CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

May 23, 2019
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Steven Compton
Jay Trumbo
Bryan Proctor
Susan Stewart
Jerry Roberts
Peggy Roark
COUNCIL MEMBERS PRESENT

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AGENDA

MR. CARLE: Good morning, everybody. Why don't we go ahead and get started. We do not have a quorum at this moment. We need nine for a quorum. We think that several other members will come in. So, if you don't know, my name is Chris Carle. I'm the Vice-Chair. Dr. Partin is probably on her way and, so, why don't we go ahead and get started.

We won't be able to do any of the formal agenda items. So, I would like to hold off on roll call and approval of the minutes but what I would like to do is go ahead and get started with Old Business.

So, if we could start with an update on the 1115 Waiver, we'll go from there.

COMMISSIONER STECKEL: Thank you, Mr. Chairman. I'm Carol Steckel, the Commissioner.

The 1115 Waiver, as you all know, is in the court system. The appellate courts will be hearing the next stage of the process and, then, we anticipate whichever side is not victorious will appeal to the Supreme Court.

We are not anticipating any activity on the 1115 Kentucky HEALTH Waiver, absent

the SUD waiver which we will talk about later, until probably July of 2020.

We actually are going to enter a period of time where the Department is keeping up to date on all of our data, all of our systems so that in July of 2020, depending on the ultimate result of the court case, we will either implement or not. Any questions?

MR. CARLE: It doesn't look there are any. Thank you.

Moving on to an update on the Opinion from the Attorney General regarding our issue related to video conferencing and the TAC meetings and so forth.

COMMISSIONER STECKEL: That is the business of the MAC and the TACs, not the Department. So, I don't have an update and won't have an update on that.

MS. HUGHES: Beth should have gotten some information back. She requested it, so, it would go back to her.

MR. CARLE: Correct. I just didn't know if she had submitted it to you. So, we will table that issue as well.

So, Carol, while you are there,

why don't you just go ahead and give us your update.

COMMISSIONER STECKEL: Thank you. There's a few things going on in the Department that have been keeping us busy. I'll just go through a series of them and, of course, interrupt me if you have any questions and we will go into more detail.

Our Pharmacy Program is consuming probably 75% of my time and the Department's time. We now are fully staffed and you all met Jessin Joseph, our new Pharmacy Director. He has a Deputy Director also from the University of Kentucky's Pharmacy Program, Doug Oiler. And, then, we've also brought on some additional business analysts and other folks.

So, we're doing several big things but we're also looking at the Pharmacy Program, what are our policies and procedures, what can we do to promote and encourage the programs being developed either through Public Health, our opioid addiction responses and how can we help be good stewards in that process.

So, in that line, we have removed the prior authorization for Buprenorphine/Naloxone up to 24 milligrams for all Medicaid beneficiaries. The goal there was start

increasing access to MAT treatment and we have started seeing an increase in these prescriptions. The number of Naloxone prescriptions among Medicaid beneficiaries increased 6.5%.

So, normally, we're worried about things that go up that much; but in this case, by that going up, we're hoping hospitalizations, emergency room visits and all those high-cost items are going down and we're starting to track that information.

I wanted to bring to your attention that there is a Kentucky hepatitis academic mentorship program that DPH hosts; and if providers go to that program, primary care providers, and they attest to us that they've completed that course, they, then, are authorized to prescribe Hep C medications. So, we've also made that change.

We are fast and furiously trying to implement SB 5 which is a pharmacy piece of legislation that was introduced last year, last Session. It is an extremely complicated bill, and, unfortunately, it wasn't written with the mind set of what actually happens in pharmacy reimbursement between MCOs and PBMs. So, we're having to work with the MCOs, the PBMs and the independent pharmacies to

work through the implementation process for SB 5.

We are on the cusp of instituting the new policy. The biggest consumer of our time and work that we're going to have to do is for every change in price up or down of 5%, we've got to either approve it or disapprove it.

As you can imagine, drug prices change every day and there are thousands upon thousands upon thousands of changes. So, we're working with a contractor to set up the system.

We also are worried about unintended consequences. And if I'm getting too far into the weeds, I apologize, but what we're worried about is, so, we've created a policy that says we're going back to April 1st drug rates. So, whatever the price was on April 1st, that's what the PBMs have to pay.

Now, there will be a reconciliation from April 1st to May 31st that either the pharmacy was overpaid or underpaid. Most pharmacies believe that they've been underpaid. We will get data on Friday that either confirms that or denies it. My fear is when we get the data by pharmacy, there's going to be more pharmacies that have to pay back money than the pharmacists think.

So, we're very carefully walking through this to not have an unintended consequence but also be in compliance with the statute.

In addition to that, on June 1st, the PBMs will be authorized to make their first request for increases or decreases but we have thirty days to approve or disapprove that, so, we're working through that process. It's been a close collaboration between DMS, the pharmacists, the MCOs and the PBMs.

The interesting thing and frustrating thing for me is that the more we get into this, the more we find what I would call offensive behavior on the part of PBMs. So, that is my personal opinion, but we are going to look at contracts. We are going to look at behaviors. We are going to look at aggregated data and we're not going to tolerate it.

And if we have the legal authority to do something, we will and we will be very strong on this issue. I have made that message clear to the MCOs. The PBMs are their subcontractors and I've also made it clear to the PBMs.

MR. CARLE: So, as far as legal standing, what would you need from that perspective since you've mentioned that?

COMMISSIONER STECKEL: Well, we're looking at what authority and we believe we have it through our MCO contracts to reach out to the PBMs and the MCOs are cooperating. Nationwide, this is all becoming more transparent and we're finding, you know how it is when you turn over rocks and bugs start crawling out and things like that. Some of the bugs are good and some of them are not and we've got to sort through all of that.

And, so, I don't have an answer to your question but we will be working with our Legal Department and with the Governor's legal office and we'll do what we have to do to protect the Commonwealth.

MR. CARLE: And just make sure that you let us know how we can support that effort within our own specific advocacy groups.

COMMISSIONER STECKEL: Absolutely. Thank you very much.

The other major piece of legislation that we're working on is with the Kentucky Hospital Association on HB 320 which is a

hospital assessment. This allows us to maximize some federal reimbursement. And as you can imagine, it's not an easy task about who gets paid what and how we're moving the funds around from the existing supplemental payment to this supplemental payment. Then you've got the whole quality component of it.

So, we're trying to make sure we don't add another burden on the hospital but use what they're currently collecting in data for quality measures.

That work is going extremely well. I think for the first time that my folks are telling me, we had a joint meeting with the Hospital Association - I'm sorry, I'm thinking about a different one - but with the providers, with the University of Kentucky and Louisville and CMS and DMS all on the same call.

So, we're trying to do more of that so that everybody understands where we're going, what we're doing and what we're trying to implement. We're meeting weekly with the Hospital Association as we move forward on implementing HB 320.

The SUD waiver which was a component of Kentucky HEALTH is moving forward. There are a variety of changes that were made in the SUD

Program, including we waived the non-emergency medical transportation but we also are covering methadone treatments. So, that will start on 7/1/19.

We made some changes in Institutions for Mental Diseases, expanding the scope of those services and, then, we also made some changes in care coordination and MAT programs, but it is a very extensive SUD waiver.

And if you have any specific questions, Lee Guice can help us with that but we're very excited about that program and believe it will help us address our program with SUD.

And, then, we changed our policies to allow peer support services to be payable if the service is performed in an ER bridge clinic and the person has a treatment plan within thirty days of engagement.

So, again, what we're trying to do is look at the system and wrapping around that person. And what policies do we have in place that inhibit a good quality care plan and getting that person to the best level that they can be and out of the emergency room, out of the inpatient stays. So, that is one of them.

The other change we made is

allowing VHSO's to offer partial hospitalization.

We've made major changes to our telehealth policy and basically we have expanded services for parity so that telehealth services are across the board. Providers must be licensed in Kentucky and acting within their scope.

The provider portal is going to track those providers that are telehealth providers and we're opening up telehealth services to homes, schools and other places where individuals are, again, with the idea of how do we make it as easy as possible for someone to get the treatments that they need.

And the telehealth services are reimbursed at the same as in-person services for fee-for-services and the MCOs, of course, can still negotiate.

Not last but not least, there are a couple of other things. Our RFP for the managed care organizations was issued last week. So, it is on the street. I suggest you all read it if you haven't. It is intimidating but I think you will find in there and in the contract, we have made significant changes to our oversight of the MCOs, significant changes in the area of pharmacy and

others.

So, we're very proud of the RFP; and other than what I just told you, I can't really talk about the RFP because it is on the street. We're anticipating their responses July 5th and, then, this will be for new contracts beginning on July 1, 2020.

I know I'm a herd, so, I say I think you would enjoy reading it, but I think you will see a very significant difference in the tone, in the oversight and the quality aspects of the RFP.

The other thing that we did that is very exciting is, I hate to admit this, but you think this is a small thing to do but it has rippled through the communities in such a positive way is we've opened up school-based services, what's called Free Care.

The previous position, and jump in if I am wrong about this, but the previous position was if you were a clinic, a service, a school, a not-profit and you provided services, a screening or a hearing test to everybody for free, you had to provide it for free to Medicaid recipients.

We've changed that now so that

if a school does that, they can still bill Medicaid for the Medicaid beneficiaries. Needless to say, this provides resources for the school-based nurses and the school-based clinics that exist and allows us to make sure that we're getting our Medicaid beneficiaries where they are instead of having the family take the child to another clinic.

So, we're very excited about that. We're rolling it out with the School Boards and that will be for the new school year.

Other than that, I think that everything else--that's just highlight of what we have been doing.

MS. STEWART: I have a question. With the MCOs, how many do you anticipate being participants in July of 2020?

