CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

July 25, 2019
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Steven Compton
Bryan Proctor
Susan Stewart
Jerry Roberts
Julie Spivey
Ashima Gupta
Sheila M. Currans
Ann-Taylor Morgan
COUNCIL MEMBERS PRESENT

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AGENDA

AGENDA
(Continued)

DR. PARTIN: Good morning. We do not have a quorum this morning, so, we will not have approval of minutes. If another person comes in, then, we will and we do have a quorum, then, we'll go back and approve the minutes.

As far as membership----

MS. HUGHES: You just got one more member.

DR. PARTIN: Okay. We do have a quorum. Our Secretary is not here today. Her father had surgery for cancer, and, so, she was not able to be here today. And, so, we will start with the roll call for attendance at our next meeting since the Secretary is the one who takes the roll.

On the agenda next is approval of minutes from the May meeting. Would somebody like to make a motion to approve those minutes?

MR. CARLE: So moved.

DR. PARTIN: Second?

DR. COMPTON: I'll second.

DR. PARTIN: Thank you. Any discussion? All in favor, say aye. Opposed? So moved. Thank you.

Under Old Business, an update from the Attorney General regarding video

teleconferencing. I have tried to call or have called the Attorney General's Office for the past three days, and my most recent call was this morning as I was driving up here.

And the person I spoke with finally - the other two days, I was only able to leave messages - this morning promised that she would get back with me right away and that was about maybe an hour and a half ago. So, I've got my phone here; and if it rings, I will take the call from the Attorney General's Office because they are so hard to reach and hopefully we will have some information regarding that Opinion.

Also under Old Business which did not get on the agenda, and partly that's because I sent out the draft for the agenda early this time, and, so, we had some late additions, but we did get a report from Beth Ennis on the Therapy TAC, and she had some concerns based on recommendations that that TAC made previously, so, this would go under Old Business.

And I'll just read from her report. I think members of the MAC have the report, but in the final paragraph, she says, second, we are still concerned that the Cabinet removed the pay

differential for speech CFY providers allowing them to bill under the supervising SLP but gave no explanation about leaving the differential in place for the PTA or COTA who are not credentialed in commercial insurances and work with the PT and the OT.

And, then, she says at the end, we would like more of an explanation regarding why one was removed and the others were not.

So, if we could request from the Department further explanation on that since that was part of a request from a previous TAC recommendation at our next meeting, it would be appreciated.

Actually, I skipped over one thing. Let me go back to notify you all that Melody Stafford, the consumer advocacy group representing minorities, has resigned. She said her work responsibilities were making it difficult for her to attend meetings.

But we do have new members and they are Ann-Tyler Morgan who will be representing consumer advocacy for disabled persons and John Dadds for the Kentucky Association of Homes and Services for the Aging. So, we welcome the new members and we

thank Melody for her service to the MAC.

MS. HUGHES: And, Beth, John already had appointments for today, so, he was not able to come. They were not appointed until Friday afternoon, so, it was late getting them word on the meeting.

DR. PARTIN: Sure. It's hard to adjust schedules on a short notice. So, our new member is down at the end of the table. Hello and welcome.

So, next up on the agenda, then, are updates from the Commissioner.

COMMISSIONER STECKEL: Good morning. We planned this beautiful weather for you so that you wouldn't be sweating as you walked into the building. So, if you think Medicaid can't do other things, now you know.

DR. PARTIN: We thank you for that. That's very nice of you.

COMMISSIONER STECKEL: I wanted to do two things. I don't have a lot of updates because I know we'll talk about some other things, but one is to introduce you all to my new Chief-of-Staff, Genevieve Brown.

MS. BROWN: Hello. Nice to

meet you all.

COMMISSIONER STECKEL: So, Genevieve is an attorney with significant experience on the federal Medicaid and Medicare aspects of the program, is from Lexington and is married to a historian and a lawyer also but brings to the table a lot of experience and we're very pleased to have her.

So, if you can't find me or Stephanie, then, please do look for Genevieve and she will be getting more and more involved as we throw her in the deep end. Any questions of Genevieve, or, Genevieve, would you like to anything?

MS. BROWN: Thank you for having me here today and I'm just anxious to learn from you. Thank you.

DR. PARTIN: Welcome.

COMMISSIONER STECKEL: And the second thing I thought we would do is I saw the request for a briefing on KI-HIPP. In all seriousness, we wanted to go ahead and do that now if that's acceptable because the program is initiated and we're sending out mailers and we're doing a lot around KI-HIPP.

So, if it's acceptable to you, Madam Chairwoman, I would like for Teresa Shield who

is our Program Director for KI-HIPP to give you an overview about the program. And I know we've put two fliers in your packet, one that is a general overview, very, very high level, and the second is more member centric. If you're a Medicaid beneficiary, it's more focused on this is information that would be beneficial for you.

So, if that's acceptable, I would like to go ahead and do the KI-HIPP briefing.

DR. PARTIN: Yes. I was hoping that you would. So, thank you.

COMMISSIONER STECKEL: Okay. Good. Teresa.

MS. SHIELDS: Thank you all for your time. KI-HIPP is the Kentucky Integrated Health Insurance Premium Payment Program.

It is designed to help those working Medicaid members who have access to Employer-Sponsored Insurance to cover the cost of their employee portion of the premium if it's found to be cost effective.

It does not in any way, shape or form affect their Medicaid eligibility. It also provides a way for possibly an entire family to be covered under commercial insurance, while still

having the Medicaid members enrolled and providing health insurance that possibly those other family members didn't have in the past.

It can be individuals or families who can apply for the program. Either the Medicaid member can be the policyholder or a non-Medicaid member be the policyholder but yet they have a Medicaid person in the family.

We have websites. We have a lot of notices going out to our members. We are engaging with employers, commercial insurance carriers. Anyone and everyone that we can think of we are getting involved in the program and getting out information to them.

Not only does it benefit our Medicaid members, because even with the commercial insurance, as our regular TPL works now----

COMMISSIONER STECKEL: Third-party liability.

MS. SHIELDS: I'm sorry. Third-party liability. If the Medicaid member currently has commercial insurance, commercial insurance pays first, then provider bills Medicaid and Medicaid provides for wrap services.

If a family is enrolled but not

all family members are on Medicaid, if it's cost effective, we will reimburse that premium but we do not provide wrap services for those non-Medicaid members.

We have done some interviews and we have actually had people tell us how thankful they are for the program and we are rolling this out to an extended population.

Because they couldn't afford the insurance premium or if they were already paying an insurance premium, it was very hard on their budgeting where now with Medicaid paying the premium for these beneficiaries, we are able to put money back in people's pockets.

COMMISSIONER STECKEL: So, this program enables us to do several things; one, get people that have access to employer-based insurance into that system so they're learning that system. They're able to access that system.

In many cases, it's a wider provider network than the Medicaid provider network and they can use those providers and we'll pick up the copay and deductibles for all of that.

The other thing it does is it allows us to expand our Medicaid budget. As you can

imagine, if it's cost effective to the Medicaid budget to have the Employer-Sponsored Insurance be the primary and we've got a formula that we use, a cost-effectiveness tool that we use that puts in all the components of it, family members, non-family members, all of that, it allows us to extend our Medicaid budget.

And not only that, but it's good for the Medicaid beneficiary in that they have a wider range of providers that they could access.

It is an extremely beneficial program, one that's used in every state, one that we have had ongoing for years. We're just now starting to highlight it as an active program.

It is a voluntary program for the beneficiaries, but the more people we can get onto this program, the more hopefully self-sufficient they become in making more decisions about their health care and the better our budget will be because of this.

So, Teresa or I will be glad to answer any questions.

MR. CARLE: Thank you very much. Have you reached out to some of the large employers and reminded them that this actually

exists? So, take, for instance, Amazon is coming in to Northern Kentucky, UPS in Louisville, so on and so forth. Are they really aware that this exists and how they could partner with you on that?

MS. SHIELDS: Yes, sir. We are reaching out to those. We have meetings set up with those. We have looked at our top twenty employers that we have in our system of our Medicaid beneficiaries who are working.

So, we are reaching out to those people. We are reaching out to their HR folks also.

MR. CARLE: Right, because, in the hiring process, you want them to really talk about this as a benefit alongside with their health care benefit that they're offering their associates.

One of the hardest groups of people to recruit in health care besides nursing is some of those entry level positions, whether it be food service, obviously environmental services, transportation, and those are the individuals that would need this assistance which you know.

MS. SHIELDS: Yes, sir, and we are actually working on--as the Commissioner and I mentioned, we have a lot of materials and notices

that we send out to people. And as we work with the larger employers, we also work with them to design material for their needs. It covers our program and what we need but it also covers their needs to provide to their employees.

MR. CARLE: Great. Thank you.

COMMISSIONER STECKEL: And part of it is targeting to those employers that we believe have workers that meet our income requirements, and we've been working very closely with the Workforce Development Cabinet.

And, then, in the Cabinet for Health and Family Services, we also have a Workforce Development Director and she has been intimately involved in all of this.

DR. PARTIN: I have a couple of questions. Does this program actually save DMS money?

COMMISSIONER STECKEL: Absolutely, yes, ma'am. Do you have the estimates? I should know that off the top of my head and I don't.

MS. SHIELDS: Currently we have 102 members involved just since May when the expanded program went live; and just on these 102 individuals,

we have saved thirty-five-plus thousand dollars a month.

DR. ROBERTS: Could you lay out exactly how this affects the budget because I see a tremendous upside but I just see the State covering more and more? Could you lay out the benefit side, where you're getting the cost savings?

MS. SHIELDS: Yes, sir. Part of our cost-effective tool, we not only look at the premium cost of the insurance, we also look at the coinsurance because the Medicaid member does not pay any out-of-pocket cost. So, we look at coinsurance and deductible.

Those members that are enrolled with an MCO, we also look at a cap fee that we were paying as part of the cost-effective tool.

COMMISSIONER STECKEL: And the savings come because we're buying them, just like with the Medicare savings programs where we're buying people into the Medicare Program, we're buying people into their employer-based insurance and, then, that employer-based insurance pays their services costs and that's where the savings are.

So, when we do our cost-effectiveness tool, their premium, any copays and

deductibles in their ESI Program, the Employer-Sponsored Insurance program, and, then, does that equal what we would have anticipated paying out in benefits for that beneficiary.

So, all of that has to equal zero or less for us to allow them to enroll in the program, but the savings come from the benefits that now are going to be paid for out of the employer-based insurance.

DR. SPIVEY: I have a question. So, is their medication covered in this also? You said no out-of-pocket expenses for them.

COMMISSIONER STECKEL: Other than those out-of-pocket expenses that every Medicaid beneficiary is obligated to pay, yes, ma'am, it does.

DR. SPIVEY: Okay. Thank you.

