DEPARTMENT OF MEDICAID SERVICES
NURSING SERVICES ADVISORY COMMITTEE

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A P P E A R A N C E S

TAC Members:

Lisa Lockhart, Chair
Dr. Eva Stone
Jennifer Wiseman
Dolores Polito
April Hester

MS. BICKERS: Ms. Lisa, it looks like the waiting room is cleared. Eva is currently logging in, so you might want to give her a moment to get on camera and microphone, but I will hand it over to you. You are muted, ma'am.

MS. LOCKHART: Sorry about that.

So from what I can tell, it is just me, Jennifer, and Dr. Stone, as far as the TAC members are concerned, is that correct?

MS. BICKERS: Yes, ma'am.

MS. LOCKHART: Okay.

So Dee Polito, I know, had excused herself, maybe --

MS. BICKERS: It gives you a quorum, and I can let you know if April logs in.

MS. LOCKHART: Okay. That is what I was just getting ready to see if I missed an email from her. Okay.

All right. So we will go ahead and move on.

Hello, everybody. Thank you for joining us today. It is a pleasure to be

here and to see all of you. This month kind of crept up on us quick. I'm sure everybody has been as busy -- everybody has been busy and the holidays are amongst -- the holiday season, so folks are busy.

After today, our next meeting will be in December, so time has a way of moving on.

The minutes from our last meeting, I am looking for approval from those.

Erin, did we post those? Did you post those again?

MS. BICKERS: Yes, ma'am.

They got sent out and I can -- if you give me a second -- can know what date.

MS. LOCKHART: I remember looking at them, but I don't remember --

MS. BICKERS: They went out 8/22.

MS. LOCKHART: If you haven't looked at them, while we are talking, if you can take a look back on 8/22 and take

a peek there. We are looking for approval of those minutes.

MS. WISEMAN: I will make a motion to approve.

MS. LOCKHART: Wonderful. Thank you.

MS. BICKERS: Jen, can you turn your camera on? My apologies.

MS. LOCKHART: I always forget that, too.

MS. WISEMAN: I know. To make our vote.

MS. LOCKHART: Okay.

Dr. Stone?

DR. STONE: I can't get my camera to turn on.

MS. LOCKHART: You were on a minute ago, but you were frozen in time.

DR. STONE: I know.

MS. BICKERS: We can come back to the minutes if Dr. Stone is having some technical issues, if you'd like.

MS. LOCKHART: When you can get your camera fixed, let us know, and in the meantime, we will move on.

We are looking at our old business. Just to review, with the end of the PH emergency, we would like an update from the cabinet on Medicaid unwinding and how things are going. We had a lot of great presentations in August.

MS. CECIL: Good afternoon. This is Veronica Judy Cecil, Senior Deputy Commissioner of Medicaid.

I just wanted to highlight a couple of things. We are now into our sixth month of renewals, the restart of renewals. I will say a couple of things just to remind folks about. We had pushed a lot of cases to, sort of, toward the end of our unwinding period. Cases that are involving children. The reason for that is we were implementing child continuous coverage where if a child's determined eligible, they are granted that 12-month continuous coverage, and there are only a couple of reasons why somebody may lose eligibility -- a child may lose eligibility -- during that time, such as turning 19.

So we do have a large number of cases now that are coming through the renewal process. But we have continued to implement a couple of different flexibilities to help us manage that workload into a system to benefit members as they are navigating the process.

For example, we just implemented extending anyone who has not responded to a notice for a month. So if somebody is coming up on their renewal date, let's say October 31st, and we have not received a response to request for information, or to the renewal packet that they're sent, we are allowed to go ahead and extend those folks for another month while we continue to do outreach to them to get them to provide that response to us. Obviously, our goal is to actually make that determination as to whether somebody is eligible or not.

We do know that folks may not be responding because they know that they are no longer eligible, either their income has increased during the public health

emergency, and as we move through renewals, but what we do want to make sure is they understand that they can get connected to other coverage, such as a qualified health plan on the Marketplace Kynect. So just making sure that people are staying covered even if they are no longer Medicaid eligible.

So we are seeing a large number of pending start to accumulate as a result of that. We are also -- while we are giving most of the population an extension for a month, we are extending long-term care and 1915c members up to two months. So we may see that someone has a redetermination date of, say, September 30th, but we might give them an additional two months to get that response in, get that renewal packet in. Again, just trying to keep people covered as they are navigating that process of responding.

