1 DEPARTMENT OF MEDICAID SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE MEETING
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13 THURSDAY, NOVEMBER 21, 2024
9:30 a.m.
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Stefanie Sweet, CVR, RCP-M
23 Certified Verbatim Reporter
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2 A P P E A R A N C E S
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4 **MAC Members:**
5 Dr. Sheila Schuster, Chair
Elizabeth Partin
6 Nina Eisner
Susan Stewart
7 Dr. Jerry Roberts
Heather Smith
8 Dr. Garth Bobrowski
Dr. Steve Compton
9 Dr. John Muller
Dr. Ashima Gupta
10 John Dadds
Dr. Catherine Hanna
11 Barry Martin
Kent Gilbert
12 Mackenzie Wallace
Annissa Franklin
13 Bryan Proctor
Peggy Roark
14 Eric Wright
Commissioner Lisa Lee
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1 MS. BICKERS: Good morning,
2 everyone. This is Erin with the
3 Department of Medicaid. It is not quite
4 9:30 and we are still clearing out the
5 waiting room, so we will give it just a
6 few more moments.
7 DR. SCHUSTER: How are we
8 looking, Erin?
9 MS. BICKERS: It is almost
10 clear. I just let in another mass of
11 people so we should be good to go. Well,
12 I speak and then it cleared backup.
13 It looks like everybody is
14 joining and you could probably go ahead
15 and start calling role. I have seen
16 several members logged in and I will clear
17 the waiting room as they come in.
18 DR. SCHUSTER: Okay. Thank you
19 very much.
20 Good morning, everyone. This is
21 our last Medicaid advisory meeting, MAC
22 meeting of 2024. Welcome. I will call
23 the meeting to order and turn it over to
24 Mackenzie to call the role, please.
25 MS. LONGORIA: All right. Good

1 morning, everyone, and I apologize I am
2 pulling a little bit of double duty this
3 morning. I am going to call our role and
4 then I have to hop back in to a board
5 meeting, and then I will be back on this
6 call.
7 Dr. Partin?
8 (No response.)
9 Nina Eisner?
10 DR. EISNER: I'm here.
11 MS. LONGORIA: Susan Stewart?
12 DR. STEWART: I'm here.
13 MS. LONGORIA: Dr. Roberts?
14 DR. ROBERTS: I'm here.
15 MS. LONGORIA: Heather Smith?
16 MS. SMITH: Here.
17 MS. LONGORIA: Dr. Bobrowski?
18 DR. BOBROWSKI: Here.
19 MS. LONGORIA: Dr. Compton?
20 DR. COMPTON: Here.
21 MS. LONGORIA: Dr. Muller?
22 (No response.)
23 Dr. Gupta?
24 DR. GUPTA: Here.
25 MS. LONGORIA: John Dadds?

1 (No response.)
2 Dr. Hannah?
3 DR. SCHUSTER: I think she is
4 not able to attend today, I think Erin
5 said.
6 MS. LONGORIA: Harry, I know you
7 are here.
8 Kent Gilbert?
9 MR. GILBERT: Up and at 'em.
10 MS. LONGORIA: Mackenzie Wallace
11 is here.
12 Anissa Franklin?
13 (No response.)
14 Dr. Schuster is here.
15 Brian Proctor?
16 (No response.)
17 Peggy Roark?
18 DR. SCHUSTER: She is not able
19 to join today.
20 MS. LONGORIA: Eric Wright?
21 (No response.)
22 And Commissioner Lee?
23 COMM. LEE: I'm here.
24 MS. LONGORIA: Twelve. That
25 gives us 12.

1 DR. SCHUSTER: So that gives us
2 a quorum?
3 MS. LONGORIA: Yes, ma'am.
4 DR. SCHUSTER: Thank you very
5 much, Mackenzie.
6 MS. LONGORIA: Yes. And I will
7 be back everybody.
8 DR. SCHUSTER: All right.
9 Thanks.
10 So the court reporter minutes of
11 our September 26th meeting were sent out.
12 I would entertain a motion for their
13 approval, please.
14 DR. BABROWSKI: So moved.
15 DR. SCHUSTER: Who is that?
16 Garth? Yes, thank you.
17 DR. BABROWSKI: Yes, Garth.
18 MR. GILBERT: Second.
19 DR. SCHUSTER: Second from Kent.
20 Any additions, corrections,
21 omissions, revisions needed?
22 All those in favor of approving
23 the minutes as distributed, signify by
24 saying aye.
25 MAC MEMBERS: Aye.

1 DR. SCHUSTER: Thank you.
2 Opposed with like sign.
3 Okay. Thank you.
4 Erin gets us organized and keeps
5 us organized so she sent out the MAC
6 meeting dates in 2025, and just to remind
7 you that they are on the fourth Thursday
8 from 9:30 to 12:30 eastern time except at
9 Thanksgiving, and this year we are going
10 to go into December, the first Thursday in
11 December, for that meeting, which I
12 appreciate because I have BH TAC on the
13 second Thursday. When we move up this
14 meeting, it is really a hassle to get that
15 finished.
16 So the meeting dates are January
17 23rd, March 27th, May 22nd, July 24th,
18 September 25th, and then December 4th. So
19 I would entertain a motion to approve the
20 MAC meeting dates for 2025.
21 MR. GILBERT: So moved.
22 DR. SCHUSTER: And second?
23 MR. ROBERTS: Second. Roberts.
24 I want to be on the scoreboard.
25 DR. SCHUSTER: Okay. Thank you.

1 All those in favor signify by
2 saying aye.
3 MAC MEMBERS: Aye.
4 MR. MARTIN: Do we have those in
5 an email somewhere?
6 DR. SCHUSTER: We do, but we
7 will also -- I will put them in a little
8 grid for you and send them out. I can do
9 that -- I do it and put the BH TAC on the
10 same thing, but we will send them out to
11 you.
12 MR. MARTIN: Okay. Thank you.
13 DR. SCHUSTER: And I guess,
14 Erin, they will be posted on the website;
15 is that correct?
16 MS. BICKERS: Yes, ma'am. Now
17 that they are approved we will get them
18 updated on the website and all of the
19 calendar invites in the next day or two.
20 DR. SCHUSTER: Okay. Wonderful.
21 Thank you so much.
22 Going back to old business,
23 Dr. Gupta, but others on the MAC have
24 brought up the issue of, you know, a quick
25 language access resource and we asked for

1 the MCOs to make just a very brief
2 presentation on how they are handling
3 that. So I'm hoping that we have our MCO
4 partners on, and I will start at the back
5 of the alphabet with WellCare.
6 MR. OWEN: Good morning to you,
7 Dr. Schuster. I was prepared for such a
8 maneuver.
9 DR. SCHUSTER: For such a flip.
10 Thank you, Stuart. You are always
11 prepared for everything, I think.
12 MR. OWEN: I try.
13 Let me know. Can you all see?
14 DR. SCHUSTER: Yes, we can see
15 that. Thank you.
16 MR. OWEN: All right. Can you
17 all see all of it clearly?
18 DR. SCHUSTER: Yes. It is a
19 side-by-side.
20 MR. OWEN: Okay. Thank you.
21 So as a refresher, the Office of
22 Civil Rights, it's federal law that the
23 Rehab Act of 1973 required Medicaid
24 providers to offer language assistance
25 services to Medicaid members. However, if

1 a provider is unable to do so for a
2 member, we ask that you notify us, that is
3 the key, so we can arrange it for you
4 instead.
5 So typically, this is done for
6 the member, there are a couple of
7 different ways, and I will get to that on
8 the right. I'm looking at the left side
9 right now.
10 And it's typically through our
11 customer services department. The
12 services include translation, sign
13 language, verbal interpretation for
14 limited English proficiency.
15 So key thing is that we have, we
16 can do in person. We actually have a
17 network basically across the whole
18 Commonwealth of locally contracted vendors
19 who can do this, but the critical thing is
20 we need it to be in advance.
21 If you want to have somebody in
22 person, which, of course, is ideal, that
23 is preferred. You want somebody in person
24 there to be the interpreter, we have to
25 have five business days of advanced notice

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1 to arrange that.
2 But if not, and we know that is
3 beyond the provider's control. The member
4 might not tell you until they show up and
5 you don't realize it until the last
6 second. We understand that. So in that
7 case, you would actually just call our
8 customer service department and we have a
9 couple of vendors that do the telephonic
10 interpreter services, so they will patch
11 you through via online telephonic.
12 So we understand this happens a
13 lot of times. You're not going to have
14 five business days advanced notice, but
15 that is ideal if we can get the notice,
16 and then literally the way that you would
17 do it, or the member or provider on behalf
18 of the member can request it.
19 We have a form that would need
20 to be emailed and this is on our provider
21 website and member website so it
22 identifies a particular need like American
23 Sign Language or whatever language, and
24 then it has the details of the appointment
25 and when and where.

1 And just to back up a little
2 bit. I also forgot to mention on the
3 bottom left, there, that we also provide
4 materials, of course, in large print
5 format, and we can provide materials in
6 braille as well for those individuals.
7 And coincidentally, I looked
8 just this week at the prevalent languages,
9 and no surprise at all it is by far
10 Spanish is the most prevalent, and then
11 second -- and there is a big drop off
12 after that -- and second is Mandarin
13 Chinese.
14 I'm looking at the last year of
15 data, the last 12 months of data, and then
16 there is a drop off to a few others --
17 Burmese, Swahili, and then there is a real
18 big drop off to a whole bunch of
19 different, you know, three, four, five
20 visits of miscellaneous languages. But by
21 far, as no surprise to anybody, I think,
22 is Spanish is number 1 and Mandarin
23 Chinese is second.
24 So the take away is basically,
25 if you tell us in advance, if you can find

1 out in advance, we can actually arrange to
2 have somebody on-site. You have an
3 interpreter on-site to assist. But it has
4 to be five business days, otherwise it
5 will be the telephonic service.
6 DR. SCHUSTER: Okay. Thank you
7 very much.
8 MR. OWEN: Sure.
9 DR. SCHUSTER: Any questions for
10 Stuart representing WellCare?
11 MS. BICKERS: Dr. Schuster,
12 there is a question in the chat. It says,
13 "Have you considered VRI? Video remote
14 interpretation?"
15 MR. OWEN: I am not aware that
16 we do that. You know, we've got a couple
17 different vendors that we do. I will
18 inquire about that.
19 DR. SCHUSTER: Thank you.
20 MR. OWEN: It's possible. I
21 mean I don't know that. I don't know for
22 certain that we do, but it is possible.
23 DR. SCHUSTER: Yes. Thank you
24 for whoever suggested that because that
25 would give you the closest to in person

1 without having to be in person --
2 MR. OWEN: Right, right.
3 DR. SCHUSTER: -- and be able to
4 see a face and so forth would be great.
5 MR. OWEN: Exactly.
6 DR. SCHUSTER: Well, thank you,
7 Stuart.
8 MS. EISNER: Sheila?
9 DR. SCHUSTER: I'm sorry. I
10 missed your hand, Nina.
11 MS. EISNER: That's okay.
12 Who pays for it?
13 MR. OWEN: We do. We pay the
14 network of our vendors. We pay them.
15 MS. EISNER: Thank you.
16 MR. OWEN: Yes. If you let us
17 know in advance, we will arrange it and
18 cover it and we will pay for it. But
19 ideally, we have to know in advance, but
20 we will provide it for free.
21 DR. SCHUSTER: And Ashima had a
22 question.
23 I'm sorry. Nina, did you have a
24 follow-up? No?
25 Ashima?

1 DR. GUPTA: When we call
2 customer service, will we have to wait a
3 long time, or should it be pretty quick to
4 get through to someone?
5 MR. OWEN: Well, customer
6 service will then contact the vendor, the
7 interpreter vendor, we have a couple of
8 different ones, so they will have to
9 connect with them.
10 I don't know -- I mean I don't
11 think there is a lengthy delay, I wouldn't
12 think so. And of course, they need to
13 make sure that they get the right
14 language. That can be a challenge
15 sometimes.
16 But basically, you would be
17 calling our customer service who then
18 would connect you. They would connect to
19 the online, to an actual interpreter.
20 DR. GUPTA: Thank you.
21 MS. BICKERS: There is another
22 question in the chat. "Is this a
23 screening question or is it on the
24 consumer to ask for language services?"
25 MR. OWEN: It can be either.

1 The member, or if they somehow, if the
2 member lets the provider know that it is a
3 need, but either one, the provider can
4 call to arrange it as well as the member.
5 But obviously, the provider has to be
6 aware of the need. The member has to let
7 them know.
8 DR. SCHUSTER: So the member
9 could call customer service; is that
10 right, Stuart?
11 MR. OWEN: Right, correct.
12 DR. SCHUSTER: Someone would
13 have to communicate with customer service
14 to say, "I have this appointment with --
15 lets say, Dr. Gupta -- on this date, and I
16 am, you know, going to need -- my language
17 is so and so?"
18 MR. OWEN: Right, exactly.
19 DR. SCHUSTER: Okay. Great.
20 Thank you very much.
21 Any other questions?
22 MR. GILBERT: I have one.
23 DR. SCHUSTER: Someone has in
24 the chat that the need should be in the
25 members record, and hopefully that would

1 be the case, that the provider would have
2 that marked.
3 MR. GILBERT: That was going to
4 be my question, Dr. Schuster, which was --
5 if I need interpretation on a single
6 visit, I am going to need it when I see
7 the consultant. I'm going to need it when
8 I go into surgery. I'm going to need it
9 when I come back for follow-up care.
10 Isn't there a way that that can
11 be automated? If that is tacked on the
12 record, couldn't their just be someone who
13 can show up when there is an appointment
14 scheduled?
15 MR. OWEN: Well, I mean, we
16 would need to know. And when the member,
17 when it is telephonic, our vendors don't
18 get personal health information -- PHI --
19 they don't know. They are just trying to
20 provide it at the moment.
21 So we wouldn't know what the
22 future appointments are going to be. That
23 would have to be communicated to us. But
24 I mean, we will do it, we would just need
25 to know each time.

1 DR. SCHUSTER: That
2 communication about future appointments is
3 going to have to come either from the
4 provider or from the member.
5 MR. OWEN: Right.
6 DR. SCHUSTER: Or member's
7 family, I assume. Yeah.
8 MR. GILBERT: Yeah. It just
9 seems to me that if there is a way for the
10 provider to indicate that need in advance
11 when they schedule that appointment, which
12 they are typically scheduling weeks and
13 months in advance, that would be more than
14 enough notice to get an on-site person if
15 that were automated from the provider
16 standpoint to say, "There's an appointment
17 for November 28th."
18 And then again, also because
19 appointments shift, of course, if that
20 were automated and it canceled, then that
21 would also free up the interpreter and you
22 wouldn't be charged.
23 So just interesting to see if
24 there are some ways that there are
25 technical fixes that could improve

1 quality.

2 DR. SCHUSTER: There was a

3 question in the chat about, "Are members

4 apprised -- are they told that this

5 service is available and whose

6 responsibility is that?"

7 MR. OWEN: You know, it is in

8 the annual handbook that was sent out to

9 members and also online, and we do have

10 community engagement staff located

11 statewide actually, different regions

12 statewide.

13 They communicate this with

14 members as well. But it is definitely in

15 the materials that we disseminate to

16 members each year.

17 DR. SCHUSTER: You know, there

18 are communities of people -- I'm thinking

19 in Louisville, Kentucky Refugee

20 Ministries, that does all of the

21 resettlement here in Louisville. They

22 have contacts with huge numbers of people

23 that come in where English is not their

24 first language, and I wonder if some

25 outreach could be done to those kinds of

1 agencies.

2 Do you all ever do that kind of

3 thing, Stuart?

4 MR. OWEN: As far as I'm aware,

5 we just use our network, we have the in

6 person ones and the telephonic vendors.

7 As far as I know, we just use

8 them, but don't reach out to other

9 entities that could provide the service.

10 DR. SCHUSTER: Well, I'm not

11 thinking about providing it. I'm thinking

12 about that's another conduit to let

13 members know.

14 MR. OWEN: Oh, oh, oh.

15 DR. SCHUSTER: I'm not thinking

16 you are providing. I'm thinking about

17 communicating with the members, because I

18 don't think that we do any of this

19 communicating to members about what really

20 is available.

21 MR. OWEN: I know that we have

22 community events that we participate in

23 and sponsor across the state during the

24 year, and I know that we share stuff like

25 this.