(Dr. Partin enters)

COMMISSIONER STECKEL: The Commonwealth takes the right to choose between three and five.

I'm sorry. The Credentialed Verification Organization, that RFP should be coming out very soon. It's at Finance but that's where we take all the credentialing in-house into one source. So, if you're a provider and you enroll in Medicaid,

you will go through the provider portal. You'll enroll in Medicaid and, then, you will have the opportunity to either choose the RFP CVO or the Hospital Association CVO to get your credentialing for all MCOs that are doing business with the Commonwealth.

An issue was raised when I spoke to the Primary Care Association that they believe they've also been authorized by the legislation to be a CVO. We don't believe that's the case but we're working with the lawyers on what the law says, but that will make it easier for providers to be credentialed. They won't have to do it with all five MCOs.

MR. CARLE: Okay. That was a question I was going to ask with regards to delegated credentialing. So, that would be effective in this next cycle with the new MCOs.

COMMISSIONER STECKEL: Correct. There will be at least two CVO's that you as a provider can choose. So, you have to do Medicaid for enrollment. And, then, once you get through the enrollment process, and using the provider portal is going to make it so much easier because if you forget something or if you fill out something incorrectly,

it's going to pop up an alert and tell you, you need the following information or this is not complete instead of the back and forth that goes on now.

Then once you're through with that, then, it will say choose your CVO to be credentialed with the MCOs and choose the MCOs that you want to be credentialed with. So, you would choose both the CVO and if you want one or four or five of the MCOs.

MR. CARLE: So, then, that process will start again, though, during the next cycle after they're selected for 2020.

COMMISSIONER STECKEL: Correct. Correct.

MR. CARLE: And, then, I had a question related to the telehealth policy expansion specifically related to the reimbursement rate because there was a site-of-service issue with that before. When would that be effective as far as the reimbursement is concerned?

MS. GUICE: I believe the regulations are going to be effective July 1 of this year.

MR. CARLE: Okay. Good because a lot of people were concerned about that. Thank

you.

COMMISSIONER STECKEL: Any other questions?

MS. ROARK: I have some questions about this SUD program, the methadone. You said you've got changes and you said you're going to, I guess, help with the methadone and how many days when they go into rehab treatments.

COMMISSIONER STECKEL: Yes, ma'am.

MS. ROARK: How many days? Is there anything added or subtracted from that?

MS. GUICE: Lee Guice with Policy and Operations. The number of days that are approved for rehab have not necessarily been changed. The beds that are accessible for that rehab are increased with this implementation.

MS. ROARK: And I have talked to a lot of parents. I've noticed when I help advocate for a lot of people in my community, if you say you've got Casey's Law when you call Eastern State or Charter Ridge, they won't accept you. I think that's discrimination myself.

COMMISSIONER STECKEL: I am not familiar with that.

MS. GUICE: Casey's Law is where parents can go to court or interested parties can go to court. If I'm your sister and you've got a substance use issue, I go to court and the court orders you into treatment. So, I'm not entirely sure how The Ridge or anyone else can----

MS. ROARK: If you have a loved one that's in danger to themselves or others, you can go to the courts and request a Casey's Law and there's steps that you've got to go through. You've got to go and have your family doctor evaluate you, a psychiatrist evaluate you. You've got to go, I think, to a 24-hour evaluation.

Some of that is roadblocks and challenges for these parents, and in the meantime, we've got people dying.

COMMISSIONER STECKEL: There'S nothing that we can do about the legal process other than as citizens, but if there is a denial of care in a facility because of this, we need more details.

If Lee can talk to you about getting maybe some names or some more details because if that's the case, then, we can respond and do some education and find out what's going on there.

MS. ROARK: Well, I personally

called those places because I didn't want to give these parents the wrong information and they told me if you have Casey's Law. So, it's kind of bad to go back and tell a parent, well, if you file that Casey's Law, they're not going to accept you. So, maybe if you can push that----

COMMISSIONER STECKEL: Let us look into that. And it's not fair to the organizations because we don't know their side of it, but let us look into it.

MS. ROARK: I think that's something very important. So, right now, how many days does each MCO have--how many days do they keep an individual in rehab? Is it thirty days that they pay?

COMMISSIONER STECKEL: Each MCO would have its own policy. So, you would have to go to each of the MCOs to ask them that, and I think that they have representatives here in this room.

MS. ROARK: And I have one more question. If--well, I've lost my train of thought. Maybe it will come back to me.

COMMISSIONER STECKEL: We'll be here.

MS. ROARK: Thank you all. I

just wanted to bring that to your attention.

COMMISSIONER STECKEL: Any other questions?

MS. ROARK: Okay. Now I remembered. I know each individual is different but how long do you keep a patient on Suboxone or Methadone? Is there a time that they could be winged off and go on the Vivitrol shot?

COMMISSIONER STECKEL: That is a clinical question that I am not able to answer. I do know that we work very, very closely. I have a new Medical Director who I think you all met the last time. I'm sorry. We will make sure that she is here the next time - Dr. Judy Theriot.

And between her and Dr. Allen Brenzel with the Department for Behavioral Health, they work very, very closely on all of this. And I apologize that they're not here but they could answer that question, but it is purely driven by clinical decisions.

MS. ROARK: I know Dr. Brenzel. Thank you. I'm just trying to gather all my information and have it correct.

MR. CARLE: Carole, could you send out the CV or resume' of Dr. Theriot?

COMMISSIONER STECKEL: Sure. I'll be glad to. She comes from the Office of Children with Special Health Needs and she's a pediatrician by training. She is from U of L, but I will be glad to send out her CV.

MR. CARLE: Thank you.

COMMISSIONER STECKEL: We're very lucky to have her. Any other questions? Thank you all.

DR. PARTIN: Thank you, Commissioner.

I'd like to apologize for being late. I ran into road construction on a one-lane road, so, anyways, I was delayed about thirty minutes.

Moving back under Old Business, an update on the Opinion from the Attorney General regarding video teleconferencing, perhaps it's my fault but I delayed calling the Attorney General's Office until we were closer to our meeting so I could get the most updated information from them.

And, then, when I did, they weren't taking any calls and I presume that's because of the election. So, I don't have any information from the Attorney General's Office but I will keep on

that and I will call and have information at the next meeting.

So, moving along, then, to reports and recommendations from the TAC, and we will start with Therapy Services today. No Therapy Services. Primary Care.

MS. HUGHES: Beth, both of those did meet but they did not have recommendations. So, that may be why they are not here.

DR. PARTIN: Okay. Podiatry. Physician Services.

DR. McINTYRE: I'm Dr. McIntyre. I'm Vice-Chairman of the Physician TAC.

We did meet last week. We had a quorum. We discussed the provider enrollment, online portal, telehealth implementation and public health trends and we had no recommendation.

DR. PARTIN: Okay. Thank you. Pharmacy.

DR. BETZ: Good morning. Dr. Chris Betz, Co-Chair of the Pharmacy Technical Advisory Committee.

I want to thank Commissioner Steckel for all of her assistance. I feel like we should be giving some time back since we are taking

up 75% of their time with everything that has been going on.

We just met on Tuesday. We did have a quorum of four of five members. The TAC had a robust discussion about various topics relating to DMS and also relating to issues in our Commonwealth. A full report to the MAC will be forthcoming.

There are no formal recommendations at this time, however, we did want to bring up something that came up recently with the primary PBM in the state.

So, what was brought up by one of the committee members was that a Medicaid managed care organization wasn't able to appropriately credential their medical clinic within a large hospital system as a vaccine provider for vaccines administered by pharmacists due to issues of reaching out to this particular PBM and not receiving any feedback.

The documented experience notes that there was an inability to converse with anyone at CVS Caremark at the time. This delayed patient care and established a major barrier to patients' access to vaccines.

So, senior Medicaid staff is

aware of this and is working with us to address this concern, but the PTAC wanted to make you aware of this, especially with what was brought up before with removing the rocks and some of the things that we're finding.

There could also be a recommendation forthcoming if it's not rectified; and also the above-mentioned incident is similar to an experience of another pharmacy and this pharmacy also expressed concerns with the increased credentialing fees charged by the PBM's.

As of May 1st, the fees increased to $1,200. So, if you want to be recognized as a vaccinator within the network, that fee is $1,200 now.

The Pharmacy TAC would like to bring awareness to some of these PBM issues that directly affect patient care within Kentucky as CVS Caremark is the current PBM for four of the five Kentucky Medicaid MCOs.

So, that's all we have. We don't have a formal recommendation right now. We are working very closely with the Commissioner's Office to work on these issues. Thank you.

DR. PARTIN: Thank you.

Optometry.

DR. COMPTON: Steve Compton, a member of the TAC. We met on April 11th. Most of the things we talked about we've covered in here today - the Medicare waiver, the Attorney General's Opinion, the RFP process for the new contracts.

A couple of other things we touched on was how to, when there are new CPT codes, how to get those on the Medicaid fee schedule without going through the regulatory process and apparently there is another TAC that has done that. We're going to look into how they have done it and just to make the process more efficient.

Another question we had was when the MCOs offer value-added benefits, if they decide to discontinue those, what kind of notice they must give. We talked about that.

That is about it. We have no recommendations and we don't meet again until August.

MR. CARLE: Dr. Compton, I have a question for you. How well do the MCOs reimburse for just a standard retinopathy for a patient with diabetes? Do they even pay?

DR. COMPTON: Yes. It depends on the level of service for your CPT code. It's a

standard E&M code like any other physician uses, yes, but they do reimburse, yes.

MR. CARLE: Good. Thank you.

COMMISSIONER STECKEL: Madam Chairwoman, can we talk about the CPT codes just for one minute?

DR. PARTIN: Sure.