MS. SHIELDS: If the Medicaid member goes to the pharmacy, they would present their Employer-Sponsored Insurance first. The pharmacy would bill that and, then, turn around and bill Medicaid.

DR. SPIVEY: Okay. Thank you.

DR. ROBERTS: So, the copay is for medication, office visits. You know, the Medicaid recipients, it wouldn't change. They would

still have those copays that we've been laying out over the last year or two.

COMMISSIONER STECKEL: Correct. Yes, sir.

DR. ROBERTS: I think it's a great program.

COMMISSIONER STECKEL: It is a phenomenal program; but just to be clear, the copays and deductibles that we do a wraparound, as you all know because you pay this out when you go to the doctor, your copay may be $10 or $20 or higher, we're going to pay the difference between what the Medicaid copay is and their ESI copay. And, again, all of that is calculated in the cost-effectiveness tool.

MS. CURRANS: The formulary, I see that this could be very beneficial to our environmental services and food service folks especially. So, if the formulary is in conflict with the employer insurance with Medicaid's, it still covers the copay of the medication because not everything is on the Medicaid formulary. Yes, it would cover the employee.

COMMISSIONER STECKEL: They would get the ESI-covered drug but they would have to pay the Medicaid copay.

MS. SHIELDS: Correct.

MS. CURRANS: Even if it's not on Medicaid's formulary. Thank you.

MR. CARLE: So, how many people do you project could actually be utilizing this?

MS. SHIELDS: High end is 10,000.

MR. CARLE: Ten thousand. You've got 102 on it right now.

MS. SHIELDS: Since May.

MR. CARLE: And you're saving about $35,000 you said a month. So, the numbers are staggering.

COMMISSIONER STECKEL: Well, and, again, I try hard not to always focus on the budget, although that is my job, but it is a good way to get people into the private market and start learning how to use the private market and making decisions that they'll be able to make in the private market that they might not be able to make in Medicaid.

So, it is a significant budget savings for Medicaid but it also helps our Medicaid beneficiaries we hope become more self-sufficient and more active in their health care decisions.

MR. CARLE: Well, you have the uninsured and, then, you have the under-insured. The under-insured make up a big portion of all the providers' issues as well. So, this is a great program.

MS. SHIELDS: I do have a HIPP Program, Kentucky Health Insurance Premium Payment Program now, as the Commissioner mentioned, that has been in existence for over twenty years.

I apologize for not bringing those numbers but I can report back to the Commissioner so she can share at the next meeting the cost savings we have had just in a year's time for the folks on that program.

COMMISSIONER STECKEL: And, then, do you want to tell them about the webinar, the Q&A session?

MS. SHIELDS: Yes. Next Thursday, August 1st, from 9:30 to 10:30, we will be having an in-person Q&A session on the program. We have invited all the MAC and TAC members, anyone who would like to attend, and we will also be sending out a call-in number for those that aren't able to attend that will be able to call in and ask any questions.

We would love to hear any

feedback and provide any additional information that you all would like to have.

DR. ROBERTS: Could you send us these flyers digitally?

MS. SHIELDS: Yes, sir.

MR. CARLE: That email actually went out yesterday as well.

DR. PARTIN: Sharley sent it.

MS. HUGHES: Yes, I sent out the notice of the meeting.

MR. CARLE: These attachments electronically would be great.

COMMISSIONER STECKEL: Just give it to Sharley and she can send it to them, or she already has it, so, she will send it to them.

MS. SHIELDS: I'd like to update this.

MS. HUGHES: Okay.

DR. GUPTA: I have one question. So, when a patient presents to an office for services and they're in this program and they only present either their Medicaid card or their commercial employer-sponsored card and they forget to present the other one, what happens then?

MS. SHIELDS: If they do not

present their commercial insurance card and the provider just bills Medicaid, a claim will deny saying the person has other insurance; but part of our outreach program to our members, it's very plainly, and we have pictures in there to show, you must present your employer card and your Medicaid card to receive the benefits of the program.

DR. GUPTA: So, if they only present the Medicaid card and it's denied, can we just bill the patient and they can submit it or do we need to search for the patient and----

MS. SHIELDS: The patient would have to provide the commercial insurance. The insurance, when we get it from the members and they're enrolled in this program or they just have third-party insurance at all, it is kept on the claims processing system and it does show in Health.net what commercial insurance and it should have all the information needed to go ahead and bill them first.

COMMISSIONER STECKEL: So, if the provider got a Medicaid card and they checked Health.net, it would show not only that they're eligible for Medicaid but----

DR. PARTIN: Could you say that

again.

COMMISSIONER STECKEL: So, if a Medicaid beneficiary comes in and they only give their Medicaid card or only--well, I guess commercial insurance, it would go through and, then, Medicaid would pick that. So, if they only give you the commercial insurance, it works the way it should because we'll pick it up in the copay and the deductibles in the wrap, right?

MS. SHIELDS: Correct.

COMMISSIONER STECKEL: If they only show their Medicaid card, then, if you look on Health.net, it will confirm not only their Medicaid eligibility but it will show you that they have ESI coverage. And, then, at that point in time, you will be able to ask them for their employer----

DR. ROBERTS: Will it have the actual information from the ESI coverage or will it just say they have----

MS. SHIELDS: No, sir. It will say who the carrier is. It will have group numbers, policy numbers.

DR. ROBERTS: That is a brilliant thing built into Health.net.

COMMISSIONER STECKEL: And to

brag on Teresa, she has done the yeoman's amount of work on this. There's been a whole team but it's been her leadership that has made this work and be successful. And we'll continue to make improvements but she's done an extraordinary job on this.

DR. GUPTA: One last question. So, if they forget their commercial card but we see it on the website that they do have it, that data on the website is sufficient where you could still see the patient without them actually having their commercial card?

MS. SHIELDS: Oh, yes, ma'am, absolutely.

DR. GUPTA: Okay, because normally we won't see a new patient if they don't have their card but that would be acceptable?

MS. SHIELDS: Yes, ma'am, I would think. Yes, absolutely.

COMMISSIONER STECKEL: Any other questions?

DR. PARTIN: Is this program required?

MS. SHIELDS: No, ma'am. It is strictly voluntary.

DR. ROBERTS: Of the 102 people

that are currently enrolled, what percentage of the employer-sponsored plans have been approved versus denied? Do you have a ballpark?

MS. SHIELDS: We have only had maybe seven, I think it's about seven denied. A couple of the folks who sent in applications and we considered it - we're making system enhancements as we go - but the only way we had to notify these folks were actually to deny their plans; but the thing was, they came to us saying I don't need help with my premium at all, I'm fine, I just don't know how I'm supposed to use both my cards.

So, it's been an education for these folks, also, explaining to them what they need to do and how they need to do it. And we even offer them, if they say I don't need help, we even offer would you like for us to go ahead and run this and see if it would be cost effective for you to be in the program. We could save you some money.

COMMISSIONER STECKEL: And I think the other component - I know I keep bragging on this program but it is a phenomenal program - but to not overlook the family coverage component; that if a family has a Medicaid beneficiary in it and that family coverage is cost effective, we're going to

pick it up for that Medicaid beneficiary, but it means everybody in that family gets health insurance coverage.

Now, they pay it and they have to meet the deductibles and copays except for that Medicaid beneficiary but it does open the door for at least providing some assistance for family coverage where we will pay the premium and buy the family into insurance, ESI insurance.

DR. PARTIN: You pay the premium for the family?

COMMISSIONER STECKEL: Yes, ma'am. Again, it has to be cost effective. There has to be a Medicaid beneficiary but, yes, ma'am.

DR. PARTIN: What do you mean by cost effective?

COMMISSIONER STECKEL: So, we have to pay less than we would normally pay for a Medicaid beneficiary if we pay their premium, deductibles and copays.

DR. PARTIN: Okay. So, if you're covering the family plan, you don't know that information.

COMMISSIONER STECKEL: For that Medicaid beneficiary. So, what we would do, we

wouldn't count the other - and correct me if I'm wrong - we couldn't count the other family members' cost but what we would say is for that Medicaid beneficiary, what would we normally pay for them.

And, then, for the family premium, what would we pay for the family premium, that Medicaid beneficiary's deductibles and copays and what will we save on the benefit side and that's the cost effectiveness; but it, in essence, pays the premium for the entire family and, then, the family is obligated to pay the copays and the deductibles for the non-Medicaid beneficiary. Does that make sense?

DR. PARTIN: Yes. Thank you. Any other questions on this? No. Okay.

MS. SHIELDS: Thank you all for your time.

COMMISSIONER STECKEL: I will just very, very quickly go through this. The 1115 Waiver, Kentucky HEALTH is still in the court system. We're anticipating I think arguments in September. And, then, when the decision comes out, we're fully anticipating an appeal to the U.S. Supreme Court. So, that time line has not changed.

The SUD 1115 Waiver component

of Kentucky HEALTH has been implemented. It went into place on July 1st and we've done a significant amount of outreach and education for that waiver and it is moving forward. So, we are doing that.

Other than those two components, everything else is just the normal part of doing business. I'll be glad to answer any questions if you all have any questions about specific issues.

DR. PARTIN: I do have a question. Medicare is planning on implementing a program in 2021 where they're going to combine the E&M codes for the Level 3 and 4 visits.

And supposedly the documentation will be a little bit less than what's required now for a Level 4 and the reimbursement is to be somewhere in between the Level 3 and Level 4 visits that they're paying right now.

So, my question is, usually Medicaid follows Medicare; and, in Kentucky, we have the limitation on the Level 4 visits to two visits per patient per year.

So, I'm wondering what the thinking is for DMS in regards to that? And I know to change that would require a regulatory change; but

since it's coming in 2021 and things tend to kind of move slow, I thought maybe we ought to be thinking about how that might work for providers.

COMMISSIONER STECKEL: I don't know the answer to that question but I will get back with you.

DR. PARTIN: I didn't expect you would but I wanted to raise the issue.

COMMISSIONER STECKEL: Thank you very much. Any other questions? Welcome, Ms. Morgan. We look forward to working with you. Thank you.

DR. PARTIN: Thank you. Okay. Reports from the TACs and we will start with Behavioral Health.

MR. STEVE SHANNON: Good morning. I am not Dr. Sheila Schuster. She had surgery Friday, a hip replacement, and the last report, she is doing well. She is looking forward to be back up and about but no pain so far. She is pretty happy about that.

I am Steve Shannon. I'm on the Behavioral Health TAC. I've been on it since it was formed. We had our meeting on July 9th. All six TAC members were there. Five MCOs were represented at

the meeting. We had staff from the Department of Behavioral Health, Developmental and Intellectual Disabilities, and due to scheduling conflicts, Medicaid staff could not attend that day.

A brief summary of the meeting - we had a report from Dr. Schuster on the May 23rd TAC meeting. We had received some communications from Commissioner Steckel. Those were distributed to people so they could see what happened at that meeting.