On both sides, we're giving members that additional time to get the necessary information to us; but also from a workload standpoint, just making sure

that we are processing those renewals.

This is creating an issue on the application side, with the increase in work on the renewal side, if there were new applications pending, that is creating some backlog for our applications as well.

Some of the things we are doing to try to overcome that -- we are bringing on additional staff on a regular basis and training them up in different ways to help offset that workload to our DCBS eligibility workers -- Department of Community-Based Services eligibility workers. So we are just trying to manage the workload as best as possible. I think our biggest concern is just making sure that members are responding. If they do have something pending, their coverage is extended until they get processed, so just encouraging folks to get that in by their renewal date. It gives them at least some coverage until that gets dealt with.

There are, you know, certain problems with certain cases and we just continue to urge folks to escalate those

to us. We work very well with the connectors, which are the individuals across the state to who are either contracted or who volunteer and have been trained to assist members with their renewals.

We have an escalation process through connectors and through insurance agents who can also, now, assist members with their renewals. So just asking, you know, if somebody is having difficulty, to please escalate those cases up to us so that we can get them looked at, and determine whether or not there is a system issue. We were hearing that individuals with pending documents were getting terminated and they shouldn't be, so we have to go in and make sure those cases are being extended as they are supposed to be.

Just a reminder to providers, we understand that you have a lot on your plate, but we really appreciate you all being a source of outreach to our members. Checking that redetermination date and

Kentucky Health MAC because it is now available.

If you know that their renewal is current, let's say they have an October 31st renewal date, or they may be they have a November 31st renewal date, having a conversation with them to make sure they understand that they might have to go through an active renewal. Not everyone has to.

If we are able to go out and check the databases that are available to us we can automatically extend -- automatically redetermine somebody so it is really just the active individuals that we are more focused on. The other thing to mention is that if somebody does come in and they say that they have just been terminated, because maybe they didn't respond to a notice, they do have up to 90 days to be reinstated, so if they could just reach out and provide that information to us, we can reinstate them with no gap in coverage.

So just encourage providers to

help members understand that that option is available to them. We have a new provider flyer out on our unwinding website and I'll be happy to put that into the chat -- the link to that into the chat. Lots of provider resources out there, other stakeholder resources, and our next stakeholder meeting is next week, next Thursday. If you are unable to attend a live presentation, we always record them and post them to be able to go back and look at it just for the most up-to-date information on what is going on with unwinding.

But happy to take any questions that anyone might have.

MS. LOCKHART: Well, first I want to comment that it seems very generous that we've automatically extended one month and then two months for long-term care. I mean, that is very generous and very flexible considering to -- accolades to you all, the extremes you have gone to to try and make sure that nobody was overlooked.

I guess my question is, at what point -- is there a plan, since you are also giving them 90 days to come back and get signed on, do we have a hard cut off so that you can better address your backlog of folks that are trying to get on the program for the first time, because I know that, population wise, I am sure in Kentucky, but across the United States, we are seeing a lot of changes and a lot of influx, and a lot of people who are applying for programs. As we look at new business, that question is going to come up.

I'm trying to make sure that I am formulating the question right. What is your plan moving forward? Is there a plan for a hard cut off? I mean, you all have been exceptional, I think, as far as being accommodating.

MS. CECIL: Thank you for that.

We have to do this within 12 months so there is going to, eventually, going to be in April 2024 -- unless there is a change in state law, we are going to

have to have a final hard stop for folks. That is going to happen.

Again, one thing that we are trying to do is continue to bring on staff, and train current staff, to be able to handle those redeterminations or processing those renewals and applications. So we really are hoping, based on the forecast that we are seeing, that is going to happen towards the end of the unwinding period, that we should have enough staff to try to handle that.

MS. LOCKHART: Again, thank you. I applaud the efforts that have gone on across the state. I'm impressed every time we meet.

Dr. Stone, did you have a question?

DR. STONE: Not a question. I was just going to comment and really say thanks for all of the work that is going into this.

On a firsthand personal experience, we had a daughter that we fostered for many years. We still

consider her ours, and she is grown, but our address is still listed for her, and she has WellCare as a secondary insurance, and I've gotten multiple, multiple calls looking for her, and I've just been so impressed that it is not just one and done. I told her today that you have to call them back.

