CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
PRIMARY CARE
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
June 27, 2024
Commencing at 10:00 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Stephanie Moore, Chair

Dennis Fouch

Barry Martin

Michael Hill (not present)

Brandon Hurley

P R O C E E D I N G S

MS. BICKERS: Good morning. It is 10:00. I saw Stephanie and Brandon log in. Did I miss any other TAC members that may have come in in a large group?

DR. MARTIN: This is Barry. I'm on here.

MS. BICKERS: Oh, my apologies. Your name didn't pop up. You slipped in on me.

DR. MARTIN: That's okay.

MS. BICKERS: The waiting room is clear if you would like to begin. Stephanie, you're muted.

CHAIR MOORE: Did it work that time? Can you hear me now? Okay.

Good morning, everyone. Thanks for joining us. We will go ahead and get started. We have established a quorum with Brandon, Barry, and myself.

So the first order of business is approving the minutes from the previous meeting. Is there a motion to do so?

DR. MARTIN: I make a motion to approve the minutes.

CHAIR MOORE: Thanks, Barry.

MR. HURLEY: I'll second.

CHAIR MOORE: Thank --

MS. BICKERS: Barry -- oh, never mind. You beat me to it. Thank you.

CHAIR MOORE: And so given that I'm the only other person, that motion will pass.

Moving on to old business, any updates from the PHE wind-down process?

MS. JUDY-CECIL: Good morning. This is Veronica Judy-Cecil, Senior Deputy Commissioner with the Department for Medicaid Services. And if it's okay, I've got a slide just to update some of the numbers for you all. I think the slide usually helps than me rattling off numbers to see them. So I am going to share my screen.

Okay. One thing that is different from what I reported the last time, in the previous meeting, is that now our flexibilities that we had implemented for unwinding, CMS -- the Centers For Medicare and Medicaid Services -- is allowing states to extend those to June of 2025, which is pretty remarkable. And I think just a

recognition that while we are coming out of unwinding, there still is a lot of workload associated with it as we, you know, have a larger number of renewals.

And what's interesting is that there is a new final rule around eligibility, and some of the flexibilities that we had under unwinding are going to be put permanently into place. So I think there was a recognition of just the success and the need for some of those flexibilities.

So just to note one thing, Kentucky had implemented automatic extensions for children. So we -- instead of requiring that child to go through a full renewal, we went ahead and extended them 12 months and then granted that continuous coverage that was mandated for all states to do on January 1st, 2024.

But we -- that particular flexibility is pending approval from CMS. Because it was not one of the traditional flexibilities that all states could implement, and Kentucky requested it specifically, they are looking at that to determine whether or not they're

going to allow us to extend that on to June of 2025. So we'll keep folks updated on that in particular so just wanted to note it.

Our flexibility tracker is out on our website, unwinding website. So, you know, if you want to refresh your memory about what those were, definitely go check that out.

And then I left on this slide the two extensions because I think that's the one that most folks kind of see because we -- when somebody is going through renewal and they haven't responded by their renewal date, we can automatically extend them to give them additional time. And we do perform some additional outreach during that time.

So we do a one-month extension for all populations if they've not responded. And then specifically for the long-term care and the 1915C waiver members, we can extend them up to three months. So they have an additional three months to respond if they haven't.

And we are actually evaluating those flexibilities to see, you know, are we seeing people come back in, and we are. So -- or at

least responding in that extra time, so it is a flexibility that's being utilized by our members, and I think that's a good thing.

And then for those interested in the 1915C waiver member flexibility specifically, we did have Appendix K which was the vehicle in which we requested and received approval for those flexibilities for those waivers. They all went -- we had to amend all six of our waivers to make permanent the flexibilities we wanted to continue be on the unwinding.

So those waivers were approved May 1st. We did a lot of communication to members, families, providers of the waivers, and we're in a transition period right now for those.

If somebody has a question specifically about a case and a waiver that maybe wasn't extended or, you know, just how the new amended waivers impact a case in particular, please make sure that you're reaching out either through a case manager, or they can call us or email us directly. It's that phone number and email address at the top there of the slide. Certainly reach out to

us.

Lots of information, though, out on our website. We've recorded webinars, so you can go out and watch a webinar to learn a little bit more about that transition and the flexibilities and amendments that happen.

