- it makes
it very difficult to sustain a practice,
especially with inflation. And we have to
pay our employees so much more than we did
three years ago just to keep them.

MR. MARTIN: I agree. It's
just Medicaid has given us a tool to use, and
if we don't use it and give them the
information, we can't get them to hold our --
hold our patients accountable.

I think if we can give them the
information, then it's up to Medicaid to
help, with the MCOs, hold our patients accountable that are missing these.

I think we're just going to keep struggling. At least they've given us a tool to use. We need to try to use it and give them the information somehow.

MR. DUKE: Commissioner, just to your question related to: What are MCOs doing? Jeb Duke from Humana.

I will tell you we're doing the best of our ability to take action. So any member on a report is getting a letter, just ensuring that we're stressing the importance of coordinating and communicating with providers. Any member in case management, either behavioral health or physical health, is getting a phone call to ask about barriers to their appointments.

And then members who are frequent flyers, members who hit the report more than once, are also getting live phone calls to try to understand why our members aren't maintaining their appointments. But we hear the frustration, and we're willing to innovate and do any recommendations. But
we're taking action with the information we do have.

CHAIRMAN PARTIN: This has been a really good discussion, and I think we've hit some points here. I think providers need to work harder providing this information to DMS and then DMS can, in turn, work on the information that they receive to help us come up with a solution for this.

So I appreciate everybody's input. It helps a little bit, you know, when you're dealing with a problem, to hear that you're not alone. So thank you for everybody speaking up.

Next up on the agenda is update on reimbursement for multiple visits on the same day.

MS. LEE: I think I'm going to turn it over to the Senior Deputy Commissioner, Veronica Judy Cecil. She's been working on this topic, so Deputy -- Senior Deputy Commissioner.

MS. CECIL: Thank you. So this is something the primary care TAC brought up, and we are continuing to do our deep dive in
this. We're working with Myers & Stauffer who does all of our rate development for our FQHCs and RHCs so that we can really understand the impact to the program.

Part of their -- their work is to research across states what other states are doing. The challenge there is that every state is different. I think you always hear: When you see one state Medicaid agency, you know one state Medicaid agency. So we're all different in how we administer the program.

But we're still gathering that information, and we will be presenting that to the primary care TAC so that they can take that information and utilize it as -- you know, whether or not they want to present a recommendation from that.

CHAIRMAN PARTIN: Okay. So do I need to keep this on the agenda for the next meeting, then?

MS. CECIL: I -- my recommendation is to, you know, allow the primary care TAC to -- because it's on their agenda, to allow them to review it since that's where it came out. But I certainly will defer to the MAC
on how they want to handle that.

CHAIRMAN PARTIN: Okay. I think that it's an issue with primary care. But if I'm not mistaken, it's also an issue with other specialties. Because people have a primary care appointment and they have a specialty appointment on the same day, and that's where we're running into the issue.

MS. CECIL: Yeah. But it's specific to the three entities that receive a supplemental payment, the FQHCs, the RHCs, and the CCBHCs. And you've got to love acronyms.

CHAIRMAN PARTIN: Yeah, right.

MS. CECIL: But the specialty -- that's what we're diving into, so it's not just behavioral health or medical, physical health appointment. It would also include, you know, whether or not a specialty -- you know, some other specialty like dental or, you know, just some other provider type service. So that's what we're looking at.

CHAIRMAN PARTIN: Okay.

MR. SHANNON: This is Steve Shannon. The four CCBHCs are just new to
this world since January, but it clearly is a question that's come up amongst ourselves as well. How does this play out? And so -- and is there a disincentive to scheduling multiple visits on the same day for a person?

MS. CECIL: So I just want to remind everybody how the rate gets developed. It's about the scope of services that are provided. So it includes, you know, all the services that are provided, all of the practitioners that provide those services. And that gets utilized to develop the rate.

And so that's why it is a -- you know, a daily rate. And if there's a change in scope, then there's -- then, you know, that can trigger a change in the rate. So, you know, it's supposed to be contemplated in the development of the rate for all services delivered on that date. That's the model.

But, again, we're taking a look at it. We understand and have heard the concerns of the providers on this, and we're going to take a look and see what we can find out and work with the providers on if there's, you know, a different model that they're
interested in adopting.

There are -- I will tell you there are
good and bad with each model, and there are
winners and losers with each model. So that,
I think, all has to be taken into
consideration.

MR. MARTIN: This is Barry, and I'm
on the primary care TAC. And Medicaid has
been working with us, and we are reviewing
the information they're giving us. And I
think just leave it on there, and I think,
hopefully, we'll come to a resolution or a
recommendation to either take it off or
recommend some action.

So we're working on it. I would
recommend just to keep it on this agenda, and
hopefully we'll be able to address it.

CHAIRMAN PARTIN: Okay. Thanks

for --

MR. MARTIN: Is that all right,
Deputy Commissioner Cecil?

MS. CECIL: I defer to you all.

MR. MARTIN: Okay.

CHAIRMAN PARTIN: Okay. Thanks,
Barry. So I will keep that on the agenda,
then.

Okay. Next is Hepatitis C prenatal screening. Number of cases and number treated. This issue came up at a previous meeting, and I think those numbers were going to be presented today.

DR. THERIOT: Hello. This is Dr. Theriot. I surprisingly was having trouble getting the numbers, and I think I'm pulling them wrong. The numbers I got were less than one percent of our pregnant women were being screened for Hepatitis C, and I really don't think that's correct.

I looked at one of our state university partnerships, and their number was 11 percent of pregnant women in Kentucky Medicaid getting screened for Hepatitis C. I was very happy with that number because it was much more than one percent. But as you know, it really should be 100 percent. So we're still looking into that.

Just to give people background, Kentucky is the second-leading state for adults with Hepatitis C. About two percent of our adults have Hepatitis C in the state, and we lead
the nation in pregnant women who are positive for Hep C. About eight percent of babies that are born to moms who are Hep C positive will end up becoming positive themselves for Hepatitis C.

And we have a wonderful treatment, so it's easy to treat, honestly. And so we really need to screen and find out every single person that has it so we can treat them and cure them.

So that's a long way to say I don't really have specific numbers right now and -- but I have been working on it, and I will try and get those for next meeting.

CHAIRMAN PARTIN: Okay. Thank you. So we'll put that on the next meeting, then. That's -- if that's correct, that's alarming because isn't that mandated, that that screening be done?

DR. THERIOT: It is. It is. Yes. And I'm actually very scared that the number, the 11 percent, is actually accurate so...

CHAIRMAN PARTIN: Wow. Okay. Well, hopefully we'll have better news next meeting.
DR. THERIOT: Hope so.

CHAIRMAN PARTIN: The next item on the agenda is just a reminder that our next update on maternal/child health will be in November.

And then before we move on to updates from the Commissioner, I wanted to just say that for our election today, we have one candidate for each position. And so at the end of the meeting, we will do our election.

But if anybody is interested in running, please let us know, so you can be added to the slate. Otherwise, we'll just do a voice vote of approval.

Okay. Next up is reports from Commissioner Lee.

MS. LEE: Hello. Thank you. So I'm sure, as many of you may have been watching the news today and to see the devastating floods in eastern Kentucky, we have seen on the news several people losing their homes. Some people are missing, definitely just devastation due to all the flooding.

We have been in touch with our MCOs
relating to some of the actions that they're
taking to make sure that individuals have
access to their medications. Dr. Fatima Ali
is also working with MedImpact to make sure
that individuals who may need emergency
prescription pills can get them, focusing on
individuals who may be in case management or
in in-patient, looking at, you know, some of
our long-term care facilities to see if
there's any impact there.

But, again, just trying to do everything
we can to make sure that individuals in the
eastern part of the state that are being
impacted by these floods have access
particularly to their medications and
healthcare services if they need them.

So we'll -- you know, more to come on
that but definitely are working with our
MCOs. And I would like to definitely thank
all of the MCOs who have initiated contact
with the department to see what they can do
in order to help individuals in the eastern
part of the state.

Our MCO partners, as you know, were very
critical in western Kentucky during the
tornados in helping ensure that not just Medicaid members but other members in the -- other individuals in the community had access to health care and the supplies that they need. So we'd just definitely like to thank the MCOs for all they're doing right now for the communities in eastern Kentucky.

One update, a little bit of sad news, is that those of you who may know Lee Guice and work with her, her last day will be tomorrow. She is retiring effective August the 1st. We definitely hate to see her go.

She has a wealth of knowledge and has been -- as you know, been very instrumental in many of the TAC meetings. In her -- as she leaves, Justin Dearinger will be acting director for a while. So if you have any questions for Lee, you can reach out to Justin.

The other bit of news that we have, I'm going to turn the conversation back over to Senior Deputy Commissioner Veronica Judy Cecil, and she is going to give you an update on Medicaid reorganization activities that have been taking place. Veronica.
MS. CECIL: Thank you, Commissioner. Dawna, I'm going to share my screen. Okay. Hopefully you all can see that. It might be a little hard to -- I'm going to Zoom in, but can you all see the org chart? Yep. Okay.

So what you're seeing here is, at a high level, what changes have been made to Medicaid. And we reorg'd as of -- we had a reorganization as of July 14th. Two of our divisions are unaffected, and that's Program Integrity and Fiscal Management. We renamed three of our divisions, and I'm going to go through those. And then we created two brand-new divisions.

So let me Zoom in. So the Division of Information System is a new division. What we did last year is we did move over staff who works on Medicaid systems, and we have a lot of them. And it's very complicated and complex, and we decided to bring those over from our sister agency that handles all of the information systems for the Cabinet. We brought them in-house so that we could better prioritize Medicaid's needs and the system's.
Several of them will be going through procurement, and we have to get approval from CMS on our financing of the system. So we really wanted to bring those folks in-house and work, so policy and our IT experts can work hand-in-hand and more closely to ensure that those systems are reflecting what Medicaid needs in those systems.

So as part of that, we moved -- well, we made that transfer last year. We created two new branches. We just moved them over into the Division of Information Systems and have created a third branch called Data Management.

So health -- the Division of Health Care Policy was renamed. It was formerly Policy and Operations, which was Lee Guice's division. We've made some major changes here, the biggest of which is creating a Maternal and Child Health Branch. We're super excited about this opportunity to focus our staff and our efforts on these two critical areas of health.

As you know, you know, with Dr. Theriot leading us, we're doing a deep dive into
maternal health and trying to figure out ways that we can improve outcomes. So now we're going to have a branch dedicated to that.

Our Benefit Policy Branch will become the Physical Health Branch and, again, solely focused on policies around healthcare services and how those are reimbursed. So we'll be looking forward to, you know, being able to do a better job of keeping updated on trends and innovation and healthcare policy through that.