We had an update on the 1115 Waiver from people in the audience. Where are we? What are you hearing? What's going on? We are anticipating, and I think it was reported at one previous meeting, Commissioner Steckel said maybe 2020 is when we're looking at an implementation date. So, we had that conversation.

We also discussed KI-HIPP. We talked about that. We think it's a great opportunity for people. We have some concerns. We have a recommendation around that, but one primary concern we have is what if the provider is a Medicaid provider but not on the private insurance? What happens in that situation?

In the behavioral health world,

that's probably more common perhaps in that direction. I represent mental health centers. A lot of us have private insurance and many of us are mental health centers are Medicaid-focused. So, what happens in that situation with KY-HIPP? Do you lose your provider? That's a concern.

We had a lengthy discussion about behavioral health service organizations. Six regs were issued relating to behavioral health service organizations. The TAC didn't know about that. We thought the Behavioral TAC, the BH TAC should have been communicated about those things.

Some concerns discussed during the meeting around those new regulations is that a behavioral health service organization may be designated as an initial understanding for mental health primarily; and if a person presents with a mental illness, they get treated, and during the course of treatment, a very common practice, if a substance use disorder is identified, a person has been self-medicating, if the behavioral health service organization can just focus on mental health issues and a different behavioral health service organization for the substance abuse, you've got to refer that person out and we think that's a concern.

The more times you've got to refer someone to services in our world, the less likely they are to go to that follow-up appointment. So, we had that discussion. We talked about that a lot and really concerned about the cooccurring issue like that.

We always have a discussion of copays and the ramifications of that. This one really relates to people who are less than 100% of the Federal Poverty Level. It is our understanding that those folks cannot be denied services for lack of a copay and we have heard that that is the case, that people have been denied services because they were unable to make a copay.

This has happened at pharmacy as well as primary care. So, we have concerns about that as well. That was discussed.

One of our TAC members who represents people with acquired brain injury, we had a conversation about the 1915(c) Waiver redesign process. There are six waivers. Two of those relate to people with brain injury, and we had concerns about those, some concerns about who is on those advisory panels, who is involved in that discussion and is it open to the public and people know who they are so they can communicate with those folks. It was

also reported that some people are expressing their frustration with the process and that was shared at the Behavioral Health TAC.

We followed up on a meeting we had in May relating to emergency medical transportation from hospital ER's or maybe primary care offices and transporting people to a hospital with a psych unit being denied and we had that conversation. Medicaid has requested that we provide that data, and we've asked as the Behavioral Health TAC through the behavioral health community to access that information, to share that with folks of those situations if they occur.

Clearly, we believe that's a non-emergency medical transportation and it's an emergency medical transportation situation that isn't being addressed and what happens to the person as they sit in the ER waiting for a ride?

So, that's what we discussed. Typically our meetings start with a discussion. We have that, and, then, we get to recommendations.

So, we have six recommendations that usually relate to what we discussed. The first one is we think Medicaid should communicate with the appropriate TAC when regulations are being released

that's under the purview of that TAC so they know about that, so they can be aware of it, they can have that communication. Clearly, TACs are advisory to Medicaid. We want to be proactive on our advisory strategy, not reactive and if we know about those regulations before they are out.

There was a webinar on June 17th. Not everyone knew about that. I represent mental health centers, not VHSO's. I didn't know about the webinar. My members didn't know about that, that we have not been on the list, but that was a concern.

So, let's try to be proactive and not reactive and know what regulations or changes are being done before it happens so the TAC can weigh in on it at that time. So, that's one recommendation from the Behavioral TAC.

The second one relates to that, those six regulations for the VHSO. We recommend Medicaid designate a staff person to meet with impacted parties, to meet with recipients of services, family members, advocates, providers so they can have that discussion about this designation and what happens when someone is identified through the course of treatment for a mental illness having

an addiction as well, and do they have to go some place else, what happens?

Kind of revisiting about fifteen years ago, the mental health centers had this dilemma when substance abuse wasn't a covered benefit and we would see people with cooccurring disorders and we could treat them for their mental illness. Our notes could say that. We would bill Medicaid. We would have to wait until the session ended and then talk substance abuse and bill State General Fund dollars for that. Fortunately, with the expanded benefit, that didn't happen, but that was a concern we had.

We see it happening again in the behavioral health service organizations. You would get at least fragmented services and that's a concern. So, meet with folks beforehand and go on from there.

The second one does relate to KI-HIPP. We are glad to hear about next Thursday. A recommendation was to have that opportunity to have that discussion about the KI-HIPP and how does it impact, especially that cost-sharing provision around a Medicaid provider that is not in the employer, is in an out-of-network. Who pays for that and how does

that work?

We think in behavioral health, we're going to see more of that situation than maybe perhaps the physical health, that there will be more providers on the Medicaid side that they are being seen at and less on the private market and what happens with that situation. So, that's a third recommendation.

A fourth one, this copay for less than 100% of Federal Poverty Level issue, our recommendation is there be communication to pharmacy and primary care around that, that you cannot be denied services if you can't make the copay if your income is less than 100% of poverty.

And the Behavioral TAC is willing to meet with the Primary Care TAC and the Pharmacy TAC to work out the best way to address that problem.

And, again, we have individuals who are severely mentally ill. If they go to a pharmacist and they don't get their medication, we've had many situations where a person believes they're not supposed to take that because they didn't get it. You don't want that to happen. So, that's our fourth recommendation relating to the copay.

The 1915(c), I know Medicaid is waiting. Can those names be released or not? I serve on one. So, I'm on one of those four groups. My name has not been released but is that permissible to release those names?

And for transparency, they know who serves on the panels and the subpanels because folks may want to approach a member and not necessarily an email to communicate with what's happening with those waivers, reach out and talk to that person on what happening there and the concerns they have in that area.

So, that's the second recommendation, but, again, we understand Medicaid is waiting to hear can they release those names for those 1915(c) areas.

And the last one is communicate with ambulance providers because we don't want people sitting around the ER who need to go to a hospital with a psych unit or a primary care with the same issue. We don't want that to happen. We need to get people where they need to get the best treatment.

Those are our six recommendations. Hopefully they're in your packet. I think I sent them to Sharley on Monday. So, you

already have those.

The other two things, you all are welcome to attend the BH TAC meeting. They're really a thrill. Our September one has been changed from September 10th to September 3rd and our November one has changed from November 5th to November 4th and we meet in this room.

That's it. Thank you. Any questions?

DR. PARTIN: I just have a follow-up comments. It's on our agenda but the recommendation for the ambulance providers to ensure transportation for mentally ill patients was a recommendation at the last meeting.

And, so, I had a follow-up question to that because the response from DMS was that DMS would work with ambulance providers to ensure proper training on Medicaid rules and regulations in regard to transporting patients with mental health illness.

And, so, my question is what are the plans to communicate?

COMMISSIONER STECKEL: Is that to me?

DR. PARTIN: Yes, Commissioner,

or anybody in your group.

COMMISSIONER STECKEL: We already have met with the ambulance providers, both private and public, and we've raised this issue. Without examples, though, all they can say to me is, if you could give us examples, we'll know.

One of the things Genevieve is doing is overseeing the Program Integrity. We could talk to them as Program Integrity but we need examples of where it has happened, specific examples, the Medicaid beneficiary and what the circumstances are but I've raised this and I was very direct to them that this was not acceptable.

But, again, their response was when and where and how and who, and I was not able to answer that question.

MR. SHANNON: We'll try and get those answers.

DR. PARTIN: It's a pretty universal problem, and, so, I feel like that's a cop-out on their part, but I appreciate you raising the issue strongly.

COMMISSIONER STECKEL: Right. And I can hold them accountable to--I mean, I can hold them accountable to the rules, but, then, when

they break the rules, if I don't have an example of how they have broken the rule, there's nothing I can do. It's a he said/she said situation.

DR. PARTIN: Sure. Thank you. And just a second before we go on to the next TAC report. I did receive a call from the Attorney General's Office and somehow the person I spoke with said it was his fault that I hadn't received a response sooner to my letter sent in March.

He didn't say what the problem was. He just said it was his fault but that they would expedite it. And I asked him if we could get a response within the next two weeks and he said he would try very hard to do that.

So, hopefully we will have a response from the Attorney General's Office in two weeks.

Moving along, Children's Health. Consumer Rights and Client Needs.

MS. EMILY BEAUREGARD: Good morning. I'm Emily Beauregard. I'm the Chair of the Consumer TAC and I'm the Director of Kentucky Voices for Health.

Our Consumer TAC met on June 11th. We did not have a quorum present specifically

because of the issue that you're talking with the Attorney General's Office about now. So, I'm very glad that you've been able to make contact. We have one severely disabled TAC member who is unable to afford the transportation and the personal assistance that he needs in order to come here to participate in person.

He is very interested in participating via video conference or he has also asked DMS if they would cover the cost of his transportation and personal assistance but those are the two options that he's able to participate; and at this point, those aren't options that are available to him.

So, we're hoping that once the Attorney General's decision is known, that we will be able to do video conferencing.

We also have another TAC member who has a sick son that she cares for. And, so, she's also unable to make a long drive to be at our TAC meetings on a regular basis and she would also really appreciate the opportunity to participate via video conference. So, we're very much looking forward to that decision.

At our June meeting, we had an

extensive conversation about the revamped K-HIPP Program which is now the KI-HIPP Program that the Commissioner and Teresa Shields shared about earlier.

And while we absolutely agree that a premium assistance program has the potential to be incredibly beneficial for working families and for DMS' budget, it can be a win/win, the program has been redesigned in a way that has raised some concerns for us regarding program compliance with federal Medicaid rules and also the information that's being presented to consumers and how they're able to make an informed decision for themselves, for their finances and for their families.

So, I'm going to just summarize some of those concerns for you and I'll have more in the report that I send to Sharley after this meeting. I apologize for not getting it to you sooner.

The first is that federal Medicare rules cap out-of-pocket costs for a Medicaid beneficiary at 5% of household income.

So, when we talk about copays, there is a rule that caps copays or any other out-of-pocket cost at 5% and DMS has to track that and on a quarterly basis determine has this person met that 5% cap, and if they have, they no longer have to pay

copays.

Well, under this program, that same rule should apply, and there are two ways in which we don't think that KI-HIPP is complying with that rule at this time.

The first is that it requires an up-front premium payment. So, rather than DMS paying the premium outright, the individual is paying, or the employee, I should say, part of the premium payment and, then, submitting pay stubs or other proof of payment to DMS for reimbursement.

So, you can see how that would be an out-of-pocket cost that for many people who are low income would be hard to float for the sixty days it might take to fully get that reimbursement.

The other way that we think this doesn't comply with federal rules with that 5% cap is that if an individual decides to go to see a provider that's under their employer health insurance network but that provider does not take Medicaid, then, none of the out-of-pocket costs are going to be covered.