1 But, yeah, as far as, we have --
2 we actually have a massive social
3 determinants of health database internally
4 where we've got Darren Levitz is the
5 director of it where we have it down by
6 county.
7 We grab information by all
8 public resources about different social
9 determinants of health needs, and we also
10 have our internal data and we have claims
11 data, because now that is flagged as
12 social determinants of health diagnoses
13 and we have a massive database.
14 And we have those needs actually
15 at the county level, like, how many. I'm
16 not sure if we include language in that or
17 not.
18 DR. SCHUSTER: I would nominate
19 that it be included, because it is a
20 social determinant of health.
21 MR. OWEN: Yes. Absolutely. I
22 will talk to him. I know it is very
23 detailed what we capture.
24 DR. SCHUSTER: That would be
25 great.

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1 Let me ask the Commissioner. Is
2 there any reason not to include language
3 in that social determinants of health?
4 COMM. LEE: I don't see why we
5 couldn't.
6 DR. SCHUSTER: Well, it just
7 seems that, you know, obviously people
8 cannot communicate with their provider and
9 can't understand what is being said to
10 them, it certainly is a barrier to health
11 and has a negative effect.
12 I see where David Barry from DMS
13 said he will be sure that the connectors
14 get reminded of that.
15 So I think the other piece that
16 we are talking about is much more
17 communication with members and their
18 families about what is available, because
19 this is a great service, Stuart.
20 You know, I think the drawback
21 is that five-day notice, probably, for the
22 providers to me cognizant. And as Ashima
23 asked, what is the commitment on the part
24 of the provider in terms of time and so
25 forth? But well worth doing.

1 MR. OWEN: Yeah.
2 DR. SCHUSTER: All right --
3 MR. OWEN: You know, we provide
4 it at least. So that's better. You
5 wouldn't be paying for the interpreter, we
6 would.
7 DR. SCHUSTER: Yeah, that's
8 huge.
9 Thank you very much, Stuart.
10 I'm going to move on because we have
11 several other MCOs to report and we do
12 appreciate that.
13 Tom James says, "Language
14 barriers are included in the World Health
15 Organization definitions of social
16 determinants of health." Thank you, Tom.
17 Let's ask our friends from
18 United to see what they have going.
19 And I will assume, Erin, that
20 all of these presentations will be posted
21 on the website and made available?
22 MS. BICKERS: Yes, ma'am.
23 DR. SCHUSTER: Okay. And can we
24 send them out to the MAC members after the
25 meeting?

1 MS. BICKERS: We already have an
2 email started.
3 DR. SCHUSTER: Okay. I should
4 have known you were already thinking about
5 it. Thank you.
6 United?
7 MR. IRBY: Good morning. Can
8 you all see my screen?
9 DR. SCHUSTER: Yes, we can.
10 MR. IRBY: Perfect. Thank you.
11 I am Greg. I'm our COO for the Kentucky
12 Medicaid plan here at United.
13 I appreciate you all allowing us
14 to present on this topic. Language access
15 is something that we care deeply about. A
16 lot of the things that Stuart talked
17 about, they are relevant to us as well, so
18 some of this might seem repetitive, but I
19 will walk through what our programs look
20 like.
21 So our policies, our programs,
22 they allow access to languages including
23 audio, large print information for our
24 printed materials. We will send Braille
25 information to members. And so we have

1 all different functionalities for people
2 who have different abilities and different
3 language preferences.
4 We do video relay services and
5 language interpretation as well. Members
6 can ask for interpretation services really
7 simply by calling our member services
8 line, the number is on their ID card. We
9 make this information available to them
10 also in the member handbook so they have
11 that.
12 A couple things that we have
13 done to make the process work a little bit
14 better, a little easier, we have added
15 some things recently. I will go to this
16 next slide.
17 Normally, prior to a couple
18 months ago, when a person would call in,
19 they would be offered a Spanish prompt.
20 We've expanded that, though, based on the
21 utilization that we are seeing. And so
22 now we have a different prompt now for
23 Russian, Korean, Cantonese, Arabic, and
24 Vietnamese, based on the members that are
25 calling us. So now our members can get

1 that right when they call member services
2 by just clicking a button and they will be
3 automatically connected there.
4 For other languages outside of
5 that, if they get to a member services
6 person who does not speak their preferred
7 or primary language, that person can loop
8 in a language line and we will have a
9 teleconference with them. We also offer
10 on-site communication services.
11 Like Stuart said, we need
12 advanced notice for us to get an on-site
13 interpreter. So five days is what we need
14 as well to get somebody on-site. And we
15 have had utilization for this.
16 One of the questions that was
17 asked to Stuart was about video
18 teleconferencing services, and so I will
19 tell you that we have used tools like that
20 before. We don't have an automated
21 solution. We don't have a primary
22 solution. But we believe in getting
23 creative to meet the needs of members and
24 providers, so we have had moments where a
25 member had a video translator for a person

1 who was deaf and used American Sign
2 Language, and we were able to facilitate
3 that electronically when there wasn't an
4 on-site interpreter available for us.
5 We have created a flyer as well.
6 This is something that we are distributing
7 throughout the community. Like Stuart
8 said, we like we engage with our community
9 partners so we have created the flyer.
10 I have given just the top
11 section of that flyer in the slides that
12 we sent over to the DMS partners. The
13 whole flyer is here. Essentially, this is
14 dozens of languages, and so people can see
15 that right in their primary language. So,
16 it's something that we do care deeply
17 about.
18 On the opposite side with our
19 providers, we also offer interpretation
20 services as requested by providers.
21 So if you do call the provider
22 services line and ask for interpretation
23 services for one of your patients that you
24 are treating, we will help to facilitate
25 that. That can be done in realtime with a

1 conference call if that is the request.
2 "So I have a member here, I
3 didn't realize they do not speak English,
4 so can you help me to have a realtime
5 conference call interpretation?" We
6 absolutely can do that.
7 In terms of the wait time, that
8 was a question that was asked, so I can
9 get provide that information now. To get
10 to our provider services line, you are
11 averaging less than 30 seconds to connect
12 to an agent, however, when you do go
13 through the interpretation line, it will
14 depend on the language.
15 Some languages have less
16 representation across those partners and
17 so sometimes it can take a little bit of
18 time -- when I say a little bit of time I
19 am saying four to five minutes, not 15 to
20 and 20. So you should be able to get
21 right through. If you have problems with
22 that, those are the things that we want to
23 hear about, because we want to make sure
24 that the tools we offer are working well
25 for you. So I would just keep in mind

1 that there are busier times for those
2 tools as you can imagine.
3 Monday is always a busy time for
4 any call center, so you might have a
5 longer time wait on a Monday as compared
6 to a Tuesday through Thursday.
7 But we try to make that a very
8 simple process. We try to make it work
9 well for you. So if you have issues
10 accessing those services, please let us
11 know.
12 I think the only other thing
13 that I would say is that we do want to
14 make sure that anything that we print,
15 that we always offer an opportunity for
16 that to be translated. So even if we
17 don't have it in realtime, if a member
18 asks for a new language that we don't have
19 printed yet, we will make that available.
20 So we will use a translation service for
21 that upon request.
22 Any other questions for UHC?
23 DR. SCHUSTER: Yeah. I
24 appreciate you responding to some of the
25 questions that were asked earlier. Thank

1 you, Greg, very much.
2 Any other questions for United
3 or Greg?
4 So on the written material, if a
5 member has a fairly unusual language,
6 obviously not one of the ones on the
7 prompt and so forth, either the member or
8 the provider, Greg, can ask for that to be
9 translated into their language? How would
10 that happen?
11 I think Greg is maybe frozen in
12 time.
13 MR. IRBY: Did I get frozen?
14 DR. SCHUSTER: Yes. You got
15 frozen. It is freezing outside.
16 MR. IRBY: So you're talking
17 about written materials?
18 DR. SCHUSTER: Right. Can
19 either a member or a provider ask for
20 those to be translated, and how would they
21 do that?
22 MR. IRBY: Yes. They can either
23 call their member services line or the
24 provider services line and they can ask
25 for that.

1 And also, a provider can call
2 the member services line on behalf of a
3 member, so maybe you have a member there
4 with you in the office, and you say that
5 they need a certain material in a certain
6 language. You are welcome to call that
7 member services line with them and we can
8 get that translated, but you can call
9 either line.
10 So we have a no wrong door
11 policy here. Wherever you come in to
12 United Healthcare, we will make sure that
13 the member and the provider are serviced
14 well.
15 MS. HENSEL: Can I just make a
16 comment to add something briefly?
17 Greg, you are doing a marvelous
18 job.
19 Krista Hensel, the CEO for
20 United. The other thing that I would just
21 call out and I think it was in the written
22 material as you shared, Greg.
23 We offer chat as well for both
24 members and providers, and especially what
25 we found in provider offices, so may be

1 curious to this group's feedback at a
2 later date, but especially for busy
3 offices, the ability to chat while --
4 like, if a front desk person is having to
5 engage with this, being able to chat, but
6 not be sitting there on hold, or on the
7 phone with someone while they are trying
8 to take care of patients, and there are
9 families coming in the front door, we have
10 heard positive feedback for that.
11 So I wanted to highlight that to
12 this group as we continue to evolve our
13 technology.
14 DR. SCHUSTER: Great. Thank you
15 very much.
16 Any other questions or comments?
17 All right. Well, thank you so
18 much, Greg. Appreciate it.
19 MR. IRBY: Thank you.
20 DR. SCHUSTER: Now let's go to
21 Passport by Molina.
22 MS. BICKERS: Dr. Schuster? The
23 name I was given of the presenter I don't
24 see logged in, so I reached out. Unless
25 someone else from Passport is on.

1 Oh, there you are. I see you.
2 MR. YOUNT: Let me see if I can
3 share my screen.
4 MS. BICKERS: You are now a
5 cohost. Sorry about that.
6 MR. YOUNT: You're fine.
7 Can you all see my screen?
8 DR. SCHUSTER: Not yet.
9 Yes, we can now.
10 MR. YOUNT: Okay. I want to go
11 over the interpreter services for customer
12 service, so let me go through here really
13 fast.
14 The importance of interpreter
15 services and healthcare. We partner with
16 GLOBO. That is our interpreter service.
17 We assist interpreter services process for
18 member and providers through GLOBO.
19 Interpreters can be -- basically
20 we assist interpreter services process
21 through member and providers. The method
22 that we use for services, we go through
23 GLOBO. Our colleague, Passport Health
24 Plan by Molina healthcare provider contact
25 center. The contact center for provider

1 is 1-800-578-0775.
2 And then we also assist with
3 case managers helping them set up
4 appointments and stuff like that as well.
5 We do telephonic services,
6 face-to-face services, coordinating
7 interpreter services.
8 The role of an agent. So in the
9 contact center, if a member calls in and
10 they need assistance with interpreter
11 services, agents will basically reach out
12 to GLOBO, they will conference call the
13 member in with GLOBO, we will technically
14 tell them the language the member is
15 needing and then we do a three-way
16 conference call with them.
17 Face-to-face services, agents
18 collect appointment details and request
19 languages, scheduling requests.
20 Our team leads basically do
21 those requests. The agent will get in
22 contact with the lead, the lead will go in
23 to the request via the GLOBO website, fill
24 out the information and submit that over
25 to basically let them know when the

1 appointment is, what type of language they
2 need, and then get confirmation.
3 Providers will receive
4 confirmation for scheduled interpreter
5 services via email.
6 Telephonic interpreter services,
7 I think I just said that. Members request
8 interpreter services, member calls member
9 services, request an interpreter. The
10 language is determined, agent determines
11 the required language, three way call.
12 The agent initiates call with
13 the interpreter for GLOBO, the call script
14 is provided. The agent provides scripts
15 to the interpreter. The member identifies
16 verification, communicates facilitation
17 and then the call is documented.
18 Our agent stays on with the
19 member and the interpreter services at all
20 times.
21 Interpreter request: Agent
22 receives a request for a face-to-face
23 service, appointment details is collected,
24 and it's detailed requesting language.
25 Scheduling: Lead agent schedules the

1 request via the GLOBO website,
2 confirmation. Providers receive
3 confirmation via email, alternative
4 languages, if the in-person interpreter
5 isn't in available, services are
6 considered. GLOBO communicates with
7 Passport for video services facilities.
8 Interpreter service benefits:
9 Streamlined communication, facilitates
10 interactions for non-English speakers.
11 Improved satisfaction, enhanced experience
12 for both members and providers, effective
13 request handling, quick and effective
14 management of interpreter request,
15 enhanced accuracy, precise interpretation
16 of medical information.
17 Conclusion. Importance of
18 interpreter services: Critical for
19 effective healthcare communication,
20 processing services, call the provider
21 contact center, contact case management,
22 types of interpretation available,
23 telephonic interpretation, face-to-face
24 interpretation, GLOBO's commitment and
25 ensuring prompt language and assistance

1 and provide accurate interpretation.
2 MR. CHAPMAN: And I will just
3 jump in and add --
4 MS. BASHAM: Thanks Jeff. Go
5 ahead, Jeff. Thanks.
6 MR. CHAPMAN: Sure. I was just
7 going to say we are actually looking at a
8 number of different solutions to make
9 things a little bit easier for both our
10 provider community and our members.
11 We are looking at some options
12 to make the call line easier to access, to
13 make a more direct so there's less wait
14 time, and also looking for some options to
15 even add some devices for some providers
16 to use so they don't to go through a call
17 line and request translator assistance and
18 set up appointments.
19 So hopefully in the next couple
20 of months here -- and we are trying to
21 expedite in as quickly as possible, of
22 course -- we will have a solution that
23 will be a lot easier for everybody and we
24 won't have to schedule in advance.
25 So more to come on it, but

1 definitely listening to some of the
2 feedback we are hearing right now and some
3 of the different needs of our members to
4 make sure that there is no abrasion on
5 either side.
6 DR. SCHUSTER: Thank you for
7 that.
8 Do you all require a five-day
9 notice as the other ones do if you are
10 going to have an in-person interpretation?
11 MR. YOUNT: That right there,
12 I'm not aware of a five-day notice. I
13 know that we put the information in, we
14 send it over to GLOBO. I can find out as
15 far as there is if there is a five-day
16 notice, but I am not aware of a five-day
17 notice.
18 MR. CHAPMAN: We do. Today
19 there is a five-day notice requirement for
20 an in-person translator.
21 MR. YOUNT: Oh, there is. Okay.
22 MR. CHAPMAN: So that is one of
23 the things that we are looking to reduce
24 the turnaround time as well.
25 DR. SCHUSTER: And the other

1 thing I would ask is that we've heard
2 about some videoconferencing. It sounds
3 like you all are not offering that right
4 now. You are doing telephonic or in
5 person, right?
6 MR. CHAPMAN: Right, right. We
7 are looking for a way to make that
8 available as well as the immediate
9 consultation, so that you don't have to
10 wait for it.
11 Of course, we all know that the
12 population can be sometimes hard to reach,
13 and sometimes it is difficult for them to
14 get to the offices for appointments, so we
15 are trying to find a solution there that
16 doesn't have any delay, and they can
17 immediately access. So that way if they
18 do come in to the office and/or if there
19 is an urgent appointment, that there is a
20 translator service available at the time.
21 DR. SCHUSTER: Okay, great.
22 Thank you.
23 Any questions from any of the
24 MAC members for Passport by Molina?
25 MS. BICKERS: There is one in

1 the chat. It says, "How do you request
2 in-person interpretation?"
3 MR. CHAPMAN: We will pull that
4 information and put it in the chat for
5 you.
6 MS. BICKERS: Thank you.
7 DR. SCHUSTER: And can that
8 request, Jeff, be made both, either by the
9 member or by the provider?
10 MR. CHAPMAN: Yes, absolutely.
11 DR. SCHUSTER: All right.
12 Any other questions then? All
13 right.
14 Well, thank you very much.
15 Appreciate you all being on and giving us
16 the information from Passport by Molina.
17 And you still all have the longest title
18 of the MCOs. Thank you very much.
19 And how about Humana?
20 MS. BICKERS: Leslie, you are
21 muted.
22 MS. CLEMENTS: How about now?
23 Can you hear me?
24 DR. SCHUSTER: Yes.
25 MS. CLEMENTS: All right. Third

1 time is a charm.
2 Thank you all so much for the
3 opportunity to chat about this. This is a
4 question that keeps coming up again and
5 again in TACs and MACs, for a good reason,
6 right, because we all know how important
7 this is.
8 I am enjoying the chat about
9 that this is a critical social determinant
10 of health, so we at Humana also take this
11 very seriously.
12 I am going to share with you a
13 couple of slides that we pulled together
14 to talk about the resources that we offer.
15 If you could give me a verbal heads up
16 when you are able to see my slides.
17 DR. SCHUSTER: We can see it,
18 Leslie. Thank you.
19 MS. CLEMENTS: Dr. Schuster.
20 So I mentioned this is obviously
21 really important to us. We have a number
22 of goals in place in our equitable
23 population health plan to make sure that
24 we are closing gaps that we see across
25 language demographics of our members.