So anyway, I just wanted to say thank you for this work, because not all families across the country are experiencing that kind of caring. So thank you.

MS. CECIL: I really appreciate that and we do have a very exhaustive outreach plan.

Not only is the state working with people who have to take action, but our managed-care organizations for our members are doing the same. There are a lot of organizations, but we thought it was necessary to make sure that we can try to reach folks before that termination happens. That is obviously our goal.

MS. LOCKHART: I applaud you.

MR. OWENS: This is Stuart Owen with WellCare, real quick.

All of the MCOs I'm sure echo that DMS has done an outstanding job with this and, especially when you compare it with other states, they really have.

And also, Dr. Stone, yes. Please call WellCare. Please have her call WellCare.

MS. CECIL: Thank you, Stuart.

MS. LOCKHART: Any other questions or comments on this topic?

All right, thank you again for that update and report. Are there any updates on the immunization fee schedules?

I can't talk today. I'm drinking coffee, but I still can't talk. I'm sorry.

Anyone?

MS. JONES: Good afternoon. This is Erica Jones with the Division of Healthcare Policy.

Could you remind me what the actual questions were regarding the immunization fee schedules?

DR. STONE: Erica, I think it was just an update for the whole TAC.

I know that you all recently looked at those schedules and changed them to update them to make sure that kids had access to vaccinations, and just wanted to be sure that that was shared with the TAC.

MS. JONES: Yes.

And I think the latest update has been the COVID -- the new COVID codes. And also adding RSV. It hasn't been added yet, but we are in the process of getting that added, and also doing the change orders to make sure that, as those claims come through, that they are approved.

MS. LOCKHART: Okay.

Any kind of estimate -- I know just for hospital systems, they are struggling to get the new vaccine. Wondering if you have any intel on that? Does anybody? It's hard to make a schedule when you don't know when you are going to have the product. I was just curious about that.

MS. JONES: Exactly. We had a

meeting with public health earlier today and we were told that there hasn't been as many providers asking for the RSV for adults as they anticipated. But the campaigns are out there, and they are strong, for wanting to immunize adults with RSV vaccine, so I anticipate that that may be getting more intense as the colder weather comes in when people are starting --

MS. LOCKHART: When people are actually getting sick.

MS. JONES: Yes.

But as of now, we haven't heard anything from any providers or any concerns from them as far as getting the vaccine or needing the vaccine or haven't been able to.

MS. LOCKHART: Okay, great. Thank you. Thank you, very much.

Any questions or comments on that? Before we move into new business?

Okay. So we will move on to new business. Thank you very much.

Number one on the list is are

the challenges for rural Kentucky different than that for more urban and heavily populated areas of the state?

MR. OWENS: This is Stuart Owen with WellCare, again.

Is this directed at MCOs, I am thinking?

MS. LOCKHART: Yes.

MR. OWENS: I do have -- it's nothing flashy, but I do have a few slides that I can share. I'd be glad to share.

MS. LOCKHART: Thank you.

MR. OWENS: Sure.

MS. BICKERS: You are now a co-host, Stuart. And as always, if you can email me that after the meeting, that would be great.

MR. OWENS: Will do. All right.

Do you all see Kentucky Rural/Urban Comparison? A chart grid?

MS. LOCKHART: Yes, we do.

MR. OWENS: All right. We have an awesome quality team, Christine Lewandowski, who I don't think is on the call today, created this, and this is

Kentucky data right here.

I don't know if you all -- maybe I need to increase it a little bit. These are various, kind of, metrics related to social determinants of health and anything related to accessing health, and so it's like priority income, Internet, transportation.

And so this is an urban versus rural break down. On the left column where you see the three, now there's the category. This is rural and urban. This for all of Kentucky. There's a couple of these categories that just have WellCare data, but this shows you rural and urban Kentuckians.

So for example, we have red squares, not circles, socioeconomic vulnerability index. And so we have a little note at the bottom. This addresses the percent in poverty, unemployment, educational level, linguistic isolation, how much income is spent on housing, and the higher the number, the more vulnerable, so you can see this is for

Kentucky, rural areas of Kentucky, 68.6 is the rating for that social vulnerability compared to 54 for urban, and you know the far right is the statewide average. So that is clearly higher for rural.

Also, just for median family income, rural it's 56,000 and urban is about 67,000. Percent of individuals over 25 with no high school diploma, it's roughly 19 for rural, compared to 12 for urban.