So, they could end up paying thousands of dollars potentially in deductible, copays, coinsurance if they're seeing somebody in the

ESI network, the employer network that does not take Medicaid.

So, there were some other concerns raised about if they only take Medicaid, for instance, but we have a concern about the providers who only take the ESI and that's something that we hope can be addressed.

And, then, the materials that members are getting and that we expect they'll get in this August 2nd mailing really put a lot of-- highlight the fact that you could have an extended network. You could have this Medicaid network plus your employer network which would give you more choices; but, again, if Medicaid is only paying when you see a Medicaid provider, your network isn't really being extended.

And we don't want people to assume that they can go see any of the providers in their employer network if they're going to have to pay out-of-pocket costs; that anyone who is eligible for Medicaid because they're low income, you're not going to be able to afford those out-of-pocket costs.

So, we want to make very clear to Medicaid members what their options are and what the responsibility would be on their part so that

they make informed decisions for their own household finances and for their health.

And we also have a concern, as I mentioned the August 2nd mailing, there's a mass mailing that is going to be going out soon. We think that it would be prudent to delay that mailing until some of these concerns have been addressed and make sure that the materials present what the network options are and what the payment responsibilities are very clearly to the Medicaid members so that they can make a decision that will work for them.

One area of confusion that we were very happy got cleared up, we just recently got responses to some questions that we had submitted in June to Medicaid, and we got the responses back a couple of days ago and Medicaid made very clear that this is a voluntary program, as the Commissioner and Teresa Shields mentioned earlier, and people will not be disenrolled from Medicaid if they're not complying with KI-HIPP.

So, that was one concern that we had and that's been cleared up, and, so, we're happy that people will have this option without a penalty.

But we do think that these

federal Medicaid rules are important. They should still apply to this program and we want to make sure that we're protecting Medicaid beneficiaries from incurring any sort of significant debt from out-of-pocket costs that could easily add up to hundreds of dollars or thousands of dollars and really put a financial strain on their families.

So, in addition to KI-HIPP, we also continue to raise concerns about mandatory copays. It sounds like the Behavioral Health TAC has been having those conversations as well.

We have been collecting stories from Medicaid beneficiaries who have been affected by these copays. We've collected close to 200 at this point and have reported them to Medicaid and DMS staff have worked with us on a couple of areas, so, informing pharmacies about the rules around who can and cannot be turned away if they're unable to pay a copay.

We think more can be done there but a letter did go out a few months ago, and we've also been working on screen changes. So, DMS has been making some modest changes to the screens to make it a little more clear for providers.

When you go into KYHealth.net,

you want to see what copay is owed, and what has been really difficult for people to understand is that above or below poverty indicator.

So, we're hoping that we can continue to make improvements in the system so that it's easier to identify who is above the Federal Poverty Level, who is below and who should be provided services when they present regardless of whether they can pay their copay.

We also continue to recommend and ask that DMS make copays optional again, but at the very least, if not that, that we use that medically frail status that was created originally for the Kentucky HEALTH waiver, but certainly the algorithm has been built.

There's a medically frail tool that can be used to identify people who are medically frail and would help to create sort of an exemption for the copays. And this, of course, is optional.

This isn't something that would be required of Medicaid by CMS, for instance, but we think it's a good opportunity to find those people who are the most vulnerable, people with chronic health conditions who probably have to go to see a provider more often, have to fill more prescriptions

and, therefore, incur more costs.

And, then, we also discussed the status of the new SUD expansion which we're excited about and the reversal of the Medicaid Free Care Rule which will expand services to kids in schools, and those are things that we're excited to learn more about and we hope that there will be more opportunities for stakeholders to provide input into the implementation of those programs.

Our next meeting will be on August 20th from 1:30 to 3:30. We meet at the Cabinet for Health and Family Services. I don't know if a meeting room has been set yet but Sharley sends that information out, and I think that's it for my report.

If you all have any questions, I'd be happy to answer them.

DR. PARTIN: Thank you.

MR. CARLE: Teresa, I have a question. This gets back to Dr. Gupta's line of questions before. You had just brought up the issue if somebody comes from an ESI and they have this but the provider isn't a Medicaid provider, that kind of falls into no man's land. And, then, obviously the patient would be responsible for that because they're

not a participating provider with Medicaid.

Does Medicaid reach out and try to get that individual enrolled or is there any kind of dialogue because sometimes you might have the usual suspects?

So, if you have a lot of people working at UPS, their friends, they say, okay, we've got this program. I go to Dr. Smith and they make that referral but Dr. Smith isn't a participating provider. What happens there to help them out with that?

MS. SHIELDS: We do have communication with the members and we let them know and it is in the handbook for the KI-HIPP Program once they become enrolled.

Should they choose to go to their employer-sponsored network provider who is not a Medicaid provider, they contact us. There's a phone number they can contact and, then, we reach out to the provider to see if they would like to become enrolled.

And, then, there is a process for a single payment, I want to call it a special circumstance.

COMMISSIONER STECKEL: A

single-case agreement with that provider for that beneficiary. And it's important to know, and this is unusual, Kentucky has only 8% of its providers that are not Medicaid beneficiaries. So, there is a high number of providers that are already Medicaid beneficiaries; but, then, as Teresa has pointed out, we do reach out and try to get everybody on the program.

MR. CARLE: Great. Thank you. Thanks for bringing that up.

DR. PARTIN: Thank you. Dental. Nursing Home Care.

MS. HUGHES: They did not meet. So, they don't have a report and they asked me to let you know.

DR. PARTIN: Home Health Care.

MS. STEWART: The Home Health TAC met on June 18th. There was a quorum. At that meeting, there was no recommendations, but since then, there has been some proposed language regarding private-duty nursing that we will have some recommendations to the MAC regarding that. We have very high concerns about that proposal.

DR. PARTIN: Thank you. Hospital Care.

MS. HUGHES: They did not meet either.

DR. PARTIN: Intellectual and Developmental Disabilities.

MR. CHRISTMAN: Good morning. Our TAC met on July 10th. We did have a quorum. Although there were no recommendations, we did have a lively discussion. It's typical there's also many other participants in the meeting. I will have to say that I think our TAC meetings have consistently been helpful for the last several months.

One of the various items that were discussed, a lot of things regarding protocol regarding work services, misunderstandings, purchase of medical equipment. A lot of these things have been resolved or will be resolved.

However, the big issue is, of course, the waiver redesign. All of the 1915(c) waivers are now going through a redesign process. Navigant, as you may recall, has been hired to help the Department with that process.

It's been going on for some time. It's going to be a while before the report is complete and whatever recommendations, whatever they might be, be adopted. I don't think anyone can say

this has been a rushed process. It's been pretty methodical.

And one of the big issues, as you can imagine, is the rate study, the rates. That's going to be one of the--well, that is one of the subjects of the Navigant study. They've done some pretty extensive cost-gathering. They're looking at personnel costs from rural areas relative to urban areas.

However, we're working in I guess - I don't know if you would call it the constraint or the principle that this will be cost neutral. So, if there's going to be any rate changes, that implies there's going to be winners and losers. Some rates will go up. Some rates will go down. And as you can imagine, the provider community is very anxious about this process.

I think one of the things that's maybe lending some unnecessary anx to this is the lack of communication. I know there is a rate study task force. We have been told that the minutes of the task force should be on the Alternative Care website. We can't find them. I would just hope that we could get those posted as soon as possible so the more communication that's out there, I think there

will be less issues in the long run. So, thank you very much.

DR. PARTIN: Thank you. The Nursing TAC did not meet. Optometry.

DR. COMPTON: The Optometric TAC did not meet. We meet again August 15th.

DR. PARTIN: Pharmacy.

DR. SUZI FRANCIS: Good morning. I'm Suzi Francis, the Chair of the Pharmacy TAC and a pharmacist at St. Elizabeth Healthcare in Northern Kentucky.

We did meet just on Tuesday, July 23rd, the Pharmacy TAC did. We had a quorum and we had a productive discussion, as we always do. I love our relationship, our working relationship with DMS.

Full minutes will be forthcoming but I did summarize and put out a report to Sharley with some highlights of our meeting.

The first one is that pharmacists are really working hard throughout the state to help Kentucky increase immunization rates. And one of the resources that we've put together to help with this is updated immunization charts to show what each MCO will cover through pharmacy benefits,

so, which immunizations can be covered. That way, pharmacists can help educate citizens across the state.

That will be going on soon. We had a version but, as you know, immunizations update and, so, we are in the process of updating that.

And, then, secondly, in response to a lot of this talk that we've heard about pharmacy copays, the past two Pharmacy TAC meetings, we've been working on some items to educate our pharmacists about these copays across the Commonwealth.

The first one is on May 24th, Kentucky Pharmacists Association did issue an email blast with a communication put out by the State that did show what copays would be for generic and brand-name drugs, the $1 and $4 copays and what drugs would fall into which classes.

And, then, they also included some information about what Federal Poverty Limit meant and when you do and do not have to collect the copays.

We decided in this past meeting it would also be helpful to show pharmacists how they can see that Federal Poverty Limit information and

message come across in the pharmacy operating systems. So, we're going to provide some education because every pharmacy dispensing system is different, so, we're going to provide some education as to where they could find that in their adjudication edits.

So, I also asked Kentucky Pharmacists Association to re-issue the email blast, too, just so that we could have a reminder about that information. If there are any questions, you can certainly contact me and I can provide more information.

Third, we also had a good discussion about an update on the work being done in response to Senate Bill 5 data transparency. Commissioner Steckel said that it would be beneficial to enlist pharmacists to help further research the cost to purchase medications by various pharmacies and the cost to dispense these medications by pharmacies, everything that goes into that - clinical services, ingredients, things like that - also including any rebates the pharmacies may get.

So, we were looking at putting together a group of retail chain pharmacies, independent pharmacies, specialty pharmacies and

seeing what might go into that in the future.

And, then, each MCO provided an update of pharmacy-related items, both operational and clinical, that they have going on throughout Kentucky.

And Jessin Joseph, a pharmacist with DMS, I have been working with him to get an update on the up and coming CMS Kentucky Quality Plan that's due to be released for comments. And sorry if I'm saying that wrong but I believe it's coming up in the next couple of weeks that that should be released because I would like to have the Pharmacy TAC work towards helping to optimize some of those quality outcomes that CMS is looking at in our state.

We also looked at the Quality Scorecard for Medicaid and looked at Kentucky measures and I'm going to work with Jessin on how we could potentially help with pharmacists.

So, if there are any questions, let me know but I think that summarizes it.

DR. SPIVEY: Can I just say something real quick just to clarify all this copay stuff?

DR. FRANCIS: Yes.

DR. SPIVEY: I know doctors and

hospitals bill and they lag behind. Like, they bill for services and, then, they get paid so many months later; but pharmacies, when they bill and they use their operating system, it's an automatic answer.