1 But we know that we can't do it
2 alone, so we think it is important to
3 reiterate some of the things that we have
4 heard in a couple of other MCO
5 presentations.
6 And the first thing is that this
7 is something that we are required to do by
8 law, right?
9 Every healthcare provider,
10 whether you are a hospital or nonhospital
11 provider, the ACA, the American
12 Disabilities Act, these are things that we
13 have been spelled out that are
14 requirements, so we really appreciate our
15 providers who also recognize the
16 importance of having these resources
17 available when our members and your
18 patients are seeking care.
19 Obviously, this is important
20 because it improves health outcomes, and
21 it improves safety and adherence. At the
22 end of the day it can create more
23 efficient processes, which will hopefully
24 save us all time and money, and can
25 increase patient satisfaction and reduce

1 the malpractice risk, which is an
2 important focus as well.
3 Just want to reiterate that this
4 is something that is required for our
5 providers to make available for patients.
6 We at Humana also provide this
7 service for our members. If we have a
8 member who is in need of interpretation or
9 translation services because they need
10 help understanding their Humana benefits
11 or the resources that we, as their payer
12 provide for them, we have a number of
13 resources available for that.
14 So this slide has some clickable
15 links that you all will have access to
16 when you receive it, and I definitely
17 encourage you to check those out.
18 Ultimately, the resources that we provide
19 are listed here.
20 So we talked about this with
21 some of the other MCOs already. Like you
22 all, we have over the phone interpretation
23 available in at least 200 languages. We
24 do offer American Sign Language
25 interpreters. We will do that both in

1 person or via video depending on the need.
2 We also have
3 linguistically-trained interpreters. So
4 if we have someone who is visually
5 impaired, we can support them.
6 As I mentioned, video
7 interpretation, but that is available not
8 only for people who speak American Sign
9 Language, but also any other language
10 need.
11 If you have access to
12 technology, whether that is a smart phone
13 or a computer, we will do video
14 interpretation with you.
15 I think everybody here has that
16 teletype service in place and then I think
17 everyone has also mentioned that we can
18 provide written material available in any
19 language, other than English, including
20 Braille, audio, large print, accessible
21 PDFs.
22 We proactively translate most of
23 our materials in both English and Spanish.
24 I know that that was something that Stuart
25 had mentioned earlier. By far, Spanish is

1 the largest secondary language that our
2 members seek, so what you see on this
3 slide is some data that we show what we
4 are noticing on our end from our members.
5 So Spanish by far is the largest need.
6 Interestingly, Mandarin is not
7 our second largest need at Humana. We
8 have noticed that our members from Rwanda
9 and Kenya, that is actually the second
10 largest need and you can see from there.
11 This obviously isn't a complete
12 list of every single language that our
13 language line has been leveraged for, this
14 is just those that we see ten or more for,
15 but there are several languages that we
16 have received a handful of requests for
17 services.
18 Again, we do make this service
19 available for any of our members and the
20 providers whenever they have questions
21 about their Humana plan. Under
22 extenuating circumstances, if a provider
23 is not able to adhere to the directions
24 from the ADA or ACA and they are unable to
25 provide an interpreter, we will work with

1 providers in those extenuating
2 circumstances to make sure that you have
3 access to those resources.
4 I will go back a couple of
5 slides. That is where the resources on
6 this slide will come in handy for you all.
7 You will call the number, you'll
8 be taken directly to a Humana associate,
9 not a phone tree, and that employee will
10 be able to get you connected to the
11 interpreter that is needed in the format
12 that is needed.
13 DR. SCHUSTER: Great. Thank you
14 very much, Leslie.
15 Do you all offer an in-person
16 interpreter? I don't remember seeing that
17 on the list. You mentioned telephonic
18 and --
19 MS. CLEMENTS: Yes. Under
20 certain circumstances, extenuating
21 circumstances, we will absolutely work
22 with members to make sure that that is
23 available if they need it. We even have a
24 few community health workers on staff who
25 are bilingual as well. So if that is

1 something that is needed, then we ask that
2 the member to give us a call, let us know
3 their situation, and we can work with them
4 to make sure that they have the resources
5 that they need.
6 DR. SCHUSTER: And again, is
7 there a five-day request time so you all
8 have time to prepare that, or what is your
9 timeframe for that?
10 MS. CLEMENTS: Let me check with
11 our concierge team to find out exactly
12 what that timeframe looks like.
13 Obviously, not every county in
14 Kentucky is going to have folks who speak
15 each of the languages, but we know what
16 our members speak so there would sometimes
17 be some kind of waiting period. It
18 depends on where the member is
19 geographically located, but I will find
20 out for sure what that looks like in our
21 policy.
22 DR. SCHUSTER: All right. That
23 would be very helpful.
24 Any questions from any of the
25 MAC members for Leslie or Humana?

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1 Let me ask you also, Leslie,
2 since others have mentioned it, do you all
3 translate your materials into a requested
4 language even though it may be way down on
5 the list?
6 MS. CLEMENTS: We absolutely do.
7 So any member who needs translation
8 services with the materials regardless of
9 what that language is, we do offer that
10 service.
11 So we automatically do it for
12 Spanish, but if you speak any other of our
13 200-plus languages, then we will make that
14 translation happen for you.
15 DR. SCHUSTER: And I guess we
16 should have asked, I'm assuming as we are
17 going through. We asked Stuart this, but
18 I didn't think to ask -- is the cost borne
19 by Humana for these services, Leslie?
20 MS. CLEMENTS: It is. It is
21 borne by Humana.
22 So it sounds like, maybe in the
23 case of WellCare, since this is something
24 that you all offer very regularly, that it
25 is like a value-added benefit that they

1 are making available and going above and
2 beyond. So it is a cost that is assumed
3 by the MCO when our members or providers
4 contact us for these resources.
5 DR. SCHUSTER: Okay. Any other
6 questions for Leslie?
7 All right. Well, thank you so
8 much for coming on. We appreciate your
9 information.
10 And we will ask Anthem.
11 MR. GILBERT: Ashima may have a
12 question. I see her hand raised.
13 DR. SCHUSTER: Oh, I'm sorry.
14 I'm having a hard time seeing those hands
15 raised.
16 Hi, Ashima. Go ahead.
17 DR. GUPTA: That's okay. This
18 is just a general question for all of the
19 MCOs.
20 Say the office scheduled the
21 in-person translator, but the person
22 doesn't show up. Then who bears the cost
23 of that interpreter coming, but there is
24 no patient?
25 MR. OWEN: For WellCare, I mean,

1 we would still pay. I would think all of
2 the MCOs would still pay. We are not
3 going to bill the provider for that.
4 DR. GUPTA: Okay. Thank you.
5 MS. CLEMENTS: Yeah, I concur
6 with that, Stuart.
7 MS. O'BRIEN: That's correct for
8 Anthem also.
9 MS. BASHAM: That's correct for
10 Passport.
11 DR. SCHUSTER: Yeah, thank you.
12 That's a great question, Ashima, because
13 we do know that the failure to keep
14 appointments can be on all sides, and
15 certainly if the patient doesn't show and
16 you've got an interpreter there -- I'm
17 sorry somebody started to say something
18 and I cut you off.
19 MR. IRBY: No worries. This is
20 Greg.
21 We are the same and I think that
22 is a good question to ask. I think when
23 we do schedule these, it's really
24 important that the patient knows about
25 that. It's important that if the

1 provider -- if you're going to do it on
2 the patient's behalf -- it's important
3 that they understand that this service is
4 being provided to them, that way they at
5 least understand somebody is going to be
6 meeting them there, and they have all the
7 details coordinated.
8 We have not had an experience
9 where we provided in-person interpretation
10 and the patient didn't show up. We've
11 never had that. So I think as long as we
12 are staying coordinated with the member,
13 that can really help.
14 DR. SCHUSTER: That's a great
15 point, Greg. Thank you.
16 Good question, Ashima.
17 Any other hands raised that I am
18 missing here, and I apologize.
19 All right. Leon, are you on for
20 Anthem?
21 MR. LAMOREAUX: I am. We are
22 actually going to start with the response
23 with my Director of Marketing, and then I
24 will go.
25 Well, let me just take a moment

1 if I could. This may be Anthem's last
2 time to participate in the MAC certainly
3 for this year until we are able to get
4 back in to the Marketplace. And I wanted
5 to just take a couple of minutes to thank
6 you and the MAC for your support your
7 partnership, and your tireless service.
8 When we look back over the last
9 four years of this contract, we will
10 always remember fondly the things that we
11 were able to accomplish and the
12 relationships that we forged through the
13 services that we were able to offer.
14 MCO roles and responsibilities
15 do not occur in isolation. It takes all
16 of us working together, and I would like
17 to give special thanks to the provider
18 community, our many community-based
19 organizations, and the advocacy community
20 that helps us to realize -- even this
21 conversation and this dialogue is very
22 important to help us sharpen the tools
23 that we bring.
24 Over the course of those last
25 four years, we've gone from a three-star

1 health plan to what the state is
2 recognizing as a four-star health plan and
3 improving quality.
4 We've brought healthy lives into
5 the world. We've actually had lives
6 saved. We've detected and treated cancer.
7 Healthy lives have been restored and needs
8 beyond healthcare have been met to.
9 I'm not going to try and go in
10 and quantify all that has happened over
11 the course of the last while, but I think
12 it is important to note that some of our
13 strategic investments will continue to
14 make a positive difference even in our
15 absence.
16 We have been investing in for
17 over three years, in the Anthem rural
18 medicine scholarships with our local
19 colleges and universities that will have
20 staying power in the Commonwealth for
21 years to come.
22 We have Food for Thought
23 locations where we partnered with food
24 stores to put them in schools.
25 We have diaper pantries and

1 resource closets throughout the community
2 and for Anthem, part of our mission is to
3 remove language as a disparity. So this
4 is very, very timely being able to bring
5 this.
6 But just to bring a close,
7 Anthem Medicaid whole health model creates
8 a member-centric process to leverage
9 clinical experience, our proprietary
10 information systems, and cross-functional
11 multidisciplinary teams to identify
12 barriers and interventions, including
13 language, to improve results for members
14 as measured by their healthcare
15 experience, key performance indicators,
16 HEDIS and STAR measures, and financial
17 success.
18 I think that we can be proud
19 what we have been able to achieve
20 together. You, individually, and we,
21 collectively, are making a positive
22 difference and I will forever, personally,
23 be grateful for your service to our Anthem
24 Medicaid members.
25 I look forward to when we are

1 able to work together again.

2 So with that, I will turn the

3 time officially over to the report for the

4 language services, but did want to at

5 least address this audience and thank you

6 all for your tireless and continued

7 service to this day.

8 DR. SCHUSTER: Thank you, Leon.

9 MS. HOPKINS: Thank you, Leon.

10 Yes. I am the Director of

11 Marketing for Anthem Medicaid.

12 I apologize, my video for some

13 reason is not wanting to share. It did

14 for like five seconds, and then it

15 removed. Can you see my slides?

16 DR. SCHUSTER: No, not yet. It

17 says that you have started screen sharing,

18 but we don't see anything yet.

19 Oh, there you go.

20 MS. HOPKINS: You can see it?

21 Okay. Thank you.

22 As many of the other MCOs have

23 stated, Anthem as well provides free

24 interpretation services available through

25 our member services and through our

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1 24-hour nurse line. So members have
2 access at any time to these services.
3 This does include face-to-face sign
4 language and TTY services.
5 We use Fluent Language Solutions
6 as our vendor which allows us to have a
7 broad network and be able to localize our
8 interpreter supports.
9 That being said, we provide
10 language assistance with a grievance and
11 appeals process. So if a member feels
12 that they did not get these services or
13 have been discriminated, we do offer
14 various options for a member to file a
15 complaint via phone, email, fax, or mail.
16 As far as providers helping to
17 support members access this, they can
18 request local interpreter services for a
19 member via a phone call or filling out a
20 face-to-face interpreter request form that
21 they can fax to the number listed on the
22 screen.
23 Anthem does require a five-day
24 notice, but the provider can request that
25 for ongoing services as needed for the

1 member. I know they mentioned if they
2 have multiple visits, we can do that.
3 That being said, on our provider
4 website we include tips for working with
5 interpreters, interpreter access
6 information, and service information,
7 display signs, and the form to document
8 these types of member requests, refusal of
9 interpreter services for members.
10 So we will cover the cost even
11 if a member -- if we provide the
12 interpreter and the member decides to
13 refuse.
14 And I wanted to provide more
15 scope into the access of materials in
16 alternative formats. Member materials are
17 offered in non-English languages as Humana
18 noted. We do automatically go ahead and
19 bill out for the Spanish materials, but we
20 do have our top prevalent languages
21 available upon request as well.
22 Alternative formats such as
23 braille, large print, and audio CD are
24 available to the members. They can call
25 member services or the provider can

1 request it on their behalf by calling us.

2 Our member service time, our

3 average wait time is 23 seconds. So we

4 will be very prompt with making sure that

5 we prioritize these types of requests.

6 If a member is unable to read or

7 understand printed materials, we do

8 provide additional assistance by offering

9 those special requests that have audio CDs

10 and things like that.

11 Do you have any questions that I

12 need to build off of?

13 DR. SCHUSTER: Let me see,

14 Victoria, if there are any questions at

15 this point.

16 I love the idea of the audio CD.

17 I assume that is done in the language that

18 the member speaks?

19 MS. HOPKINS: It is.

20 DR. SCHUSTER: Well, that is

21 great.

22 Any questions? Am I missing any

23 hands up? It looks like we are good.

24 MS. HOPKINS: Okay. All of our

25 materials also provide the language

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1 assistance tagline so our members, as they
2 receive their information, they get those
3 next steps as well for the support.
4 DR. SCHUSTER: Great.
5 MS. HOPKINS: Thank you.
6 DR. SCHUSTER: Thank you so
7 much. We appreciate it.
8 And last but not least, because
9 they are at the top of the alphabet, and
10 we went the other direction, we have
11 Aetna.
12 MS. BURTON: Good morning. Let
13 me share my screen. It has been a little
14 slow this morning.
15 My name is Carolyn Burton and I
16 am the Strategic Communications Director
17 here at Aetna Better Health of Kentucky.
18 DR. SCHUSTER: We see your
19 screen, Carolyn. It is up.
20 MS. BURTON: Okay. Perfect.
21 All right.
22 So in regards to language
23 access, we are an accredited -- we have
24 our health equity accreditation from NCQA.
25 So part of that makes language access a

1 central facet of our strategy in how we
2 approach communications and operations.
3 We have a health equity
4 subcommittee that actually met recently to
5 analyze our plan's language needs.
6 Here is a brief summary of the
7 languages accessed and spoken by our
8 members. And then the bottom graph shows
9 the language usage throughout 2023. In
10 our member handbook that we publish every
11 year, we include language and a
12 nondiscrimination notice. It is also
13 available online in the member portal and
14 mailed to members at least once a year.
15 Beginning in 2025, we will offer
16 health education classes in Spanish, which
17 is our number two language spoken by
18 members.
19 And then we also have member
20 services procedures in place to assist
21 with connecting members to translation and
22 interpretive services. So that includes
23 for Spanish, for ASL, even Swahili and
24 additional languages.
25 So what the language access

1 looks like in practice, if a member needs
2 language services, they can call directly
3 to member services who will then connect
4 them to the language line and the call
5 will connect them with the language line
6 rep for a three-way call with the member,
7 and then the interpreter interprets the
8 call in realtime.
9 Depending on what language is
10 requested will depend on how long that
11 wait time is. And then at the doctor,
12 with the provider, that process is
13 mirrored. The only difference is, as my
14 colleagues have mentioned earlier, is if
15 you are able to schedule ahead of time, we
16 need a 48- to 72-hour notice, but if you
17 are able to schedule ahead of time, we can
18 have that live interpreter.
19 We also offer videoconferencing,
20 which was, for obvious reasons, very
21 popular during the public health
22 emergency, but a lot of our efforts
23 revolve around this language line.
24 We also offer materials in
25 Spanish so our required materials like

1 member handbook, our SKY companion guide,
2 our value-added benefits guide, are
3 available in both English and Spanish
4 consistently, but our member materials are
5 also translated as requested into Spanish
6 whether through our translation portal or
7 through various partners or vendors.
8 We also have an online community
9 resource guide that is available in
10 Spanish, so that is going to link members
11 to important community resources.
12 Our Spanish speakers can
13 instantly translate our Aetna Better
14 Health of Kentucky website just by
15 touching this button at the top of the
16 navigation, and again, we utilize CQ
17 fluency as a vendor for a portal for
18 translating our materials.
19 In 2025, we want to improve our
20 visibility of language access information
21 on the website, and then in addition to
22 doing as requested materials and key
23 materials, we are going to offer all of
24 our marketing materials with Spanish and
25 English and trained department leaders to

1 use CQ fluency for translation of
2 materials.
3 With that being said, I know
4 that was a bit of a speed run, but if you
5 have any questions, I would be happy to
6 share.
7 DR. SCHUSTER: I love the idea
8 that you are doing health education in
9 Spanish in 2025. That is fabulous.
10 I think my other question is:
11 Do you translate your written materials
12 into any requested language if somebody
13 had a different language?
14 MS. BURTON: Yes.
15 DR. SCHUSTER: I assumed so, I
16 just wanted to make sure. So you include
17 videoconferencing as well as in-person
18 providers?
19 MS. BURTON: Correct. If
20 requested ahead of time, which I know we
21 will do our best to work with providers
22 and meet their needs, but especially
23 within that 48- to 72-hour window, we can
24 try to set something up.
25 DR. SCHUSTER: Okay.