I also wanted to just sort of flag for folks that we took some additional what we call enhancements or some changes to the population, that when we went out and verified their income on the trusted data sources, they were -- they appeared to be no longer Medicaid eligible. Their income was too high. But they were eligible for a Qualified Health Plan and Advanced Premium Tax Credit.

So APTC, that Advanced Premium Tax Credit, is what makes those Qualified Health Plans out on the Marketplace affordable. Sometimes it's at no cost or at a very low cost in terms of premiums for individuals. So we would transition those folks, what we call cascade them, to that eligibility for APTC and send them a notice.

So we -- we met with CMS and made some

changes to our process for those individuals, to give them additional time and information to actually respond to the Medicaid renewal first before we transitioned them to APTC.

So what that means is for these folks, instead of just sending the notice of -- that their Medicaid is going to be terminated based on the income information, we're going to send them a prepopulated renewal form and give them that opportunity, that 30-day opportunity to respond to that before moving them over.

What we did for those folks that we did cascade to APTC eligibility from May of 2023 to January of 2024, we did some activities around those folks. If they, for example, were terminated from Medicaid and never came back to Medicaid, in April, we reinstated them to Medicaid fee-for-service, and we then sent them a renewal packet to have them be able to go through that kind of renewal process.

And then for those folks who may have terminated from Medicaid but enrolled in a Qualified Health Plan, if there was a gap

between that termination and the enrollment in the Qualified Health Plan, we reinstated them to fee-for-service to help cover any claims they may have had.

And then we also -- for folks that, then, just enrolled directly into a Qualified Health Plan, we sent them an outreach notice just reminding them, you know, at any time, you can apply for Medicaid if you think you're still eligible to come back in.

So I wanted to point this out because you all, as providers in particular, may see someone go from managed care to fee-for-service. And then if they reenrolled into Medicaid, then they'll go back to managed care.

So, certainly, we want to make sure providers understand that during that period of time, when they've been reenrolled retroactively to fee-for-service, if you have claims for an individual that comes in, we encourage you to submit those claims to fee-for-service.

If there are questions about that, certainly reach out to the department. We

really are trying to support our members through this kind of transition, retroactive transition. The good news is it's a retroactive that's in their benefit, that, you know, they're going to get coverage. It's not that they're getting terminated retroactively. So you may see those folks.

CHAIR MOORE: Veronica, do you have any concept of how many people fall into those categories?

MS. JUDY-CECIL: Yeah. And we are -- so we are kind of waiting for the activities to complete. Because we identified them, you know, back in, like, March and then by the time in -- April came that we reinstated them, so people's circumstances had changed.

And so we're kind of letting the activities sort of flow through to see the final numbers. But we are talking about 30,000 individuals who, in total, who kind of fit into one of these buckets.

And we -- we did split -- so about 20,000 of them were the ones that we reinstated and have gone through another

renewal. And they were split between May and June, so about 10 to 11,000 in each of those months.

And you will note, and I will point out, as we go through the May renewal numbers, that you're going to see a little higher termination rate. And that's because it's these -- we had these additional folks that we sent renewals to that, you know, have already gone through essentially a renewal during their original renewal month but, because of the activities around this population, were reenrolled and then given another renewal.

So you're going to see a -- we did find that for the May renewals -- we don't know June yet. But for the May renewals, the majority of the ones we reinstated did not respond, and so there's a higher number of procedural terminations as a result.

We're -- you know, I think the challenge -- and we've mentioned this throughout unwinding -- is we don't know where people are going. We can track somebody who's left Medicaid and gone to a

Qualified Health Plan because they're in our integrated system. But if they're out there and they have commercial coverage, we have no way of knowing that. If they've got it through their employer, we have no way of knowing that.

So that's been kind of the difficulty in ensuring that everybody is still covered in some way once they leave. But we do have a high -- a higher-than-normal termination for May renewals, and that's because of this population.

Okay. So apologies I don't have through the end of May, but I certainly can let you know that the trend line for Medicaid enrollment was going down as we come through unwinding, especially as, you know, folks that we've been extending, they reached their maximum extension period and then we have to terminate if they don't respond.