DR. FRANCIS: Realtime.

DR. SPIVEY: Right. Yes, it's realtime. You get a copay back. That's what you do. A community pharmacist fills three hundred, four hundred prescriptions a day and maybe 40% of those are Medicaid prescriptions.

So, they're going by exactly what they're being told that's coming back, and I appreciate that the TAC is looking into educating the pharmacists on this.

DR. FRANCIS: Yes. And those take extra work on pharmacists, especially with the quarter changeover. That's been a lot of education we've had. We've had many examples of pharmacists where patients have been mad at the pharmacy because last week, it was no charge. This week, they go to pick up their drugs and it's a $12 charge because the new quarter reset.

So, this is just a little bit different in the way pharmacists--you know, they're not used to--it's usually your copay is your copay

and it's not looking, well, do I really need to charge this copay? Do I not need to charge this copay? So, I think that it's just an ongoing education process.

DR. SPIVEY: It is. So, I just wanted everybody to understand that they're just not ignoring these people that are coming in and that they're not purposefully not doing that. It's just a whole different way of looking at it and it's just also volume that they're looking at, too. All right. Thanks.

DR. PARTIN: Thank you. Physician TAC.

DR. GUPTA: We did not meet.

DR. PARTIN: Podiatry. Primary Care.

MS. CHRIS KEYSER: Good morning. My name is Chris Keyser. I'm the Executive Director with Fairview Community Health Center in Bowling Green. I'm also the Chair for the Primary Care Technical Advisory Committee.

The Primary Care Technical Advisory Committee, we met on July 11th of this year. We had a quorum.

Many of our agenda items asked

for a response from DMS. However, due to scheduling conflicts, no one from DMS was able to attend. We did receive a letter from the Commissioner addressing our agenda items and asking if there were additional information that we could provide. So, this was reads into our minutes.

We then moved on to our other agenda items to develop recommendations for this committee.

The following recommendations were approved by the committee for submission today. In addition to our formal recommendations, I would like to request the three corresponding attachments that you all should have, I believe, to be introduced into the record as well.

The first one is a letter to Commissioner Steckel. The second was the full telehealth service coverage regulation, and, then, recommendations for preventive health care for adolescents.

So, in regard to our recommendations as it pertains to the telehealth regulation, 907 KAR 3:170, which went into effect on July 1st of this year, the Primary Care TAC submits the accompanying recommendations.

Again, you will see the formal letter from the Commissioner requesting consideration of the recommendations, as well as the same recommendations added to the corresponding portions of the regulation itself. They're in red, so, they should be readily easy for you all to identify.

These recommendations were created via a partnership between the KMA and the Kentucky Primary Care Association and the Kentucky Academy of Family Physicians.

The second recommendation that the Primary Care TAC would like to submit today is a recommendation on behalf of our committee and the KPCA who represents primary care providers across the State of Kentucky to emphasize the importance of the preventive pediatric health care visit to families and adolescents by making it a requirement for high school entry.

This would assist us in reaching our goal of healthy adolescents who can achieve success in both school and life.

Do we have any questions regarding those?

DR. PARTIN: No?

MS. KEYSER: Thank you very

much. I look forward to subsequent meetings.

DR. PARTIN: Therapy Services. We did have the report from Beth Ennis from the Therapy Services but there were no recommendations other than that request that i read.

Next on the agenda are presentations from the MCOs. We've got three. We will need to limit those to about fifteen minutes, if we can keep that on schedule, and that will allow us some time, maybe a few minutes to ask any questions.

And, then, if there's time left over, we did receive a response from WellCare to some questions that we asked at the last meeting. And if there's time, we can ask any questions we have on that updated material that we received from WellCare.

So, let's go ahead and we'll go alphabetically. So, Aetna will be up first.

COMMISSIONER STECKEL: If I could just interrupt. Remember that we're in the middle of an RFP. So, the only thing that can be discussed in this room at this time is current operations, not anything about what you may do under a new contract if you're awarded a new contract.

So, in order to comply with the procurement laws, we have to be crystal clear about

that.

MR. CARLE: Commissioner, you're no fun.

COMMISSIONER STECKEL: There's a women's prison in Alabama called the Julia S. Tutwiler Prison for Women and it's been my mantra - I am not spending a single day in the Julia S. Tutwiler Prison for Women.

So, whatever the equivalent is for Kentucky, and I would think that you all would, whether it's the women or men's prison, would also want to comply.

MR. CARLE: Well, you're the one in the stripes today.

COMMISSIONER STECKEL: True.

MS. PAIGE MANKOVICH: Thank you all. We will be mindful of the time, so, we'll get through this as quickly as possible.

MS. PAIGE MANKOVICH: My name is Paige Mankovich. I'm the Director of Strategic Planning at Aetna Better Health of Kentucky.

MS. DONNA HALL: Hi. I'm Donna Hall. I'm the Director of Quality Management with Aetna.

MS. CHRISTINA BOWLING: Hi.

I'm Christina Bowling and I'm the Director of Provider Network at Aetna.

MS. KELLY GANNON: Hello. My name is Kelly Gannon. I'm the Director of Clinical Services.

MS. MANKOVICH: So, we will just dive right in here. I believe you all have this in front of you.

Our first slide is a snapshot of Aetna's presence in Kentucky. You will note that we had in 2018 236,000 Medicaid lives. So, our Medicaid line of business is our largest presence in Kentucky.

We are contracted with 31,189 individual providers and that includes our hospital groups as well, and 581 of those providers are a part of a value-based agreement. That number is continuing to grow as we engage in additional agreements like that with our provider network.

MS. HALL: So, I just want to touch quickly on our quality outcomes and do some highlights there. We have had a really strong performance in our most health plan rankings.

For the 2018 and '19 period, we received a commendable accreditation. Part of that

highlight centers around our consumer satisfaction where we received high scores for that as well.

Additionally, on our most recent performance for our HEDIS 2019 project, we showed a 74% improvement on our rates or 74% of our rates improved. Additionally, we had 30% of our rates that improved by four or more percentage points.

MR. CARLE: So, that 74 is just across the board on all the HEDIS measures.

MS. HALL: That are included within that project. So, there are about 129 measures that were included in that project.

So, some of the trends that we wanted to talk about in our improvement bucket, we have positive, consistent gains that we are seeing and several of those are centered around our preventive measures and includes immunizations, well child and weight-related measures.

For the performance measures where we continue to meet the high marks related to the NCQA benchmarks that are published, we have year over year continuous performance. Some of the highlights with that are around access and availability, our dental and, then, some of our

chronic conditions such as respiratory and cardiovascular.

Areas of opportunity are consistent themes and they're related around behavioral health and some of the wellness activities.

MR. CARLE: So, when you say women's health screening, are you specifically talking about mammography?

MS. HALL: Yes, breast cancer screening, yes.

Additionally, what we wanted to highlight was that we acknowledge our strong performance that we've realized over our quality outcomes is a direct impact of not just the member interventions that we have but also related to our provider engagement.

So, we feel that it's very important to reinvest back into our provider community and we have a strong VBS solution that creates some sustainable investment within the health of our members.

So, I just wanted to highlight the VBS impact on our health outcomes. The three tables that you see there, the first one are the

results if we were only to measure the VBS groups that are included. The second table is our Aetna scores without the VBS impact. And, then, in the third table, you can see the overall impact which includes both Aetna and the VBS partners, and you can see that our scores are generally higher when we include the VBS impact.

We are consistently working to align the strategies with our providers through those innovative partnerships. So, we're always creating different VBS programs that meet the individualized needs of the providers.

Currently, we have 38% of our Aetna enrollees that are served by a VBS partner and 43% of our PCPs are in a physician incentive plan.

MR. CARLE: For the group, could you tell us what these acronyms mean, AWC, BCS? I'm assuming it's an adolescent wellness visit, a colonoscopy, but I don't want to assume that.

MS. HALL: No. No problem. So, AWC is adolescent well care. BCS is breast cancer screening. CCS is cervical cancer. CDC are your comprehensive diabetic measures. Chlamydia total. Your CIS are your childhood immunizations. Your W15 is your well child for the first fifteen

months, those visits included in that. And, then, your CDC again is a comprehensive diabetic testing.

MR. CARLE: So, is that the A1c?

MS. HALL: Yes. The A1c is that one.

MR. CARLE: And the CDC eye exam is just specifically a retinopathy?

MS. HALL: Correct. So, in addition to the provider strategies, we also aim to do some innovative solutions. So, I just wanted to touch on some of our innovations that we have.

This is just one of many, but one of the new ones that we have is related to the diabetic retinal eye screening. We call it the Eye Spy Program which is to screen, prevent and improve those measures. I think a lot of the MCOs target that measure specifically due to the diabetic prevalence within our community.

This particular program promotes the diabetic retinal screening in partnership with the Walmart kiosks around the state. And, so, the member is able to do an attestation at the kiosk and also get their gift card reimbursed locally at that kiosk.

We did have a launch week in mid-June. So, on average, we do about thirty-five screenings per week; and in that first launch, we went up to sixty-one screenings.

Next, we also have a partnership with the University of Pennsylvania. They implemented a study called the Kentucky QuIPS which is a Quit Incentive for Pregnant Smokers. They reached out to DMS last year and asked if the MCOs could help participate in this study to launch their research to see if the financial incentives really did improve the quit rate with pregnant smokers.

So, we did launch that study in Quarter 2. We have a partnership with Big Sandy Health Care that is helping us do this study and we are in Phase 1 of that right now.

MS. BOWLING: So, another innovative partnership that we have is a unique agreement with CPESN which consists of six independent pharmacies. This program is doing extremely well and we plan to expand on that.

Some of the benefits of this program is medication reconciliation and support and education to members with high-risk regimens.

So, I'm going to turn it over

to Kelly now and she is going to present some additional details.

MS. GANNON: So, our CPESN results as of June 15th, I wanted to highlight specifically our case conferences that we've had and some of the care plan activities that we have been able to complete, specifically medication review where we're synchronizing activities around pharmacies and prescriptions, also about education through smoking cessation and nutrition and exercise, and referral to Aetna behavioral health case management which is a big piece as well.

We also have made some care plan activities around the social determinants of health, so, it's secondary gains that we get from this program.

Another innovation that I would like to talk about is the Strong Start Re-Entry Program. We know that jails are the largest provider of behavioral health services in our nation and it's smart for us to be partnering with them in this endeavor.

So, we partner with the 90-day Jail Substance Abuse Program that is at the Kenton County Detention Center. We have introduced our

program to 500 unique inmates and we've had forty accept us as their care coach to help them in the transition when they re-enter society.

Only two members have returned to jail as a result of these interventions. So, thirty-eight have remained out of jail over six months.

We have a comprehensive three-year goal or plan for opioids and we have three strategies that I'd like to highlight very quickly.