What is kind of surprising is over on the right there, the food desert tracks. Rural is right about 6 percent, but urban is almost 22 percent, which indicates that it is more challenging, there are more pockets in urban areas where getting food is a challenge than rural areas. And then, further down, we have a couple categories here, with the red squares; average number of households with no computer at all, 15.7 percent for rural and 9.5 with urban. Percentage of households without Internet, 23.6 in urban -- rural and 15.5 in urban. And so

obviously, there are challenges in both areas and they kind of differ, but we have particularly noticed that for WellCare, for example, we have 60 percent of our members in a rural area and Eastern Kentucky, in particular, we got more -- we have 160,000 members, which is more than all of the other plans combined in Eastern Kentucky.

So some of the challenges that we particularly see is number 1, the individuals of higher acuity, they tend to be sicker, so they have health -- multiple health conditions, health problems and particularly in Eastern Kentucky, there are fewer specialists, you know, different healthcare specialists. Particularly in pediatric. There are some -- really statewide, that is a challenge, like with pediatric specialists, but it is even more pronounced when you get into Eastern Kentucky.

So we do contract with -- all of the border children's hospitals, and those usually have a really robust network of

the doctors and nurses and allied professionals, so we contract with them to try to address that need, and also Telehealth is one thing.

And kudos to DMS, way before even the COVID pandemic, DMS has a very expensive coverage of Telehealth. They were way in front of the rest of the country. A lot of people didn't discover until the COVID pandemic, but DMS already had a very expansive coverage -- progressive coverage for Telehealth and it was extended even more during the pandemic. So that's definitely helped. We've got 89 different provider types that we've looked at that we have paid a Telehealth claim to, and it's over 12,000 distinct providers, so that is one of the tools that we used.

There is a challenge, as well, our care management team tells us, with nonemergency transportation, and because one of the requirements for that is that you have to demonstrate that you do not have access and it is not available --

transportation is not available. So that is a little bit of a hurdle, for example, when the car's being worked on, the member has to get an attestation from the mechanic that it is being worked on.

One of the things our care management -- we do outreach to members who basically show up as being an owner. For example, you have a couple that maybe split up and you've got the individual still on the title to the car as a co-owner, but they don't live with the person anymore. So that's one of the things that our care management team does is work with those individuals and educate them how to go to the county clerk's office to get their name removed so it's no longer showing that they are a co-owner on a car.

Absolutely -- you can see that there are challenges in both areas, really, but definitely, those are the few challenges that we see in the rural areas.

MS. LOCKHART: Thank you very much. That was very helpful.

And you are talking about the pediatric difficulties, women's health in general, OB/GYN -- that continues to be a challenge, especially in rural areas.

I know one of the things that prompted that line of questioning for this group, is concerns about changes in healthcare offerings across the state and what that will mean for rural facilities. It poses a great deal of concern, I'm sure that's shared by everybody on this call, what that would mean, since a large portion of our state is rural. The impact could be devastating.

I think by the information, the data that you just had in front of us, I think you said 64 percent, I believe, of our state is considered rural, so the impact could be huge.

Anyway, thank you very much. That was very informational and I appreciate that.

MR. OWENS: Sure.

MS. LOCKHART: Anybody with any comments about that?

MS. NACHREINER: This is Jennifer from Aetna.

I think -- you will get a consistent message across MCOs. I think our membership distribution is going to claim to what our particular data looks like, but I think one of the things that was really interesting to us as we started looking at this rural versus urban challenge, is what is the percentage of our friends and neighbors in the commonwealth who qualify for Medicaid by county, and looking at that distribution, because you will begin to see that in those more rural, eastern areas, in particular, the percentage of those who are Medicaid recipients goes way up.

From -- if you are looking holistically, like you said, on the impact of any policy change or facility change, or something that is going to impact facilities, it will likely disproportionately hit the members that we serve versus your commercial or Medicare, because we are covering those lives.

I echo what Stuart said from a transportation challenge perspective. I think broadband access is also an issue in some of those areas which can hinder our ability to reach them with other avenues like Telehealth.

I would like to leave with this caveat, too. One of the things that we have seen recently, actually, is counter to what we have been thinking from a rural urban perspective. We are seeing - we are looking at all of our quality measures with an equity lens now. So do we have demographics that are not seeking services at the same proportion in an urban area as they are in a rural? Or men versus women? Or black and brown versus white?