MS. GUICE: Lee Guice again. We have in Medicaid ironically just recently, very recently talked about implementing some standard procedures for when we will add CPT codes.

We believe that we're going to implement a policy of January 1st and July 1st every year so that in between those times, if new providers are added to be able to offer a service for a code that's not on their fee schedule, for instance, or the units need to change or Medicare comes out with a new CPT code after our standard processes, we're going to ask you for ninety days' notice from any of the providers who want to have a new code added.

We believe ninety days will give us ample time to go through the internal processes we need to have to get them added (a) to the system, and, (b) to the fee schedule which is apparently what the MCOs rely on the most what we

post on the website.

So, we're taking a new approach to how and when we can post those things on the website. Previously, of course, we would never post a CPT code on our fee schedule that our system was not prepared to handle a claim for.

Now with the claims that our system handles are reduced by 90% than they previously have been before MCOs, we believe we can internally handle any claims that are submitted for a new CPT code that we've posted that we're maybe three weeks away from actually implementing on the system.

So, we're going to lay all this out in a policy so that everyone understands what the expectations are on your side and on our side so that you will know what to do. You will know how to handle the process. You will know what to expect. We will know what we can expect and what we're expected to do.

So, we're also changing some of our internal processes in order to handle the January 1 effective date a little bit more effectively, we hope, we hope, because we're not always in charge of when we get the information, but, generally, we think that we know a few more ways to automate some of our

processes so that we have a better chance of actually making January 1.

COMMISSIONER STECKEL: And as we implement these policies, we will be reaching out to the various provider groups to just double check and do on-the-ground checks.

MS. GUICE: Right. That's what we're looking at, we're talking about. When it's documented, when it's ready to go, yes, we will get some input.

DR. PARTIN: So, just to clarify, between January and July of every year, DMS is going to, if there are any changes to the CPT codes, they will be added during that time period; but after that, there won't be additions?

MS. GUICE: Okay. So, you have two six-month periods of time where you can bring up or if provider groups know that there needs to be some difference or your licensure changes periodically that allows you to bill for some codes that we don't put on your fee schedule, then, we need to know that in that six-month period.

DR. PARTIN: The January to July.

MS. GUICE: Right, but don't

tell us after April because we won't be able to add them to be effective in July. So, there will be two effective dates - January 1 and July 1.

COMMISSIONER STECKEL: It's still to be worked out. Those are the effective dates but the details are still to be worked out. I just thought it was important for you all to know.

I know CPT codes and the speed by which we get them posted has been an issue but we wanted you all to know that we were working on it and that we would be reaching out as Lee and her team develop the policy to make sure that it all comes together.

MS. GUICE: And we will send it out certainly to ask for feedback. Are we clear on what we're asking for? Are we clear on what we're thinking about? Do you understand it? And, then, when it's finalized and implemented, there will be an educational period for providers.

DR. PARTIN: We would appreciate getting that. Thank you.

The Nursing TAC did not meet. Intellectual and Development Disabilities. Hospital Care.

MR. CARLE: I don't think they

had any recommendations. I'm not representing them but I did want to thank DMS and the Commissioner for the work that you're doing on House Bill 320.

DR. PARTIN: Home Health.

MS. STEWART: The Home Health TAC met in April. We had no recommendations and we meet again in June.

DR. PARTIN: Thank you.

Nursing Home Care.

MR. TRUMBO: Nursing Home Care TAC did not meet. We do have a meeting scheduled for July 11th.

DR. PARTIN: Dental.

DR. SCHULER: Good morning. My name is Dr. Phil Schuler representing the Dental TAC.

We met last week with a quorum. The one recommendation that we did have was that currently we have to check eligibility on Medicaid patients day of treatment.

Historically, we have been able to do that on a monthly basis where they were eligible for the full month and we'd like to make a recommendation to go back to that full month eligibility if that's possible.

It creates a dramatic workload

increase on the administrative side of the practices. If a patient has an appointment early in the day, sometimes it's really hard to get their eligibility verified. And if we can't verify their eligibility, a lot of the providers won't see them that day.

They have arranged transportation and other things which makes it really challenging for the distance that some of these folks have to drive to get care and then show up; and if we can't get their eligibility checked on that specific day, they may or may not get the care. They usually don't get the care that they are needing.

And that doesn't include all the days that we've got providers working where they might not be able to interact with state government because they are closed and on Saturdays and weekends as well.

So, that was the one recommendation that we would make to the MAC.

DR. PARTIN: I'm just curious about why it's difficult to check the eligibility. In the primary care practices, we check eligibility every time. So, I was wondering what was different with dental.

COMMISSIONER STECKEL: And if I

may, Madam Chairwoman. I'm sorry. We should have reached out to the Dental TAC when this came up.

I think there was a miscommunication on this issue and that, in fact, eligibility is still appropriate for that month. So, we think there was some miscommunication about this policy.

So, I understand that it's going to be a recommendation. We're going to follow up on it, but we believe that when you check that eligibility, just like with the primary care doctor, that eligibility is for a month.

DR. SCHULER: That would be fabulous and we can talk about that.

COMMISSIONER STECKEL: Yes, absolutely, but we apologize for the miscommunication, but I think that there was a little bit of snafu in policy discussions.

DR. PARTIN: Okay. Well, then, I withdraw my question.

DR. SCHULER: And I may or may not have to withdraw my recommendation but I'll keep it as a recommendation and we'll evidently talk outside of this meeting.

DR. PARTIN: Yes, keep it and,

then, we'll get a response from DMS to your recommendation.

DR. SCHULER: Yes. Thank you all. That's all the recommendations we have.

DR. PARTIN: Thank you Consumer Rights and Client Needs.

MS. BROWN: Thank you. I'm Miranda Brown, Vice-Chair of the Consumer Rights and Client Needs TAC.

The Consumer TAC met on April 16th. We did not have a quorum, but one of our members with disabilities has been unable to attend the past two meetings due to a lack of transportation and personal assistance.

This has been an ongoing concern of our TAC. DMS has offered to make accommodations related to parking and building access but has not yet clarified whether they are responsible for transportation, personal assistance or interpretation services.

So, without these accommodations, we cannot expect consumers to be able to fully participate in meetings, especially if in-person attendance is required.

We do understand that DMS and

Protection & Advocacy are seeking legal opinions on the Cabinet's responsibility to provide this assistance under the ADA; but as a short-term solution, we have asked that DMS staff provide a meeting space with teleconferencing equipment to hold future meetings.

We have continued to raise concerns about mandatory copays. Now that the Kentucky HEALTH Waiver has been blocked again in federal court, we have heard from many consumers who assume that they are still considered medically frail and should not be required to pay copays.

This is at least, in part, due to the fact that no communications have gone out to these members to explain that the medically frail designation does not exist without the waiver.

Regardless of whether the waiver is in place, these same individuals are still experiencing the same challenges with chronic illness, activities of daily living, mental health conditions or substance use disorders.

So, because of their health conditions, they are disproportionately burdened by the requirement to pay copays since they typically need more regular care and prescription medications.

So, for these reasons, we are concerned that Medicaid recipients with these health conditions are being put in a bind, that they are being required to ration their care or go without basic needs like food and electricity.

So, we've asked that DMS consider voluntarily adopting a medically frail designation to exempt these individuals from all cost-sharing in the meantime.

So, Kentucky Voices for Health has been collecting stories from Medicaid recipients who have been affected by the new mandatory copays and will be sharing these with DMS through the TAC. A copy of the data and stories collected can also be shared with MAC members electronically.

We did not have recommendations from our last meeting due to not having a quorum, but our next meeting will be June 11th and we have requested a meeting room with the necessary equipment and technology for teleconferencing.

DR. PARTIN: Thank you. Children's Health TAC.

MS. KALRA: We did not have a quorum but we did meet, so, therefore, we don't have any recommendations.

DR. PARTIN: Thank you.

Behavioral Health.

DR. SCHUSTER: I'm going to make up for the lack of recommendations.

Good morning, Commissioner. I'm Dr. Sheila Schuster, Chair of the Behavioral Health TAC, and we met on May 14th and had a quorum of five of our six TAC members.

We welcomed the new TAC member, Gayle DiCesare who was appointed as a representative fo the Brain Injury Alliance of Kentucky.

We also had all five MCOs represented, a number of members of the behavioral health community but no DMS or DBH/DID staff members.

We talked about the last MAC meeting and we're all in agreement with the report made at the MAC meeting about the ability of the TACs to set their agenda and conduct business as we have been conducting it.

We had an update provided by various attendees who had information on the Kentucky HEALTH 1115 Medicaid Waiver. One of the issues that was discussed was the reaching out. Apparently, about 5,000 letters have been sent out to Medicaid recipients about the Kentucky Integrated Health

Insurance Payment Program which is called KI-HIPP which is the program where Medicaid would pay the premium for an employer-sponsored health insurance coverage.

We understand that there is going to be a planned mailing in August of letters to perhaps as many as 90,000 more Medicaid recipients. We had a lot of questions about KI-HIPP and felt like we didn't have much information about it, and our concern is that we're front-line people.

And, so, when people get these letters, we're concerned that they are going to turn to us and say is this something that I should do. In other words, should I go off Medicaid as we know it and pick up coverage from the employer, have Medicaid pay the premium.

So, we feel like there needs to be some training and information provided about that.

We also followed up on an important issue that we had discussed last time about the proposed changes and, then, the change in those changes to the therapeutic rehab program and I talked about that at the last MAC meeting.

We are very pleased that DMS has re-thought that change in policy in terms of the

way the hours are required for people to attend this day treatment program.

We would again respectfully request that in the future when DMS is contemplating such a significant change to a mainstay treatment program, that the TAC be apprised before the change is made so that input can be given instead of a situation where the policy is rolled out and, then, the input is given and, then, the Department has to pull back or revise the policy that they made.