The division of -- our new division -- new-named Division of Quality and Population Health was formerly Program Quality and Outcomes. Program Quality and Outcomes used to do both quality and managed care oversight.

And we felt like it was really needed to -- we needed to break those out into separate divisions. Because, again, our goal here is to drive outcomes. I think you've heard Commissioner Lee mention on several occasions we want to be more than just a payor of claims. We want to be a driver of healthcare policy to improve the outcomes of
So this division is being refocused to do that. We've created an Equity and Determinants of Health Branch. This branch, as it says, will be focused on: How do we address the inequities and disparities across the state that affect our members?

You know, CMS, the Center for Medicare and Medicaid Services, our regulatory agency, is very much focused on how can we better address the determinants from the Medicaid program. It's allowing MCOs to utilize, you know, funding for those determinants, and it's housing and food and clothing and jobs. And so how can we improve the overall health of our members, not just for healthcare coverage.

The former Disease and Case Management Branch has been renamed Population Health because we want to look through that lens as we develop our policies. We want to be able to focus on those chronic conditions. You know, we really need to be -- we just understand we need to do a better job of ensuring that we're -- our policies and our

our members.
programs can address those across the program.

And then our quality -- our MCO Quality Branch has just become the Quality Branch. Again, focused on -- we have a quality strategy we're working on right now. It's going to be looking at and doing more reviews of the services, of the coverage, and ensuring that we're paying for quality services.

And then a Research and Analytics Branch that will provide us the necessary data so that our policies are data-informed, we're making changes based on that data, and ensuring that the data is usable, is quality data and actionable.

The Division of Health Plan Oversight is the other new -- brand-new division. This will be the division that takes over all of the oversight of the Managed Care Organizations. But I'm also happy to announce that the Health Benefit Exchange which does the Marketplace, the qualified health plans, it has moved into this division. And the director for Health
Benefit Exchange has come over, Edith Slone, and she is now the new director for the Division of Health Plan Oversight.

We wanted to do that because this division is going to help us ensure consistency and continuity of care across the different plans, from Medicaid to Qualified Health Plans and potentially in between.

If there's a -- I know you all are aware that we're talking about a Basic Health Plan, so all of that would fit under this one division so that we have people that can see across that continuum and understand it and help people navigate it.

So as a result, we've created a new Appeals and Complaints Branch, so all of the appeals and complaints related to the Medicaid program and for MCOs and for Qualified Health Plans will fall in that branch.

We renamed the MCO Contract Management to just Contract Monitoring. So they will be, again, enforcing the MCO contract but also looking at the agreements with the Qualified Health Plans to make sure that
everybody's in compliance.

And then we moved -- from Policy and Operations, we moved Eligibility and Enrollment under this branch, again, because we want that continuity and consistency in understanding how eligibility is affected by all the programs and be able to seamlessly move people across.

So I think the other really great change here is our former Community Alternatives Division has been renamed the Division of Long-Term Services and Supports. We decided to align all of the long-term and community programs into this one division. And that, again, is part of our logic of making sure there's consistency and continuity.

People often move from long-term care into community programs and community programs into long-term care. So now we have all of that under one division. We created the Long-Term Care Facilities Branch. That's the nursing facilities, the ICF/IDDs. And so -- so those folks -- anything related to nursing facilities or nurse-aide training, all of that will -- has moved over to
Long-Term Care Facilities Branch under the renamed division of Long-Term Services and Supports.

What we're hoping is that this is seamless to providers and to members. You know, again, some of it has just been a change in name and -- but a refocus for the department. And what we're hoping to gain from this is bringing on additional staff.

You know, our -- our resources have always been limited, and we have a fabulous staff that's -- fabulous employees here under the department. But because our day-to-day is -- we're so overworked and overwhelmed, this will give us the opportunity to bring on some additional staff with different skill sets; for example, bringing on people who are familiar with population health, you know, bringing on some diversity in the skills that we already have, and being able to focus where we should which is, you know, improving the lives of our members.

So that is a really quick and high overview. I'm happy to take any questions.

CHAIRMAN PARTIN: Veronica, the
columns in white, are those still there or are --

MS. CECIL: Yes. Right. There was no change to the Division of Program Integrity and to the Division of Fiscal Management.

CHAIRMAN PARTIN: Okay. And then, secondly, could you send all of the MAC members a copy of this flow sheet?

MS. CECIL: Absolutely. Happy to do that.

DR. SCHUSTER: Veronica, this is Sheila Schuster. Two questions. One is: At some point, can you tell us who are in those big boxes that head up those divisions?

MS. CECIL: Absolutely. So I'll just go real quick, but we'll add the names for the version we send.

DR. SCHUSTER: Okay.

MS. CECIL: John Hoffmann is acting director for Division of Information System. John has been with Medicaid for a long time. He was previously the assistant director in the former Division of Program Quality and Outcomes. But he's now acting director of
Information Systems.

Angie Parker, who was over Program Quality and -- Program Quality and Outcomes, remains the director of the new -- of the renamed Division of Quality and Population Health. So Angie Parker will still be there.

As we mentioned, Lee Guice was formerly Health Care Policy leaving August 1st, so Justin Dearinger will be acting director there.

Edith Slone from the Health Benefit Exchange has become the new director for the Division of Health Plan Oversight.

And then Pam Smith remains the director for the renamed Division of Long-Term Care Services and Support.

DR. SCHUSTER: And who's in that Division of Program Integrity?

MS. CECIL: That's Jennifer Dudinski.

DR. SCHUSTER: Oh, yeah. Okay.

MS. CECIL: She hasn't changed, and then Amy Richardson is the director of Fiscal Management.

DR. SCHUSTER: Thank you. And then
I have one more question, and that is at the very top. And, of course, I love seeing behavioral health right up there at the very top of your chart, but I'm a little confused about what that means. Because you've got --

MS. CECIL: Yes. Sure. I'm happy -- yeah. I'm happy to explain that. So behavioral health does not have its own branch. It's just -- it's basically a unit. It's a program, and it does come under the Commissioner's office. Leslie Hoffmann, the other deputy commissioner, heads that -- that program.

DR. SCHUSTER: Okay. I knew that she was there. I guess I was thinking that it would go under, you know, where you have physical health and the other categories.

MS. CECIL: Yeah. So I will share, Dr. Schuster, that we had lots of conversations about whether to create a new branch for behavioral health, but we really want to keep it under the Commissioner's office.

DR. SCHUSTER: Well, we like having the Commissioner's clout up there with
behavioral health, so I'll take that. Thank you. Appreciate it.

MS. CECIL: You're very welcome.

Are there any other questions?

(No response.)

CHAIRMAN PARTIN: Okay. Anything else from the Commissioner?

MS. LEE: I do not have any additional updates at this time, and I do apologize. I'll have to be dropping a little early today, but you all will be in very good hands with the senior deputy commissioner and the rest of the Medicaid staff that are on here. I will be on for a while longer, but I will be dropping maybe around 11:30 or so. So no other updates at this time.

CHAIRMAN PARTIN: Okay. Thank you.

And then next up, then, is an update on the Basic Health Plan and unwinding.

MS. LEE: So we are on pause right now with the Basic Health Plan. As you know, we had started out with an original start date of 1/1/23. We did listen to some of the concerns, particularly potential carriers who were concerned about maybe being able to
develop an adequate provider network. So it is on pause right now, and we will give further updates as we get them.

Related to unwinding, we -- as you may know, the Public Health Emergency has been extended again. We have a communication plan that is ready to go. Our main concern and focus for unwinding is going to be on our members, making sure that we have accurate and updated addresses for them so that we can reach out to them.

Also want to make sure that our provider community knows that if you have someone in your office and you notice that they have a change of address, if they're a Medicaid member, instruct them to contact the Cabinet, if they have not, to update their address.

Again, as we go forward, we'll have a 60-day notice from -- prior to the Public Health Emergency ending from CMS. So the current one extends into October of 2022, so we will again provide information as that becomes available.

And then we are also going -- right now, we're going through a lot of the
flexibilities that we have been afforded under the Public Health Emergency and implementing some of those as we can. So that when the Public Health Emergency ends, there will not be a huge disconnect or interruption of services, particularly around telehealth.

We have updated our telehealth regulation. The only thing that we're waiting on as far as telehealth is concerned is guidance from the federal level regarding HIPAA-compliant platforms. As you know, during the Public Health Emergency, providers have been allowed to use Zoom and FaceTime and those sorts of things, so we're waiting to see if we'll be allowed to continue those platforms in telehealth but, again, waiting on information from the Federal Government.

And, again, our goals are to comply with all requirements, all state and federal requirements. We want to prevent any unnecessary terminations in the Medicaid program. Again, that's why it's really important for us to have accurate, updated addresses.
We are working with our Managed Care Organizations to kind of stagger mailings based on individuals who need to be redetermined when the Public Health Emergency ends. So as you are aware, right now, the Department cannot terminate anyone except for presumptive eligibility members, individuals who pass away, individuals who request to be removed from Medicaid, or individuals who move out of the state.

So right now, we do have individuals who have never done a redetermination or who may have forgotten that they need to do a redetermination when the Public Health Emergency ends. So, again, definitely focusing on our member population and keeping everyone enrolled that qualifies in the program. And we want to have some sort of smooth transition for those individuals who may lose coverage but qualify for a Qualified Health Plan.

And as the senior deputy commissioner reported, we now have Kynect and the Qualified Health Plans, the state-based exchange, in our department which will make
some of those transitions and communications a lot easier. So, again, just focusing on our members.

And I think that I will turn it over to the senior deputy commissioner for anything I've missed and to talk about our communications strategy.

MS. CECIL: Thank you. As the Commissioner mentioned, we are working on a communications strategy, and that is for very different reasons. One is for member, obviously ensuring that the member understands what action he or she might need to take to maintain eligibility.

The other is for the provider. We want to make sure providers understand what's happening. You know, there were some flexibilities that we implemented related to providers so making sure that all the providers understand how the unwinding affects them. But, also, it's important for providers to understand what's happening to the member.

And we want to make sure our advocacy organizations that we know we're going to
need to utilize to help get the message out -- and we do want a common message. We want to make sure everybody is telling everyone the same thing to try to reduce any confusion.

So we will have a very comprehensive communication plan, and what we don't want to do is roll it out too early because we don't want to create chaos or fear or anxiety unnecessarily. And so we -- you know, that's why we just continue to monitor the status of the Public Health Emergency.

The 60-day notice will be what will trigger our moving forward with the communications. And until then, as the Commissioner mentioned, we really just want -- we're asking members and we're asking kind of everyone just to encourage members to make sure their information is updated in our system so we have contact information.

We do plan to leverage the Managed Care Organizations. CMS has allowed states to utilize them kind of a little differently than normal, including being able to update contact information and us be able to rely on
that without a secondary verification.