We are seeing that our men in urban areas who are black or brown are not seeking care at the same rate as their counterparts in rural areas, or women. And, particularly concerning to us is those who maybe have a history of substance use and the lack of follow-up that they are getting there. So that is

something that I think -- I just want to challenge us as we are thinking about rural/urban.

I don't want to forget about our friends in the urban areas because there are challenges there too, although the density, and the population, and the access is there, we do still have challenges that we are seeing in our data from an access perspective. So I just want to leave with that.

MS. LOCKHART: That is a very valid point. That is a very valid point.

And we have spent some time at past meetings discussing that, and especially when you look at the black and brown communities, a sense of distrust of healthcare institutions, and what kind of an impact we can have, as nurses, on that, and one of the avenues that we discussed as a team, was getting to them when they are young, and instilling that trust of healthcare institutions in them, because, historically, there have been issues that we have to own as a country. And how do

we tackle that and overcome that? And that is part of what you see in that data. It's right there in front of them, but they have an innate fear of going, and their loved ones and family members and friends and associates share that same fear that they've come to accept culturally, if you will, as part of their environment, and how do we overcome that and combat that?

A very valid point. A very valid point.

DR. STONE: Speaking from an urban perspective, nursing perspective, in our district with about 100,000 students, very stark disparities in access to care for our black and brown children and for, most significantly, children living in poverty.

What we have found internally, in doing weekend events, is that parents who are working labor jobs that have to be there all day, the healthcare system just isn't necessarily set up to meet those needs of families with social determinant

issues, which is why it makes engaging all the stakeholders that can help ensure access are able to do that and bill for those services.

I just wanted to say that we are fortunate in implementing a new electronic health record to add to the discussion that will work with the managed-care organizations, so when parents opt in to this system, when students have multiple visits to the school nurse, for example, or there's things built in to the platform, that will alert to the insurer. Parents have to opt in that they want to participate, but for example, a child with asthma that sees the school nurse several times in a week, that will trigger an alert to the managed-care organization so a care coordinator can reach out to the family and really, with that goal of providing wraparound services for families, and ultimately helping ensure healthier, healthier kids, but also lower cost for their care.

MS. LOCKHART: Excellent.

A lot of proactive things. We had this same conversation with KNAC, the Kentucky Nurses Action Coalition. We have these same conversations about healthcare disparities and equities and how do we reach these populations and encourage them to -- you know, you can put all of the work you want to in developing programs, if you can't get them into the system to engage with you. How do you get them to engage?

Good conversation. Thank you.

Anybody else have any thoughts they want to offer on that?

MS. WILSON: Yeah. This is Carrie with Humana. How are you doing?

MS. LOCKHART: Hi. Good.

MS. WILSON: So some of the things we have seen in the past, especially in the rural areas, was transportation. Just trying to get good transportation to and from appointments. And another thing we have seen in the past, as well, is access to food, or healthy food.

Another one would be with the children and making sure that they get the vaccines as well. And pushing for those well-care visits.

MS. LOCKHART: Excellent. Thank you.

Anyone else?

MS. LEWIS: Hi. This is Suzanne from United Healthcare.

So I'd like to echo what I have heard about transportation, and this is both from a rural and urban standpoint. We have our member population in both areas, so we've got some in Eastern Kentucky and some of the rural parts of Western Kentucky. We have a concentration of members in and around the urban areas, and overall, we see that transportation is a bit of a challenge.

As I think somebody was talking about, you know, having ownership of a vehicle, maybe it is working, maybe it is not, or it's a partial ownership type of situation. We have had certain types of challenges there. But not just that, we

have had members who live on a bus line, and have been told that they won't qualify for transportation because they are within walking distance of a bus stop, but unfortunately, our particular member is not capable of getting to that bus stop, whether that is because of challenges with mobility, or because of their chronic condition, or maybe they don't feel safe going to that bus stop. So again, I think we -- I just echo the transportation challenge. Getting folks to their appointments is the biggest challenge that we see across the board.

And then, as far as food deserts, I want to speak to that a moment. I know there is a program -- and I'm going to get this wrong, probably, so I apologize -- but I believe that, was it Norton's that was doing a subscription food pantry? Does anybody recall hearing about this, where at -- they had an actual food pantry for members in this particular location -- or maybe they are going to -- I heard something about this recently.