We also looked at a document that DMS provided entitled Public Notice on Substance Use Disorders and had some questions about the units of service provided by peer support.

We also continue to have concerns about mandatory copays. We reviewed some of the information that KVH has gathered. Two areas where the problems are noted most frequently are at the pharmacy and at primary care offices, as you can imagine.

So, a number of groups in the room had talked about input from consumers and family members. It seems fairly clear to us that people are not keeping their appointments because they are afraid they're going to be asked for a copay and they

don't have the money for the copay.

And it also seems to us that there are a number of people that are below 100% of the Federal Poverty Level for whom services cannot be denied but, in fact, are encountering service denial either at the pharmacy or at the primary care office. And we feel like it's a lack of education of front-line staff and we have some recommendations. We also are concerned again that people will not get the services that they need.

We had some input on the 1915(c) waiver redesign from two members who were present who serve on the Advisory Panel and the Quality Improvement Subpanel.

We again talked about the medically frail designation and had the same concern that was expressed so nicely by Miranda Brown from the Consumer TAC that people thought they had been given that designation and thought that they would not have cost-sharing and now they're being charged copays. So, I think there's some confusion out there.

A new issue was brought to the table by several participants that involves the refusal by ambulance drivers to transport persons

with mental illness from a hospital that does not have psychiatric services to one that does have the necessary psychiatric services.

These patients have been evaluated by a mental health professional usually in the ER of the first hospital and found to be in need of services on an emergency basis. The patients are willing to go voluntarily to a facility which offers psychiatric services but are in need of ambulance transportation which is being refused for a variety of reasons.

The ambulance drivers are saying that they don't have to take mentally ill patients which seems like a clear violation of parity if not other things, social justice among them. They say that it's not safe for them. We're not talking about people who are acting in a violent manner and those kinds of things.

So, what is happening is that people who are in need of these services are not getting them.

So, we have a number of recommendations. One is that as DMS pursues perhaps an expanded rollout of this Kentucky Integrated Health Insurance Payment Program that they provide

some education to the MAC and to any of the TACs that request it so that MAC and TAC members and their organizations can be in a position to answer questions about that program and the BH TAC would be very interested in getting that education.

We recommend that more information be provided by DMS to the BH TAC and to behavioral health providers and MCOs about the change in calculating units of service for non-clinical behavioral health services provided by peer support personnel, and that's part of the SUD waiver that was talked about earlier that's going to go into effect on July 1st.

We recommend that DMS provide education to the pharmacy and primary care providers with regard to collection of copays and the necessity for identifying Medicaid recipients whose income is below 100% of the Federal Poverty Level for whom services and medications cannot be denied.

The Behavioral Health TAC is willing to meet with both the Pharmacy TAC and the Primary Care TAC to further discuss these issues and to work on ways to educate providers, front-line staff and beneficiaries about copays and to identify those for whom services and medication cannot be

denied.

We recommend that DMS revive the classification of medically frail and reinstitute the claims analysis and attestation processes in order to identify current Medicaid beneficiaries who meet the criteria, and once given that designation, to exempt them from all cost-sharing requirements for Medicaid services.

We recommend that the members of the 1915(c) Waiver Advisory Panel and all the 1915(c) Subpanels be identified which is something that we've asked for a number of times and have been told that the names of those participants would not be released and a process established so that individuals may contact these members to provide input on various aspects of the waiver redesign and that there be transparency in how the panel and subpanels are functioning with regard to receiving input and utilizing it and helping to create the final waiver products.

The last is that we recommend that DMS investigate the problem identified in several rural areas of the state, for example, in the CMHC regions of Pathways which is Ashland, Mountain Comp Care which is Prestonsburg and Lifeskills which

is Bowling Green and those surrounding rural areas where ambulances are refusing to transport individuals with mental illness from a hospital that does not have psychiatric services to a hospital in the region which does have psychiatric services. This would appear to be a significant violation of the parity law.

If DMS determines that some of the confusion is caused by a lack of clarity in the regulations, then, we recommend that DMS identify the specific regulation language which needs to be addressed.

I would also like to thank DMS for the work that is being done on the school health free care services. We in the mental health community are very excited about the possibility of increasing access to mental health services through that change. So, thank you very much, Commissioner and Lee.

Our next meeting will be on July 9th and we will be meeting in Room 125 of the Capitol Annex. I'm happy to answer any questions.

DR. PARTIN: I have a comment rather than just a question on the EMS issue. This is a problem in primary care as well. If we have a

patient who is suicidal or who has some other acute psychiatric illness, EMS won't transport those patients to the hospital from the clinic. Sometimes we call the police. Sometimes we call a family member but it's not the best situation. So, it's not just hospital to hospital.

DR. SCHUSTER: Not just hospital to hospital. You're saying it's also from a primary care office or clinic.

DR. PARTIN: To a hospital.

DR. SCHUSTER: To a hospital. It's a real problem. There certainly are cases where persons who are having a psychotic break, for instance, could be difficult to handle, but you're probably looking at in involuntary hospitalization at that point where law enforcement is the appropriate thing. We're talking about voluntary admissions, right, where the person says, yeah, I need help but i need to get there.

DR. PARTIN: Mostly for primary care, that would be somebody who was suicidal.

DR. SCHUSTER: And I don't know whether DMS is the appropriate venue to start. It seems like that's one place where the ambulance drivers are saying we don't get paid to transport

mentally ill patients. That's a problem and we know that's not true and we know you all are not saying that, but it would be really helpful to have some communication from DMS to whoever these EMS providers are. And some of them are county. Some of them are private. I don't know.

MR. CARLE: Sheila, what I was going to ask, what you're alluding to, though, is that a certain region, you have certain facilities or it's statewide?

DR. SCHUSTER: Well, we had representatives there, Chris, from three different CMHC regions, so, Ashland and that whole region. Remember, our CMHC regions, there's only fourteen of them. So, they take in eight, nine, ten, as many as twelve counties.

So, the Ashland region, that entire region, Prestonsburg, that entire region, and the Bowling Green and it's mostly in the rural counties. And I could get some more information, I think, from the CMHC's.

COMMISSIONER STECKEL: We'll look into this.

DR. SCHUSTER: Thank you very much. I mean, it really is a problem and it seems to

be a real discrimination against people with behavioral health issues.

COMMISSIONER STECKEL: I totally agree.

DR. SCHUSTER: Thank you very much.

DR. PARTIN: Thank you. You had a question or a comment? You need to come to the table.

DR. McINTYRE: I'm Dr. McIntyre again. I'm an ER doctor in Flemingsburg and I have worked all over the state in the last thirty years and the problem isn't limited at all to mental health.

The worst place I ever worked in terms of getting ambulance access was in Barbourville where the EMS service - and this is twelve years ago, so, the problem hasn't improved at all - the EMS service absolutely refused to take any mental health patient. We would have patients sitting in the ER sometimes for two or three days waiting for some form of transport.

I have actually taken male patients in my own car to Hazard until the hospital said that's just not appropriate. We can't allow you

to do that anymore.

And the problem wasn't limited to mental health patients. The EMS agency would also refuse to transport medical patients.

I actually went to the EMS Board and talked to them about the problem and was shot down. The EMS Board said these county EMS agencies are only required to take patients to the hospital, not to do any transports and that we were free to call any other EMS agency in the state to try and get a patient transported.

Well, that would work in Lexington, Louisville, Frankfort where there are private EMS agencies that do transports but it was a non-answer as far as Knox County where there's no private ambulance service within probably eighty miles of the county.

It's not even limited to Kentucky. I did some part-time work in the last eight months in New Martinsville, West Virginia close to the Wheeling area and exactly the same problem of transporting medical patients. After midnight, we couldn't transport patients anywhere outside of the local area and a lot of people needed a higher level of care - the same thing now in Flemingsburg. We

can't get transports for medical patients or mental health patients after midnight. It has to do with the staffing of the EMS agencies.

And in Barbourville specifically about mental health, the answer we got on why they wouldn't allow transporting mental health patients, they talked about their liability insurance. What if a patient jumps out of the vehicle, refuses transport? We have no means to make them go and we would be liable if they jumped out of the vehicle.

So, it's an intractable problem. I would think the EMS agency, the state EMS agency, state EMS Board would be the group to try to get to address this problem, although I'm not optimistic that there would be any answer to it.

DR. PARTIN: Thank you. That completes the reports and recommendations from the TACs and we will move along to New Business.

And now we are going to get some updates from MCOs and let's do WellCare first.

MR. ORRIS: Good morning. My name is Ben Orris. I am the COO for WellCare of Kentucky and I am joined by.

MS. MAGRE: LeAnn Magre and I

am the Manager for the Foster Care Adoption and Adult Guardianship Program.

MR. ORRIS: I want to start by thinking you for allowing us this opportunity in front of the MAC committee to present.

The value of managed care is how we're approaching this. We don't often get this opportunity but we are often the recipient of I guess information that isn't I think always reflective of the value that we believe we bring to the state and today we think is our opportunity to get that out in front of you guys. So, I just wanted to thank you.

So, very briefly, the footprint or who WellCare is. We are a national government-sponsored-only health care program in the United States. We are in all fifty states for Medicare and Medicaid offering services to about 4.5 million members for both Medicaid and Medicare and serving PDP as well.

Locally here in Kentucky, we have about 484,000 members, of which about 450,000 of those members are Medicaid recipients.

We have got 290 associates here in Kentucky or associates representing and serving the residents of Kentucky. We've got six locations

throughout the state as well.

Some of the topics we're going to key in on today I believe were prescribed by the MAC committee, of which one was what are some of the other type services that you guys do that brings the value that we speak of.