1 Any questions? Kent, I see your
2 hand.
3 MR. GILBERT: Thank you for this
4 information.
5 This raised a question for me.
6 I recently had a minor procedure and was
7 sent home with a list of written
8 instructions as follow up care at home.
9 My question for you and maybe all of the
10 MCOs is: How is that interpreted? In
11 other words, there I am, I have just had
12 an esophageal scan or a colonoscopy or a
13 scope and I'm handed this piece of paper.
14 Who translates those documents and are
15 providers doing that? Are you able to do
16 that?
17 MS. BURTON: So we wouldn't have
18 any control over provider materials.
19 MR. GILBERT: If a provider
20 wanted to have that translated --
21 MS. BURTON: Yes, we would work
22 with providers to make sure that they have
23 what they need. I don't know that that
24 situation in particular has come up yet,
25 but we would definitely work with

1 providers to meet that need.
2 MS. HOPKINS: Due to approval
3 processes, all of our member
4 communications have to go through that
5 formal approval, and so we can translate
6 our internal materials, but it would be
7 very challenging to try to translate the
8 provider-based materials that are provided
9 by the office, but what we could do is, I
10 think that is when you would really begin
11 those local services, in-person
12 translations, via phone calls, those types
13 of services to provide that wraparound
14 support for the member to make sure they
15 understand the materials and any ongoing
16 next steps.
17 DR. SCHUSTER: Yes. That feels
18 very much to me like a case manager
19 wraparound, whatever. But that is a great
20 question.
21 MR. GILBERT: And it occurs to
22 me that having written follow-up care is
23 so important because what you are told in
24 a translation session and then you are
25 loopy, or you may or may not have good

1 memory, or you may be a human being who
2 forgets what they told you -- three times
3 a day with four pills, or four times a day
4 with three pills -- and it's important
5 that we think about from a provider
6 standpoint.
7 I realize the problem with that,
8 but it does occur to me that that is
9 another thing that a provider might need
10 to get these materials for this patient
11 for this day in some form that they can
12 take home with them, and I think the open
13 question is: What kind of services are
14 available to providers to do exactly that?
15 MS. HOPKINS: One of the things
16 that I want to be sure I touch base on
17 that piece of it, is we try to educate the
18 member about the access to these types of
19 services very early on, through -- at
20 least I know that Anthem provides English
21 and Spanish new member orientations, so we
22 do have someone on the ground that is
23 bilingual speaking, our community health
24 workers, we do have bilingual speaking
25 educators, health educators, and community

1 health workers on that piece of it to try
2 to make sure that we bridge those gaps and
3 get them within that first 90 days of
4 entering the health plan.
5 So that way, when they come to
6 the office they have those tools, but also
7 making sure that we translate with our one
8 pager that we have for the providers set
9 to have those tools as well. So great
10 question.
11 DR. SCHUSTER: And I would just
12 say in the chat, that Tom James whose is
13 here with Passport by Molina, but as a
14 physician who is still working with QHC,
15 says, "I have some EHR materials in
16 Spanish or English, but I use Google
17 translate for written material."
18 So that provider is kind of
19 taking it on himself.
20 Thank you, Tom, for sharing
21 that. But those are good points.
22 Thank you, all. Thank you
23 Carolyn.
24 MS. HOPKINS: Thank you.
25 DR. SCHUSTER: Thank you to all

1 of our MCO partners.
2 This has been a very rich
3 discussion and it feels like we've kind of
4 covered the waterfront on our language
5 access, but, you know, happy to put this
6 back on the agenda if something else comes
7 up, but after you have a chance to look
8 more closely at the PowerPoints and kind
9 of look through if you have some other
10 questions, we can certainly entertain
11 those at an upcoming MAC meeting.
12 So thank you, all.
13 Commissioner, I am going to turn
14 to you with changes due to the court
15 ruling in the Anthem case, please.
16 COMM. LEE: And I am going to
17 turn it to Deputy Commissioner Veronica
18 Judy Cecil. She has a really good
19 PowerPoint presentation, some good
20 information that she is going to share
21 with us now.
22 DR. SCHUSTER: Wonderful. Thank
23 you. I love Veronica's PowerPoints, so
24 I'm looking forward to this.
25 DEPUTY COMM. CECIL: Thank you.

1 That is quite the compliment. Thank you,
2 Dr. Schuster.
3 Good morning. Veronica Judy
4 Cecil, Senior Deputy Commissioner for
5 Medicaid.
6 We will obviously be sharing the
7 slides and have them posted following the
8 meeting. There has been a change and we
9 have been doing our best to try to get the
10 word out to folks, but the injunction was
11 listed in the Anthem lawsuit so we have
12 already started pursuing the transition to
13 remove Anthem as a Medicaid managed-care
14 organization. We provided that notice on
15 November 1st.
16 This a very high level timeline
17 and a nice visual for people to see what
18 is going to be happening, the big items
19 happening or activities happening over the
20 next two months. We did stop allowing new
21 members to choose Anthem and current
22 members to choose Anthem, to change to
23 Anthem, effective on November 9th.
24 The only exception to that is
25 infants, and the reason for that is --

1 keep in mind that Anthem will be a
2 Medicaid MCO through December 31st, so
3 they are still active and covering
4 services through that date. Because we
5 have Anthem members having babies, those
6 babies are always put with the mother's
7 insurance or coverage, so we are going to
8 continue to enroll infants to be on the
9 same plan as their mother and they will
10 both then be reassigned together to the
11 same MCO at the end of the period.
12 We did a system automatic
13 reassignment. In order to make this
14 easier on our members, we were going to go
15 ahead and just reassign the Anthem
16 population. I will talk a little bit
17 about how we did that, but we wanted --
18 because this is a short period of time, we
19 wanted to help members through that
20 process so we have done an automatic
21 reassignment.
22 We sent out member notices and
23 provider notices, so those went out on or
24 around November 12th, so members should be
25 receiving those already through the mail.

1 As I mentioned, December 31st is
2 the last day of coverage by Anthem for
3 services and for the date of services.
4 A couple of other tidbits, we
5 are allowing a continued reassignment to
6 Anthem. If you recall -- I'm sorry
7 reinstatement. If you recall, we
8 reinstate members as part of our public
9 health emergency unwinding flexibility.
10 If they come back within 90 days, we can
11 reinstate them to their date of
12 termination.
13 Again, because Anthem is still
14 an active MCO through December 31st, any
15 reinstatement that would have gone back to
16 Anthem, we are going to continue that and
17 then we will reassign any member through
18 our reassignment that happened on November
19 10th, and if a member hasn't chosen
20 another MCO, we will do another system
21 reassignment at the end of December to
22 make sure that all of those other members
23 have another MCO. That is effective
24 January 1. So starting January 1, that
25 new MCO does take over.

1 When we did that system
2 reassignment, there was approximately --
3 and these numbers are shifting a little
4 bit. There was approximately about
5 157,000 Anthem numbers.
6 We decided to split those
7 between Humana and United. There are
8 various reasons for that and they had the
9 lowest enrollment numbers. We wanted to
10 ensure a smooth transition by just
11 reassigning to two MCOs instead of all
12 five, because we need to make sure that
13 all of these members have a smooth
14 transition to from Anthem to their new
15 MCO. By limiting the number of MCOs that
16 they are transitioning to, that sort of
17 helps us manage it.
18 We did an equal split or a near
19 equal split between Humana and United for
20 those members. And again, they have an
21 effective date of 1/1/25.
22 We already mentioned that right
23 now a new member cannot choose Anthem and
24 a current member cannot change to Anthem.
25 I mentioned the reassignment. And -- the

1 reinstatement.
2 And the other thing I wanted to
3 mention is you may recall that we have an
4 automatic re-enrollment to their previous
5 MCO if a member re-enrolls in Medicaid.
6 If someone is disenrolled from Medicaid
7 and comes back and reenrolls within 120
8 days, we will automatically put them back
9 to their original MCO. So that is
10 occurring as well for Anthem.
11 If an Anthem member who was
12 disenrolled comes back in between now and
13 the end of December, then we will
14 automatically reenroll them into Anthem,
15 but then they will go into a reassignment
16 for that 1/1/25 effective date unless they
17 choose their own MCO.
18 That is an important activity
19 that we want to discuss and make sure that
20 people understand. Members always have
21 the opportunity to choose their MCO and to
22 change their MCO. We are in continuous
23 open enrollment now so they don't have to
24 wait for an open enrollment period. If a
25 member wants to choose their MCO for any

1 reason, they can do it right now. The
2 same will be for the Anthem reassigned
3 members. Even though we have
4 automatically reassigned them to an MCO,
5 they can come in and request a change at
6 any time to one of the other MCOs.
7 So that is still available and
8 we are helping members. We have had some
9 calls from members wanting to go through
10 that so we are allowing it, and if a
11 member did that before yesterday, then
12 they could have actually requested a
13 December 1 effective date for that.
14 That is the other nuance here.
15 If they didn't request that December 1 and
16 they come in starting today, that would be
17 a 1/1/2025 effective date.
18 You will see some members, and
19 the members may change and actually go to
20 the new MCO effective December 1st.
21 I mentioned we are going to do
22 another mass reassignment at the end of
23 December in case there is a member who
24 came in hand has not been reassigned and
25 has not chosen an MCO by that date.

1 We have regular meetings going
2 on throughout the week with all three
3 MCOs: Humana, United, and Anthem. We
4 have individual meetings with them, and
5 meetings collectively with all of the
6 organizations so we can make sure that
7 everyone is on the same page, that we are
8 identifying issues and addressing them
9 immediately.
10 We have already developed a
11 readiness kind of review for the two MCOs
12 taking on the new population to make sure
13 that they can handle that volume, so we
14 are working through those with them and we
15 have kind of a wind down checklist for
16 Anthem to make sure that we are covering
17 all of the areas.
18 I want to make sure to see that
19 there is no coverage, that there is no gap
20 in care, and that members will seamlessly
21 transition from Anthem to their new MCO.
22 Other ways we are doing that is
23 identifying members who are in care
24 management. Inpatient, out of state,
25 pregnant, we are identifying those

1 individuals just so that we can make sure
2 that we can reach out to them and help
3 them understand what is happening. We've
4 got them.
5 Their transition is going to be
6 as smooth as we can make it and that
7 handoff is going to be a very warm
8 handoff.
9 We've done a lot of
10 communications. I hope that everyone on
11 this call has at least heard or seen a
12 communication of this. The member notice,
13 the provider notice.
14 We also -- in addition to
15 mailing the provider notice, we sent an
16 email blast to all of our providers in our
17 partner portal. Every provider enrolled
18 in Medicaid has to have an email address.
19 We did send out a notice that way as well.
20 We did platform announcements.
21 It is on Connect, it is on Kentucky
22 HealthNet. We did, for all Anthem members
23 that have a self-service portal account,
24 we posted in their account an announcement
25 of this change so that they were aware of

1 it, as well as in the worker portal.
2 So our sister agency, our
3 Department of Community-Based Services is
4 well aware of what is going on.
5 We also distributed and
6 hopefully you all saw it as representative
7 of the MAC, we presented to all of the
8 TACs, we have a gov delivery email
9 distribution list. We sent it out that
10 way. If you want to get on that list, we
11 can share that information with you so you
12 don't miss any announcements from
13 Medicaid. We sent it out to key provider
14 associations and advocacy organizations to
15 make them aware.
16 We do have a dedicated phone
17 line, and this is for Anthem members only.
18 Anthem members can call Kynect or they can
19 call this dedicated number if they are
20 having issues with the transition, if they
21 are concerned about if the MCO isn't
22 working with them and they are worried
23 about what is going to happen on January
24 1. They are trying to make appointments
25 and it is not happening.

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1 So we encourage Anthem members
2 to call this number if they are
3 experiencing any problems with the
4 transition.
5 We do you have a dedicated
6 website: Kentucky Medicaid Anthem
7 Transition. We are trying to keep it
8 updated with information and in particular
9 that next bullet point which is the
10 Frequently Asked Questions document.
11 We really try to do a great job
12 of thinking of these questions ahead of
13 time and cover all of the various
14 scenarios, but if you think we have missed
15 something and you think there would be a
16 really great question to add to that,
17 please submit to us, we are happy to.
18 We are about to update it with
19 some additional questions that we have
20 gotten, so that will be a living document
21 that we will continually update. As we do
22 that, we will do our best to notify folks
23 with the same announcements that we have
24 distributed earlier. We are going to keep
25 those folks updated as we update those

1 FAQs.
2 That is the presentation on the
3 Anthem transition and happy to answer any
4 questions.
5 DR. SCHUSTER: I will say,
6 Veronica, thank you for that presentation.
7 I thought the FAQ was very well done.
8 DEPUTY COMM. CECIL: Thank you.
9 DR. SCHUSTER: It is easy to
10 read, so if people -- talking about
11 language, has that been translated? Is
12 that available at least in Spanish?
13 DEPUTY COMM. CECIL: Good
14 question.
15 I know we were working on that,
16 but I don't know if that has been
17 completed.
18 DR. SCHUSTER: Okay.
19 DEPUTY COMM. CECIL: I will take
20 that back.
21 DR. SCHUSTER: Since we are
22 talking about equity and language access,
23 but I did think it was well done.
24 Garth, you have a question?
25 DR. BABROWSKI: Yes,

1 Miss Veronica, I was wondering if this
2 information could be sent as a one-pager
3 or whatever as we all pretty much
4 represent our professional organizations.
5 I would like to send this to the Kentucky
6 Dental Association office.
7 I am making some notes, but I
8 can't write really fast, so could this
9 information be sent or emailed directly to
10 our respective associations?
11 DEPUTY COMM. CECIL: Absolutely.
12 We don't have a one pager created, but it
13 wouldn't take us very long to get that
14 done. I'm sure we could even get it done
15 by the end of today and get it out to the
16 MAC representatives and get it posted to
17 our website so that it can be downloaded
18 and shared.
19 DR. SCHUSTER: Great suggestion
20 Garth. Thank you. That can be done.
21 MR. MARTIN: Hey, Veronica, I
22 guess, of course, it is going to go to the
23 connectors, right?
24 DEPUTY COMM. CECIL: Absolutely.
25 MR. MARTIN: I took pictures and

1 sent them too, I just want to make sure.
2 DEPUTY COMM. CECIL: They should
3 have received it, especially the FAQs. We
4 notified them just as we were aware of the
5 transition, and I think we've been trying
6 to keep them updated on any changes.
7 DR. SCHUSTER: What about the
8 CHWs? Do you all have a form of
9 communication with the CHWs as a group,
10 Veronica?
11 DEPUTY COMM. CECIL: No. I
12 think we would always leave that up to the
13 provider to share the information, but we
14 can see about sending it through our
15 sister agency and asking them to
16 distribute it.
17 DR. SCHUSTER: Yeah, and also if
18 you are going to send out to provider
19 groups, you might include the Kentucky
20 Association of Community Health Workers.
21 DEPUTY COMM. CECIL: Yes. Great
22 suggestion.
23 DR. SCHUSTER: I would put them
24 on the list too, because they are the ones
25 that people turn to in the community and

1 they are in regular communication with
2 people.
3 Any other questions? Am I
4 missing any hands raised? All right.
5 Thank you. That was excellent. Lots of
6 answers to lots of questions.
7 We had a presentation at our
8 last meeting about NEMT, non-emergency
9 medical transportation, and I will tell
10 you because the Thrive Kentucky group does
11 a road show all over Kentucky and we just
12 wrapped up our last one Tuesday, so we did
13 seven or eight.
14 And the number one question the
15 community people asked is, housing is
16 always number one, and transportation is
17 always number two.
18 So I think we were a little bit
19 concerned at the last meeting when we got
20 the presentation about whether brokers
21 have been fully educated and whether
22 beneficiaries have been further educated,
23 so I put that on the agenda and
24 Commissioner Lee, I don't know who is
25 going to respond.