But if we think about the challenges that our members have with food and transportation, if we can get folks to healthcare, why not have access to other needs at that same location? So the idea of a food pantry being available for our Kentuckians, wherever they may be located, being able to access food and healthcare at the same time would certainly be a wonderful approach. And if you think about it, as an incentive to get to care. So again, I think I read or heard about that, and again, I thought it was just such a wonderful idea of bringing needed services together and maybe working with -- I want to say they were working with Dare to Care -- and I believe that's maybe they are working with it or discussing it -- Thank you, Stuart.

MR. OWENS: You're welcome.

MS. LEWIS: Stuart knows all of this stuff. You are such a rock star. I look forward to hearing you when you come on these meetings. He's always got his slides, and he's always got his stuff, and

it's just so awesome.

MR. OWENS: Thank you. But I had to Google. I cheated.

MS. LEWIS: Well, hey, you Googled fast.

Anyway, again, what a wonderful idea to partner with a community-based organization who brings in needed services and offer healthcare.

So when we think about looking through an equity lens and we know that there is fear and distrust of healthcare providers, being able to try to bridge the gap with some other needed services like basic needs -- foods or a clothes closet -- you know, again, we have to figure out the transportation issue to get people there, but once they are there, being able to serve more than just one need is my thought.

DR. THERIOT: I was a pediatrician in that clinic until I stopped seeing patients, and it is wonderful, except I can tell you that transportation is still a problem because

some of the patients could not bring the food home with them, because they had to go home on the bus, or they weren't sure of their ride. So yes, it was wonderful and we do partner with Dare to Care, but it's still got -- there are some logistics going on that are a barrier.

MS. LEWIS: I think transportation is just such a challenge regardless of urban or rural.

Yes. Each area has their own challenges, but I say that transportation is one of the biggest ones across the state. Thank you.

DR. STONE: At least from a pediatric perspective, you know, Kentucky has established Family Resource Youth Service Centers who are addressing many of these needs for children, at least, because, you know, they submit data to the cabinet on the amount of kids who participate in backpack programs at the school, which means they are getting food sent home with them on a regular basis and on the weekends, and the schools that have

family resource centers and clothes closets and have all of those things, and now we need to make sure that the health care is provided.

And I would posit that yes, transportation is an issue across the state, but children living in poverty come to school, so anything we can do to support the delivery of services like we've done with Family Resource Youth Service Centers would go a long way in helping to change the trajectory of health in Kentucky.

MS. LEWIS: And meeting people where they are at. I think that's absolutely the right approach to meet people where they're at. We continue to have the transportation problem and we are not able to solve it -- it is a widespread problem. We have to meet people where they are at and go to them. Mobile units, and things like that. Yes. Absolutely.

DR. THERIOT: I hate to say it, but I'm just going to say it. The food pantry in the clinic -- it is Dare to

Care, but the food is things like fruit cocktail in heavy syrup and jarred tomato sauce with a lot of sugar in it, so in my opinion, it is not very healthy. And then we got fresh vegetables one week, and we were so excited that we got fresh vegetables, and they were beets. Beets. Raw beets. I don't know how many people on this call think, you know, I really want to eat some raw beets today. So for families who aren't used to cooking and having fresh vegetables, I would think that a beet is not the thing to give them. So anyway, I just had a problem with that and I think we have to offer good foods, but also healthy foods and foods that people are more likely to eat. Not just any food should be in the food pantry.

MS. WILSON: Right. Apples and oranges for kids. They love that stuff. Or maybe partner with some farms and access they can give. I'm sure they do. I've heard of them doing that anyway. But yeah, definitely not beets. I can't see them liking that.

MS. KUNTZ: This is Stephanie with Anthem. Can you guys hear me?

MS. LOCKHART: Yes. Sorry. I couldn't get off mute, but, yes.

MS. KUNTZ: No worries. Sorry I was muted on both my phone and my computer. So I'm sorry about that.

I just wanted to echo what everyone else is saying. It is both rural and urban, and I know definitely in the rural areas due to, most of the time, lack of providers, especially specialty providers when we get into maternal -- there is a lot of maternity deserts out there, so not a lot of OB providers. And for the providers that do exist in the rural areas, their appointments are scheduled very far out, so it might take you three or four months to be able to see a provider. So then you are back into the same transportation needs for the members that they have to travel a little bit further because they have to get into a provider sooner.