And I think one of the biggest things for us is our community impact program. When we came to Kentucky in 2011 when managed care went live, this was part of our initial launch. It was our community impact and it was different from some of our competitors.

And by that, I mean we are very involved with our community service agencies. We came with the integrated care model that not only addressed the medical, pharmaceutical and behavioral care services but also the social service care.

We didn't carve out BH because of the importance of understanding the BH and the frequent comorbid conditions that go along with behavioral health, and we treat social services similarly. I kind of look at it as there's the pharmaceutical, the medical. There's the behavioral, but, then, there's also the social service component of that.

There's some additional information when we get into care field management that we will go a little bit deeper on that.

The reason for the focus on the social services is basically because we know that those are the things that drive a member's true health. Very little of medical care helps define a member's health. It's more about their environment, their behaviors, their genetics. The actual care they receive has very little to do with their health.

So, for us, it was important to come and bring a program that addressed those social services, those social determinants of health by way of general transportation, medical transportation, food, utility assistance, housing assistance.

A member is not likely to go see a medical care provider for treatment of some condition that they have or to seek preventative services if they don't have a means to know where their next meal is coming from. So, that's why that has been so important for us.

At WellCare, we branded that community impact and we have invested millions of dollars in the program and employed dozens of social service workers to help drive this program.

What it basically is is a database of thousands of social service agencies to which we get referrals either from our care managers, from providers' offices to help close those social care gaps.

My guess is there is probably-- well, I won't bet money on it but my guess is just about every physician office and community mental health center and clinic and FQHC would have a card that instructs that facility on how to outreach and gain access to our community assistance line which is a line that is staffed by dozens of people to help close those social care gaps.

In 2018, we served nearly 10,000 members in Kentucky and accessed nearly 50,000 social services for our members.

So, the question of does it work or not? In collaboration with the University of Kentucky and the Robert Woods Johnson Foundation, they did some analysis.

So, when we partner with these agencies, oftentimes we're able to collect data. So, we know when one of our members is accessing a food pantry. We know when they're taking advantage of a transportation or getting a utility bill paid.

We're able to then take that information and look at the data prior to them closing a social service care gap versus afterwards, and you can see some of the outcomes in the bottom right - 4.8 times more likely to schedule and attend a PCP visit than a similar population that may or may not have had a care gap that wasn't closed; 2.4 times more likely to improve their BMI or one and a half times more likely to have better diabetes-related treatment compliance.

So, when we talk about social determinants of health and its impact to health, we hit the ground running with our program here in Kentucky, and it's no different nationally for us at WellCare.

Field care management. This is the slide I was alluded to and I touched on it briefly that the behaviors and the environment are something that drive a member's health.

Our ability and our investment in our care coordinators, these are social workers, these are nurses and these are people that are in the field. Medicaid members are oftentimes very difficult to get a hold of.

We can mine the claims data all day long and we can see when someone needs a care manager. Reaching out to them, getting access to them regularly is a very difficult challenge. They are very transient. Sometimes they don't have phones. So, we employ again dozens of field outreach case managers that are actually going to emergency rooms, going to hospitals, going to CMHC's to help find these members to get them into the care management program.

We've got over 100 care managers employed of our 290 employees that help just facilitate and coordinate the care of our members to help drive improved outcomes, and these are associates of ours that live in the communities with which they work. These aren't strangers to the communities, right. They know the schools. They know the agencies with which they are outreaching to.

One of our crown jewels and why I asked LeAnn to join us is a program that she has launched related to our foster care program. She is going to take some time to go over that.

MS. MAGRE: Thanks, everyone, for letting us be here today.

I'm going to talk about our

innovative program that we have for transition age foster youth. JOOL/Kumanu Health Coach is a program that we launched in October of 2018. It was a pilot program that DMS graciously and DCBS graciously allowed us to work on, and it utilizes technology and social networking to engage our members.

We wanted to focus on helping these members to develop a strong sense of purpose and build their life goals and we targeted the transition age foster youth, the seventeen-year-olds and above on this in order to help them start working toward their adulthood.

As these kids move from being in care to being on their own, they have some issues and some concerns that they have to face, and we know that getting in front of that can be helpful to them.

So, we wanted to start this program with them. We wanted to continue to engage them as they transition out of foster care. We wanted to help target their health issues and their treatment goals and also work on them building a sense of community, as well as their own sense of purpose within the program.

One of the key things that we know about kids that are transitioning from foster

care, they are at high risk of being homeless. They are at high risk of using drugs and alcohol. They don't always get their education completed before they leave care which makes it even more difficult for them to continue to get their education later on. Their employment rate tends to be high and, then, also criminal behavior is a risk as well.

So, we built this program, and one of the things that we did in order to build the program is we talked to foster youth. We talked to current foster kids as well as former foster kids and asked them what the program would look like if they thought it would be successful, and they helped us to build it.

They helped us to put some pieces of that in place and they told us that you need to give us some incentives if you want us to actually do this program. So, we did. We included gift cards and games as part of the process.

The program is an app that you find on a Smartphone. And on page 7, you will see a picture of the Welcome to JOOL app that's on the phone.

We as part of this program are giving the foster kids a Smartphone if they don't

have one. We built this program very carefully to ensure that the kiddos are getting a phone that is pretty controlled, pretty locked down. They can't run around and access a lot of websites they shouldn't be accessing, all that kind of stuff.

We worked hand-in-hand with the guardians, DCBS workers and the care providers to ensure that they understood the program, that they understood exactly what the phone would do and get their permission, of course, to do that.

So, you can see some of the information on page 7 about that. And if you want to go to the website that is listed on here, please do. There is a video on there that will help walk through exactly what JOOL will do.

We have 106 kids that are enrolled in this program. We are working to get to 250, being able to engage kids and get to them, and to walk through this process has been slow; but what we are finding is that over half of the kids that are enrolled in the program are using it actively.

They like this program. They are charting in it. They are developing their goals. They are getting daily tips that are sent to them based on the information that they are inputting into

the app and we are starting to see some pretty wonderful outcomes coming out of it.

On page 8, you will see that some of the youth are charting what their energy level is and what affects their energy level on a day-in and day-out basis. You will see that their baseline has moved up, so, their energy is improving and they're reporting that.

You can see their weekly energy trends. Tuesdays are really a good day to engage a foster youth on some kind of activity or program. This might be the best day for them to take a test at school because their energy is high.

I would not want to engage a kid on Sunday. They are not in a good mood on Sunday based on this information that we're finding and this can us with programming. This can help us inform their guardians, as well as their care providers around some of the days of the week that might be best to engage them in some purposeful activity.

And, then, you will also see some of the factors that are influencing their energy levels, their activity level, their own creativity, their presence in their life, what is important to them. Are they present in that and are they actively

participating in that? Their sleep is important to them, as well as their eating.

And, then, on page 9, there's some positive feedback from the foster youth themselves. We get information from them and they send us information.

One of the components of the program that the kids asked us to do, every day, a daily tip is sent out. Whenever a kid gets into the program and charts their day about how they're doing and how their goal is going, the program will send a tip to them that's based around the information that they have inputted into the system.

And the foster kids told us that they wanted to be able to write their own tips and be able to share that information with other kids that are also in the program and we were able to do that. And we've had several kids write to us and we have put their tips into the program itself.

As you can see, a couple of kids that we have captured some of their information, JOOL gives me daily goals to use and focus on and coping skills to use. I want to climb a mountain and motivate others to overcome their obstacles as well.

And, then, this one. This is

an actual tip that we have in the system. It's okay to have bad days and make mistakes. Just try to look on the positive side of things and remember that you will make it through just fine. You can make an infinite amount of mistakes but something or someone will always pull you through and help to make things right themselves. Just take one day at a time. Don't try to plan too far ahead, so, if things don't go as planned, then, you can always try and change that plan.

That's pretty inspiring. So, we're very proud of the program. We're proud of the work that's being done. We're excited to come to the end of the program and learn from it because I think this is going to be something that we'll be able to use going forward for our kiddos.

MR. ORRIS: Awesome. Thank you, LeAnn.

There's been some talk about the Kentucky HEALTH 1115 Waiver. And when that was announced formally probably over two years ago, with all of the complexities that were coming out specifically around the community engagement requirements, premium requirements, medical frailty, yes, we initially panicked.

But, then, after we kind of rallied ourselves over several months, we asked the question what could we do? What could we as WellCare do as a health plan to help improve our members' opportunities to stay enrolled in their managed care. We can't help them if they lose their benefits.

One of the most glaring obstacles that's the primary reason why the waiver has been remanded was the work requirement.

So, what we did was go meet with every workforce innovation board in the State of Kentucky to ask them what it was that they were fearful of, how could we help.

And by and large, the response that we got from that was we need customer service. We need people. We're going to have an additional 400,000 people in the State of Kentucky that are going to probably be at risk of losing their benefits if they don't have a job. They're going to be starting with the workforce boards and the career centers. What could we do to help. They wanted fund support, customer service and they needed something, a technology that would help them as well.

So, we went out and contracted with a company and it's one of its kind in the

country and developed WellCare Works. At the time, it wasn't WellCare Works. It was just going to be a product that would help members meet their volunteer requirements or their work requirements; but after the waiver was suspended the first time and, then, again the second time, we pushed forward with this.

It's an incredible investment that we're making to the State of Kentucky to keep access to this for our members.

And what it is is an application, a computer-based tool for members to go out and do job searches, build resume's, take training. When I talk about building a resume', it's not the opening up a Word document and doing a resume'. It's filling out a template, right. It's like a Wizard, I guess you would call it. You answer questions and the output is a resume'. They've got training clinics. It's live peer-to-peer coaching for people.