We're going to work with our MCO partners on reaching out to their members specifically affected. And so I think that'll maximize the resources on who -- you know, how can we keep these members covered.

And we're going to be using lots of different ways of communication which is what this slide speaks to. Just really quickly, so that you all understand the way we process renewals, there's an automatic processing that goes on behind the scenes once we turn -- flip the switch to restart everything. So that'll happen behind the scenes.

What that does is a lot of people can be what's called passively renewed. We have all the information. We can verify all that information. There's no additional action needed from the member. And so those folks go down the passive renewal lane, and they'll get a notice of renewal, no additional steps.

It's the ones that have to do something actively, so they have to respond to a request for information because we couldn't
verify something. So it's the active renewals that we're going to focus on.

Right now, we estimate around about 180,000 people may be subject to an active renewal. That changes every month. Sometimes the system is able to verify somebody. Because this is all kind of going in the background anyway. Even though we're not doing any terminations, it's happening. And that's why we can kind of identify how many people may be subject to an active renewal.

So we'll send out that active renewal packet. I mean -- yes, that renewal packet. They'll get it. It'll tell them exactly what it is that we need. They upload the information. They can do that various ways. Then it'll be reviewed, and either a notice of renewal will be issued or the notice of denial. Of course, we always -- the member has the opportunity to request a review or to appeal any denials.

And then we're going to send this out to everybody. I know it's probably a little hard to see, but this just goes through a
scenario, a timeline if, for example, the PHE does end on October 13th.

I think what's important for everybody to realize is that, again, we start the process pretty early. And we give at least 40 days' notice to the member that they, you know, may potentially be deemed ineligible. So this sort of walks through kind of what that looks like.

So if the PHE ends in October, November would be the first month that we could terminate people. So, again, it kind of goes back two months. We'll start the renewal process the next month, the month before a termination, a potential termination. They'll receive notices. They'll be able to work on those notices.

We'll be working closely with the MCOs, making them aware of which members are potentially subject to a termination. They'll be doing outreach. We're going to work very closely with our connectors and other organizations to make sure there's a ton of support out there for people so that we don't let anybody slip through the cracks.
And then so, again, November -- the end of November would be the first time since the pandemic and the Public Health Emergency that we might have to terminate somebody. So we'll get this out.

One other thing to note is that the home and community-based programs, the 1915 (c) waivers, we have what's called an Appendix K that has created the flexibilities for those programs. It expires six months after the PHE ends. So we'll be continuing to monitor those, so they'll have a different timeline and different communications but just wanted to note that.

CHAIRMAN PARTIN: Okay. Thank you. So that was a very thorough explanation about what's going to happen with the unwinding. So at our next meeting, what I guess we'll need to know is an update on the Basic Health Plan and then where we expect we are in that process of unwinding.

MS. CECIL: Right. We'll know by the next meeting whether it's been extended again, the Public Health Emergency, be extended again. So, you know, again, until
that 60-day notice, things are just status quo. We're not doing any terminations. The flexibilities stay in place. It's just when we get that 60-day notice, we'll start doing major communication.

CHAIRMAN PARTIN: Thank you. And then you're going to send us all of the slides; right?

MS. CECIL: Sure will. And we'll also post it to our website.

CHAIRMAN PARTIN: Okay. Perfect.

Okay. So we have a little under an hour and a half left for our meeting. And so I would like to ask the TACs to keep their reports short so that we can get through all of those and have time for any questions that were left over for Aetna and Anthem and then the reports from Humana and Molina/Passport.

So let's go ahead and, again, please just keep your report short. Tell us any pertinent information that we need to know and then your recommendations so that we can get through all the TAC reports quickly. First up is behavioral health.

DR. SCHUSTER: Good afternoon. We
met on July 14th, and we had a quorum,
approved our minutes. We continue to have an
issue around payment for members who have
dual coverage. We've solved it, I think, for
Medicaid and Medicare but not for Medicaid
and commercial insurance. So Angie Parker
from DMS was very helpful in giving us some
follow-up information.

We also had a discussion about the
no-show data portal, and we will be asking
for more detailed information about who the
providers are who are making reports.

We had a very important discussion, I
thought, about provider credentialing. And
at our next meeting, we will have someone
there from Kentucky Hospital Association.
They have worked with Aperture to create a
credentialing alliance, and three of the MCOs
belong to that. So we're trying to get a
handle on how that works and how it will help
providers speed along the credentialing
process.

We also looked at telehealth, and we
were very happy to have Jonathan Scott, the
reg guru from CHFS, talk to us about
907 KAR 3:170. I advise you all to look at that. That's the recently-adopted reg from Medicaid about changes in telehealth. So that was very helpful, and we had lots of questions answered as well.

We also are following the work of the interim task force in the legislature on emergency medical services. I've spoken to you all before about the problem of transport, particularly for people with behavioral health issues, where the ambulance drivers and EMS are taking the position that they don't have to transport, quote, those crazy people, end quote. So we're -- we worked on House Bill 777, and we're continuing to monitor that task force.

We did have one recommendation. The behavioral health TAC recommends that DMS issue a Frequently Asked Questions document to members and providers on telehealth services based on their most recently-approved regulation. So that is our only recommendation.

We will meet again September 8th, and I think that's record time for me to talk about
behavioral health. Thank you.

CHAIRMAN PARTIN: Thank you, Sheila. Could you give me the citation again for that regulation?


CHAIRMAN PARTIN: Thank you.

DR. SCHUSTER: Yeah. Well worth looking at. And if the department can do an FAQ, I think it would be super helpful to providers as well as to consumers for that matter, and that was our recommendation.

CHAIRMAN PARTIN: Okay. Thank you.

Next up, children's health.

(No response.)

CHAIRMAN PARTIN: Okay. Consumers rights and client needs.

MS. BEAUREGARD: Good morning, everyone. I'm Emily Beauregard with Kentucky Voices For Health, and I'm the chair of the consumer TAC.

We met on June 21st, and we met remotely using Zoom. We had a quorum present. We did discuss at that time wanting to go to some sort of hybrid meeting option and have one
meeting a year where we're in person
together, similar to what the MAC has
discussed. And I think everyone was in
agreement with that decision. But with the
rising COVID rates, I think that we'll be
putting that off for a little while yet.

We were very pleased to learn at our
last meeting that Kentucky has received
approval from CMS to lift the five-year
waiting period for legally-residing pregnant
immigrants who are otherwise eligible for
Medicaid. This is something that our TAC has
recommended in the past, and we think that,
you know, this is a great way to improve
maternal health, a good step in that
direction. I know that's been a priority of
the MACs recently.

And we were also happy to hear that the
governor has approved all appointees for the
new Health Equity TAC. We hope those
meetings will begin soon, and, again, another
great opportunity to work on reducing
disparities in maternal health.

We discussed network adequacy again at
this meeting. We recognize that most
Medicaid members are really unaware of network adequacy rules and how to request an out-of-network provider when a particular MCO's network isn't sufficient.

And we really appreciate that Angie Parker put together a draft memo in response to a request that we had made for information that could be shared with consumers that explains the rules, their rights, and how to change MCOs if the network won't meet their needs. We're going to review this draft and discuss it again at our next meeting and may have some recommendations that come out of that.

We also revisited the State's spending plan to invest in home and community-based services with ARPA funding, and we understand that, you know, that's on hold right now due to a directive from the legislature to increase provider rates. But we also understand that CMS requires, you know, our rate study to be conducted to justify any rate increases.

And all that said, it seems that this has perhaps delayed any -- some plans in
paying for on-boarding costs of PDS employees that are hired by waiver participants. And, you know, the waiver participants are unfortunately having to shoulder the burden of these costs for on-boarding their employees while they're on incredibly limited and fixed incomes. And so that is a concern.

And it may be that I'm not completely understanding this issue, but it continues to come up. And it's an issue that's being raised by one of our TAC members who is a participant in a home and community-based services waiver.

So we have submitted to -- well, to you, Dr. Partin, and to Erin our report along with a statement from Arthur Campbell, who is one of our TAC members, about this issue. So please share that with MAC members if you can. I'll be sure to -- I believe it was Dawna who was staffing today. I'll be sure to share it with you as well.

And I think that covers, you know, most of what we discussed at our last meeting. We didn't have any recommendations this time, which is unusual for us. But I do expect to
have a few at our next meeting.

And I just wanted to touch on a couple of things that were discussed earlier. You know, transportation is a huge barrier to people getting to their appointments. When you were talking about the no-show rates, we know that transportation is always cited as the primary barrier that people face.

And so thinking about how nonemergency medical transportation can help to address some of that no-show rate and what we can do to improve access through the NEMT program, I think, is a good goal for us and perhaps for the MAC to start exploring. And then, you know, community health workers, I think, could also be part of the solution there.

And, you know, thinking about the unwinding and what we need to be doing in order to make sure that people are aware and responding to those renewal notices, I hope that providers will be part of the solution.

You know, when people are coming in to see their provider, asking if their, you know, address is up to date and making sure that they are updating it in Kynect or that
the provider is filling out a form to update that address, I think, could be really beneficial. There is a form that exists that most providers aren't aware of, but we know that people often don't find out that they've been disenrolled until they seek care either at a provider's office or go to the pharmacy. And so that's just something else that I would suggest keeping in mind. And I think that's it for us.

CHAIRMAN PARTIN: Okay. Thank you, Emily. Next up is dental.

DR. BOBROWSKI: Yes. This is Dr. Garth Bobrowski, and we don't have any specific recommendations from the TAC at this time. But we did want to express our disappointment in the -- our request from last time about a fee increase. We want to thank the primary care TAC for bringing up and bringing it to the forefront of the lack of dentists and access to care from eastern Kentucky. But the -- and I'll be brief here. But even the KDA and the executive committee of the KDA
had reached out. The -- part of the DMS response was based off of an ADA report that is not a hundred percent accurate. And they were showing that the -- I've got part of it here, that Kentucky ranked the highest in the nation in terms of reimbursements at 104.8 percent. And, folks, that's just not so.

But as was reported earlier, I know with one of the research things on Hepatitis C, she said, well, some information came in as one percent. Some of it came in as 11 percent. And sometimes -- as you all know that have done research or been involved with that, sometimes your research design and methodology can affect your outcomes of your research or sway your thoughts on your research.

But the -- this is kind of why a lot of dentists have quit seeing a lot of the adults. The No. 1 thing was the low reimbursements. No. 2 was the failed appointments. No. 3 was the administrative burden that they're put under.

But I did want to thank Dr. Caudill and Avesis for their increase in some of the fees
to the participating dental providers, and I
did want to thank them for that.

The -- and I'll just leave it at that
for today. Thank you.

CHAIRMAN PARTIN: Thank you,

Dr. Bobrowski. Next up is nursing home care.

(No response.)

CHAIRMAN PARTIN: Home health care.