1 COMM. LEE: I can respond, and I
2 think I have Justin on the line, too, to
3 provide additional information.
4 The Office of Transportation
5 Delivery did meet with the brokers and
6 provided updated information to them
7 related to the changes in the regulations,
8 so they have been updated.
9 We have not submitted or sent
10 any information to our Medicaid members,
11 but the brokers have been educated on
12 those new policies.
13 Justin, if you are on the line,
14 if you have anything to add other than
15 that.
16 MR. DEARINGER: Yes, absolutely.
17 I wanted to let you all know that we
18 continue to receive and have always
19 received -- we get comments and questions
20 and complaints and we track those down
21 individually one by one with our
22 contractor who then also looks into that.
23 One of the issues that we saw
24 with the changes in the regulation is due
25 to the high staff turnover sometimes with

1 the brokers, a lot of the new people
2 coming in had received some older
3 material, so some of those policy and
4 procedure manuals have not been updated
5 like they should have been updated.
6 Also they had stacks of forms
7 and form letters that they had retained
8 from before the administrative regulation
9 changed.
10 So we found some examples as we
11 were looking into these issues of policy
12 and procedure manuals that weren't
13 up-to-date, or I guess some outdated
14 policy and procedure manuals. That always
15 happens when you don't keep a master
16 policy and procedure manual online and you
17 get a paper copy and someone gets a hold
18 of the incorrect paper copy.
19 And then when you do printings
20 and have extra stacks of paper or letters.
21 So we had instances where letters went out
22 that were outdated and used the old policy
23 and then we had a couple of policy and
24 procedure manuals with a couple of the
25 brokers that new employees got a hold of

1 and were using that.
2 So our contractor went to each
3 broker and did a whole new round of
4 education and explanation to make sure
5 that those brokers were using the correct
6 policy and procedure manuals to make sure
7 they were all updated, make sure they got
8 rid of all the old documentation and
9 letters and updated all that with new.
10 And that they educated members that were
11 using NEMT about those changes.
12 So I think we got all of those
13 things taken care of and again, we have
14 several numbers for individuals to call if
15 they have any questions or issues or
16 concerns, and we look at any issues that
17 we have on a case-by-case basis also.
18 DR. SCHUSTER: That sounds
19 excellent, Justin, and I can imagine that
20 the outdated manuals and forms and so
21 forth.
22 Can you put in the chat the
23 number or numbers that people can call if
24 they've got questions or concerns?
25 MR. DEARINGER: Absolutely.

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1 DR. SCHUSTER: Thank you very
2 much.
3 Any questions from anyone for
4 either Justin or Commissioner Lee on this
5 topic?
6 We are all very excited about
7 these changes and it is top of mind for
8 people working in communities, so we just
9 want to make sure that all of the good
10 changes actually get into place so people
11 can use them, because we ought to have
12 more usage of NEMT with the changes that
13 were made.
14 All right. Erin, who is my
15 alter-ego noted that I skipped B, which is
16 unfortunate because that is one of my new
17 loves, this Beneficiary Advisory Council
18 or the BAC.
19 Commissioner Lee, can you update
20 us about where we are with the BAC at this
21 point?
22 COMM. LEE: We are still
23 evaluating.
24 I know Dr. Schuster, you, and
25 several members on the MAC and our

1 Technical Advisory Committees are very
2 anxious to provide some input.
3 We believe that we will have to
4 do legislation this upcoming session. We
5 are getting close.
6 So what we are planning on doing
7 is having some sort of a forum in December
8 to gather input from individuals on the
9 MAC and TACs, various individuals, so we
10 can gather some feedback on ideas on how
11 we think this is going to work, the
12 transition, the timelines. We do have to
13 establish that Beneficiary Advisory
14 Committee by July 1st of 2025, so we know
15 that we are on a little bit of a time
16 crunch.
17 We are hoping to get that forum
18 together sometime in December to gather
19 input from various folks that will be
20 impacted by the changes to the BAC and the
21 MAC.
22 DR. SCHUSTER: Thank you. You
23 had mentioned, I think it was at the
24 Thrive Kentucky forum, perhaps building
25 the BAC from the Consumer Rights TAC. Are

1 you still thinking along those lines?
2 COMM. LEE: I think we are and I
3 think that we will definitely have the
4 need input from the Consumer Rights TAC,
5 because it will definitely impact them in
6 how they see that transition happening of
7 the potential members that we can include
8 on the BAC, and who will eventually be
9 serving on the MAC, because at a certain
10 point in time, we have to have 25 percent
11 of that Beneficiary Advisory Council would
12 be serving on the MAC as well, so just
13 walking through all of those topics and
14 issues and figuring that out as we move
15 forward.
16 DR. SCHUSTER: Yes. It is
17 actually 25 percent of the MAC members
18 have to come --
19 COMM. LEE: From the BAC, right.
20 DR. SCHUSTER: Okay, so that is
21 going to be a huge change for the MAC.
22 And that doesn't go into effect for
23 another year or two years?
24 COMM. LEE: Yes, there is a
25 phase up and I don't have all of those

1 percentages, but there is a phase up over
2 the years.
3 I think by 2027, 25 percent of
4 the MAC has to be made up from members of
5 the BAC. I think that is in 2027, but
6 there is a little bit of a ramp up that
7 doesn't have to automatically happen on
8 July 1st of 2025.
9 DR. SCHUSTER: Got it. So we
10 have to get it going.
11 I think it's going to be really
12 important. Some of this I mentioned to
13 you. I have been on national calls about
14 this. There are some states that
15 essentially have a BAC essentially as a
16 subcommittee of the MAC, so they do have a
17 lot of experience with this.
18 I do think it's going to be
19 really important that we incorporate
20 representation of voices from
21 beneficiaries and their family members and
22 caregivers, that we do a lot of support
23 and education, orientation and ongoing
24 support, so that, you know -- I think any
25 of relatively new members of the MAC, and

1 I will pick on Kent for a second.
2 There is a huge number of
3 acronyms and policies and so forth that we
4 all get very familiar with and that is
5 going to be alphabet soup for people. So
6 if we want to feel comfortable and
7 participate, I think that we are going to
8 have to do a lot of that work.
9 COMM. LEE: As you mentioned
10 Dr. Schuster, at the national level there
11 are several resources for states for
12 messaging and how to make Medicaid members
13 feel welcome and included and make sure
14 that their voice is heard. So we are
15 definitely looking at all of those
16 resources at the national level and
17 reaching out to sister agencies as well as
18 other state agencies and their partners on
19 the national level, including NAMD, the
20 National Association of Medicaid
21 Directors, the National Association of
22 State Health Policy, State Health Value
23 Strategies also has some really good
24 documents.
25 They are holding webinars on a

1 routine basis specifically related to the
2 Beneficiary Advisory Council, and I
3 believe that Erin has been participating
4 in this many of those as she can.
5 DR. SCHUSTER: That's great.
6 The other thing that I would ask, if you
7 are going to have a December forum, we ran
8 into this from working on the 1915(i).
9 December is a hard month for
10 people with holidays and weather and so
11 forth. So I hope in addition to whatever
12 kind of forum or meeting it's going to be,
13 that there will be an opportunity for
14 people to submit recommendations or
15 comments or suggestions to you via email
16 or some other form.
17 COMM. LEE: Exactly. And this
18 is the group on this call, all of the
19 members of the MAC and the TACs now can
20 submit comments to us.
21 I know that the final rule is a
22 little bit dense so there are some very
23 good summaries on the BAC and the MAC out
24 on some of those national websites, we
25 would be more than happy to pull down the

1 ones that we think are the most easy to
2 read and outlines of the requirements. I
3 know NAMED has very good ones with the
4 dates and everything it, so we will be
5 more than happy to get some of those to
6 Erin and let her get them out to the MAC.
7 We can always submit comments to
8 Erin, and she will make sure that they get
9 in the appropriate hands here in the
10 department. The forum that we are talking
11 about, it doesn't necessarily have to be
12 person. I think it is better in person,
13 but we could do something virtually here
14 too, just depending on the weather and how
15 we can get this scheduled.
16 DR. SCHUSTER: I really
17 appreciate the offer have some fairly
18 distilled kind of the Cliff notes of the
19 final CMS final rules because it is a lot
20 to go through.
21 COMM. LEE: It is.
22 DR. SCHUSTER: And Kent, I see
23 your hand.
24 MR. GILBERT: I wanted to circle
25 back to the online stuff. When we do

1 start integrating BAC members, we have not
2 had an in-person meeting since I have been
3 on the MAC, which has been working great.
4 I'm not suggesting -- but I do think that
5 there is, particularly for folks that want
6 to forge connections, perhaps -- and new
7 settings -- maybe it is time that we ought
8 to consider, Madam Chair, when we
9 integrate, having at least one in-person
10 meeting so that we can have some better
11 integration both in terms of personalities
12 as well as understanding to ask questions
13 on the side, which it is hard to do in a
14 virtual setting.
15 It may reinvigorate that
16 conversation when we start to integrate
17 folks. I just want to throw that into the
18 mix.
19 DR. SCHUSTER: Thank you. And
20 when Dr. Partin was still chairing the
21 MAC, she did a much better job of bringing
22 up that issue of do we want to go, at
23 least sometimes, back to in person.
24 Some of you may know, I am still
25 kind of iffy in my walking post hip

1 replacement, so I am trying to minimize
2 the amount of in-person stuff that I am
3 doing, but I do think that it really does
4 make a difference.
5 Certainly at the point where we
6 are inviting the creation of the BAC and
7 so forth, it probably is a really good
8 time for us to be meeting in the warm
9 weather.
10 So thank you for that, Kent.
11 Any other additions or questions
12 on this topic?
13 All right. Thank you,
14 Commissioner.
15 Veronica, back to you. An
16 update on the unwinding flexibilities and
17 the status of our Kentucky kids.
18 DEPUTY COMM. CECIL: Thank you.
19 Let me bring the slide back up. I will do
20 my best -- I keep going in the wrong
21 direction.
22 Here is the graph that we have
23 been sharing just to kind of show from
24 January 2023 to current. This is actually
25 October renewals so this reflects what

1 happened with our October renewals.
2 We do it on the 15th of the
3 month because people kind of drop off and
4 come back on and in fact, we were pretty
5 much on what we thought would be the
6 population that would drop-off and that
7 was defined by looking at the system
8 income had increased or some other reason
9 why their eligibility should end.
10 We have leveled out, as you can
11 see. That is really good. We've got a
12 little bit of a bump up and we are kind of
13 returning back to pre-public health
14 emergency, normal turn in Medicaid, where
15 we see about 20,000 or so drop-off and
16 come on in a given month. So we have
17 leveled out.
18 Just a reminder, we have come
19 out of that first public health emergency
20 unwinding of renewals, the restart of
21 renewals, that approximately 1 million
22 individuals who had to go through it.
23 We are now completely in --
24 those have been completed and we have
25 moved into folks going through a second

1 renewal since the restart of renewals and
2 folks that are new enrollments that came
3 in last year and newly enrolled are going
4 first. So we have moved into a normal
5 cadence of renewals.
6 Our flexibilities are still in
7 place through June of 2025. A couple of
8 those that we have highlighted primarily
9 is that reinstatement, in that 90 days we
10 can reinstate someone back to their
11 termination date if they come in and
12 provide us the information and we have
13 determined them eligible.
14 We have extensions that we
15 allow. So if we have sent a renewal
16 packet to someone and they have not
17 responded by their renewal date, we can
18 extend them for one month for all
19 individuals or up to three months for
20 long-term care or 1915(c) waiver members.
21 So those flexibilities can continue.
22 The child automatic extension is
23 currently continuing. CMS has not
24 required Kentucky to pull that back, so
25 that child renewal extension that is

1 automatically renewing the child for
2 another 12 months is continuing and we
3 hope that that continues through June of
4 2025, but we will keep folks updated if
5 that changes.
6 What that does mean is starting
7 with July renewals in 2025, children will
8 have to go back to having a
9 redetermination. So as we approach that
10 date, we will certainly do a lot of
11 outreach around that, because in that
12 three years of no renewal happening, folks
13 got use to not having one, so we will be
14 doing a lot of outreach around that.
15 We did make some of those
16 flexibilities permanent in 1915(c)
17 waivers. A lot of information out on our
18 website about what those were. Not all
19 flexibilities for the 1915(c) waivers were
20 put permanently into place, but we think
21 some really great ones that help our
22 members.
23 And then we do, or are
24 continuing our CMS monthly reports, the
25 Center for Medicaid/Medicare Services,

1 monthly report. There is a report that
2 follows the renewal month and then another
3 one that is updated 90 days later that
4 lets CMS know of any pending cases that we
5 processed and whether those individuals
6 have been approved or terminated.
7 So there is currently an
8 original CMS monthly report and an updated
9 and those are on our website.
10 These are the last couple of
11 months since we meet every couple of
12 months we always try to have at least this
13 information available to you.
14 The October renewals, you take a
15 look, we have 61,174 individuals who went
16 through a renewal. We had 52,815 who were
17 approved, 1,557 that were terminated and
18 we had four pending when that October
19 31st date passed over, so we do have four
20 pending cases as a result for October.
21 We extended 6,798 of those
22 individuals and the reason as I mentioned,
23 was that extension will allow at least one
24 month for all individuals, or up to three
25 months of the 1915(c) or long care. So in

1 that bucket could be folks that were
2 actually extended also from September and
3 from August, possibly.
4 And then we are tracking
5 reinstatements in that far right column.
6 As you see already for October we have 275
7 that have been reinstated from that
8 termination at the end of October, and we
9 continue to track these as a way to see
10 how are people coming back in.
11 All of these reports are on our
12 website so if you really want to dig down
13 deep into ex parte rates and ex parte is
14 when we can automatically approve someone
15 without them having to take any action or
16 any other information. There is more
17 detail on the website for that.
18 Here is the website. Just a
19 reminder that medicaidunwinding.ky.gov,
20 there is a lot of information on there.
21 We have our stakeholder meetings, our
22 monthly stakeholder meetings are recorded
23 and posted there. FAQs are on there.
24 We've got lots of flyers still. We will
25 maintain this site because we feel like

1 that information is very helpful to folks
2 and we will kind of keep reminding folks
3 that it is on there.
4 New providers and advocates and
5 new families know that there is
6 information out there, because what we
7 created for the unwinding is also
8 applicable now in terms of renewal and how
9 you get help and how to navigate it, so we
10 are keeping that information out there and
11 still going to remind folks -- I'm sorry
12 if you get tired of hearing us talk about
13 it, but we feel that it is important that
14 information is out there, and that
15 communication that anybody can pull that
16 down and they can share it and they can
17 post it in their office. We ask folks to
18 do that so we can keep everybody aware of
19 what is going on.
20 One last plug, and that is that
21 it is open enrollment for qualified health
22 plans. Very different from Medicaid. In
23 Medicaid it is continuous open enrollment,
24 when you are eligible, you enroll.
25 Qualified health plan is very

1 different. There is an open enrollment
2 period going now starting November 1st,
3 runs through January 15th of 2025.
4 However, if you want your coverage to
5 start by January 1, you have to enroll by
6 December 15th, so we are going to keep
7 making sure that folks know that this is
8 happening and they need to go out there
9 and choose a plan or renew their plan.
10 There are more issuers, more
11 plans out there, we have a new dental
12 carrier, but there is the Kynect hotline,
13 (855) 459-6328. We encourage members and
14 individuals to call that if they need help
15 and our fabulous connectors and insurers
16 throughout the state can help anybody with
17 choosing, enrolling, or renewing a plan.
18 I am happy to take any
19 questions.
20 DR. SCHUSTER: A wonderful
21 PowerPoint as always, Veronica.
22 DEPUTY COMM. CECIL: Thank you,
23 Dr. Schuster.
24 DR. SCHUSTER: Any questions
25 from anyone? All right.