In speaking with the vendor, and we meet with them several times a month just to get a better grip of how things are going, people call in for their conversation with their coach just to say, hey, I've got an interview at four o'clock today, can you help pump me up for it, and that's the

kind of stuff that goes on through this.

So, it's the online job seeking resource but it's also that phone support. So, we've hired and staffed in our Hazard, Kentucky office called community assistance people that are very well-versed in this application and they are there to help our members navigate this system as well.

And, then, the third thing, we built a product out of it. So, it's WellCare Works but it's the community assistance line that provides support around the WellCare Works' application. It's the phone support. It's the application as well.

And, then, we've wrapped a third item and that's just general education support, so, GED, ACT, SAT test preparation. So, these are all things that are now part of someone mentioned earlier the additional benefits that plans can offer. WellCare Works is one of those.

We launched it as a pilot in Northern Kentucky and Region 5 which is the Lexington area but you can see that the system has been accessed by members in 59 counties across the state.

Getting word out to our members through mailers and whatnot isn't necessarily the best approach we've learned. So, through our

community engagement team, the people that have developed the call line, these are also the associates that live in the communities and they are the ones that are out forming the connections and partnerships with the social service agencies.

They are training their social worker team on our WellCare Works to help them learn and understand the application. They're in career centers. They're in shelters for domestic violence. One of our big ones is the Eastern Area Community Ministries.

They're trained on WellCare Works, so, when a member comes in seeking help or support, they're able to show them WellCare Works, get them logged on to the member portal and get them access to the system.

MR. CARLE: So, before you go on, I'll let you catch your breath a little second there. Do you have any numbers associated with this? How many actual contacts are there? I guess it would be both for your program that you can see you're passionate about, but also with regards to the WellCare Works, how many touches did you actually have?

MR. ORRIS: Mr. Carle, the next

page.

MR. CARLE: I wasn't reading ahead.

MR. ORRIS: Thank you. I appreciate it.

So, it was a bit of a slow push through the mail. We started it in January is when we went live. We sent our first mail out at the end of December and, then, we sent another one out in March, as well as we started ramping up our touches to our community agencies. And you can see the impact that that has had.

So, we've had over 427 job searches. We know through working with these agencies that people are getting jobs through this application. We wouldn't otherwise know other than for the fact that we have relationships with the agencies. We know when they're working with our member and navigating.

We get feedback and stories from those agencies that say Mary who has been working with us for two years here at the domestic violence shelter used your application and got a job. Those are the good-news stories that we have been waiting for and those are starting to roll in.

Job Alerts is something that I didn't mention but that's something where when they go into the application and they provide their personal information and they fill out their profile, what do I want to do, what are my qualifications, what do I like, when a job comes up and meets their profile, it will send them a notification on their phone to let them know, hey, something just posted that might be right for you. You ought to go online and send in an application for it, and that kind of makes them first to market, right, when some of these jobs come about.

It's not thousands, tens of thousands of people that are accessing it but the broader we launch this, the more action we're going to get on it, but right now we feel like the best way is word of mouth and working with our social service agencies. We tried the mailers and the marketing type approach and it wasn't super effective.

DR. PARTIN: I'm just going to interrupt you for a second here. It looks like you've got some really good information to share with us but we also need to give the next MCO an opportunity to present their information before we have to close the meeting.

So, if you can wind it up maybe in about ten minutes.

MR. ORRIS: Oh, absolutely. Absolutely, and I apologize for running over.

Member Mobile app, it's just another application, another piece of technology for our members that gives them the ability to help navigate the plan, PCP, find an urgent care near you rather than going to an emergency room. It's mostly used for changing PCP currently but it's another application that we have thousands of people accessing to help them with technology because they're so hard to reach.

MR. CARLE: Do you have criteria for changing PCP's?

MR. ORRIS: Criteria for changing PCP's.

MR. CARLE: So that they just don't doctor shop and doctor hop?

MR. ORRIS: We have a pharmacy lock-in program for people that might be doctor shopping or hopping. So, they would have criteria but the average person who wants to change their PCP, no.

You've heard a lot today about

our value proposition and quality is no different. I believe this was one of the items that the MAC committee wanted to see.

These are some measures and improvement that WellCare has been able to show for our member population since 2012, the first full year that we were in operation through our last full complete year through HEDIS and you can see some dramatic improvements.

This isn't by accident I think is the only point I want to make here. This is large investments. This is 50 people in our Quality Department and probably no less than fourteen quality practice advisors. These are people that are out in the doctors' offices making thousands of visits a year with the provider relations team closing care gaps, providing lists, teaching the practices how to code appropriately to get the credit.

I don't think it's always an issue of the members aren't getting the quality care. It's just sometimes a matter of getting the documentation and it's very regulated and, so, we help with that.

In our work here that I suspect every managed care plan is doing, these help drive

Kentucky's quality national rankings. That's what makes this so important for Kentucky. I won't dwell on that but we're very proud of the work we do around quality and some of the demonstrated outcomes that we have been able to show.

MR. CARLE: So, could we also see followup? You've got the well-child visits which are nice and impressive. You're documenting your BMI's better, but could we see annual well list visits for the adults?

MR. ORRIS: Sure.

MR. CARLE: Also - and these are just right in line with HEDIS - mammograms, colonoscopies. Do you use FIT test and ColoGuard or does it have to be a full-blown?

MR. ORRIS: We follow the HEDIS criteria of the NCQA but I do believe that ColoGuard, FIT test, the actual colonoscopy all meet the criteria for an exam for a year.

MR. CARLE: Okay. And, then, kidney monitoring either with the microalbumin or a urine protein for nephropathy and, then, just the last one I was concerned about also, you've got some nice diabetes measures here. We talked about the retinopathy before but medication adherence for

diabetes.

MR. ORRIS: Is one you would like to see?

MR. CARLE: And I'm going to be consistent with everybody.

MR. ORRIS: Absolutely. Absolutely. Yes, those are very difficult measures to affect but we've got a lot of strategies through our Pharmacy Department and working with the pharmacies trying to make them a pharmacy home.

Our members may not see a PCP but once a year but they're seeing their pharmacist probably twice a month, so, using them as a tool to help close care gaps by leveraging their technology on their screen when someone walks in not only incentivizing them for medication adherence measures but also saying you're due for a colonoscopy or a mammography or something like that because they're getting pinged at many levels.

Pharmacy should be no different. So, we're starting to launch some of those initiatives to help drive quality.

Emergency room, this and the next slide around our PMPM costs, there are so many ways to slice and dice and examine what's going on

with emergency room costs and emergency room utilization but we kept it very simple. We wanted to show increased costs in our Emergency Department. In 2015, WellCare for our membership spent $139 million on ER services; and in 2018, that number climbed to about $180 million and that's despite the reduced utilization.

So managed care, what we can control and what we can leverage are our initiatives and our strategies to reduce ER utilization, and you can see some of the strategies we employ on the right there but those have been successful over time in reducing our utilization.

The costs, it's a function of contracting and it's a function of hospitals' reimbursement methodology which is a percentage of billed charges. If hospitals increase their charges, we're going to pay more for emergency room.

Medical expense trends. This is another one that I could fill a binder and I'm sure I have ten binders on my desk to do exactly that. So, there's just so many ways to examine our medical expense.

But I thought for this group at this level, if you want more detail, more

information, we would be more than happy to provide, but all we did here was just kind of look at the cost drivers of our medical expenses over the last three years.

So, in 2017 compared to '16, you can see that one of the primary drivers for us was outpatient and ER spend where pharmacy in '17 compared to '16 was actually a reduction. That flipped a little bit in 2018 where pharmacy became our primary cost driver for our medical expense trend and contributed 5.2%.

A couple of points I left out on medical expense. So, Kentucky average annual percent growth in health care expenditures per capita from '91 to 2014 just after managed care went live was about 5.4%.

In 2018, the national Medicaid spending increase - this was from CMS - was 2.2% and WellCare is in line with that national trend here for our membership in Kentucky of a 2.2% medical expense trend.

Given our time, I won't get into too many of the details that are driving it but suffice to say it's a lot of pharmacy. It's the buprenorphine, it's the increased access to those

services. Once they access that, it drives Hep C screening, it drives inpatient utilization as well but it's needed. I mean, that's not an indictment. I mean, we're doing what we need to do to improve access for these services, but there's a cost to it and I think we are all understanding of that.

Very, very quickly are some of our access measures. Contractually, DMS puts within our contract provider access measures. For PCP's, it's no more than thirty miles or thirty minutes in urban areas, and in rural, it's forty-five, forty-five and a PCP ratio not to exceed 1,500 to 1.

WellCare, our network, I think we have the largest network in the state and we meet our network adequacy requirements at 100% and our PCP-to-member ratio is 101 to 1, and hospital we're at 100% access as well. We've got a contract with every hospital in the Commonwealth.

Appointment and availability, we are also required to do these audits and report back to DMS. We hire the Myers group. These are independent surveyed audits. They call the practices every quarter and it's not disguising himself as a member trying to make an appointment. They self identify that it's an audit and it's regulatory.

It's part of your contract with us that you're required to meet certain access standards.

For our primary care and pediatrician, we fared very well. The standard is 90%. This last quarter, the last quarter with which data was available, we missed our urgent for PCP at 87.4.

We get detailed information on the practices that do not meet these standards and we follow up regularly with them to let them know of their requirement. They are re-audited again the following quarter; and if they do not meet the adequacy standard at that point, they are put on a cap.

Behavioral health, for the most part, we do okay, most importantly on the crisis stabilization which is most important. However, on the urgent which is a 48-hour turnaround, we have some access issue and I think there's just a large population of members seeking urgent behavioral health care, and right now, we're working with our practices to see how we can improve and enhance that access.

With that, I am happy to answer any questions you might have or provide followup in

addition to the measures on quality you had, Mr. Carle.