MR. REINHARDT: Good morning,

everyone. Evan Reinhardt with the home

health TAC. The TAC met on June 21st and had

some robust discussion on reimbursement rates

which continue to be a concern in our space

as well as some other ongoing old business

topics. And we did not have any

recommendations at this time.

CHAIRMAN PARTIN: Okay. Thank you.

MR. REINHARDT: Thank you.

CHAIRMAN PARTIN: Hospital.

MR. RANALLO: This is Russ Ranallo

from the hospital TAC. We met on -- we met

on June 14th, and we had a quorum. We had no

recommendations. DMS provided us a metric

report on the IPRO and denials, and we are

reviewing that.
We also had discussion on incarceration data, and adjustments and fixes with that continue to be ongoing and a few others that are in my report. But for sake of time, that's all.

CHAIRMAN PARTIN: Okay. Thank you.

Intellectual and developmental disabilities.

MR. CHRISTMAN: This is Rick Christman. The IDD TAC met on July 19th. Main order of business was that we learned that the State is still waiting on approval from the Federal Government, CMS, for approval of the rate increases that are contained in the state budget. Beyond that, we had no recommendations. Thank you.

CHAIRMAN PARTIN: Thank you.

Nursing TAC.

(No response.)

CHAIRMAN PARTIN: I believe the nursing TAC put in the chat that they had to leave early, so I don't think they had any recommendations. And they can submit a written report.

Optometry?

MR. COMPTON: Steve Compton. We
met on May the 5th. We had a quorum. We had some great discussions. We meet again next week, but we have no recommendations.

CHAIRMAN PARTIN: Okay. Thank you.

Persons returning to society from incarceration.

MR. SHANNON: Yes. This is Steve Shannon. We met on July 14th. We had a quorum. We have no recommendations, but we continue to get updates on the 1115 waiver amendment for folks returning from incarceration. I think our real work will start then.

We did hear updates about other state initiatives that will impact folks returning. One is AppalReD, encourages people being hired. I think employment is a big part of that and the recovery-ready communities.

There will be a Senate Bill 90 implementation council that will look at diversion as people get arrested, so they don't go into incarceration. They go to treatment.

And the Opioid Abatement Advisory Commission, we got an update about that
commission as well in the attorney general's
office. Thank you.

CHAIRMAN PARTIN: Thank you.

Pharmacy.

DR. POOLE: Yes. This is Ron Poole
with the pharmacy TAC. We met on July 20th,
had a quorum. I'm cutting this in half even
though it's going to seem lengthy because we
had a couple of, kind of, hot topics for
sure.

In trying to cut it down, in
negotiations with legislators for
House Bill 48 in 2021 -- it passed in March
of '21, and it went into effect July of '21.
The Kentucky Department of Medicaid Service
was excluded from this law due to the
discrepancy in the Centers For Medicare
Services not recognizing pharmacists as
healthcare providers. And I want to
reiterate that point just then.

I'm sure it's -- you can imagine how
embarrassing it is for pharmacists who fill
for 48 million Part D recipients nationwide
that we're not still recognized as healthcare
providers. But the Kentucky Department of
Medicaid Services would have to have filed for a waiver, which they can, in order to comply with this law.

The Kentucky Department of Medicaid Services have received 827 million dollars from drug rebates from Senate Bill 50 that we got passed in 2021. It didn't go into effect until July of 2021. So looking at potential ample funds to develop and create clinical pharmacist services, taxonomy codes, billing codes. To date, all we have is a HCPCS code in order to develop just for consulting with immunizations.

Clinical pharmacy services, just brushing over, we did this -- I was on the board of pharmacy when we developed a lot of these clinical services for pharmacists that we worked in correlation with Kentucky Medical Association and also the Kentucky Academy For Family Practitioners where we do acute uncomplicated UTI testing -- all this is point-of-care testing -- Group A strep testing, flu prophylaxis, and antiviral testing, colorectal cancer screening, TB testing, pharmacogenetic testing,
anticoagulation clinics and models.

To also being able to dispense under
protocol for tobacco cessation and alcohol
use disorders, travel health prophylaxis,
allergic rhinitis, emergency contraception,
anaphylaxis treatment, where people can just
come in and get an EPI pen in an emergency
situation and it be legal.

Same thing with naloxone. They can come
in and get a prescription without having to
worry about getting a doctor because it's by
a medical doctor's protocol.

Expanded immunization protocols, which
has been around the longest of all of these.
Oral contraceptive evaluation. Opioid use
disorders, working with monitoring and
potential interaction and intervention with
those, the long-acting injectable, education
and administration for antipsychotics.

All of your adherence education and
packaging that's been going on for some time,
and then all of your just educational
programs on self-care conditions, self-care
with diabetes, OTC probiotics, interview and
recommendations, and things that somebody --
a lot of people know about is transitions of care, chronic care management, and remote patient monitoring.

The motion was, you know, due to the charge of the CMS memo on 5/12 of '22, which states that state Medicaid programs are expected to give all provider types authorized to administer COVID-19 and childhood vaccinations under the HHS COVID-19 PREP Act.

Declaration, opportunity to enroll as Medicaid providers and receive Medicaid payment, not only for actually delivering or injecting vaccines, but also for stand-alone vaccine counseling about these types of vaccines provided to beneficiaries for eligible -- for EPSTD.

And due to the passage of House Bill 48, an insurer, or a third-party administrator for such insurer, shall provide reimbursement to a pharmacist for a service or procedure at a rate not less than provided to other nonphysician practitioners if the services -- if the service or procedure is within the scope of practice of pharmacy, would
otherwise be covered under the policy plan or
closest to the service or procedure, or
provided by a physician, advanced nurse
practitioner, and physician assistant. In
addition --

(Brief interruption.)

DR. POOLE: In addition to all

other compensation that may be reimbursed to

a pharmacist under this chapter, the

employer, insurance, or payment obligor shall

be liable for reimbursement of a pharmacist

for a service or procedure at a rate not less

than that provided to other nonphysician

practitioners for the service or procedure.

The PTAC asks for the MAC to ask and

encourage the Kentucky Department of Medicaid

Services to enroll individual pharmacists as

Kentucky Medicaid providers. In addition to,

PTAC asks the Kentucky DMS to create taxonomy

codes, billing codes specific to pharmacists

performing vital clinical services, and

create equitable and unbiased pharmacist

reimbursement models for providing these

clinical services which can greatly improve

the quality of life and the status of one's
health care for all of our Medicaid recipients.

The second discussion was on NADAC pricing, which is what our reimbursement is based on for our prescription drug claims. We have heard plenty of reports from all over the state of some reimbursement not being up to date on NADAC.

Adrienne McCormick with MedImpact educated us, the PTAC, on how NADAC prices are updated, from manufacturers' increasing prices to then updating First Databank to NADAC being updated by Myers & Stauffer to MedImpact and Magellan databases picking up these price increases from NADAC database. The process may take two to three weeks.

In addition, the website and report generated by the National -- or the NADAC comparison data is rather lengthy. This last one dated July 20th that was just issued -- so what Medicaid does is they go back -- or excuse me. What Magellan and certainly MedImpact do is they go back and they backdate some of the price increases because of the process taking two to three weeks,
which is nice.

But to be able to go back and query over 21,000 different NDC numbers is rather time-consuming. And me personally, I'm decently tech savvy, so I was able to create a little piece of software that allowed me to look at the 21,825 different NDCs and compare them for the date ranges that were backdated to see which drugs I could re-bill -- or reverse and re-bill. Not everybody has that ability to do that.

So the TAC -- the motion was the PTAC requests that all pharmacy Medicaid providers be informed of the website and report that can be accessed which informs each provider of drugs that have had their price increases backdated are eligible for reversed and re-billing for increased reimbursement.

In lieu of the difficulty of pinpointing with such a lengthy report to go through, we ask that MedImpact work with us on creating -- with the pharmacy providers, working with us on creating and sending an electronic report to every pharmacy enrolled with Medicaid MedImpact and each of the
pharmacy claims that were reported by the
NADAC as a price updated for each pharmacy's
system. That's -- that's a request and a
motion for consideration.

I have spoken to Adrienne McCormick in
person, and she was nice enough to get on the
call with us the other day. But that is our
request, and that is the end of my report.
Sorry about the length. Thank you. I did
cut it down.

DR. HANNA: Can I just make just a
couple of comments, if possible? Do we have
time? Just quickly, I just did want to
say -- I want to voice some concerns, too, as
far as with the provider -- you know, being
able to enroll as providers as pharmacists.

Because I just wanted to say that, you
know, during the pandemic, pharmacists have
provided -- we've been open continually
during the pandemic and provided over 70
percent of the vaccinations across this
commonwealth. And CMS has recognized
pharmacists as being an important healthcare
provider, not only in the delivery of
vaccination services but also in
consultation.

In light of that, they clearly stated this in their expectation and memo that they did send to Medicaid providers, and it's hard for me to understand how this can be ignored as a directive.

Also, I wanted to, you know, just say that now as we're faced with this challenge in distributing Paxlovid in many areas of our state who have limited access, pharmacists can help in this endeavor. But because we are not -- don't have a provider number, it's very challenging because there's no reimbursement for this. And those who are providing this understand what that takes.

You know, there's a lot of time involved in looking for drug interactions and making sure you have lab levels and that type of thing. Without that ability, it makes it hard. And so many of our -- you know, our patients may, you know, be challenged with having access to Paxlovid. So that's another area where I find this challenging.

And during the PAC meeting, there was a comment made that part of the reason for not
recognizing pharmacists was due to fiscal considerations. There were some other points made, but that was one of them. And that is somewhat challenging for me to understand. You know, as Dr. Poole has submitted in his report, the services that pharmacists do provide focus on public health. And I do ask the Cabinet if the charge of DMS is to focus, you know, primarily on fiscal savings -- you know, that comment was made which kind of bothered me -- or on providing access to care.

As, you know, Dr. Poole said, we found the savings from Senate Bill 50 were 800 million. And in the rebates alone, it seems that some of these savings could be reallocated to help provide these valuable health -- public health services to the, you know, beneficiaries that we serve.

And that's why I think this is a very valuable thing. I think that the Department of Medicaid Services should follow the directive of, you know, CMS and look to providing, you know, pharmacists with an ability to go through these services and be
listed as a Medicaid provider. Thank you.

CHAIRMAN PARTIN: Thank you. Any other comments?

(No response.)

CHAIRMAN PARTIN: Okay. Then we'll move on to physician services.

DR. GUPTA: This is Ashima Gupta. We did not meet.

CHAIRMAN PARTIN: Thank you. Primary care.