1 Well, thank you very much, and
2 just a reminder about important numbers.
3 Justin has put into the chat two numbers
4 which could be very helpful on NEMT: The
5 denial of services hotline number and then
6 a separate number for complaints,
7 comments, and concerns.
8 Thank you, Justin, and I think
9 that there are agencies and people on
10 sometimes, the providers get involved in
11 people not getting to their office for
12 their appointment because of
13 transportation, so thank you.
14 An update on waivers, and I've
15 listed several here, the reentry, 1915(i)
16 SPA, 1115 SMI SUD, and the current HCPCS
17 waiting list numbers. So there is a whole
18 laundry list there.
19 COMM. LEE: And I am going to
20 give an update on the reentry and then I
21 will turn -- I think Ann Hollen is on the
22 line -- that part of behavioral health and
23 intellectual disabilities is going to be
24 administering the 1915(i) waiver for us.
25 But as far as the reentry, the

1 reentry implementation plan was submitted
2 on time on October 30th, our monitoring
3 protocol is due November 29th, and then
4 the reinvestment evaluation plan is
5 December 29th, so we are looking for a
6 late fall, summer 2025 implementation of a
7 reentry.
8 We did send an REI, we got an
9 REI for our 1115 or 1915(i) and we did
10 send that back to CMS last week and we are
11 hopeful for a January 2025 start date for
12 that SMI.
13 For the 1115 SMI, we are looking
14 for December 2024 approval. So just next
15 month. That is an update on those
16 waivers. I think Ann may have a little
17 bit more to share on the 1915(i) but
18 before she jumps into that, I will give
19 you an update on the number of individuals
20 on the waitlist.
21 Currently, we have 2,418
22 individuals on our Home and
23 Community-Based waiver waitlist. Of
24 those, 322 are under the age of 18.
25 Michelle P., we have 9,249 members on our

1 waitlist with 6,255 being under the age of
2 18.
3 We have 3,515 individuals on our
4 SCL waiver waitlist with 769 of those
5 being under the age of 18.
6 So in total, there are 15,182
7 individuals on our waitlist with
8 46 percent of those or 48 percent at or
9 below the age of 18.
10 Do you have questions about
11 that, Dr. Schuster?
12 DR. SCHUSTER: That is so
13 helpful to get that under 18 because I
14 don't know that we have had that data
15 before, and for those who may not be
16 aware, there has been a lot of work
17 already looking at a children's waiver --
18 Medicaid children's waiver -- that would
19 serve kids, as I recall, on the autism
20 spectrum, kids with serious emotional
21 disturbance, and kids with chronic health
22 conditions.
23 There is money put in the budget
24 by this legislators to really get busy on
25 this waiver. Not for this first fiscal

1 year, but the second fiscal year of the
2 biennial budget.
3 So I think that we have all been
4 concerned, parents will do whatever they
5 have to do to get services for their kids,
6 and some of these waivers were not really
7 designed necessarily to take care of kids.
8 So that is really helpful. I appreciate
9 getting those numbers, Commissioner Lee.
10 COMM. LEE: And I would like to
11 add that about 80 percent of those
12 individuals who are on a waitlist qualify
13 for Medicaid, so they are receiving some
14 services through Medicaid, they are just
15 not receiving the array of services that
16 they could be receiving through Home and
17 Community-Based waivers, and that does
18 include, as you know, the Participant
19 Directed Services option.
20 So the bulk of the individuals
21 on the waitlist are receiving services
22 through the Medicaid program. Right now,
23 it is just not those very specific Home
24 and Community-Based waivers.
25 DR. SCHUSTER: Right. They're

1 not getting the enhanced services that are
2 required and that they really need.
3 Certainly, the wait time for the PDS
4 services continues to be a question so we
5 have asked for some input at various TAC
6 meetings. We appreciate that.
7 DEPUTY COMM. CECIL: I think Ann
8 Hollen is on the line. If she has any
9 information that she would like to update
10 on the 1915(i).
11 MS. HOLLEN: Good morning. Ann
12 Hollen, Executive Advisor with the
13 Department of Behavioral Health
14 Developmental and Intellectual
15 Disabilities and I am the 1915(i) lead for
16 our department.
17 We are still in partnership with
18 DMS. We are still working through the
19 questions and responses with CMS. We are
20 hoping that this working on it in draft
21 format will get us a faster approval time.
22 We also continue to work on the
23 system changes, provider type for
24 enrollment, and we are still targeting an
25 implementation date of July 1st, 2025.

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1 So more to come, as we get
2 approvals we will have even more
3 information to give. That is a quick
4 overview.
5 DR. SCHUSTER: Thank you, Ann.
6 And just a reminder that the
7 1915(i) for severe mental illness or
8 co-occurring severe mental illness and
9 substance abuse disorders and the primary
10 thing that some of us advocates have been
11 pushing toward are those residential
12 services that I think every family member
13 of someone with an SMI really wants that
14 peace, but there is also respites that
15 will be offered to family members which we
16 never had before and some really enhanced
17 services, so we are anxious to get it
18 going.
19 Thank you, and we appreciate
20 that feedback.
21 MS. HOLLEN: Thank you.
22 DR. SCHUSTER: I keep on here --
23 is there still a work group, Commissioner
24 Lee, over at DMS that is kind of looking
25 to improve communication with potential

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1 Medicaid beneficiaries and recipients?
2 DEPUTY COMM. CECIL: Yes. That
3 conversation continues to happen. Just
4 recently, Alicia Clark went to a meeting
5 with the connectors and gave information
6 on -- for example, Medicaid 101 was
7 specifically focused on long-term care.
8 Those sorts of things, PACE, waivers.
9 So Alicia, I am not sure if you
10 are on the call, if you want to add a
11 little bit more, but I think the
12 information was very well received.
13 So we are educating connectors
14 so they can provide information on
15 applicants to the services that are
16 available to them. I don't know if Alicia
17 is on the call if she would like to add
18 anything for her meeting.
19 Alicia, if you are speaking, you
20 are probably on mute. She may be in
21 another meeting or stepped away for a
22 moment. But, yes, we are continuing those
23 conversations to make sure that the
24 communication with potential members
25 continues to be out in the community so we

1 can educate not only our connectors, but
2 others who are involved with this
3 communication strategy.
4 DR. SCHUSTER: Thank you. And I
5 am delighted to hear that the training,
6 reminder, education, or whatever, with the
7 connectors because that is so important
8 when people are first coming to Medicaid.
9 I know that there were some
10 questions on the application that would
11 tip someone towards looking at a waiver,
12 so that is important.
13 I still -- I guess,
14 Commissioner, worry that the average
15 Kentuckian, whoever he or she may be, is
16 still uneducated or not aware of,
17 particularly, the waiver program, so we
18 talked at the Equity TAC -- and this was
19 several meetings ago -- about getting more
20 materials out at health fairs and that
21 kind of thing.
22 I know there were some
23 improvements done to the CMS website. I
24 guess I am wondering if people don't know
25 to look for it on the website, I'm afraid

1 they're not going to go to the website to
2 find it, so I am trying to figure out how
3 to get more information in the hands of
4 people.
5 DEPUTY COMM. CECIL: I
6 definitely understand that, and I think
7 that one of the concerns is the waitlist
8 wait numbers. Once we put the information
9 out there, what sort of -- what can we do
10 to ensure that individuals who find out
11 about the waivers actually can get
12 services?
13 So with those waitlist numbers,
14 it is kind of like a Catch-22. If we
15 inform you about it, how can we come and
16 serve? Not that we don't want everybody
17 knowing about the options that are
18 available, because it does help us, but
19 how do we do that communication without
20 giving false hope that there may be
21 something available for those individuals,
22 particularly based on those 15,000 on the
23 waitlist.
24 And I think, Dr. Schuster, you
25 mentioned the children's waiver, you know,

1 that may be a help in helping us reduce
2 once that is implemented and followed
3 through, that may be a strategy that helps
4 us reduce some of these waitlists or at
5 least make sure the children are receiving
6 the services that they need early on.
7 So I understand the need and
8 desire to communicate, but how do we
9 balance in keeping with that challenge?
10 It's definitely a challenge with the
11 waitlist.
12 DR. SCHUSTER: Well, that's
13 where creating a Beneficiaries Advisory
14 Council will be very helpful, because we
15 will have many more people that are
16 directly affected to give us some advice
17 about that.
18 But I hear you, because I think
19 it is difficult to offer and then not
20 really be able to offer it. And I see
21 where Kelli has put the website for that
22 new waiver information and so forth in the
23 chat.
24 Thank you for that, Kelli. That
25 is very helpful.

1 And David, those documents that
2 were shared with agents and their
3 connectors around the Medicaid waivers.
4 MR. VERRY: Yes, ma'am, it is a
5 slideshow that Alicia did. It is
6 extremely helpful from someone who doesn't
7 know what a waiver is.
8 DR. SCHUSTER: Super.
9 MR. VERRY: It is very public
10 facing. Speaking with bias, they did a
11 fantastic job. We still get reviews of
12 this information. No one else in the
13 country does this. Their navigators just
14 help them with the Marketplace and maybe
15 Medicaid, so it is remarkable the work
16 that is being done.
17 MS. CLARK: Can you all hear me?
18 DR. SCHUSTER: Yes. We can hear
19 you now, Alicia. How are you?
20 MS. CLARK: Thanks, David, for
21 putting that in there.
22 And Kelli did put -- we have the
23 actual website that she put in there, and
24 if you go down to the bottom of it, we try
25 to share that with everybody because we

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1 even break it out. Participant resources,
2 how to find providers, different available
3 waiver services, and on that same part
4 there, we have things for providers, we
5 have sister agencies, different contacts
6 and stuff, that is a really good webpage
7 or website thing that people put together.
8 And then just another thing to
9 let you all know what we are working on,
10 is we are working through a welcome packet
11 that could be shared with individuals for
12 when they first come on and they are
13 on-boarded. So that is something that is
14 in the works. It is not completed yet,
15 but I think that that is going to be
16 really, really helpful and it is going to
17 be geared towards members, but I think it
18 is going to be really helpful for
19 providers as well.
20 DR. SCHUSTER: That's great.
21 Thank you, Alicia, and thanks to David and
22 Kelli.
23 So those are all things that are
24 in the works. If you miss it in the chat,
25 Erin is always great about sending that

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1 out to the MAC members.
2 So thank you. That makes me
3 feel better.
4 DEPUTY COMM. CECIL: You are
5 very welcome.
6 DR. SCHUSTER: I appreciate
7 that. So one last thing, Commissioner, I
8 have heard from a couple of primary care
9 providers that they heard from their
10 patients that MCOs are sending people for
11 home visits and there were some screenings
12 going on and some referrals being made.
13 It was very confusing to me and
14 it is very confusing to the primary care
15 providers, and they were told that it was
16 called closing care gaps. Are you
17 familiar with this at all?
18 DEPUTY COMM. CECIL: I am
19 familiar with that. I will have to get
20 some more information and maybe lean on
21 some of my MCO oversight staff who are on
22 the phone and if they are familiar with
23 those oversight services, I can get some
24 specific examples to follow up on.
25 DR. SCHUSTER: I put it on here,

1 and then I thought we are going to need
2 some specific examples. I would like to
3 follow up with you. I think the confusion
4 was the primary care provider was supposed
5 to be the captain of the care, if you
6 will.
7 Patients were confused because
8 people were coming in and having
9 questionnaires or having screenings and
10 telling them that they need to see
11 somebody else as a follow-up, and I am a
12 little bit confused about that piece.
13 DEPUTY COMM. CECIL: I do think
14 that the managed-care organizations have
15 health risk assessments, and I don't know
16 if that is going to be when the individual
17 comes, if that's part of a managed risk
18 organization. They do health risk
19 assessments, but I don't know that -- yes,
20 Dr. Theriot put in the chat that they are
21 doing a health risk assessment, so I'm not
22 sure what the member gets when they do a
23 health risk assessment, but it is to help
24 the managed-care organizations ensure that
25 if they do have any sort of risks or

1 conditions, that maybe need to be taken
2 care of, that those individuals are either
3 doing care management or that they are
4 connected with the correct Medicaid or
5 medical provider to take care of their
6 specific needs.
7 So that is the only thing that I
8 can think of, Dr. Theriot, because it is a
9 requirement that the managed-care
10 organizations do a health risk assessment
11 on their members.
12 DR. SCHUSTER: Okay. I guess my
13 question is, then, after they have done
14 this and there is a communication with the
15 patient, is there communication back to
16 the primary care provider?
17 DEPUTY COMM. CECIL: I am not
18 sure how everyone -- how every MCO handles
19 that situation, so we can definitely get
20 some more data. Maybe something at the
21 next MAC meeting, we will have the
22 managed-care organizations show what they
23 do with the health risk assessments and
24 how they use that.
25 DR. SCHUSTER: I think that

1 would be very helpful, and I'm wondering
2 if it was the health risk assessments, but
3 it seems to me that if I am the primary
4 care provider, and again, the patient is a
5 little bit confused about somebody came
6 and asked me some questions and then they
7 say, "I need to go see this kind of
8 doctor," or whatever, I would feel like I
9 would want to know what they were seeing
10 on this health risk assessment and to whom
11 was the referral made.
12 Was it the job of the MCO, I
13 guess is my other question, to actually
14 make those referrals?
15 DEPUTY COMM. CECIL: It looks
16 like Dr. Partin put something in here that
17 there is feedback to the PCP. But we can
18 definitely get the managed-care, or at
19 least one or two of them to present on
20 that rather than having all five. We may
21 just choose an MCO or two over the next
22 few and spread them out over the MAC
23 meetings, just to see how they are using
24 those, what sort of data they are
25 collecting and how they communicate with

1 their member.
2 DR. SCHUSTER: Thank you. And
3 thank you for that feedback.
4 I guess it is confusing for the
5 patient and I assume it is confusing for
6 the primary care provider.
7 DEPUTY COMM. CECIL: And Krista
8 has raised her hand, and she can probably
9 give us a little bit more information on
10 how United specifically deals with those
11 risk assessments.
12 MS. HENSEL: And we can do a
13 follow up with someone on my team who
14 might be much more knowledgeable of it,
15 but I will just -- first and foremost, I
16 would say if you have examples of that
17 where there is confusion at it is United
18 Healthcare, feel free to reach out to me
19 or anybody on my team, and we want to
20 reduce any confusion that there might be.
21 The other thing that I would
22 just add so thank you Dr. Partin for
23 putting it in there, I think we do a
24 pretty good job of tying to keep all of
25 our providers -- especially PCPs --

1 informed.

2 I also suspect it could be the
3 kind of work that our community health
4 workers and our clinical teams do on the
5 health plan side where we do see gaps in
6 care going on. Reaching out to members
7 and encouraging them to get those needs
8 met, whether it is an immunization that
9 needs to be done, a well visit that needs
10 to be completed where we haven't seen
11 they've done it in the year, a mammogram,
12 any of those good quality measures where
13 because of where we sit seeing all of the
14 financial transactions coming
15 back-and-forth, we can see when there's
16 not -- when it looks like something might
17 have been missed somewhere in the system.

18 So that's part of what we do and
19 we feel like it is our responsibility to
20 help people live healthier lives.

21 MR. CHAPMAN: And we also like
22 to link that to, does the member have SDOH
23 types of needs? Does the member have
24 secure housing? Do they have resources
25 for food? Do they need transportation

1 support outside of NEMT? Is that
2 transportation to a food pantry?
3 So the HRA is actually used for
4 a lot of different things. Referral to
5 behavioral health to make sure that the
6 primary care provider knows that they need
7 to work with a provider as well, so it
8 could be a lot of different things there,
9 but ultimately, it is all to help the
10 member and then for better coordination of
11 care.
12 DR. SCHUSTER: Yes.
13 MS. HENSEL: And I think any one
14 of us, if there are examples where it's
15 confusing to a provider, we are happy to
16 track down individual cases and make sure
17 to reduce that confusion.
18 DR. SCHUSTER: Yeah. I was
19 really hearing it from the providers and I
20 think we are all about people getting --
21 making sure there aren't gaps and getting
22 referred to move on and stuff, but the
23 apparent lack of communication or
24 coordination was the thing that really
25 caught my attention. So this is very

1 helpful, and we will reach out and maybe
2 have a -- spread out the feedback, but I
3 think it would be helpful to have that
4 feedback from the MCOs.
5 So thank you very much.
6 MS. BICKERS: Dr. Schuster,
7 Angie drop some contract language that
8 I've copied into the follow-up email for
9 you guys.
10 DR. SCHUSTER: All right.
11 Great.
12 MS. BICKERS: So that may help,
13 and I can also request all the MCOs send
14 that information to me before the next
15 meeting if you'd like, and we can send
16 that out for you guys to review for any
17 questions or we can do the presentations
18 scattered, whichever you prefer. Just let
19 me know.
20 DR. SCHUSTER: We will see what
21 our January agenda looks like, and it may
22 be since we are in a legislative session,
23 we may really be concentrating on
24 legislation around MAC changes and the
25 back and forth, but thank you for that.