So, we're going to target members with chronic pain to participate in a multi-modal approach and really introduce evidence-based practices rather than just prescribing of opioids.

We're going to reduce the inappropriate opioid prescribing for members because we're going to look at multiple prescriptions, combinations of benzos and opioids and target those to reduce the impact by 50%.

Lastly, we're going to increase percent of members with opioid use disorder and get more treated with medication-assisted programs, so, lots of targets there.

Continuing with our opioid strategy, we're really about trying to prevent,

intervene and support and I'm going to highlight a couple of things in there.

So, in our prevent strategy, we're really looking at enacting quantity limits and day supply limits on the initial prescriptions of opioids. We've already instituted that.

We also are incentivizing our PCP providers on Screening, Brief Intervention and Referral to Treatment (SBIRT) so we can get more referrals, more screenings of substance abuse and more referrals out to our mental health or behavioral health substance abuse treatments.

DR. PARTIN: I have a quick question. I think that using non-opioid modalities for treatment is an excellent way to go, but I'm wondering in some of the rural areas like where I am some of these things are not available.

So, what do you propose to do for people in rural areas where they may not be able to get quick access to psychotherapy or there's nobody doing acupuncture and that kind of thing?

MS. MANKOVICH: I think access just in general in the rural areas is a very important thing that we're focused on. It does take some creative thinking, some outside-the-box

thinking, but we have provider relations representatives in the field in all eight regions of the state. So, a lot of times, it's engaging with them. They know the area. They know various provider types that might be available that may not be on our radar.

So, you're right. I think it is a challenge, but it is our goal and we are trying to think outside the box and really engage a lot of different community partners and other provider types that may be there just to make sure we do focus on that access.

MS. GANNON: So, that's on the provider side.

On the care management or case management side, we work with the individual to find transportation maybe to an adjacent county, whatever it might take to help them get those other services.

DR. PARTIN: Okay. Thank you.

MS. GANNON: In our second part, our interventions for opioid initiatives is that we have now made Narcan a covered prescription without a prior authorization.

We also spend a lot of time and a lot of effort on Neonatal Abstinence Syndrome

program supports and we have a dedicated case manager who identifies all those who are at risk of withdrawal and we provide ongoing case management.

In our supportive efforts, I'd like to highlight that. Jonathan Copley, our CEO, has just been named the Chair of the Opioid Response Program for Business under the Kentucky Chamber of Workforce Center. And as a part of that, he is supporting efforts and initiatives that will continue to work on the opioid epidemic.

Finally, we have sustained year-over-year reduction in opioid medication claims. We really believe that this is because of the innovative programs that we've put into place.

So, for example, in Region 4 is where our CPESN is located and you can see that at this rate, we really believe that we're going to come in 4,000 less than we did last year, but you can see that we've been steadily reducing those claims over a long projected period of time.

I also would like to say that in our Region 7 and Region 8 is where there's a lot of Neonatal Abstinence Syndrome and you can also see that there's large decreases in those areas as well. So, we'll continue with our efforts in those

innovation areas.

MS. STEWART: I have a question about this graph. Do you have a graph that correlates your membership in the same time frame to see if it's a decline in membership or is it a decline in prescriptions?

MS. GANNON: That's a good question. No, we don't have that chart here but that's something we can provide.

MS. BOWLING: So, to continue on, some other innovative partnerships that we have is with the Children's Alliance which focuses on a unique population of children and adolescents with behavioral health needs.

We also have a partnership with KVC which provides a four-phase treatment design with a wraparound model to avoid youths from entering into a higher level of care and to successfully stabilizing and reunifying them back into their natural home environment as quickly as possible.

And, then, we also have a partnership with the Kentucky Hospital Association to do our delegated provider credentialing with a focus on reducing administrative burden for our provider partners.

MS. MANKOVICH: We do have just about one minute left. So, we will speed through the rest of this.

The next page, you will see some of our member centric innovations. Those are obviously very important to us. One thing I will highlight is the Duffle Bag Program.

It's a way for us to provide duffle bags for our members who are in foster care. They're often in transition. It's a small way for us to try to help them preserve some dignity while they're in transition.

The next slide shows our Emergency Department utilization. You'll see that year over year, our member visits and our spend are down. We believe that that's due to engaging providers in VBS arrangements, as well as focusing on providing care management services to more of our high utilizers.

Our PMPM trends are up. We do have some bullet points there on the page that would explain why a lot of that is - additional coverage of Hepatitis C medication, Buprenorphine, Vivitrol, and our BH utilization has increased.

MR. CARLE: Let's go back to

Page 23, ED utilization. What do you attribute your success in bringing down the total use of that?

MS. MANKOVICH: Well, I think it's bringing down total visits as well. We're seeing a lot less there. We are seeing----

MR. CARLE: So, how are you doing that?

MS. MANKOVICH: Through the VBS agreements. So, we do have in all of our VBS agreements incentives to engage more with the PCPs rather than going to the ED first.

The same thing on the care management side. So, we have reports. We know who is visiting the ER frequently. We have care managers reach out to them, offer to assist, get them in with their PCP. If they would like to change their PCP, we can help with that, just really encourage that level of care prior to going to an ER.

MR. CARLE: It's obviously been very successful.

MS. MANKOVICH: Yes. I believe we are at time. We have one last slide, if you'd like for us to proceed.

MS. BOWLING: The last slide is just around the network adequacy. And what I would

say to that is obviously our network is adequate at this time, but we're always looking for opportunities to try to contract with various providers in various ways through our VBS agreements, through special arrangements and things like that just to make sure that we're able to cover all of our members' needs.

MS. MANKOVICH: Are there any other questions for us at this time? We will provide that graph comparing the membership totals and the opioid usage. We're happy to supply that.

COMMISSIONER STECKEL: If you would provide that to Sharley, please, she will take care of it.

MS. MANKOVICH: Yes, ma'am.

MR. CARLE: The other thing we'd like to see, just to be consistent with these specific measures, adult wellness visits, breast cancer screenings, colorectal cancer screenings, medication adherence to diabetes meds, oral, cholesterol meds, obviously statins, cardiovascular disease, medication adherence and, then, hypertension.

And, then, we'd also like to see something on your claims processing as far as paid and denied claims over the last three years.

We're just trying to be consistent----

MS. MANKOVICH: Absolutely.

MR. CARLE: ----with the questions that we asked the other MCOs.

MS. MANKOVICH: Yes. So, we will provide all the supplemental information to Sharley. Thank you.

DR. PARTIN: Okay. Next up is Anthem.

MR. LAWRENCE FORD: Thank you, Dr. Partin. My name is Lawrence Ford. I'm the Director of Government Relations for Anthem Blue Cross and Blue Shield. I represent the Medicare, commercial, all things Anthem. Sometimes that's good, sometimes it's bad but I've been there about thirty years.

I have Leon Lamoreaux who is the president of our Medicaid Division for Kentucky and he is going to make the presentation and I am here for support if there should be some questions.

MR. LEON LAMOREAUX: Dr. Partin and members of the committee, I appreciate the opportunity of being here with you today.

Let me first introduce myself. I'm Leon Lamoreaux. I have been in the health care

industry for thirty-eight years, been in health insurance for twenty-seven of those years, worked specifically in the lines of Medicare and Medicaid for the last thirteen, worked with Anthem in this particular role for the last six and in this state for the last eight months.

My batteries get charged when I'm in the presence of those who give their lives in the service of others. And, so, I wanted to just take a moment to thank each one of you for the service that you provide likely to both our Anthem commercial members as well as our Anthem Medicaid members.

To give you a little bit of background, Anthem Blue Cross and Blue Shield, looking on Page 1, many of you are probably familiar, we've been in this state for eighty-one years. We have locally with our commercial, Medicaid and Medicare 1,335 associates scattered throughout the state with a concentration just outside of Louisville. We ensure actually 1.85 million members, 132,000 of which are Medicaid.

In the right-hand side of Page 2, I wanted to just point out we're a fairly new entrant into Medicaid, having entered during the time

when the Affordable Care Act was going into effect through the expansion of membership, and that brings some interesting things to our particular member mix.

Normally, within a typical Medicaid health plan, about 70% are the TANF population, Temporary Aid for Needy Families. In our case, because we came during the time of growth, almost 50% of our population are childless adults through the Affordable Care Act population and about 32% are the TANF population.

We are NCQA-accredited. We've done many things to help with bringing some new quality initiatives to our health plan.

One of my main areas over the course of my career, half of the time was spent within integrated delivery networks and the other half was spent within Blue Cross Blue Shield plans, but my very first encounter was with Intermountain Health Care who focused primarily on quality. So, that's one of the backgrounds that I come with.

As you can see, beginning on Page 3, we've had some significant improvements, from twenty-seven to twenty-eight in the measurement year, 115 of our 148 including sub-measures. HEDIS measures have had remarkable improvement.

I've given you an example of just some of like in the classification of medication adherence. Some of these are pretty remarkable.

Also for CAHPs, as reported by the members themselves, we've had eight of nine scores with remarkable improvement for the child, and five of nine scores are at or above the 75th percentile for adult.

The reason behind that is, one, a focus. Two, we've made significant investments in our staff to support it. Three, we've made process improvements that allow us access to many electronic medical records for data retrieval and the value-added benefits, that you probably heard of the PQIP or the BHQIP if you're a behavior health provider. About 46% of our membership is tied to a provider that is on one of our value-based incentive programs.

When we look at some of the notable statistics, just moving forward to Page Number 4, we were asked to prepare some interesting information about how are we doing with claims, claims processing. For all of 2018, 99.4% of the claims were processed within thirty days, exceeding the requirement of 90%, and we did that on an average of 6.1 days.

Twenty nineteen trends continue at 99.2% of claims paid within thirty days, now at an average of 4.17 days of claims processing.

Member calls and provider calls, right now, we're running at 6.8 seconds average speed of answer; 3.8 average speed of answer for the provider community.

There was a question a little bit ago about what is the cost? Right now, for 2019, looking at our June numbers, year to date through June, we're spending $458.60 per member per month to cover the costs associated with Medicaid.

We're running right now at a 96.6% medical cost ratio which means of every dollar we receive from DMS, 96.6% of that is going to pay the medical claims.

MR. CARLE: How does that compare to previous years?

MR. LAMOREAUX: It's running a higher medical cost ratio in previous years. Last year, I think we were 91.2.

MR. CARLE: Before you leave Page 3 and 4, just like we asked our friends from Aetna, we'd like to see some specific measures if you could.

MR. LAMOREAUX: Certainly.

MR. CARLE: So, adult annual wellness visits, breast cancer screens, colorectal screens, and you've got some of this in here but we'd like to see it for the last three years, '16, '17 and '18.

COMMISSIONER STECKEL: Chris, if I could just interrupt you. If you don't mind, Sharley can work with you and get that list and we'll make sure to send it to everybody at the same time so that they've got a complete list.