MR. MARTIN: Yes. This is Barry Martin. Our chair, Mike Caudill, could not make it today, so I'm giving the report. We met on July 7th, and we had a quorum. And we continue to work well with DMS and the MCOs on various aspects and appreciate Dr. Bobrowski's comments about us tag-teaming with the dental TAC on trying to help the dental shortage and the dental disparity throughout the state which leads us to the two recommendations from the primary care TAC. They both relate to dental.

One is for a state policy review of the current dental workforce shortages in Kentucky including the use of dental
auxiliaries to expand healthcare workforce capacity. That recommendation is supported by DMS.

The other recommendation we had was related to dental, of course, and it's for a policy review relating to current dental enrollment levels and state-funded dental colleges, in-state and out-of-state dental graduate retention levels and dental scholarships, dental loan and loan forgiveness options for Kentucky dental graduates.

Review the equity of current dental fee reimbursements provided by the state Medicaid program and its MCO contractors, and review the policies and programs that support local coordination, care coordination and the integration of dental prevention and treatment services into hospitals, public health departments, school health clinics, FQs, and RHCs, of which DMS supports that recommendation as well. So those are our two recommendations.

CHAIRMAN PARTIN: Okay. Thank you.

Next up is therapy services.
(No response.)

CHAIRMAN PARTIN: Okay. It looks like we don't have a report from therapy services. So I'd like to have somebody make a motion to accept the recommendations from the TACs. Could somebody please make a motion?

MR. MARTIN: This is Barry. I'll make a motion.

CHAIRMAN PARTIN: Second?

MS. ALDRIDGE: I'll second it.

CHAIRMAN PARTIN: Who is that?

MS. ALDRIDGE: Teresa Aldridge.

CHAIRMAN PARTIN: Thank you, Teresa. Is there any discussion?

(No response.)

CHAIRMAN PARTIN: Okay. All in favor, say aye.

(Aye.)

CHAIRMAN PARTIN: Any opposed?

(No response.)

CHAIRMAN PARTIN: Okay. The reports are accepted. Next --

DR. SCHUSTER: Madam Chair, this is Sheila Schuster. I actually thought, as a
member of the MAC, that I would receive the
written reports from the TACs. Did I miss
that, or have they never been circulated to
the MAC members? This is only my second
meeting.

CHAIRMAN PARTIN: They should be.
We should receive the reports from the TACs.

DR. SCHUSTER: And I assume that
they would be circulated prior to the meeting
so we could look through them beforehand?

MS. CECIL: They're not always
presented to DMS prior to the meeting. It's
after the meeting, after the report has been
given and the recommendations have been
approved, that then we send them out. But I
will double-check to make sure the reports
are going out along with other
communications.

DR. SCHUSTER: Yeah. I don't
remember getting them after the last meeting.
That was my first meeting on the MAC.

CHAIRMAN PARTIN: And, also, the
response back to the TACs. The MAC has not
been receiving the response from DMS for all
the TACs. We used to, and we haven't been.
So I would like to request that.

MS. CECIL: Okay.

CHAIRMAN PARTIN: That all the MAC members receive the response to the recommendations from the TACs.

MS. CECIL: Okay. I'll double-check with Erin, but I'm pretty certain she sent those out about two weeks ago. But we'll follow up.

CHAIRMAN PARTIN: Okay. Thank you.

DR. SCHUSTER: Thank you.

MR. MARTIN: Deputy Commissioner, will these reports be the actual transcribed minutes, or will these be condensed into summaries?

MS. CECIL: No. So whatever report is submitted by each TAC is what will be sent to the MAC members. I know there's been a question from several of the TACs about the transcripts versus meeting minutes.

Prior -- we had a previous court reporter who was willing to provide minutes that was not necessarily contracted work from the department, but she -- for some TACs, they requested minutes, and so she prepared
those.

Unfortunately, our contracted court reporters that we use now do not provide minutes. So the transcript for most of the TACs have been what has constituted the minutes of the meeting. And so, you know, they should be reviewed. And if there are any necessary changes, that should be noted in the next TAC meeting.

We have had some problems, and we're working through those, on the timeliness of receiving those transcripts. But we are committed to providing those to each meeting 30 -- to the members of each meeting 30 days after. So you at least have, at a minimum, 30 days to review those and note any necessary changes.

If -- you know, TACs certainly -- and, again, it's kind of all over the board. Some chairs do their own minutes, but the transcript -- so at a minimum, the transcript will serve as the minutes. But, certainly, TACs are very different in how they utilize that information and turn them into minutes.

MR. MARTIN: I just wanted to
forewarn Sheila that she will be getting a whole lot of information.

MS. CECIL: I appreciate that.

Thank you.

DR. SCHUSTER: Well, I might be really interested in reading it all. Thank you. I just think it's -- I think it's very helpful to know what different areas of providers and consumer representations are looking at and discussing even if you don't have a recommendation. Because I think it gives you a sense of: What are the issues that are bubbling up out there, and are they being heard from from other parts of the DMS world?

MR. MARTIN: Yeah. You'll have a lot of bedtime reading, Sheila, when you get the transcripts.

DR. SCHUSTER: Okay. Thank you for the warning. No, I don't want the transcripts.

MS. CECIL: Right. So to clarify, Barry, what generally -- when there's a report made from a TAC, there is something typed up, one page or two pages typed up that
the Chair sends as the actual report.

MR. MARTIN: Okay.

DR. SCHUSTER: Yeah. I was not
volunteering to read the transcripts. I
barely skim through the ones for behavioral
health, and so thank you.

MR. MARTIN: You're welcome.

CHAIRMAN PARTIN: Right. So just
to summarize, in the past, we did receive the
reports that the TACs submitted. We have not
received those in a while. So if the TACs do
submit a report, then, that will be
disseminated, then, to all the MAC members.
And then the recommendations -- the response
to the recommendations from DMS should also
be sent to all of the (audio glitch).

Okay. Next up is questions from the MAC
for Aetna or Anthem on their previous
presentation from May. Any questions?

(No response.)

CHAIRMAN PARTIN: Okay. Then we'll
move on to the reports from the MCOs. And we
probably need to limit those reports to no
more than about -- a little over 15 minutes
so that we can get through the rest of our
meeting. First up is Humana.

MR. DUKE: Good morning. My name is Jeb Duke. I'm the health plan leader for Humana Healthy Horizons. I think if you give us control of the screen maybe, we can bring up our presentation.

MS. CLARK: Okay. I've just made you a co-host. You should be able to share.

MR. DUKE: Awesome. I think Rebecca Moran will be sharing her screen, and if she can't, I will figure out the technology and bring it up. Well, let me go ahead and try it.

MS. MORAN: I think I might have to be made co-host. Oh, there we go. I just got access to do it.

MR. DUKE: Perfect. Thank you again for the opportunity to speak. I think we had planned to keep our comments to around 15 minutes. There's a lot of data that the MAC requested, and what we've done -- I think there's 33 slides. We've put all the core of the data requests into the appendix. So we'll be available to answer questions after our comments or, during the next MAC meeting,
to come back with any specific requests.

Humana was founded in Kentucky. We remain a Kentucky organization. As we think about Medicaid, we've been in the Medicaid program in Kentucky since 2013. But this is actually our third year of being a fully-integrated health plan with all Humana resources.

What that means is every -- every part of our organization from a process perspective, from an organizational perspective, is made up of Kentuckians. If you call us, our provider call centers, our member call centers, our claims adjudicators, our clinical intake teams, our physicians, and our nurses are all Kentuckians. And we're here to support Kentuckians with a high level of focus on doing the right thing.

From our perspective, our membership is split 50/50 between urban and rural. But since we joined during the expansion of Medicaid, what we have found is that, primarily compared to the other organizations, we serve more members through expansion. And through that, we have a much
higher prevalence of members with substance abuse and opioid disorder use.

And you'll find that in a lot of our programming. It's really focused on clinical care for adults and people with high acuity and chronic needs.

If we want to go to the next slide. We're going to spend a little bit of time talking about benefits and what value-added services or expanded services are.

Rebecca, next slide. Well, I'll keep going. Expanded benefits are benefits that go beyond fee-for-service Medicaid, so they're things that address social determinants. They're things that address access to care, and really things that are geared towards training, interventions to ensure members have access to preventative care.

One of the things we do is a workforce program. So in our workforce program, we do things like employment coaching. We provide reimbursement for our members who need daycare during an interview. We provide transportations to interviews. We provide
reimbursements for GED testing, and we provide reimbursement for our criminal expungement. So the goal is to find people who want to get back to work and wrap resources around them in order to get them back into the workforce in Kentucky.

In addition to that, Humana has recently announced we're going to be hiring 200 new associates in rural Kentucky really geared towards those communities that were impacted in western Kentucky through the tornados.

If we think about our basic needs programs, again, expanded benefits, we offer additional access to cell phones. That means you're going to get more data. You're going to get more talk time, and you're going to get more texts so that there's no reason a Medicaid member enrolled with Humana is not willing to either pick up their phone and speak with us or to one of our case managers, or they're not willing to use their data to use one of our digital apps to access key information for their health care.

We also do things like sports physicals. And one thing that I'm really excited about,
and it's -- from a timing perspective, it's pertinent. We're now offering free back-to-school haircuts. So any of our members enrolled in Humana can go get to the barbershop or to the beauty shop before we go back to school, and they can show up ready to learn on the first day.

We also offer significant expansion for wellness programs. So things like diabetes, tobacco cessation, weight loss programs, our 24/7 access to a physician. All of these programs can have interactive, video-enabled digital access for our members for clinical programming.

In addition to that, we do programs for pregnant women to include our rewards program, support with breastfeeding. And one thing that's somewhat unique is that we're now offering access to doula services. So if a member wants those supports during their pregnancy, they can come to Humana, and we will reimburse providers for access for those services.

Rebecca, next slide. Part of our rewards program, if we think about expanded
benefits as well, is our access to rewards programs. So at Humana today, a member can feasibly get $540 of rewards, gift cards, for doing things like preventative services, vaccinations, or participating in our programs for pregnancy. I'm excited about what this opportunity provides when we think about incentivizing members to do preventative care and improve outcomes.

What I'll tell you is we're going to do more. So we're looking at our benefits for next year. We're going to increase it. We've seen the impact it has on our quality programs and our HEDIS. And we're going to double-down on it. We want our members engaged in their care, and we want tools that are available to encourage them to do that.

Next slide. So from an operational perspective -- and I think we provided this in a MOAC. So a lot of attendees, I think, attend the same meetings. But network is important to Humana. So the No. 1 job that we have as a health plan is ensuring that our members have access to physicians and access to care.
From Humana's perspective, there's -- across a slew of provider taxonomies, we offer every single provider that has a Medicaid ID in the state. That includes all acute-care hospitals. It includes all CMHCs, long-term care hospitals, inpatient psychiatric, critical access hospitals, FQHCs, psychiatric residential centers.