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1 Let's move into our TAC reports.
2 Alphabetically, behavioral health is up
3 first.
4 I am going to curtail this. I
5 will say that we keep coming back to the
6 audit issue, and you will see several
7 recommendations around that. We also had
8 a new issue come up around difficulties of
9 approval of residential or SUD or
10 substance use disorder treatment services.
11 And we will be reaching out to both
12 providers and MCOs for some data to
13 discuss in our January meeting.
14 So the recommendations, are
15 these -- the BH TAC believes the audit
16 issue needs to be addressed because the
17 volume of audits continues to escalate.
18 We feel that recommendations are in order
19 so that clear audit parameters may be
20 established, which would address these and
21 this would go to DMS.
22 The appropriate rationale for
23 audit should be articulated while an
24 increase in units may not be a sufficient
25 reason for an expanded audit. The number

1 of cases audited should be capped at an
2 acceptable and appropriate level, maybe a
3 percent of total claims or a percent of
4 individuals served.
5 If the sample size indicates
6 additional audits are necessary, then the
7 MCO may proceed. The audit timeframe
8 needs to be clearly delineated in needs to
9 be cleared both of MCOs and providers, and
10 there are concerns about a relatively
11 small number of providers who are,
12 perhaps, causing some problems, but that
13 alone should not be a sufficient reason to
14 audit similar providers for that reason.
15 The second recommendation is
16 that any MCO audit requests provide a
17 reasonable amount of time to the provider
18 to provide the requested information at a
19 minimum 15 days when there are fewer than
20 ten records requested; 30 days when the
21 request is for between 30 or fewer than 30
22 records; and 60 days when more than 30
23 records are requested.
24 And just as a side note I will
25 tell you that there are providers that are

1 getting requests for literally hundreds of
2 records with a turnaround time of seven
3 days and they have to beg and plead for an
4 additional seven days.
5 And then the last recommendation
6 is that DMS develop a process that would
7 allow a provider to verify that an MCO's
8 prepayment audit request has been approved
9 by DMS. Providers that receive a
10 prepayment audit request from an MCO need
11 a process where they can verify that, and
12 having that process in place will save
13 time and resources for the providers and
14 for the DMS staff.
15 We had a new issue that came up
16 in terms of how ABA or applied behavioral
17 analysis services and whether they were
18 going forward by one MCO and only going to
19 be allowed for individuals with an autism
20 spectrum disorder diagnosis which is
21 causing great consternation, so we are
22 looking at next steps in discussing that.
23 And then there are some members
24 of the behavioral health community that
25 are working on trying to straighten out a

1 problem with how IOP services are being
2 billed because of the rolling one week
3 requirement.
4 So it seems like our agendas get
5 longer and longer, and the meetings get
6 longer and longer, but obviously lots
7 going on in the behavioral health
8 community.
9 How about Children's Health? I
10 believe they last met on October 9th.
11 DR. GUPTA: Dr. Schuster, I have
12 a quick question for you.
13 DR. SCHUSTER: Yes?
14 DR. GUPTA: Those large audit
15 requests, like 100 or so, are those from
16 psychiatrists or do you know specifically
17 what type of providers those types of
18 audits are being requested for?
19 DR. SCHUSTER: I don't know
20 specific to psychiatry, Ashima. Most of
21 them go to the practice or to the
22 community mental health center, BHSO; in
23 other words it goes to the practice and
24 then they ask for, I think, a random
25 selection of huge numbers of audits. In

1 other words, they are not sending in
2 patient names to be audited, so I don't
3 know that it is related to the actual
4 provider of services, and probably, there
5 are multiple providers of services
6 depending on these places.
7 I think that would be accurate,
8 but I can go ahead and check on that.
9 DR. GUPTA: I am just curious.
10 I will present what I have from our
11 meeting.
12 DR. SCHUSTER: Okay. Thank you.
13 Yes.
14 Is there anyone on from
15 Children's Health, Erin?
16 MS. BICKERS: I do not see
17 anybody. They did meet, they did not have
18 any recommendations and have approved
19 their 2025 dates.
20 Doctor B. dropped off the call.
21 He just wanted to let you know that they
22 are working on there 2025 dates and have
23 three new members, so I emailed him and
24 asked if he could please provide me with
25 that information.

1 DR. SCHUSTER: And is that in
2 the Children's Health TAC?
3 MS. BICKERS: No. That was for
4 Dental. Sorry. I skipped over Consumers
5 because he just dropped in the chat that
6 he wouldn't be on.
7 DR. SCHUSTER: Okay. Thank you.
8 Consumer Rights and Client
9 Needs?
10 MS. BEAUREGARD: Good morning,
11 everyone. Emily Beauregard with Kentucky
12 Voices for Health and Chair of the
13 Consumer TAC.
14 It is hailing outside. Is that
15 happening to anybody else right now? I am
16 just sitting here looking out the window
17 and it is kind of wild weather for the
18 first cold day of the year.
19 So the Consumer TAC met on
20 October 15th. We had a quorum present.
21 We discussed a number of our usual topics,
22 but I wanted to highlight a few for you
23 all today.
24 And actually, before I do, back
25 to the issue of language services, I think

1 the reports from the MCOs were incredibly
2 helpful.
3 I am really glad to know how
4 much effort MCOs are making in providing
5 access to language services and at the
6 same time from a consumer perspective with
7 six -- soon to be five -- MCOs providing
8 these services, I feel like consistency
9 and uniformity is really, really
10 important.
11 That is not to say that any one
12 MCO has a better or worse process, they
13 are just different, different enough in
14 how you request, and the time frames, and
15 all of that. And I think that if there
16 could we a language line, one single
17 universal line and when someone calls that
18 line, there could be a screening question
19 asked if the coverage is Medicaid
20 Fee-for-service, if it is Anthem, Aetna,
21 Humana, any of the different MCOs so that
22 they could be billed appropriately, that
23 could go a long way in simplifying this,
24 especially for those times when you need
25 realtime language services, when someone's

1 calling in to the doctor's office or to
2 talk to a provider, make an appointment,
3 when you can't wait five days to get that
4 in-person interpreter, which I still think
5 is a great opportunity. It's certainly
6 good to have in-person interpreters when
7 you can, but we also need to have some
8 other options.
9 That is what I would like to
10 recommend, and I should do it through a
11 TAC recommendation, but I just want to
12 take the opportunity to bring that up
13 again today because uniformity is really
14 important here.
15 And then, as far as the TAC
16 meeting that we most recently had, DMS
17 presented findings from their first survey
18 of Medicaid members and that survey was
19 with a really specific focus on the end of
20 the public health emergency and the
21 renewal process that everyone has just
22 gone through over the past year.
23 We were pleased to hear that
24 79 percent of respondents rated their
25 experience with Medicaid favorably. We

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1 know that Medicaid is an incredibly
2 valuable program. We want people to have
3 a good experience when they are enrolled
4 with Medicaid.
5 The survey also revealed that a
6 number of issues need attention and that
7 is particularly around procedural
8 terminations as paperwork issues and
9 improving the resolution process when a
10 beneficiary does reach out to DCBS or to
11 Kynect for help.
12 One of the findings that stuck
13 out in particular was that while most
14 issues were resolved by DMS on the same
15 day or within seven days, and I guess I
16 should say it could have been DCBS or
17 Kynect, any time somebody was reaching out
18 to the state. Most issues were resolved
19 within the same day, within seven days,
20 but 21 percent of issues remained
21 unresolved. That is a large number of
22 issues that people are calling in about
23 and not able to resolve.
24 I don't think the survey got
25 into what some of those issues are, but I

1 think further investigation is important.
2 And we were told there were
3 going to be some data briefs that DMS is
4 putting together and we are looking
5 forward to seeing those and seeing how we
6 can further reduce those administrative
7 barriers, the paperwork problems that
8 people have experienced, particularly
9 uploading documents, we know that has been
10 a big issue, and then any other issues
11 that are leading to dis-enrollment of
12 people who are actually Medicaid eligible.
13 One silver lining of the public
14 health emergency is that children enrolled
15 in Medicaid starting in, you know, 2019 if
16 that's when they were born, or 2020, have
17 now had nearly five years of continuous
18 coverage.
19 There is really good evidence
20 that continuous coverage without gaps
21 leads to better access to care, better
22 health outcomes, to reduced administrative
23 costs.
24 So much so that many states are
25 taking this step to make continuous

1 eligibility permanent from birth to the
2 age of 6.
3 So I think with the unwinding of
4 the PHE as we've had kids covered for at
5 least five years, Kentucky is in a good
6 place to evaluate the benefits and the
7 cost of continuous eligibility for young
8 kids to see if this is something that we
9 can make permanent here.
10 At our last meeting, we also
11 finalized the access to services form that
12 is soon to be available to beneficiaries
13 and those that are struggling to find a
14 provider in their area or to make an
15 appointment with that provider within a
16 reasonable timeframe.
17 We are waiting for DMS to have
18 that form online and publicly available so
19 the form beneficiaries can actually
20 complete it, but this is going to be a
21 really important tracking tool for DMS so
22 they can identify network adequacy issues
23 and pinpoint issues that need to be
24 addressed either through MCO contracts or
25 workforce initiatives.

1 Finally, we briefly discussed
2 the design of the new Beneficiary Advisory
3 TAC, or Beneficiary Advisory Council, and
4 appreciate the conversation that you all
5 had earlier this morning.
6 I know it has a very similar
7 purpose to the Consumer TAC's focus on
8 beneficiary needs and rights and I do
9 think that there needs to be more
10 discussion about how these TACs either
11 interact or if there is really just no
12 need for a Consumer TAC, at least in the
13 form that we have it now.
14 So we are looking forward to
15 that public forum and opportunity to make
16 some recommendations. We do have one
17 recommendation that the TAC has already
18 made. It is just one minor
19 recommendation. I think that many more
20 need to be made, but we wanted to put this
21 one forward first as we were talking about
22 language access.
23 We really do want DMS to
24 strongly consider stakeholder input. I
25 think the whole point of the Beneficiary

1 Advisory Council is exactly that, to have
2 stakeholder input. So looking forward to
3 what that ends up looking like and how,
4 even if the Consumer TAC has a new role,
5 how we can support that.
6 So the two recommendations that
7 we are presenting for your consideration:
8 The first is that DMS conduct an analysis
9 of the cohort of children ages 0 to 6 who
10 have experienced continuous eligibility
11 due to the public health emergency
12 maintenance of effort requirement,
13 compared to a similar cohort who did not
14 experience continuous eligibility.
15 And the second recommendation is
16 that DMS in planning for the
17 implementation of the BAC, consider how to
18 adequately present and serve the full
19 diversity of Medicaid members in regards
20 to language, including translation and
21 interpretation for BAC members who prefer
22 a language other than English.
23 Our final TAC meeting for 2024
24 is scheduled for December 17th at 1:30,
25 and our 2025 meeting schedule has been set

1 that we are continuing our meetings for
2 the third Tuesday of every even month at
3 1:30. And I will be happy to answer any
4 questions.
5 DR. SCHUSTER: Thank you, Emily,
6 and we will take those recommendations
7 under advisement. We appreciate that.
8 Emergency Medical Services met,
9 I think, on November 4th.
10 MS. BICKERS: Keith had a
11 conflict and could not be here today.
12 They didn't have any recommendations.
13 Their 2025 schedule is set.
14 DR. SCHUSTER: Thank you.
15 Hospital Care met on October
16 22nd.
17 MS. BICKERS: I am scrolling but
18 I don't see Russ.
19 DR. SCHUSTER: We can assume
20 from that that there were no
21 recommendations either?
22 MS. BICKERS: No
23 recommendations, yes, ma'am.
24 DR. SCHUSTER: Okay, thank you.
25 IDD, Intellectual and

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1 Developmental Disabilities met on October
2 1st.
3 Oh, there is Russ.
4 MS. BICKERS: Oh, there you are,
5 Russ.
6 MR. RANALLO: I couldn't get off
7 of mute. Can you hear me?
8 DR. SCHUSTER: Yes.
9 MR. RANALLO: We met on the
10 22nd of October. We did not have a
11 quorum. We went through, we had follow up
12 on several old business items including
13 NDC issues and soft denials.
14 Partial hospitalization
15 guidance, medical records burden, we did
16 have one item from DMS on asking just to
17 streamline newborns with invalid Medicaid
18 IDs.
19 They give us some information on
20 some errors that the providers are making
21 when they are putting in the newborn IDs
22 that is creating issues for their side.
23 So we said that education helped.
24 We do not have any
25 recommendations and our next TAC meeting

1 is on December 10th of next month.
2 DR. SCHUSTER: Thank you very
3 much. Appreciate that.
4 Now we can go to Intellectual
5 and Developmental Disabilities.
6 MS. BICKERS: Dr. Gupta's hand
7 is raised, but I'm not sure if that is
8 previous, or if she had a question.
9 DR. SCHUSTER: I think that was
10 probably earlier.
11 Actually, Ashima, I will say
12 that a psychologist put in the chat that
13 she gets audit requests for particular
14 patients, so I stand corrected on that.
15 DR. GUPTA: Thank you.
16 DR. SCHUSTER: Yes. IDD.
17 Is there anybody to report from
18 the Intellectual Developmental
19 Disabilities TAC, Erin?
20 MS. BICKERS: I am scrolling I.
21 I am not seeing anyone.
22 DR. SCHUSTER: It used to be
23 Rick Christman, but I think it is somebody
24 else now.
25 MS. BICKERS: It is. We have a

1 new chair. It is Wayne and I don't see
2 that he is on. They did meet. They did
3 not have any recommendations, and they
4 have set their 2025 calendar. They also
5 meet, I believe, it is January -- I'm
6 sorry. I'm trying to skip December. They
7 meet December 3rd.
8 DR. SCHUSTER: Okay, thank you.
9 Optometric?
10 MR. COMPTON: Yes. Steve
11 Compton from the Optometric TAC.
12 We did meet on November the 7th.
13 We had general discussions about some of
14 the things, you know, day-to-day things
15 that have come up.
16 Our licensing board can now send
17 our licenses to DMS electronically so we
18 no longer have to each submit those
19 individually.
20 We had a discussion about the
21 upcoming driver's license changes that are
22 effective January 1st, but we have no
23 recommendations, and we meet again on
24 February the 6th, and we did set our dates
25 for next year. That is all I have.

1 DR. SCHUSTER: Thank you, Steve.
2 Take a second and just remind
3 people of the changes around the driver's
4 license because that is going to affect a
5 lot of people.
6 MR. COMPTON: Beginning January
7 1st, 2025, when you go to renew your
8 driver's license, you will have to either
9 pass the vision screening, much like most
10 of us did when we turned 16 and then never
11 had to do it again, or take a form filled
12 out by a vision specialist stating that
13 you are either able to pass the Kentucky
14 minimum requirements to drive or that you
15 failed. So it will be different.
16 We've moved all of the driver's
17 licensing things to regional offices, so
18 this is part of the ongoing changes that
19 will be different, but it's time.
20 I think Kentucky is one of the
21 last six states in the country to enact a
22 vision screening when you renew your
23 driver's license, so should make the roads
24 safer.
25 DR. SCHUSTER: Maybe we decided

1 that we should find out if people who are
2 driving can see where they are going.
3 MR. COMPTON: It's not a bad
4 idea.
5 DR. SCHUSTER: I think one of
6 our local TV stations covered this, which
7 I thought was interesting. But I think
8 what happens at the license renewal place
9 is that if you fail there you can't get
10 your license renewed, is that right, until
11 you have an exam?
12 MR. COMPTON: It's until you
13 have a vision specialist is how it is
14 termed in the statute. KED is coming to
15 our office in the morning to interview my
16 partner about the vision changes so I
17 don't know when that will air, but I'm
18 glad they are not interviewing me.
19 DR. SCHUSTER: It was fresh in
20 my mind since you were on.
21 Thank you, Steve. I just
22 thought we found that informative and
23 educational.
24 Steve Shannon. Persons
25 Returning to Society from Incarceration?