MR. CARLE: That's great.

MR. LAMOREAUX: Thank you. We've got it. And, fortunately, you will see some pretty remarkable improvements and we look forward to showing that off.

There's so many measures and it gets so confusing, but to be able to drill that down, we'll be glad to be able to show that to you.

MR. CARLE: Thank you.

MR. LAMOREAUX: So, when we look at emergency room utilization, this year over last, we're running at 4.2% less than we were. Just to give you an idea, though, of relativities, we're running at 743 visits per 1,000 population. And to

compare that to a commercial population, commercial runs at about 182 per 1,000. So, we still have a long ways to go to be able to help teach and train this particular population to appropriately use the emergency room or to use other forms of care as they have access to it.

Looking at the network adequacy, our networks are derived from our commercial networks, and being the largest commercial insurance carrier, obviously caring for roughly 68% of the state's commercial population, and the fact that our networks are derived from that, we have in all cases saved, this one that points out in the middle of the page, allergists, we meet 100% of the network adequacy requirements but we're constantly trying to work to continue to build that network adequacy.

When we look at some of the innovations for the future, or not the future, but as we're incorporating things, I started with the concept back in 2016 in Wisconsin with what I called back then whole-person health.

And what this is is basically recognizing that our membership is a patient this much of this much of their lives, and we needed to be

able to build an infrastructure or within an ecosystem that we've now come to term the social determinants of health.

So, when we're looking at our members, our planning begins with the member in the center of our focus, with the providers in the peripheral of our vision, and our care management processes are designed to identify risk, target engagement, navigate and advocate through this very complex health care system, and identify both not only the physical or behavioral health care plan but also a social determinants plan.

We recognize that access to food, jobs, child care, transportation and housing have a huge impact on a member's ability to be self-reliant. And, so, our whole processes have been built to incorporate some of these additional things.

We're seeing remarkable improvement. Just as a for instance, speaking of emergency room, in my life up in Wisconsin, we had a gentleman on the first ninety days of being with the health plan, he was in the emergency room 105 times, most of those as ambulance-assisted.

And we were able to secure housing for that individual. In the ninety days post

his experience, there were seven hospital visits, three relapses back into some challenges with substance use disorder, but a remarkable difference both in terms of consumption of resource, quality of life and the expenditures.

When we look at complex care management, it's my long-held belief, and as you can probably see from utilization statistics, 1% of the Medicaid membership in Anthem spends 28% of the dollars. Eleven percent of the membership spend 68% of the dollars.

So, we have organized our care management processes to be available to all but to focus on those of greatest need.

Two examples - I won't go into all of the details - but we call this our Focus 100 where our top highest risk 100 members, we're encircling them with 24 by 7 by 365 care management services to help them through the day-to-day needs that they have.

We're trying to do that through an integrated care team that incorporates a nurse, a social worker or a behavioral health specialist, a pharmacist when available to recognize that we need to treat systems of people, not just little component

parts of those individuals.

We tie in together the care coordination of the past with the social services and supports, as evidenced by the whole-person health, and, then, the tie to the community resources. We recognize that as a health plan, we cannot address all needs, but we work with our community partners, many of you included, to be able to address the total needs of our membership

Another example is our Hope Program. It's an acronym for High Outreach to Promote Engagement. These are the frequent flyers, the ones that are difficult to engage. We mobilize people into the field to go out and do the work necessary to help our members.

We have a couple of other examples of work that we've done. I want to bring to light the Member Empowerment Program. This is something we implemented at the first of 2019.

We built this program designed to accommodate the Kentucky HEALTH implementation which assists members in seeking employment, education, looking at some of the barriers to re-employment and self-sufficiency.

And we determined that that was

consistent with our way of doing things and the whole-person health. So, we implemented that along with some extra benefits to help people achieve and empower themselves to do the right thing. It's person-centered. It has access to innovative value-added benefits that address specific needs.

One example, the most popular example is an expungement benefit. We're helping members who are having a hard time getting a job to expunge their records and to be able to then re-enter the workforce; tangible opportunities for member economic mobility and improved health outcomes; connections to existing community-based economic and social support systems; and just in general a whole social service circle to be able to help members re-engage back with the community.

If you will recall, the very first part of my comments were about our member mix being a little bit different than a typical Medicaid health plan. Fifty percent of our members are adults.

We have a very high instance of substance use disorder. In fact, 24% of Anthem's current Medicaid membership has within the last two years a substance use disorder. So, we have

organized a lot of extra support and programs specific to our membership.

I'll give you just a couple of examples - 180 Health Partners. This is a relationship that we have. It puts people in the field working with pregnant women so as to avoid some of the complications of the Neonatal Alcohol Syndrome and so forth.

We've also been doing work with the University of Kentucky's Continuing Education Program where we're identifying and helping to train providers in rural communities to do MAT therapies. We need to be able to get more access into many of the rural providers.

The last one that I will bring to your attention is what we call the Harm Reduction Program. We're working with the Louisville Metro Department of Health, with Norton's Hospital System and the University of Louisville to help educate and train not only providers but members about safe practices of their needle exchange and so on and so forth.

This has a direct correlation and we've been able to document improvements in reductions in endocarditits, reductions in staph

infections and many of the other kind of complications that come with improper needle use and tied to our specific population.

So, as we look at not only today but continuing to serve this population, we have got systems, we've got people, we've got processes, but I think most importantly, we have a dedication to the Commonwealth of Kentucky for the last eighty-one years, and a belief that we are a part of this community and working together with our provider partners and our other community partners that provide many support services to our members, we'll be able to help achieve truly the idea of improved quality, of enhanced experience at a reduced cost.

Are there questions or thoughts or comments?

DR. PARTIN: I have a question about Project ECHO. For the front-line clinicians and the training, does that include physicians and APRNs?

DR. LAMOREAUX: Yes, absolutely. We need to be able to provide help and support.

What we find, in fact, this was

some of the work from the University of Louisville, compassion fatigue is a very big problem. Providers over and over again are treating members who may or may not be taking the steps they know need to be done.

And, so, being able to work and help providers supporting in particular the substance use but also other populations we find of great help, regardless of the level of the practitioner, to be able to address those needs.

DR. PARTIN: So, how do the providers access this program if they want the additional training?

MR. LAMOREAUX: Let me work with our team and I can follow up with you directly to provide a resource about how to engage that.

DR. PARTIN: Thank you.

COMMISSIONER STECKEL: Again, if you will direct all information to Sharley so that it goes out to everybody officially, please.

DR. PARTIN: Any other questions?

Okay. Humana.

MR. JEB DUKE: We'll try to be respectful of your time and go relatively quickly

here.

My name is Jeb Duke. I'm the Executive Director of Kentucky Medicaid for Humana. My team here, I have Lisa Galloway, our Medical Director, and Joe Vennari, our Pharmacy Director, and Kristen Mouter, our Population Health Director.

We'll just spend a couple of minutes talking about Humana. Humana is a health and wellness company that seeks to improve the lives of our members through integrated care.

In Kentucky alone, we have over a million members who we serve through TRICARE, Medicare, commercial and 150,000 members we serve through our Medicaid contract.

We have over 12,000 associates in Kentucky with twenty-five physical locations and we conduct over 100,000 hours of community service each year.

As Kentucky's second largest employer, we contribute over $1 billion of economic impact to the state, as well as over millions of dollars of contributions through charitable contributions.

With that being said, I'm incredibly excited to announce and communicate that

as of January 1, 2020, Humana will be Kentucky's first and only Kentucky-based, fully integrated Medicaid managed care organization. Over the next several months, Humana will be hiring over 500 associates to support Kentucky Medicaid.

So, what does that mean for providers and members? What that means is member calls, provider calls, authorizations, claims, enrollment, clinical reviews, care management, outreach and marketing, legal, compliance, contracting and network will all be done in Kentucky by Humana.

We will no longer be utilizing services from CareSource or from Beacon. We will no longer be utilizing resources from CVS Express Scripts. Humana will be utilizing fair pass-thru passing with Humana pharmacy and will be utilizing Humana behavioral health for mental health services.

We will utilize our best-in-class technology and code base allowing us to advance our care integration model, as well as be more responsive to providers and stakeholders.

CareSource will remain in Kentucky independent of Humana serving their other lines of business.

So, along with advancing our operating model, we also have been creating new capabilities with our population health model. Our clinical guidance exchange will link new role types within our care support teams.

Social determinants of health coordinators will connect members into community resources. Community health workers will live within our communities and provide greater access and connection points for our providers.

Housing specialists will seek to maintain members in their current housing, and if they lack housing, they will seek placements for them.

Our behavioral health and physical health nurses will be co-located and operating within the same system, improving outcomes for our members.

We believe by addressing population health with a fully integrated approach, we are going to increase our health outcomes for our members, as well as reduce overall health care costs.

Chris is going to talk a little bit about care management.

MS. MOUTER: Our care

management team has maintained a consistent goal of improving the quality of life for our members and our community partners. How we achieve that goal is by focusing on members with chronic illnesses, impairments, comorbidities and high-risk pregnancies.

Our care management team uses assessments to determine our physical health needs, our behavioral health needs and our social determinant needs.

Through that assessment process and through our stratification processes, our members are grouped into three major categories. We have a high risk category which addresses the ones I just talked about - the chronic illnesses, impairments, high-risk pregnancies and comorbidities.

Our rising risk population, that is our members who may have a care coordination need, so, they may have a new diagnosis, may need some education, some coordination in the community with providers, things like that.

And, then, we have our self-management group. Those are our healthy individuals who we provide tools, resources and education to so they can manage the health care system to help guide their own health care needs and their own well being.

Our care management team is comprised of registered nurses, master's-prepared social workers and community health workers. Seven community health workers were hired in the past year and they are located in the community to assist with resources and to address some of those social determinants of health care needs that we currently see for transportation, may connect them with food banks, things like that.

Our current care management team is located regionally in the community and they are related to our member proximity. And, so, that means they know what our local resources are and also they can go and have face-to-face meetings with those members.

We engage our members in a variety of community settings. That may be at the hospital, community agencies, the provider agencies and at their home, and this is to establish a rapport and have a good working relationship with that member.

Next, we'll talk about quality improvement. So, as our product has grown, we've seen the greatest growth of our population in our expansion population. That population typically has

not been familiar with the health care system. So, they're not seeing their PCP and having that preventative care.

So, Humana-CareSource has developed focused strategies and interventions to help with that engagement and to help with those quality needs.

So, I'm going to talk about a couple of those key initiatives that we've done to help raise some of those quality measures.

One of the initiatives will be around outreach that we do and the other initiative is around how we partner with our provider relations team with providers.