MR. CARLE: I'm good.

MS. STEWART: I have a couple of questions. One, you didn't present any data on provider relationships or claims data denial rates or audit percentages.

And I would encourage you to have more regional provider meetings in more locations because the ones you had were about three hours away one way for providers to get to that. So, that's really not conducive to work with providers for a day trip.

MR. ORRIS: Thank you for that advice. And what Ms. Stewart is referring to is WellCare conducts provider summits annually where we have historically gone to I think five cities. This year, we cut it back to four but tried to blanket as much of the state as we could, but we will take your advice. Are you in the west?

MS. STEWART: I'm in East Kentucky. I'm close to Virginia and my closest one was Ashland.

MR. ORRIS: Okay. We've had them in Hazard in the past, haven't we?

MS. STEWART: You have an office there. That would be great.

MR. ORRIS: Duly noted. Thank you, but those provider summits are great opportunities for our providers. We just had one last week, in fact, in Bowling Green.

They're attended by over 200 providers all across the spectrum of provider types where we present similar information but, then, also have breakout sessions for claims, for credentialing, for behavioral health, for authorizations where providers have an opportunity, in addition to the 400-plus office visits we make in a month through our PR team, to ask us questions and kind of put ourselves out there and be responsive partners to our most important partner, our providers.

Any other questions?

DR. PARTIN: Our next meeting will be in July. Would you be able to provide us the information that we've asked by then?

MR. ORRIS: Absolutely, and that's on the additional HEDIS metrics and, Ms. Stewart, you would like some information on authorizations and denials. Did I catch that right?

MS. STEWART: Just about claims

data, denial rates, percentage of denials under audit, things that providers are interested in.

MR. ORRIS: Okay.

MS. HUGHES: And, Beth, I'm assuming you want just a written report from them because you're going to have three MCOs presenting at the next meeting.

DR. PARTIN: Correct.

MR. ORRIS: We will follow up in writing.

DR. PARTIN: Thank you. And next we have Passport.

DR. HOUGHLAND: Good morning. I think it is still technically morning, correct?

DR. PARTIN: It is.

DR. HOUGHLAND: Madam Chair, distinguished members, my name is Steve Houghland for the record. I'm the Chief Medical Officer for Passport Health Plan, and joining me is Dr. Liz McKune who is our Vice-President for Health Integration.

Hopefully, you received in enough time a more formal presentation. It wasn't my plan to read this line by line. So, unless that pleases the committee, we can do that.

But I think in the interest of time, and we recognize that we're probably keeping you from lunch and your day's activities, and we were operating under the idea that we had about twenty minutes for a presentation, I was actually thinking about something less than that, allowing enough time for an opportunity for the members to ask questions.

Our team members have already taken note of the items that have been requested from the previous presentation. I recognize that some of those are not included in this and we had not planned on addressing that but we will have that in writing for you in advance of the next meeting as well.

DR. PARTIN: Okay.

DR. HOUGHLAND: Just as a quick reminder, Passport is a nonprofit provider-sponsored health plan that has been in operation in the Commonwealth for over two decades, beginning originally as a regional health plan in 1997 and, then, in the early 2010's did expand to a statewide managed care organization.

Today, we are proud to help serve over 300,000 Medicaid recipients in Kentucky and help serve the Commonwealth in that regard.

I'm not going to run through

this history lesson for you. There's some good information in the first slides.

One of the things that we were asked to talk about - and we did not get into real granular detail on this, and, so, I will apologize in advance and we will provide that information in writing to you - are some things that we have been doing, things we're proud of and quality is obviously one of those.

There are some areas that we have had consistent performance at a high level in, well-care visits being one of those and EPSDT services for children is another area that we have had consistently high performance in, but I think we need to recognize that there are some things that us in combination with our provider network have opportunity to make improvements on.

Some of those have been in behavioral health, access and availability in that end. Physical health is an area that we see that we can make some improvements in, also working with our provider network and customer satisfaction.

The Consumer Assessment of Healthcare Providers and Systems' surveys that are done on an annual basis have shown that our members'

perceptions of the care that they have been receiving from their providers is a place that we can improve upon, and we continue to work with our organic provider network to help make some improvements there.

Things that I would call out, and there are some discrepancies here, and that happens in surveys - it's really interesting - but when you look at the overall health plan rating, we have consistently performed well in getting care quickly and rating of the health plan; but, then, when the questions that are more specific to our provider network performance, there seems to be a paradox because our members have said that they have concerns about getting needed care.

And, so, how does that marry? On one hand, they say that they are getting care quickly and are satisfied with what the health plan is doing, but, then, on the other, they say that the care that they are getting isn't. So, this dissonance is a little bit of a challenge at times.

One of the things that we in particular recently have set out to try to get better alignment in is our initiatives and expectations related to our provider network and how do we engage

them and how do we engage the members, and instead of asking completely disparate sets of expectations or trying to enforce different expectations is to really try to get alignment in that, and drawing upon a lot of the work that the Cabinet has done recently with the Kentuckiana Health Collaborative in developing core measure sets to try to help narrow down some of the multitude of measures that different organizations look at.

If we incentivize our providers and try to provide engagement opportunities for our members to hone in on those core measure sets so that it works together as opposed to being a tug of war in what we're trying to get people to do and a lot of those are very intuitive - focusing on preventative services, things like breast cancer screenings or cancer screening for both the provider and the member, other preventative services like early child visits and focusing on immunizations and, then, things that we know are impactful, things like diabetes care, cardiovascular disease, medication maintenance.

Those are all things that we know can make a difference. And if we align both the member activity and the provider activity, we feel

like we can be a lot more successful, and as a result, the Commonwealth will be much more successful.

To provide a little bit more information on those, I will turn to my learned colleague.

DR. McKUNE: In terms of our provider engagement, we have been working to create incentive programs and value-based contracts that are tied to these metrics and trying to improve the health and move that needle.

As well, we have invested a lot of time, energy and resources in creating an enhanced reporting package so we can do a better job of providing feedback in a more timely manner so providers can track and understand where the individuals they are responsible for are in terms of having their assessments done and receiving the types of care that they need in a timely manner.

We have worked very hard to streamline our enrollment process. We look forward to participating in the standardized credentialing process that will be implemented very soon, but we historically had had some cumbersome challenges there that we have worked hard to facilitate improvement

in.

We have also participated in some of the PIP pilot partnerships. Primarily at this point, our partnership has been with Park DuValle - it's a family health center there in the Louisville area - where we focused on transitions of care and avoidance of ER stays with ambulatory-sensitive conditions.

Some of the other things that we have done in terms of looking at alternative contracts in the behavioral health space have focused on trying to improve the coordination of care for our members that have severe mental illness.

We have worked with one of our largest community mental health center providers and done targeted outreach for members with severe mental illness. Through this process, we have seen a 70% reduction in medical inpatient stays, a 38% reduction in ED visits and a 61% reduction in behavioral health hospitalization.

So, I think by us targeting what we know about these members who have severe mental illness that, on average, they die 25 years sooner, that addressing those comorbid conditions that go along with that can have some real cost

savings as well as health improvements for those members and hopefully help sustain and maintain a longer life.

Additionally, I'm now looking at Member Engagement on page 9, if you want to follow along. We have been working to integrate technology for communication with our members. We have recently implemented a texting program to communicate with members.

As well, we have been having a focus group across our organization to look at new member experience. We feel like if we can engage members in that first 90 days that they have Medicaid benefits and help them become not only engaged but active in their care, that we can hopefully help them have a better care experience as a whole while they are receiving Medicaid benefits.

We have been working on trying to receive better ongoing member feedback to improve the member experience. We are in the middle of revising our member incentives to more closely align with our quality metrics. So, we are hoping to roll out a completely revised set of incentives in 2020.

And, then, the other thing that we are currently doing is looking at having our

community engagement individuals partner with providers so that if providers want to do something to improve their health metrics, let's say they want to increase well-child visits and they would like someone from the plan there to help explain benefits to parents and those kinds of things, that we would provide staff onsite to help support and provide information during those periods of time so that we can do the background work and the legwork so that providers have the opportunity to address those metrics and members get their questions answered.

MR. CARLE: So, did the provider incentive programs and the value-based contracts have positive outcomes from your perspective and the providers' perspective and did it drive a change?

DR. McKUNE: I think that we have learned a lot in the process. I think we have become smarter, and I think the first ones that we rolled out were four years ago in terms of behavioral health - the primary care side has been much longer - but we have learned a lot.

Initially, it's like how do you move that needle and help providers take on more risk. So, we started off really initially with just

some performance incentives so that if we saw some positive metrics, that there was an opportunity to earn dollars versus there being more risk tied to the actual health outcomes and those might move up and down as the health needle moves up and down.

And, so, we have seen some positive metrics, and I think the providers have been very patient as we've kind of moved through that.

The biggest barrier, I think, has been being able to get the data that's useful for all of us out of the system when we want it and being able to hone in and make those targeted pieces of information that are relevant available.

DR. HOUGHLAND: If I could expand on that a little bit and in a little bit different lens as well.

So, we certainly haven't declared victory by any stretch of the imagination, and I think the reality is that what we have done so far, it would be hard to extrapolate that and scale it to a much larger population of members to be served and providers.

And one of the things that I don't believe we have done systematically, not just Passport but probably as a community, is willing to

assess the willingness to change and not just the willingness but the ability from both sides as far as how easily are our systems adaptable, how quickly can they connect to be able to facilitate some of the transfer of information and in a manner that it's really actionable, and I think that's a big challenge that we have.

When you look at individual organizations that want to do things, I think that's great; but the reality is is that when you're one of the few that are trying to do something, at the end of the day, the law of averages does take effect. And if you're only one mover, then, it's hard to move that everywhere.