1 MR. SHANNON: Thank you all. We
2 met last Thursday and we will meet again
3 in January. We have no recommendations,
4 but we did have a great presentation from
5 the Department of Corrections regarding
6 their reentry efforts.
7 I think it would be beneficial,
8 even if that PowerPoint was shared with
9 MAC members, we didn't really have a
10 coordinated effort until 2018, but in six
11 years they have really expanded services
12 prerelease. It is invaluable and it will
13 help people and it ties in nicely the 1115
14 waiver that we hope to see operational
15 soon.
16 We also welcomed a new consumer
17 member, Nathan Thomas, has joined. He is
18 a person with lived experience.
19 As he said, he has been
20 incarcerated and been a Medicaid
21 beneficiary.
22 In terms of the BAC, I think it
23 would be beneficial for each TAC to have a
24 consumer representative, if that's not
25 already the case and they can actually

1 feed information to the BAC itself. I
2 think it is great to get that voice.
3 Obviously, it was his first
4 meeting, but I think he will be an
5 invaluable member to the TAC going forward
6 and he is glad that he is there. No
7 recommendations.
8 MS. BICKERS: Steve, I do want
9 to mention that he also asked for the
10 application to go forward to the governor
11 to be a part of the MAC. I am just
12 waiting for him to resubmit that back to
13 me.
14 MR. SHANNON: I think he would
15 be a great choice and I will reach out to
16 Nathan to make sure he gets that
17 application back to you, Erin.
18 DR. SCHUSTER: That would be
19 great.
20 Steve, I think there would be
21 some interest around what Department of
22 Corrections is doing around reentry. I
23 think in the previous MAC meeting, we had
24 talked about thousands of people coming
25 out of jails and prisons in Kentucky every

1 day. Do you have that presentation that
2 DOC made?
3 MR. SHANNON: I bet Erin has it.
4 Do you have it, Erin?
5 MS. BICKERS: I do. I can send
6 it out to the MAC. It was great.
7 DR. SCHUSTER: I will share with
8 the BH TAC folks, obviously. Those are
9 overlapping issues. But thank you, Steve.
10 Our friends over at Pharmacy?
11 I think Susan is not in the
12 meeting.
13 MS. BICKERS: She was unable to
14 attend.
15 I do know they did meet and they
16 had recommendations. Did they provide
17 those to you to present to the MAC,
18 Dr. Schuster?
19 DR. SCHUSTER: No, they didn't.
20 MS. BICKERS: Okay. We may have
21 to ask that they present them at the next
22 one since they don't have someone and
23 didn't ask someone else to present.
24 Because I think I'm not allowed to present
25 them. It has to be a MAC member or a TAC

1 member.

2 DR. SCHUSTER: I hope I didn't

3 miss it, but is that in previous

4 recommendations? They do want pharmacies

5 to be reimbursed by Medicaid for

6 administering LAI's, which are long-acting

7 injectables.

8 I am going to make that

9 recommendation because I know that that is

10 a recommendation that they made, and if we

11 have not entertained that before, this is

12 really a critical issue.

13 So the recognition from the

14 Pharmacy TAC was that Medicaid reimburse

15 pharmacists for the administration of

16 long-acting injectables for the treatment

17 of people with severe mental illness. I

18 will leave that off -- just long-acting

19 injectables.

20 And the explanation is that, at

21 least in the behavioral health field,

22 these are recent developments where

23 instead of trying to get people to take

24 their medications literally every day, you

25 can give them an injection that carries

1 the same amount of pharmaceutical agent
2 over a month's time or two months time.
3 And I think there are even some that are
4 being developed for three months or six
5 months, and it is a huge step forward to
6 address the difficulty that we have with
7 people with severe mental illness just not
8 knowing that they are sick, and therefore
9 not wanting to take medication. So we
10 will make that recommendation on behalf of
11 the Pharmacy TAC.
12 Physicians TAC?
13 DR. GUPTA: So we had we met and
14 had quorum on October 18th via Zoom.
15 We discussed three major topics.
16 We do not have any recommendations.
17 Our first topic was discussing
18 the revised cost study completed by
19 Milliman that analyzed what it would cost
20 the state to move CPT codes 99213 and
21 99214 to 100 percent of the Medicare fee
22 schedule. Based on the study results, the
23 projected cost to do this annually would
24 be $130.8 million with the state having to
25 cover 30 percent of this cost. This would

1 mean an increase of roughly $38 million
2 annually to the state Medicaid budget.
3 We will be continuing these
4 discussions outside of the TAC with the
5 legislature.
6 Our second topic under new
7 business, we discussed 907-KAR3:005
8 section 4 to section 7, which contains
9 language that states coverage for an
10 evaluation and management service shall be
11 limited to "one per physician, per
12 recipient, per date of service."
13 This language has created a lot
14 of confusion and difficulty amongst
15 practices, both in terms of billing and
16 providing care, so especially if a patient
17 comes in for both a sick and wellness
18 visit, it is definitely more practical for
19 the physician to be able to take care of
20 both on the same day, but if a physician
21 does that, they will lose out on
22 reimbursement on one of the two, so as it
23 is right now, the only way to be fully
24 reimbursed for taking care of both an
25 acute and a wellness issue is to have the

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1 patient come back.
2 But that also puts a lot of
3 strain on the patient to make that trip
4 back and it is a strain on the physician.
5 So we are continuing to discuss
6 this with the MCOs to find a resolution.
7 Lastly, per the request of the
8 MAC, we discussed recruitment in the
9 Medicaid program both generally and
10 specific to behavioral health. We pulled
11 several psychiatrists to gather their
12 experiences with audits of behavioral
13 health recently.
14 Many behavioral health practices
15 said they haven't experienced an increase
16 in audits, but some of them did. Those
17 who did share that there have been an
18 increase in the number of records
19 requested and that the records have been
20 more extensive, sometimes going back up to
21 a year.
22 Specifically with labs, the
23 audits were looking for documentation with
24 medical necessity, seeking to ensure that
25 each lab has some effect on medical

1 decision-making. And this is basically
2 the extent to which the psychiatrist told
3 us that they were experiencing an uptick
4 in audits. And that concludes our
5 meeting.
6 DR. SCHUSTER: Thank you,
7 Ashima, and thank you very much for asking
8 them about the audits, because we
9 obviously have made several
10 recommendations that will hopefully
11 address some of the concerns that some of
12 the psychiatrists have.
13 Let me go back, because I do now
14 have the recommendations from the Pharmacy
15 TAC.
16 Another recommendation was:
17 Request to DMS to accept pharmacists as
18 providers who are able to order, manage,
19 and bill for community health workers, for
20 patient interventions, visits, and
21 encounters.
22 And then the second was actually
23 a little more extensive. It was the
24 long-acting medications, the antipsychotic
25 medications. But other maintenance

1 prescription medications that are
2 administered by injection, B12,
3 Depo-Provera, allergy shots, and
4 testosterone shots.
5 So those were, they actually two
6 recommendations, so I will enter those for
7 our consideration on their behalf. Thank
8 you.
9 And then the Primary Care TAC?
10 MR. BARRY: I don't think
11 Stephanie is still on here, so I will give
12 the report on behalf of the Primary Care
13 TAC.
14 We met on 10/24 at 10 a.m. We
15 had a quorum, but we had no
16 recommendations. Erin has provided us
17 with the TAC calendar for the Primary Care
18 TAC for the next year.
19 And then we will have a new
20 chair for the next meeting. His name is
21 John Lillibridge. He works with Fairview
22 Community Health Centers.
23 DR. SCHUSTER: Okay. Thank you
24 very much, Barry.
25 MS. BICKERS: Barry, do you mind

1 sending me his contact information?
2 MR. BARRY: I sure will.
3 MS. BICKERS: Thank you.
4 MR. BARRY: I think we have a
5 new provider on there, Patrick, but you
6 should have his though.
7 MS. BICKERS: I have Patrick.
8 Thank you.
9 MR. BARRY: Thank you.
10 DR. SCHUSTER: Thanks.
11 And last, but certainly not
12 least, the Therapy TAC.
13 Is anybody on from the Therapy
14 TAC on, Erin, that you see?
15 MS. BICKERS: I am not seeing
16 anybody, no, ma'am.
17 DR. SCHUSTER: Okay. You said
18 that Home Health wanted to speak for a
19 moment about a roundtable that they had
20 yesterday?
21 MS. BICKERS: Yes. I thought
22 they might want to highlight that to the
23 group.
24 DR. SCHUSTER: Yes, I'm happy to
25 have Home Health tell us about that.

1 MS. STEWART: Erin, is that me
2 or Evan?
3 MS. BICKERS: Well, I thought
4 that Evan was on, but then I started
5 scrolling and I thought maybe he left, so
6 if you don't mind, Susan, I was just
7 trying to highlight all of the good work
8 you did yesterday.
9 MS. STEWART: We had a
10 roundtable yesterday with representatives
11 from DMS to talk about our struggles with
12 recruitment, retention, and -- you caught
13 me offguard and I have lost my train of
14 thought.
15 But when I was driving to
16 Frankfort, I had no idea that we would
17 have that much conversation with those
18 representatives to discuss and highlight
19 the struggles that home health agencies
20 are having across the entire state with
21 managing the referral base with the amount
22 of staff that we have available.
23 We talked about the erosion of
24 aid services across the state as a result
25 of implementing of MCOs.

1 We talked about our struggles
2 with recruitment and retention. That is
3 about it in a nutshell, but Evan probably
4 could have done a more eloquent job at it.
5 DR. SCHUSTER: So was this a
6 meeting with DMS and just your TAC
7 members, Susan?
8 MS. STEWART: No. We opened it
9 up to anyone within our association that
10 wanted to make the trip to Frankfort to
11 have this sit down, and we had a
12 cross-section of hospital-based agencies,
13 for profit, independents, and we had a
14 cross-section of the state, I think every
15 region of the state was represented.
16 DR. SCHUSTER: Wow.
17 MS. STEWART: It was very good.
18 DR. SCHUSTER: That shows you
19 the power of having in-person meetings,
20 back to Ken's suggestion.
21 MS. STEWART: Absolutely.
22 DR. SCHUSTER: Zoom does not
23 take the place of those in-person
24 meetings.
25 MS. STEWART: We've missed the

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1 relationship building.
2 DR. SCHUSTER: Yes, and you also
3 miss the body language and the other
4 things that you get in in-person meetings,
5 so thank you for that, and thank you,
6 Erin, for bringing that up.
7 My notes are that we have
8 recommendations from the Behavioral Health
9 TAC, Consumer Rights and Client Needs and
10 the Pharmacy TAC. So I would entertain a
11 motion to accept the TAC recommendations
12 and send them on to DMS.
13 MS. EISNER: This is Nina. I
14 will make that recommendation.
15 DR. SCHUSTER: Thank you, Nina.
16 And a second?
17 DR. PARTIN: I will second.
18 DR. SCHUSTER: Beth, thank you
19 very much.
20 All those in favor, signify by
21 saying aye.
22 TAC MEMBERS: Aye.
23 DR. SCHUSTER: Any opposed? And
24 abstentions?
25 Thank you very much. Is there

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1 any new business to come before the body?
2 MR. ROBERTS: There is a
3 situation that I brought up in a previous
4 meeting. Our Chief Medical Officer from
5 my organization reached out to Dr. Theriot
6 and discussed it briefly, and it involves
7 bundling of certain services for durable
8 medical equipment.
9 As physician suppliers,
10 particularly in podiatry, in rural areas,
11 there is a lot of equipment and wound care
12 products and compression garments that we
13 use that are not readily available at our
14 surrounding vendors. For certain wound
15 care dressings and collagens, there's
16 nobody else inside of southern Kentucky
17 that stocks these things that I can just
18 give the patient a prescription to walk
19 down the road and get.
20 Unfortunately, with a lot of the
21 MCOs, they are bundling the reimbursement
22 for these services with the visit or with
23 the wound debridement.
24 Not only is it kind of a loss of
25 a profit center, but it is also costing us

1 the price of these products, which is
2 considerable sometimes.
3 I think Dr. Mike King who is our
4 CMO reached out to Dr. Theriot and I
5 believe with the conversation it is really
6 left up to the MCO. They are given some
7 leeway as far as internal modifiers and
8 bundling services and those kinds of
9 things, but it is really an obstacle to
10 treatment for some of these patients.
11 I do want to work with the MCOs
12 directly, because I think that is probably
13 the next step for us, but we may need
14 some, at least, advisement from DMS as far
15 as how to get these products for our
16 patients.
17 DR. SCHUSTER: Thank you for
18 bringing that up, Terry.
19 I don't know if Dr. Theriot --
20 she was on earlier, wants to speak to
21 that.
22 DR. THERIOT: I'm on. Yes. I
23 talked to Dr. King about it, and actually
24 his concern was that because of the
25 bundle, some products are in the bundles

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1 that are more expensive than the other
2 products, and if they are unbundled, it
3 might actually save DMS some money.
4 I sure that is not for
5 everything, but that was so long ago, I
6 think I will have to get with our policy
7 department and Justin Dearinger and go
8 from there and see what we can do about
9 it.
10 MR. ROBERTS: Certainly, you
11 know, we see on the Medicare side when you
12 are dealing with a Medicare Advantage
13 plan, you know, the services that are
14 covered under traditional Medicare are
15 required to be covered under the Medicare
16 Advantage plan, but they don't necessarily
17 have to pay the same rate for them.
18 I would assume that with
19 Medicaid Managed Care it is the same
20 principle.
21 I understand that the fee
22 schedules may change, but, you know, when
23 you are talking about a product that cost
24 you several hundred dollars out of pocket
25 to provide for the patient, and then

1 particularly in the wound care and then
2 not getting reimbursed for at least the
3 cost of the product, that is painful for
4 the practice.
5 The alternative is basically the
6 patient doesn't get the product that they
7 need and that is not good for anyone.
8 Dr. Theriot, if you'd like to
9 reach out to me directly, I am happy to
10 have a more in-depth conversation and then
11 we can kind of go from there.
12 MS. BICKERS: Sorry. There is a
13 question in the chat saying: Can you say
14 again which DME products you are asking
15 about?
16 MR. ROBERTS: It's specifically
17 wound care dressings and compression
18 garments, which are considered a wound
19 care dressing by code.
20 DR. SCHUSTER: I will make a
21 note and we can put that on the agenda for
22 next time and it will give you all an
23 opportunity to talk about it and get back
24 to us about where you are with it.
25 DR. THERIOT: Sounds good.

1 DR. SCHUSTER: All right. Thank
2 you very much.
3 Any other new business?
4 The good news is I am giving you
5 back about 12 minutes of your day here.
6 So you can get bundled up before you go
7 out.
8 Let me wish everyone a very
9 happy Thanksgiving. I am very thankful
10 for all of you who serve on the MAC and
11 those of you who serve in DMS and sister
12 agencies, and all of those who are
13 interested enough and care for your
14 patients to join us and watch these
15 proceedings and so forth. Happy holidays
16 in whatever way you celebrate.
17 And Dr. Ali from Medicaid
18 Pharmacy would like to make an
19 announcement. Absolutely. It's always
20 good to hear from you, Dr. Ali.
21 DR. ALI: Thank you. I just
22 wanted to mention a date and time change
23 for the quarterly PNT meetings beginning
24 in 2025. Instead of the third Thursday of
25 the first month of the quarter, it will be

1 the third Tuesday. So the first one will
2 be January 21st, that's a Tuesday, from 1
3 p.m. to 4 p.m. We will be sending out
4 letters to our prescriber and pharmacy
5 provider community, but also wanted to
6 mention it here.
7 DR. SCHUSTER: Thank you. I am
8 delighted to hear that. I just happened
9 to be at a social gathering with one of
10 your PNT members and she was saying how
11 difficult it was for her because that is
12 such a heavy clinic day on Thursday.
13 DR. ALI: Right.
14 DR. SCHUSTER: So I am sure that
15 she will be thrilled. It is important,
16 obviously, for all of the PNT.
17 For those of you who don't know,
18 that is Pharmacy and Therapeutics. They
19 make really tough decisions and
20 recommendations around what are the
21 preferred drugs and what kind of drugs
22 should be moved on and off the Medicaid
23 formulary and so forth. And Dr. Ali is
24 the Director of Kentucky Medicaid pharmacy
25 services.

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1 So thank you, Dr. Ali. I am
2 glad that we caught that.
3 Happy holidays to you all.
4 Thank you for being on. I will see you on
5 whenever we meet next, January 23rd at
6 9:30, 2025. Happy new year.
7 (Meeting adjourned.)
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2 C E R T I F I C A T E

3

4 I, STEFANIE SWEET, Certified

5 Verbatim Reporter and Registered CART

6 Provider - Master, hereby certify that the

7 foregoing record represents the original

8 record of the Technical Advisory Committee

9 meeting; the record is an accurate and

10 complete recording of the proceeding; and

11 a transcript of this record has been

12 produced and delivered to the Department

13 of Medicaid Services.

14 Dated this 3rd day of December

15 2024.

16

17 /s/ Stefanie L. Sweet

18 Stefanie L. Sweet, CVR, RCP-M

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