In addition to that, we have over 6,000 PCPs, over 700 OB/GYNs. And when you compare Humana's network from a specialty perspective, we believe we offer one of the broadest networks of specialty care. So when members needs -- have high needs, they can come to Humana, and they can have access throughout our network.

Across our next slide, how do we maintain that network? So you can build a network, but it truly does have to be maintained. I know we talk about -- a lot in the MAC about: Are we meeting our time and distance requirements that are within our contracts with DMS?

At Humana, yes, we are. We plot our members on a monthly basis ensuring that time
and distance to all contractually-required physicians are meeting those standards. But we're also serving our providers and members to get feedback and recommendations for improvements.

We're also using tools that would suggest to us on a monthly basis what providers are in our other networks. So our commercial or our Medicare providers that may be good targets to bring into our Medicaid program and also providers that exist on the master list from Medicaid that don't exist in our network today, so we can reach out to them to contract.

And lastly, we actually -- we look at utilization. So we talked about the Non-Par process a little bit earlier today. So we look at our members' utilization and request from providers to have a single-case agreement. And what we do is we can convert those single-case agreements and make them participating providers within our network.

Next slide. So we're going to talk a little bit about population health in our clinical programs. Kristan Mowder, I'll do a
handoff to you.

MS. MOWDER: Hi. This is Kristan. So I'm going to talk with you about population health and the focus we have on that. The core of what we do as a health plan is to use our data sources to create various risk stratification methodologies. Those could be like identifying chronic conditions, our prediction of what we might want to see, and severity models to generate those risk levels. These risk levels then inform our outreach for case management and SDoH supports.

Through this identification, we attempt to help members focus on making better decisions, encouraging them to work with their healthcare providers, promote prevention activities, address SDoH needs, and reward for their healthy behaviors through their Go365 programs which Jeb just talked about.

So along with what you just saw on the other slides, we reward for those preventative and quality visits such as the prenatal visits, postnatal visits, child
visits, diabetic screenings, and then offer those SDoH activities like our workforce development program and housing assistance.

Next slide, please. So this is what we're going to talk about, incentives aimed towards improving our health. And so Jeb talked a little bit about our Pacify and our Vida programs. And so our Pacify program is for, you know, prenatal and newborn support.

What we've seen in that program as far as outcomes is that we've seen a 12-percent increase in our prenatal visits and a 15-percent increase in our postnatal visits. And we use this program in conjunction with our moms first case management program.

With Vida, you know, that program is geared towards our prediabetics and our Type II diabetes. And so some of the outcomes we've seen with that is our medication adherence increased by 50 percent and PCP visits up to 29 percent. And so that can be a self-serve application, or it can -- we can also refer from our case management chronic condition program.

Some of the other things that we have
going on in population health is our VOA partnership where we're using community health workers along with the community health workers that we have, and they are in the targeted six zip codes within Louisville that they're focusing on for us.

We also have some programs around ER diversion, and so we have MDLIVE access, which is a telehealth access. And that's to help promote diversion from ER or urgent treatment when those are levels of care that really aren't, you know, needed for what's really going on with the member.

Our Where to Get Care program is multifaceted. So that program is where a member goes into the ER, and they get a letter or, like, a flyer that talks about, you know, reasons to go to the ER, when to go to your PCP, when -- you know, maybe the telehealth might be important, you know, all of those things. And then it also gives information about how to outreach to our case management if they need additional support.

Then with our HIE expanded integration, we also look at that data around ER visits as
well and then we give those that were identified 24 hours after that visit and turn those over to our case management team for them to be able to outreach and help them with whatever needs they may have.

From a quality perspective, we've enhanced our SDoH assessment. So we have questions in our different assessments when we do outreach around SDoH and then we also implemented what's called the Prepare which is very SDoH specific. And then we also educate our providers on that Prepare as well.

Here recently, we've began additional work on colon cancer screening. That's really good to the PIP that we have going on, which is a project improvement plan. And we're working on being able to send out in-home test kits around colon cancer screening.

And then as Jeb mentioned, you know, we have the Go365 rewards to reward for those healthcare pieces and then also, you know, SDoH. And they can get up to, you know, $500 in incentives around that.
Let's go to the next slide, please. So here we're going to talk about addressing care gaps, and so that's gaps in care related to, like, our HEDIS and quality. And as you can see, you know, we've had some year-over-year success in working with our membership on improving those. So we've just put on here some of our basic healthcare pieces that you look at.

So, like, our comprehensive diabetes care, we've seen great increases in that. Our prenatal and postnatal visits, we see increases in that. Our child visits, you know, we've seen increases in two out of the three. And we're doing interventions to help focus on that 15 months to 30 months, to be able to help increase that, and then we've also seen increases in our weight assessment and counseling.

And so through that data integration that I talked about before that identifies members for outreach, we have processes in place. When they do get ahold of them, they do a preventative screening that addresses all of these gaps in care.
We're also looking at our data integration to make sure that we're picking up all of the claims data and HIE data to give credit for those to help close those gaps. And then, you know, like I said, putting that information in our assessments to make sure that we're really identifying and working with the members when we are able to work one on one with them.

So I will go to the next slide, please, and I will turn it over to Brent. Thank you.

MR. WILKERSON: Thanks, Kristan. And we just have a few more slides as we wrap up the content we had prepared today. What I would add is, you know, like Jeb mentioned, we've got a pretty heavy appendix with a lot of content that specifically answers a number of questions or requests in the original list of items. So that will all be in the broader presentation slide deck.

You know, just as we close out, we did want to touch on a couple of quality recognition programs. We engage with our primary care provider network with two programs, the model practice and the quality
recognition program. These are both -- both incentive-based. And they require our primary care physician groups to -- and their member panels to meet certain quality measures.

These quality measures, the targets themselves are developed annually. And depending on whether you're eligible for the quality recognition program or the model practice, you're eligible for incentives calculated on a per-member, per-month basis. And that could be payable on a quarterly and annual basis.

I think the important thing, as we think about the value of these programs, you know, they do create an opportunity for increased engagement between us and the provider community. They definitely increase the amount of reporting and data sharing between us and the primary care providers and, ultimately, just greater alignment between all of the health care stakeholders on the quality-focused initiatives that we're all focused on.

The last thing I would say here, when we
talk about the scope and the reach of these programs, 90 percent of our members are aligned to PCPs that are eligible to participate in at least one of these programs today.

And so we can go to the next slide. And so the last slide in our prepared content, we did want to acknowledge COVID vaccination rates and our process to both, you know, quantify and maintain a status for all of our members and how we've used that data and other incentives.

You know, the first thing I would say is, you know, for 18 plus months, we've been integrating a broad array of datasets; right, to get that single source of truth across the members we serve and understand their vaccination status to continually refresh that data and understand at an aggregate level what the vaccination rates are across the members we serve, across the number of demographic segments.

A lot of the trends we see are the same trends that, I think, the other MCOs would see as we look at the broader Medicaid
population as a whole. You know, we see higher vaccination rates among higher age bands. We see higher vaccination rates among certain regions, specifically Region 3 and Region 5.

You know, this tracking and trending has been important over the last year and a half in the aggregate. But I think a lot of the value has also come from the way in which we track and trend this at a member level and how we allow this information and this analytical process to drive downstream outreach, education to our members, inquiring are there barriers that an individual has to becoming vaccinated that we can help remove.

And so we pair a lot of care management outreach and engagement with our members, and we've paired that with -- and all MCOs have offered incentives, to some extent, for becoming vaccinated, and we have, too. So those have been in place.

The last thing I would say, we still see, you know, a material proportion of our members that we don't report being vaccinated, and we see that across the
program as a whole. But one thing we did in
Q3 and Q4 of last year was to actually
develop a study and engage with our members
that were unvaccinated, so a study
specifically on the members we serve,
inquiring from them, you know, their thoughts
on the vaccination. And if they are truly
hesitant, you know, what are those reasons.
So we wanted to understand from their
perspective how we might be able to tweak our
approach through incentives or outreach and
better understand barriers.

We do see among those that indicated
they're still not vaccinated and they're
hesitant to become vaccinated a lot of the
themes that we see nationally throughout a
lot of studies. You know, a lack of trust in
the vaccine, concern for the side effects,
and then just the way in which, you know, the
rapid development of the vaccine occurred,
you know, some were kind of still on the
divider trying to understand maybe later but
not yet. We want to see as more data comes
in. So just another way in which we wanted
to engage with our members and understand
from their perspective any hesitancy.

So I'll pause there. That is all the content we had prepared for the -- for the main presentation. As I mentioned, we've got a lot of content in the appendix to answer a number of other questions.

CHAIRMAN PARTIN: Thank you.

Anybody have questions?

DR. BOBROWSKI: This is Dr. Bobrowski. I've got just a couple. I'm a Humana dental provider, but I notice you mention on one of your slides that there was some expanded dental benefits. And you don't have to take time right now, but if I could get some information on that.

And then the other question I had is: Do you have quality measures for dental on, like, receiving these quality bonuses? I know you've got them set up in other health areas, but I haven't seen anything for dental. And you can email me or -- I know we're short on time today.

MR. DUKE: I appreciate the question, and maybe we can follow up with some more detail. So one thing I would make
sure that we're being transparent on is there's a Humana dental network that supports our commercial and Medicare members.

And in the Medicaid space currently today, we do partner with Avesis. So the Avesis contracted rates and the Avesis network are different than the Humana dental network. And that's something, you know, we're looking at long-term.

But in regards to enhanced payment, we don't currently have an enhanced payment program for dentists, but we do reimburse to primary care physicians mostly, and are moving into behavioral health. I think as managed care continues in the state, we'll look at other specialty provider types and figure out where we can move the number on quality. And I'll get some more detail on those responses.

DR. BOBROWSKI: Thank you.

MR. DUKE: Thank you, sir.

CHAIRMAN PARTIN: I have a question about the meals program. How are meals provided in rural areas to participants?

MR. DUKE: Great question. So our
meals program is for members who are discharging from the hospital. Those meals are sent to the members frozen. If they request it, we do have shelf stables. But when it's issues with refrigeration, we can provide alternatives.

And, also, during COVID, we opened that up. And, also, during the response for western Kentucky, we opened that up to all members. So in times of emergency, we provide extra access to food. In others, it's to improve and reduce readmission rates. But primarily, the mechanism is via mail, UPS, FedEx.

CHAIRMAN PARTIN: Okay. Okay.
Thank you. And then the other thing is: Can we make all these slides available, sent to the MAC members, and then also available on our website so other stakeholders can --

MR. DUKE: Absolutely.

CHAIRMAN PARTIN: Okay. Thank you.

Any other questions?

(No response.)

CHAIRMAN PARTIN: Okay. Thank you very much.
And we will move on to Molina and Passport. Do we have --

MR. SADLER: Hey, guys, that's my cue. This is Ryan. I am popping online, just dialing a couple of folks here this morning to check on them from the flooding.