So, the first one is a telephonic care gap campaign which was related to preventative cancer screenings. We targeted breast cancer, cervical cancer and colorectal cancer. Our quality team provided targeted outreach to our members to help engage with scheduling appointments and we had a 23% reach rate with that which is pretty good with the Medicaid population.

As you can see in the chart to the side on our breast cancer screening, we've had a 20% raise over time improvement in that rate.

The next initiative that I will talk about is around our clinical care gap initiatives and programs and that is surrounded and based upon our Clinical Practice Registry report. That Clinical Practice Registry report identifies care gaps around preventative services and screenings for our members. And our Clinical Practice Registry is delivered to our Tier 1 providers through our provider relations team through their strategic visits.

And as you can see in that report, one of the measures that we look at is our comprehensive diabetes measure, and you can see we've had some gains in that measure as well, as high as 22%.

And I just wanted to mention another project that we did and it was around the statin therapy for patients with diabetes. We also did a clinical outreach for that, telephonic outreach. And as you can see, we have had a 25% increase in that measure as well.

I will turn it back over to Jeb for the network access.

MR. DUKE: Humana continues to maintain an adequate network. We have one of the

largest network providers in the state. Due to time, I think we'll just move forward.

DR. GALLOWAY: Good afternoon. I'm going to talk a little bit about our ED utilization. Humana-CareSource, emergency room utilization reduction has been a primary focus with us. You can see the graph there. Our utilization has for the most part steadily declined since 2017.

We have had some specific measures that we feel have contributed to that. We had a campaign. We are able to run reports monthly on our ED utilization and it targets members that have had more than four or more visits in a rolling twelve months so that we kind of know who over time is kind of popping out as our outliers for ED use.

So, we had a campaign where we targeted about 900 members that fell in that category of the four or more visits and the campaign included sending a letter to our members that kind of addressed and focused on advising them and making them aware of our 24-hour nurse line that they can call to talk to if they have questions about do they need to go to the ER or just general medical questions.

There was also a brochure in

there that educated the members on appropriate use of the emergency room versus when you can see a PCP and such, and, then, there was a little magnet that we included that had the 24-hour nurse line number on it. So, they could just stick it right on their refrigerator to kind of remind them.

A second initiative we did this year was we developed an after-hours brochure and it specifically talks about when it's appropriate to go to the ER, when it's appropriate to go to the urgent care, the retail clinics, and we're using that as education for both our members and providers where we're putting those in our provider packets with the visits to help - not that they don't already know what the appropriate use - but just kind of to remind them to, in turn, educate their patients when they are in to bring that up.

And, then, part of our ambulatory care sensitive conditions' performance improvement project that we're doing this year is focusing on ED reduction for asthma, diabetic and our heart disease. So, we've started some initiatives on trying to target those members specifically that have had three or more ER visits in a four-month time frame to try to connect up with them through our case

management to make sure they're getting their medicines filled, that they're doing their care gaps and stuff so that they do not end up in the ED and eventually in the hospital because they're not managing those chronic conditions.

If you will flip to the next page, it looks at our medical and pharmacy costs. This was a comparison from 2015 to '19 and it's a bar graph that compares year to year on percent increase in our spend. As you can see, it highlights the medical, pharmacy and, then, our total cost of care.

Just to point out, the medical cost is a significantly larger bucket than our pharmacy cost. So, you can see that the total cost of care tends to align more with the medical costs than the pharmacy costs.

In 2017, you can see we had a significant increase in our medical cost and that was primarily related to an influx of a significant number, several thousand, SUD members. There was some terminations to some of the SUD providers by some of the other MCOs. So, we had a shift in membership.

I think Humana-CareSource has tried to really maintain a broad network, especially

in our MAT providers and we've tried to work with them to make it easy for our members to get access for SUD treatment, but, as you can see, that did result in a significant increase in costs for us.

Just to highlight a couple of other things on the graph, the last couple of years, we've had a higher increase in our pharmacy cost and we feel like that's been primarily due to the number of members that we're treating for Hepatitis C which is a very costly drug, as well as our SUD members with the treatment of the Buprenorphine and the Vivitrol.

MR. DUKE: I think we're getting pretty close to our fifteen-minute limit. We wanted to allow some time to answer any questions that you all might have as well in regards to any of our transitions or previous statements.

We could continue past the fifteen minutes or would you like us to spend time for questions?

DR. PARTIN: Does anybody have any questions right now? Go ahead and finish, then.

DR. GALLOWAY: Slide 10 basically goes over our population health management approach, how we identify our sub-populations, our

outliers and how we work to kind of prioritize those larger populations that need more focused management and help. I'm not going to spend a lot of time on that slide, if you have any questions.

We did want to highlight some of our women and children's health programs. We do have targeted populations for our pregnant women. That includes following them for a year after delivery or women of child-bearing age and, of course, our infants, children and adolescents under twenty-one that fall under the Early and Periodic Screening, Diagnostic and Treatment.

We have some specific programs that target these populations. We have a Babies First Program for our pregnant mothers which encourages them to get in early for their first prenatal visits, to make their prenatal visits, their postpartum and it also follows all the way through with the babies for their well baby checks and the mothers can actually earn incentives for their visits as well as their babies' visits after delivery.

We have some education for our women of child-bearing age to encourage use of the long-acting reversible contraceptives. We have a whole EPSDT team that outreaches to these members to

encourage them to engage in a system and getting in to see their physicians to kind of close these care gaps for preventative and comprehensive services.

And the last one is just the progesterone initiative for our high-risk pregnant women if they have to go on the progesterone to try to help prevent pre-term labor. We do engage them in case management to try to help and follow them.

DR. VENNARI: Just to continue with medication therapy management, this is something we at CareSource and Humana-CareSource does now and we will be bringing in-house to Humana directly.

But just to go over the three different aspects that we're going to concentrate on is the CMR's which is the Annual Comprehensive Medication Review, TMR's, Targeted Medication Review, and Medication Reconciliation.

So, what is a CMR? It's an interactive person-to-person or telehealth consultation performed by either a pharmacist or a qualified provider for the beneficiary with an individualized written summary.

We're delivering this through realtime consultation in person or by telephone or by telehealth. The recipient is a member and/or

authorized individual.

And, so, we have different qualified providers in the network. We have pharmacists, pharmacy interns. We have physicians, nurse practitioners, registered nurses and physician assistants.

What we're looking at is all the medications the member is taking, including other prescription drugs, OTC, herbals and any dietary supplements and it's all combined together to create and help create better medication therapy and optimizing patient outcomes.

Materials are provided to the member. It is a medication list and an action plan, if necessary.

A Targeted Medication Review, this is more of kind of a computer-run type of process. This looks at the medications for potential interactions and different therapy problems. Again, they're followed up by a provider or with the member to recommend to the prescriber and resolve any potential medication therapy issues.

And, then, Medication Reconciliation or Med Rec, we contact members post-discharge to review and reconcile any medication or

follow-up with the prescribers, and the goal here is to also provide a written summary and an action plan for the member.

DR. GALLOWAY: I'll say two things about our self-management tools. These are targeted. They're open for all our members, specifically our kind of lower-risk ones. We encourage use of this. We have the myHealth which addresses physical health. There's journeys they can take that cover, as you can see the list, some of the different journeys.

And, then, we have the myStrength side which is the behavioral health self-management tools. These are available to the members through our member portal online and there's also modules that they can do for the myStrength as well as a lot of just self-help tools on parenting, weight and stress management, etcetera.

We really tried to do a good overview at our provider forums for our providers to make them aware of these tools again so that they could encourage their patients to utilize these.

MS. MOUTER: As a side note, as providers on the myStrength, it's only available to those who are thirteen years and older. I just

wanted to make sure you're aware of that.

MR. DUKE: The remaining slides cover part of the innovations that Humana brings to markets. What Humana does is we pick strategic communities throughout the U.S. and we determine and define them as a Bold Goal Market.

And what we do is we partner with business, with government, with providers and with CBO's to help improve the overall health of the community. So, through strategic investments and through coordination of those different stakeholders, we seek to improve the overall health defined by unhealthy days.

So, we coordinate, we work together and, then, we measure over time to see how, as a group, we can bend the needle on unhealthy days for our members and the broader community.

DR. PARTIN: Any questions? Thank you very much.

We have a few more minutes. Is there anybody from WellCare here? I just had a quick question about the slides that you sent to us.

So, on the slide, it was Page 4 and it's the claims process, paid and denied, you don't have to tell us right now but can you provide

us information on why the claims were denied and maybe the top three to five reasons?

MR. STUART OWEN: Stuart Owen with WellCare. I can provide you that definitely. There are a lot of actually denial codes. I think among the top is prior authorization required and not obtained. I know that's up there a good bit or there's other insurance and there's no explanation of an EOB from the other carrier, but you want like the top----

DR. PARTIN: Yes, the top five.

MR. OWEN: Okay. Sure.

DR. PARTIN: Okay. And, then, there's also a column for percent of medical necessity claims denied and that seemed to me kind of like a misnomer. I mean, if it's medically necessary, why are you denying it?

MR. OWEN: Maybe it's not phrased properly. It's of all claims denied, that's the percent that were denied for not being medically necessary. So, I think it's 0.47%, 0.44. So, of all claims denied, the percent that are denied for the service not being medically necessary is that percent.

DR. PARTIN: Okay. Those were

my two questions. Anybody have any other questions? Thank you. So, just send that information to Sharley on the claim denials.

MR. OWEN: Okay.

DR. PARTIN: Under New Business, Chris had a request.

MR. CARLE: Just that at the next meeting, I'd like to have a presentation on what DMS is doing related to advanced care planning. It's certainly something that will reduce our cost moving forward and make our constituents' lives a lot easier, as well as their families.

COMMISSIONER STECKEL: Absolutely.

MR. CARLE: I would like to recognize the Commissioner and her team's efforts to work down the backlog of the credentials and getting individuals in the state credentialed. So, all the providers would like to thank you for the development of that team, their responsiveness and the outcomes that you're getting.

COMMISSIONER STECKEL: Well, and I have to give credit to Genevieve Brown. She has taken that under her wing and taken charge and worked with the team and Program Integrity, and thank

you very much for that recognition.

MR. CARLE: It's obvious. So, thank you.

DR. PARTIN: And, then, next on our agenda is the election of a Chair, Vice-Chair and Secretary.

And Sharley suggested and I agreed that since we have new members coming in and they're not all here today and we've had some people leave, that we postpone the election until our September meeting, but I want to make sure that that the rest of the Council is in agreement with that. We are? Yes?

DR. SPIVEY: I second that.

DR. PARTIN: Okay. So, we will put that on the agenda for the next meeting.

MS. HUGHES: And if anybody wants to run for one of the positions, let me know. So far, nobody has spoken up.

DR. PARTIN: Thank you. So, having said that, any other business to be brought forward? No?

We do not have a quorum any longer. So, will just adjourn without a motion.

MEETING ADJOURNED