MR. CARLE: And the providers don't like it but it's the economic reality of the industry that we're in. CMS wants to be out of the risk by 2025 and they're going to do everything they can by hook or by crook to make it happen.

So, if, in fact, that's working again, as somebody that represents providers and hospitals, we're trying to deal with it to your point, but it's just the wave of the future.

DR. HOUGHLAND: Well, I don't think you're alone obviously in that feeling and we

don't either. It's just the pace in which to get better is I think really the question, and is it sampling still? Probably at this point.

MR. CARLE: Okay.

DR. HOUGHLAND: So, we did actually highlight something that is of mixed results and it's a topic that I've heard in this room before and others around the Commonwealth and that's what is happening with ER utilization.

So, what we present actually tells a little bit of a mixed story. When you look at our own membership and the ER utilization trend over time, the absolute utilization of the ER has seemed to decrease based on our claims information from 2016 to 2018 in particular.

The first month of 2019, it seemed to move up a little bit one month really doesn't necessarily speak to that trend but overall utilization does look like it's moving in the right direction.

The place where we have not been able to have as much success is avoidable or potential avoidable ER utilization, using the New York Classification Schedule identifying those which arguably, admittedly, there's some issues with that

classification but it's widely accepted and it's out there.

We have not seen that same impact. So, what it looks like is happening is that avoidable utilization still continues a lot the same, but through interventions and better provision of preventative services through the entire network and system, we have been able to make a difference in the overall impact.

So, it is still positive, just not exactly what we were looking for. And when you look at the utilization from a regional standpoint, there's not a lot of difference. Admittedly, our population of members outside of the Louisville Metro area is smaller, and, so, it's more subject to skewing. There's not a massive difference from one region to the other as far as what appears to be behaviors of members using the ER as a first sight of service.

What can we do about that? Well, we continue to look at how do we embed more of our team members and really more peers and using the concept that people that are in a similar situation to our members are more likely to have impact and that communities really do drive medical decision-

making, maximizing community health workers, population health managers within a practice to inform the practice about what is happening in realtime are all initiatives that we're taking on at this point.

Recognizing the time and moving quickly, if you move to Slide 14 and 15, these are some snapshots of engagement in four of our main care management programs and showing an increase in that. We did make a pretty dramatic model change in our care management programs at the end of 2017 into 2018 and that continues.

We shifted from really a traditional care management model which was primarily referral-based of both internal and external referrals to one that is more predictive in identifying members who are at risk for having an untoward event -a hospital, re-admission, etcetera - and using predictive modeling to try to identify those members that we can impact at an earlier stage to prevent the downstream unwanted consequence.

That has taken some time internally for our team to kind of embrace that model and also from the members to understand how that really works for them. And over time, we have seen

our engagement rate, an acceptance rate from the members grow from the twenties and thirty percent which is kind of more typical of what you see in a lot of care management programs that are offered to mid-forties, upper forty percent range which is really - I have a bias - but it's a very exceptional rate to be reporting.

And, again, recognizing the time, I think we'll move quickly to Liz.

DR. McKUNE: We're going past Slide 16 which shows network adequacy in terms of the reporting that we share with DMS.

Seventeen, this slide represents the number of behavioral health providers and the dramatic growth that we've seen over time. You can see there in 2014 when we had the State Plan Amendment implemented how providers providing outpatient services outside of a community mental health center were allowed to enter the network for the first time.

So, you can see how that growth has changed over time, that we started off in 2014 with about 1,296 providers and today we have over 3,200 providers.

So, we'll go ahead and pass to

Slide 19. Here we have a slide that summarizes our foster care pilot that we implemented in conjunction with DMS and DCBS, as well as the Department of Behavioral Health and Developmental and Intellectual Disabilities.

We served fifty-nine children. We actually added a full evaluation team along with the implementation of this program so that we could have an independent review of the effectiveness of the program.

They went in and looked in the charts at DCBS to look at what is going on with the children, what is the history, what are those kinds of things involved so that we could have some standardized metrics to determine if we had done an effective job of implementing this evidence-based practice that had worked in other states around the country.

So, we basically identified children that were at risk of disrupting their foster home placement because of their behavioral health needs. And when we pulled the data originally for Jefferson County which is where the pilot was conducted, there were over 700 children that were on that list that already had three or more moves in the

last two years and were at risk of another move because of their behavioral health.

When we looked at that data as well, one of the things that sticks with me is the highest number of moves that a child had had out of those 700 in two years was thirty-nine times.

And, so, we worked very closely with the Department of Behavioral Health. They were able to secure a grant to bring in High Fidelity Wraparound Training for staff here in Kentucky and that's the model that we approached the providers that partnered with us that we wanted to see and use.

So, we used the HFW wrap evaluation tool to determine did we maintain fidelity to the model. Did we implement it like it was supposed to be implemented, as well as looked at the different outcomes.

We had the chance to go and share our results in January at the CMS Quality Conference. Dr. David Hanna and Stephanie Stone from our team will also be presenting at the National Family Focus Treatment Association conference later this summer about the results because we felt like we went there initially to learn what should we do in terms of what should be implemented here and now it's

time to also share what we learned with others that are also trying to figure this out.

I guess the most exciting outcome that we saw were that we had a 150% increase in children living with their natural or adoptive family members compared to the six months pre-intervention.

So, while this involved a higher investment in outpatient services, helping those children develop a network that was an informal network as well, so, if things started to go bad one day, that they didn't have to just rely on their therapist, that they had a full support system around them, we saw that even though there was a high investment in working with the provider, that we had a bundled rate so that it would cover whatever the child needed and we tracked as well trying to determine are there additional things we need to look at adding to benefit so that children in foster care placements could be successful.

Are there other things that we need to think about as a whole, and we wanted to reduce that barrier for providers so that they could just make sure that the kid had whatever they needed during the process.

Even though there was that additional investment at a much higher rate than, say, targeted case management pays today, we still saw an overall reduction in spend for each child that participated $161 per member per month.

The other thing that I wanted to just kind of mention today while we were having some time together were the efforts that we are trying to impact the opioid crisis through.

Currently, we have a dedicated substance use disorder program manager, Dr. Cheryl Hall. She joined our team from the Kentucky Department of Corrections where historically the majority of substance use disorder treatment in the state was provided before it became a Medicaid benefit.

We have participated in an SBIRT Collaborative sponsored by the Center for Health Care Strategies. This has been more of a preventative effort in trying to increase the number of primary care physicians and nurse practitioners who assess for substance use disorder in adolescents.

The research shows that by screening when people are in that stage of adolescence, that if they're not using at that point,

should they use in the future, they know that the primary care is a place to go for support should they begin and need assistance in the future.

We also have started a partnership with 180 Health Partners to provide case management for women who are pregnant and have a substance use disorder where there will be hands-on nursing and case management provided for these women that will assist them in getting to appointments. It's been effective in other states and we're hopeful to see similar results here.

We have also worked with providers to develop a stepdown intensive outpatient and case management program for pregnant women who go and have detox and, then, frequently they were just discharged into the community. So, we have worked to create a program for them to step down into.

We also have partnered with providers recently to look at how do we create better opportunities for members who have endocarditis. So, they might have bene using substances and now have a comorbid medical condition that requires IV antibiotics.

Frequently they're not allowed to use the IV antibiotics in the substance use

disorder setting. So, we have worked with providers and really put the ball in their court in saying what can we create that would allow someone to not only get that important medical care through the IV's that they need, but at the same time, participate in that important substance use disorder care.

And, so, providers have been really creative and we're happy to report that we are now contracted and will be able to provide some solutions for those members at least in the Louisville area at this point and hopefully can expand to other parts of the state.

So, any questions that you all have about the information we've shared today?

MR. CARLE: Like we asked, if you could also provide the HEDIS measures and the denial rates that Susan asked for, that would be great.

DR. HOUGHLAND: We'll do.

MR. CARLE: Thank you very much.

MS. ROARK: I have a question. Are you guys thinking in the future that you may do the work program as well?

DR. McKUNE: We actually are

participating in a couple of different programs where we have access to supports in the community and connect members to those supports.

So, while it's different than what's talked about in the previous presentation, we are part of an independence readiness project there in the Louisville community where foster children that are aging out are getting connected to work, as well as additional training or schooling.

We have been part of the planning committee for that where we have brought employers to the table so that we can help people better make those transitions.

And, then, we are one of the steering committee members for a shared social services record that's being piloted in the Louisville community right now where if someone needs help connecting members to, say, assistance with housing or food or transportation, they're able to call in.

It's Internet-based as well. It's sort of like an app. It's kind of like Uber that someone responds and you get a response back and, then, that information is housed. So, if that person needs assistance in the future, you're able to

go in and see who they have been connected with in the past and how has that worked. It's called the United Community project there in Lousiville.

MS. ROARK: So, nothing geared toward Eastern Kentucky?

DR. McKUNE: We have another resource that we use with all of our case managers called Healthify that's statewide that our members can call in and we will assist them with connecting to resources in their community.

MS. ROARK: Okay. Thank you.

DR. PARTIN: Thank you very much.

Does anybody have any other business they would like to bring forward?

MS. HUGHES: I thought about this this morning. Your next meeting will be July which will be the time for the elections for Chair, Vice-Chair and Secretary. So, if anybody wants to run, let me know and we can do elections next time.

DR. PARTIN: Yes, ma'am. Okay. So, having said that and we do not have a quorum, so, we will just adjourn.

MR. CARLE: Before everybody goes, I would like to recognize Dr. Neel who is one

of our contemporaries. He put a lot of time into the MAC and as well as medicine in general in the State of Kentucky. So, it's great to see you again, Doctor.

MEETING ADJOURNED