I see Dr. James on. Meredith, are you on to share our presentation? Thanks.

MS. NORRIS: I think I just need to be made a co-host as well, Ryan.

MR. SADLER: Okay.

MS. CLARK: I just added you as a co-host.

MS. NORRIS: Okay.

MR. SADLER: This is not a halo. I just have a glowing effect on the top of my head. So, anyway, apologize for the screen there.

MS. NORRIS: I think it's starting to share maybe.

MR. SADLER: Dr. Hanna, I see you there.

MS. NORRIS: Okay. Can you see my screen?

DR. JAMES: Not yet.
MR. SADLER: Not quite yet.

MS. NORRIS: It's thinking about it. Okay.

DR. JAMES: There you go.

MR. SADLER: Good. Okay. Well, by way of formal introduction, my name is Ryan Sadler. I'm the plan president and CEO of Passport Health Plan by Molina Healthcare. I think all of you guys know the parent company of Passport is Molina. Molina is a large Medicaid organization actually based out of California, but we operate health plans -- I think it's 19-some-odd states across the country and so, of course, here, too, in Kentucky.

I'm in Louisville and as are most of our staff, although we do have staff scattered throughout the commonwealth. We've got around 700 today, and we're hiring. We're looking for another 400 or so staff to join us, so you may see or hear that out in the community.

And we can go ahead and advance to the next slide, please. I'm going to tee this up in terms of some introductory comments and
then the real subject matter experts on the
team will chip in and provide some detail but
happy to answer any questions along the way
as well.

So, look, you know, Passport has been
around, and Molina has been around for quite
a while. On the Molina side, we started as a
provider-oriented organization. We were
started and founded by Dr. Molina
specifically operating clinics for low-income
individuals. And that's been the basis upon
which we built Molina and that we've expanded
in that way.

So our -- our sole focus really is
government-sponsored health care
predominantly for the underserved and
underprivileged. It's the lens through which
we think about our entire business.

We do operate a small plan on the
Marketplace in Exchange. We also operate a
small Medicare line as well, but it's really
intended to be supplemental to our members
that might need access to care as they move
through the continuum, not necessarily to be
our primary focus. So in Kentucky, it's
probably 99 percent Medicaid-focused and then we have a home for folks to land if they need access to our services beyond Medicaid.

But, look, central to our model is intended to be a provider-focused orientation. You know, our company ceases to exist without our provider partnerships. And if we're doing business well for you, then you'll be able to do business well, you know, for our patients and our members. And so we try to be mindful of that as we're working in the community.

And, you know, hopefully you're finding that working with us, there is some ease at which to do that. If there's not, then that's on us to address and constantly want that feedback. To the extent that we need to make some changes, we want to be open to that.

Next slide. These are just some of the commitments that we've made to the commonwealth and we continue to deliver on. I mentioned our 1,100 jobs and our staff locally. You know, one of the beautiful things that we've got going on right now as a
result of the pandemic is that, you know, as people are backfilled -- not terminated. But let's just say they resigned for one reason or another wherever they may be in the country, I can backfill those people here in Kentucky, oftentimes, in a financially-advantageous way but also, you know, selfishly because I want to, you know, build a bigger and better presence here in Kentucky.

And so as we're doing that, we're saying, you know, we don't need all 1,100 jobs for our health plan, so to speak, but we've got plenty of room to hire them for the enterprise at large. So we've got sort of this regional operating model which is supplementary to our health plan and operation as well. So that's how we're able to staff as many people as we do.

You see our membership number. It's about 330,000 members. And just -- if you could go back real quick. And, of course, our network, no surprise. Like most of the Medicaid MCOs, we've got a significant number of providers and systems.
We are really an any willing-provider operation. So if folks want to participate in the Medicaid program, we want you to network. We've tried to be as open a network as we can.

And then just finally, our -- you know, our multimillion dollar investment and contribution strategy through our community organizations. That's something we promised to do when we came here, and we're delivering on that every day as we support our folks that need help.

So let's -- yeah. Let's advance to the next slide. This is really just a small victory lap. I'm pretty excited about this. We were nominated through Louisville Business -- Louisville's Best Places to Work through Louisville Business First. And so, anyway, there's 50 organizations on the list.

And I say this, and I raise this, just because in this world of remote setting, trying to create some sort of culture where people want to be here, they want to contribute, they want to focus on member services and taking care of our patients.
It's, you know, it's harder and harder every day. And so drilling down into how we create a culture of folks that are excited to be here and choose to be here every day is a big priority. And, in turn, that, I believe, generates better outcomes for our patients and our members.

Next slide. Go ahead. I think we can go back one. Just a quick note. We do try to incorporate these Remember the Member slides and stories into our presentations, a lot of this internally. But I just -- it's important for us on the insurance side, on the payor side, to step back and remember what all you guys see every day on the front lines as providers just how we are impacting the lives of the members that we serve.

And for some of us, you know, we can actually have that personal interaction with the members. But for most of us on the payor side, you know, we're back office. And so trying to remember the mission that we're all here to serve, which is patient care, has got to be top of mind.

And so this is just a way, an example,
of how we're trying to connect our people to that member interaction. So this will be in the slides, and I don't want to read it to you. But please feel free to review it, and you'll get a sense of, kind of, how we interact. And in particular, this story is about our tornado relief which is all the more pertinent today in and around the flooding relief efforts that we have going on as we speak.

So just at a high level, we're reaching out to every staff member who lives in the impacted communities over in eastern Kentucky right now. We're texting and calling all of our members that are impacted in these counties that live there. We're cross-referencing those members with anybody that's been in active case management. We're making direct outreach to those folks to make sure that they're doing okay.

We're cross-referencing that with any member that has received a prescription in the last 30 days under the premise that maybe their prescription that they need is now gone because of the flooding, and how do we make
sure they have access to an emergency fill and the like. So there's a lot of outreach happening as we speak to make sure we're connecting the dots where we can.

And in some cases, we can't help. And in some cases, we are able to connect those dots for folks that are -- you know, lost power and in the coming days may still have lost power and just need access to food that can stay, you know, nonperishable.

So, anyway, lots of work going on. This is a good example of that from the tornado relief perspective, but it's really the playbook we're following again today in eastern Kentucky. So I just -- if I don't make it clear, our thoughts and prayers are with our folks that are out there now because some of them are going through some tough times.

Okay. So next up is our membership slide. This gives you a breakdown of where our members are, age ranges and the like based on region. Clearly, the majority of our membership is in the Louisville area, but you get a sense they're -- of the breakdown
as we look at our footprint across the commonwealth.

Look, I'll just tell you just briefly, you know, particularly for our provider partners, I have a real sense of commitment to making sure that our services are available just as much in the east and west part of the states -- part of the state as they are in Louisville.

I think it's really important that, you know, if I believe that our services we're providing are great, maybe even exceptional, I want to make sure that those same services are available to our members, you know, in the rural parts of the commonwealth as well. And so I think I have an obligation to make sure that I'm doing as much there as we are here. And so you'll see that kind of come through in the slides and, hopefully, over time as we continue to grow.

All right. I'm going to turn it over to our quality folks, so we'll make sure we've got our quality team on.

MS. ANDERSON: Hi. Good afternoon.

This is Leslie Anderson. I'm with the
quality interventions team.

We can move to the next slide.

All right. So we completed our preliminary 2021 HEDIS data and compared that to our performance from last year, and we're seeing an improvement in over 60 percent of our measures across the board. So we're very excited about that.

Some of the areas that we've seen the greatest improvement in are the diabetes A1C control, and that's really a reflection of the work that we're doing for the diabetes management Performance Improvement Plan.

And, also, we had a big push this year to try and get folks back in to see their PCPs, you know, especially since a lot of people sat out in 2020 because of the pandemic. And we're seeing that the efforts that we put in are really working when it comes to our well-care visits for our kiddos.

So across the board, from birth through adolescents, we saw improvement.

Prenatal/postpartum is also a focus measure for us, and we have a maternity care program as well as some value-added benefits,
and we're seeing that pay off in improvements for our timeliness of prenatal care.

And then also our follow-up after hospitalization for mental illness. This, again, is kind of related to the work that we're doing for the Performance Improvement Plans, this one for the social determinants of health. We have an enhanced discharge planning process for those folks that have been hospitalized for behavioral health, and we're seeing great improvements there.

We've also identified some areas that we are focusing on for this year. For the cancer screening, we have started a partnership with the American Cancer Society, and we are identifying barriers for folks and strategizing ways to get people to get those cancer screenings completed. And then we are also focusing on the entire behavioral health domain of care as a focused opportunity for us this year and moving forward.

Next slide, please. And this is just a year-over-year snapshot of our HEDIS performance. Again, you know, 2019 and 2020 were before the Molina acquisition. But as
you can see, we have made improvements across the board.

For that last one there on the chart, the well-child visits, the HEDIS measures changed moving into 2020, which is why we omitted 2019, since it wasn't an apples-to-apples comparison. But, again, improvements in all of those domains of care.

We're also very excited that we have launched our value-based contract on January 1st of this year. We are currently -- it's a targeted rollout for certain providers, and 51 percent of our membership is actually already covered by the value-based contract with the provider groups that have signed already this year.

It is PCP-focused, and it is quality-driven, so it is a lot of HEDIS performance. We're looking at NCQA and plan performance and then, of course, it's patient centered. So all of the reports that we're giving our providers can be drilled down to the member level, so they can see exactly what each member is in need of as far as screenings and services.
And we also have an SDoH Z coding component as part of our value-based contract. That allows us to kind of get the more holistic picture of the member outside of just physical health.

Next slide. And then this is a snapshot of our value-added benefits program. We have a very robust program of extra benefits and incentives that we offer our members. So, like I had mentioned previously, prenatal/postpartum is a focus for us, so we do offer our members an infant carrier or a car seat if they have a prenatal visit in their first trimester. There's also lots of opportunities for earning gift cards for well-child visits.

And then on the bottom there, it says diabetic A1C screening, but we actually offer a number of diabetic benefits. So we have A1C screening. We also have a gift card for eye exams. And then new, as of January 1st of this year, we're offering a 25-dollar gift card for our members that complete diabetes self-management and support classes just to help support that effort to drive -- drive
our diabetic members to the resources that are available to them.

Next slide. And then, again, these are just some additional benefits. The health risk assessment, the 25-dollar gift card there was also a new addition that was added at the beginning of this year that helped support the efforts, again, for the SDoH Performance Improvement Plan, and it also helps us to get a more complete picture of all of our members.

And then there are a number of gift card incentives for cancer screenings. And it's not listed here, but we do have a value-added benefit of a free FIT kit for at-home colon cancer screening for all of our eligible members.

And I will sign it over to Stephanie.