So we do have an empowerment

team, which is what we call it to work on the social determinants of health, and we have certified community health workers that address each of those issues of transportation and food and clothing and employment, Internet, cell phone. We try to really work on, like the rest of the MCOs do, we try to look at where the needs are for healthcare and transportation, the food, and really work our extra benefits, you know, our healthy rewards or added benefits around those, so we can offer gas cards and those sort of items that will really help our members get to these important appointments. Because if they can't get to their well visits, and get vaccinated, and their OB appointments, then there are going to be issues down the line.

So anything we can do, I don't know if its transportation, but also getting more providers working together in those rural areas. Thank you.

MS. LOCKHART: Thank you. Anyone else?

A lot of good dialogue today. Very appreciated.

Okay. I'm going to turn my camera on. Dr. Stone, you were the last person -- are you okay to approve the minutes? I'm just going to backtrack for a second. You are muted.

DR. STONE: If my camera is not off, I'm muted. Absolutely.

MS. LOCKHART: Okay great.

Back to -- really in closing, a homework assignment for some of you, should you choose to accept it. For our December meeting, we are requesting five- to ten-minute presentations to include member incentive member benefits that are available and how do members receive their benefits. There is one. And the other is, the surge in immigration affecting the ability to provide services, and that one is me.

I am curious because I'm watching the news and I'm looking at some of the programs regarding the surge in immigration, and the coming into some of

our cities, and the struggle that's going on trying to provide both healthcare and education. Those are the big two. And housing. We have a lot of them living on the streets, now, and it is a struggle. A lot of the cities and healthcare organizations are like, "Uncle. We are overwhelmed."

I know that Kentucky is seeing some surge from that. Nothing compared to like what we are seeing in Chicago, New York, California, Texas, all of those areas. It doesn't compare to that at this time, but I'm sure it's been impactful for you all, overall, and our school systems are going to be greatly impacted.

And my -- the ask, here, is are we already thinking along those lines, kind of, proactively preparing for what we are going to do -- especially thinking of our original conversation today about how your backlog is starting to occur, and this just adds to that.

I know hiring is part of that, but we are interested in some

presentations from you all about what your plans are to try to manage that when it occurs, because it will occur.

Any questions about what we are asking? Everybody? We are good?

MR. OWENS: I think we are clear with the homework assignment.

MS. LOCKHART: You've got a whole month -- two months.

MR. OWENS: Yes. We appreciate that, Professor.

MS. LOCKHART: A little heads up. All right. Good.

MS. CECIL: I will say from a Medicaid enrollment, we are not seeing -- we definitely track our enrollment on a weekly basis, and we've not seen a spike that would be related to this.

MS. LOCKHART: Okay. All right.

I'm certainly happy to come back in December and continue to monitor that and let you know if there are changes for the Medicaid program.

MS. LOCKHART: Okay.

MS. CECIL: That might not

necessarily mean that in the communities there aren't issues, but in terms of Medicaid enrollment, there still may not be an impact.

MS. LOCKHART: Okay. Apples and oranges. Thank you so, so much.

And that is all we have for our agenda today. Is there anything from the group or anything from the TAC members that are on the call that we didn't get around to today?

(Background noise.)

Sorry. I am at work. And it is a hospital, if you couldn't tell. Is there anything else for the group that we want to bring up?

No? Okay.

Well, with that said, it looks like we are able to adjourn a little early then. Can I have a motion from the TAC members to adjourn?

DR. STONE: So moved.

MS. LOCKHART: Okay.

MS. BICKERS: Lisa? You didn't officially approve the minutes.

MS. LOCKHART: Okay.

MS. BICKERS: Because they were so far apart, we have to have somebody, you know, we got to go through the process again. My apologies.

MS. LOCKHART: So I am asking for approval of the minutes. Dr. Stone?

DR. STONE: So moved.

MS. LOCKHART: Okay.

Ms. Wiseman, are you on here?

MS. WISEMAN: Yeah. I will second.

MS. LOCKHART: Okay, great. So moved. Minutes approved.

MS. BICKERS: Thank you, ladies.

MS. LOCKHART: And with that, we will go ahead and motion to adjourn as well. I'll see you all in December.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 3rd of November, 2023

/s/ Stefanie Sweet

Stefanie Sweet, CVR, RCP-M