MS. STONE: Hello. I'm Stephanie Stone. I'm our AVP of healthcare services here at Passport, and I'm going to move quickly through my slides because I know we are very short on time. But I am happy to answer any questions today or following today that any of you may have.
This slide just shows that we are leading the charge. We are the first health plan as far as the percent of our vaccine-eligible members who have received a COVID vaccine. And, of course, we slice this and look at it many ways. We have multiple interventions to try to increase vaccination rates, and it is always a focus, to -- and especially now that the six-month and older crowd are now eligible for the vaccines as well.

You can go to the next slide. Our care management services are, of course, individualized to the needs of every member that we serve. We have different acuity levels that basically increase the intensity and frequency of the work with our members based on the needs of those members with level one being lowest acuity, focused more on health education, and level four being the most intensive services that we provide. And all of our services and care management are focused on helping to improve our members' health and quality of life.

Next slide. This slide just illustrates
that we have a large, multidisciplinary care management team. It includes licensed clinical professionals as well as certified community health workers and certified peer specialists working within our team.

Next slide. So related to -- one of the aspects related to social determinants of health, every health risk assessment that is sent to our members initially and annually include questions related to social determinants of health. Those questions can trigger further interventions such as depression screening and additional care management services.

All of our members that are in care management effective January of 2021 complete the Prepare SDoH screening. I know Kristan mentioned that earlier from Humana. We have been doing that since January of last year as well to help us further identify barriers to our members accessing health care.

Next slide. Our community engagement team works with a wide array of advocates in the community to identify barriers at that community level. This slide is just
illustrating some of the factors that are being influenced by these collaborative efforts.

Next slide, Meredith. We have, as I mentioned before, certified community health workers. We call them community connectors. We also have housing specialists who do exactly what you might think. They're working to address any and all barriers and needs that our members have related to housing. We also have certified peer supports that Dr. Hanna is going to talk a little bit more about in a minute.

But these roles, I kind of look at them as helping to provide families and members with that first meal of fish so that, then, we can go on to teach those individuals to fish once they have the full belly.

So we have a collaborative related to social determinants of health with UofL's Peace hospital. We've been working to facilitate enhanced discharge planning to include social determinants of health-related information.

I won't go into a lot of detail due to
the time, but I will say this has been a successful project. And because of the success, we're expanding this to include another treatment facility in the next month or so.

You can go to the next slide. So I do want to spend a little bit of time here. This is our Emergency Housing Voucher Program that we're very proud of. The Louisville Metro Housing Authority and the Coalition For the Homeless came to us last year with an identified need. They had a grant to provide emergency housing vouchers, but one of the stipulations of that grant was that they needed to have housing navigators to be able to walk individuals through the process and ensure their success after -- before and after receiving the emergency housing voucher.

There was a staffing need. There weren't enough housing navigators to be able to accept all of the vouchers and give them to individuals in our community.

So we, at Passport, agreed to allow our housing specialists and community connectors
to act as housing navigators for any of our members who happened to be eligible or receive one of those vouchers. This took the burden off of our community partners and allowed them to focus their housing navigation efforts on our non--individuals that weren't Passport members. And we took on the -- on carrying the load for our members who were receiving these vouchers.

You can go to the next slide. So as a result of this, there were 200 emergency housing vouchers that were awarded within the Louisville community. 103 of those went to Passport members. We currently have 26 members that are in active housing navigation and 45 members that have been housed.

Note that that number is only our members, not their children or partners that may have been housed with them. So the actual number of individuals housed is much higher than that that were impacted by our team being able to step in and provide these services.

Next slide, Meredith. So what we gained from this besides helping individuals, of
course, was strengthened partnerships with our community agencies that serve those experiencing homelessness or those at risk of losing their housing. We gained invaluable knowledge about navigating those systems within at least this part of our state.

And due to the success of the collaboration that we had on those emergency housing vouchers, we've been asked to partner on a new project serving individuals who are experiencing homelessness and living in homeless encampments.

So great success overall, and we're excited to see where it goes next. And I'll turn it over to Dr. Hanna.

DR. HANNA: And I see we're at time. Can I just check and see if we're to continue on here or what the -- I just wanted to -- well, I'm going to keep going. So --

CHAIRMAN PARTIN: If you can keep it real short. Because right now, we're at time for our whole meeting, and we've still got a couple of other points to make. So if you can make your points real quick and then just share your slides after.
DR. HANNA: Okay. That sounds good. I'm going to tell you two things about peer support specialists. First of all, Passport is innovative in the fact that we use people with lived experience; that is, people who have actually experienced a substance use disorder or mental illness as staff to do outreach.

And we have -- our staff are in recovery. But for those conditions, being in recovery doesn't mean that the condition is in the past. Chad Corgill, one of our peer support specialists that lives over in Rush, he says to me, "Dave, I've been sober for 13 years. But every single day, it's a decision."

But what's important about that is when they reach out to people, they become a living embodiment of hope for our members who are struggling with use of substances or mental illness, that change in their life is possible.

And our goal of our peer support specialists is that they will engage with people and help them get connected with the
services they need. We're not trying to replace or duplicate services in the community. And their outreach is explained in the slides that's here.

And we are really focused on reaching the people that can't be reached. I'm just going to tell you this. Tammy Hedge is another one of our peer support specialists who lives in Louisville, and we were talking about going into the community as COVID began to ease last year. And, you know, some of the places that our peer support specialists have to go aren't the most attractive places. And she said to me. She says, "Dave, I'll go anywhere." She says, "I know what it was like not to be able to get myself the help."

And so that's what we're trying to do with our peer support specialists. They've worked with members with opiate use disorders and our high emergency department utilization, really trying to connect with people to help them get the help they need. And, Meredith, I think you can move on.

MR. SADLER: Hey, I think we'll probably just wrap --
PARTICIPANT: Hanna, eastern Kentucky is wide open.

MR. SADLER: Yeah. From the Passport side, I think we'll just wrap, and we'll submit our slides to you guys. And if you have any questions, happy to answer them or reconvene next time.

CHAIRMAN PARTIN: Okay. Thank you very much. So, again, if the slides can be shared with all of the MAC members and also put on the website for stakeholders to see those. And then if we have questions at our next meeting, we can bring those up.

Does anybody have any questions now that they would like to ask?

(No response.)

CHAIRMAN PARTIN: Okay. Then moving along, next item is election, and we have three people for each slot who have submitted their names; myself as chair, Dr. Bobrowski for co-chair. And, Teresa, did you submit for secretary again?

MS. ALDRIDGE: Yes, I did.

CHAIRMAN PARTIN: Okay. Did anybody else want to submit their name for
nomination?

    MS. CECIL: We didn't receive any other nominations, Dr. Partin.

    CHAIRMAN PARTIN: Okay. Thank you. Then we'll just do a voice vote in favor of these three candidates.

    MR. MARTIN: Do you need a motion to accept the slate, Dr. Partin?

    CHAIRMAN PARTIN: Yes, please.

    MR. MARTIN: I'll make a motion to accept the slate as submitted.

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

    CHAIRMAN PARTIN: Okay. All in favor, say aye.

    (Aye.)

    CHAIRMAN PARTIN: Anybody opposed?

    (No response.)

    CHAIRMAN PARTIN: Okay. So our chair, co-chair, and secretary will remain the same for the coming year.

    We have one item of new business, and Dr. Gupta has some points and questions that she would like to raise.

    DR. GUPTA: Thank you, Dr. Partin.
My question for DMS and the MCOs is: How do the organizations plan to handle the fallout from the abortion ban in Kentucky?

Specifically, there's an estimated general overall increase expected for maternal death that's an overall increase of about 21 percent with an increased increase in non-Hispanic black women of about 33 percent. So this means that year over year, up to 33 percent of non-Hispanic black women are expected to die in some regard to pregnancy.

Also, how are the organizations planning to take care of the increased foster care demand financially which will also increase the poverty rate which equals increased violence which also increases the death rate? There will be less women working, increased mental health illness, decreased access to health care by -- from OB/GYNs. Already in the state, there's not -- I think 50 percent of the counties do not have one OB/GYN.

And then lastly, what -- how is DMS and the MCOs planning to help women who are Medicaid recipients to obtain abortions across state lines? Will they help with
transportation? Will they help finance paying for the abortion?

So those are just some things I've been thinking about, and I'm pretty sure you all have been thinking about it, too. And you don't have to answer it now. This is for maybe some future meetings.

CHAIRMAN PARTIN: Thank you, Dr. Gupta. So if DMS could -- that would be a recommendation or a request from the MAC for DMS to respond to at our next meeting.

Does anybody else have any other business that they would like -- oh, somebody just made a comment.

MR. MARTIN: This is Barry. I just want to give kudos to DMS. They've been doing a lot of really good things, especially over the last year or two years. And I think sometimes we get lost in the things that we need and want, and I think they've done a really good job. And I'd like to tip my hat to them. I mean, can we do better? Of course. But we can all do better.

CHAIRMAN PARTIN: Thank you, Barry, and I agree. It's been a pleasure to work
with Commissioner Lee and Deputy Commissioner Cecil. They have been very responsive to our concerns and our questions and any recommendations from the TACs and also engaging in discussions about future issues.

So yeah, I would like to echo your comments.

DR. SCHRUSTER: Madam Chair, this is Sheila Schuster. I would like to thank Dr. Gupta for so comprehensively outlining many of the issues and concerns that we -- many of us have had, and I appreciate her bringing that forward to put on our agenda for the next meeting and also want to re-enforce what Barry just said.

You know, the Medicaid staff has been, I think, immensely responsive in so many ways. Some of us are working on separate issues like the SMI waiver and the SUD waiver and so forth and just have found the staff to be ready and willing to meet with us and explain what's going on and keep us in the loop. So I appreciate that.

DR. THERIOT: In response to Dr. Gupta's question, we have been discussing this, the issue internally and with some of
our MCO partners. We don't really have an answer for you right now, but we are -- we welcome the chance to talk about this at the next meeting.

CHAIRMAN PARTIN: Thank you. Okay. So I will put that back on the agenda for the next meeting, and hopefully by then, we'll have some feedback.

Okay. So this has been a busy meeting. Does anybody else have any other issues that they would like to bring forward?

(No response.)

CHAIRMAN PARTIN: Okay, then. Can we have a motion to adjourn?

MS. ROARK: I make a motion to adjourn.

MS. ALDRIDGE: I second it. This is Teresa.

CHAIRMAN PARTIN: Thank you, Teresa. Any discussion?

DR. HANNA: Bye, everybody.

DR. SCHUSTER: Thank you.

CHAIRMAN PARTIN: All right. Meeting adjourned. Thank you.

(Meeting adjourned at 12:36 p.m.)
CERTIFICATE

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

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

Dated this 9th day of August, 2022.

/s/ Shana W. Spencer
Shana Spencer, RPR, CRR