So at the end of May, with the terminations related to May renewals, we're down to about 1,480,000, still very much higher than when we started the Public Health Emergency but definitely down from the 1.7

million we had enrolled at the beginning of unwinding.

So this busy page, just remember, is just reporting -- on the left side are original CMS monthly report. This is the report that's due on the 8th of the month following the renewal month. So, for example, the May renewal month, that report was due June 8th.

And then on the right side is our updated CMS monthly report. CMS' ask states that following a 90-day period after the renewal month, to file an updated monthly report by the 15th of the following month to report any pending actions that were processed.

So just to walk through, for example, in February, we had one pending case, which was processed. And so we reported for our updated report, we, you know, processed that person, and they are -- you know, get put into the appropriate bucket.

So these are all out on our website and, of course, we'll send the slides after this presentation if you really kind of want to

dig into the numbers following this presentation.

And then just to report the most current numbers for the month of May, we did have 94,705 individuals that went through a renewal. Of those, 51,534 were approved. And then there's that really kind of higher termination number, 37,461. Again, that large number of that, about 11,000 of those individuals, were the result of the APTC reinstatement and renewal.

But as, you know, we're seeing -- as we come out of the Public Health Emergency unwinding, just to note that May was really the last month -- and this is going to really be hard to understand. It's the last month of the first round of renewals following the Public Health Emergency. So we call those the first renewals of unwinding.

Now folks are going to start moving into a second round of renewal following the end of the Public Health Emergency. So as we come into our June renewals, we really are primarily seeing either individuals who were newly enrolled in June last year or

individuals that are going through a second renewal following the public health unwinding.

We did extend 4,894. Those two extension buckets, they could possibly be in the one month or the three -- up to three months, and then we had 816 pending.

And on the far right, you see we're still tracking reinstatements. And this is something that's going to -- a flexibility that will continue until June of '25. The reinstatements are folks that have been terminated for procedural reasons, so they didn't respond. But they came in within the 90 days following the renewal month and were able to provide the information, and we were able to determine them eligible.

So in that bucket, for example, for the May renewals, it's June 27th -- well, this is -- sorry. This is as of June 14th. We already had 1,828 individuals get reinstated because they came in after their termination.

And we're tracking those numbers because we kind of want to see what is that -- that churn that's happening with the

reinstatements.

CHAIR MOORE: Can you just --

MS. JUDY-CECIL: Yeah, sure. Go ahead.

CHAIR MOORE: Just in that number -- and this is probably difficult or near impossible to evaluate. But those people who are coming in after that 90-day, do you feel like that's coming as a response of them going to a healthcare provider and that healthcare provider saying you don't have coverage, let's help get you reinstated? Or did they just open the mail on the 91st day and feel inspired to complete their paperwork?

MS. JUDY-CECIL: No. I think it is very much they are seeking health care and are finding out that they're terminated.

CHAIR MOORE: Okay.

MS. JUDY-CECIL: That seems to be the biggest bucket, yeah.

CHAIR MOORE: Okay. That was my suspicion but --

MS. JUDY-CECIL: Yeah.

CHAIR MOORE: -- I didn't want to

make that assumption.

MS. JUDY-CECIL: And despite, you know, we -- and I've mentioned this numerous times. The multiple points of outreach that we do, not just, you know, sending them a notice in writing, but we're calling them. We're texting them. We're trying our best to reach folks, you know, giving providers the ability to check their redetermination date in KYHealth-Net. You know, we were trying all ways to reach the individual as they were going through renewal.

But yeah, you know, we see it at the pharmacy in particular, individuals trying to go and get their prescriptions. And so that's -- that is where we are typically finding them.

So we appreciate providers, you know, again -- and I'll go to the next slide -- pulling down these informational flyers and bulletins and helping members as they come in, terminated members in particular as they come in, have the information about what they can do. You know, they're arriving in your office. What do they do to go back and get

their coverage restored?

And if outside that 90 days, you know, it's still important that they, you know, reach out to us, so we can go through a redetermination for them and possibly get them back in and have them -- they will have to reapply at that point. But it's not quite as easy if it's in that 90-day -- as if it was in that 90-day period.

So we will continue to have these available. As we come out of unwinding, we've learned, I think, a lot of really great lessons in how to outreach and provide information and really work with our stakeholders and supporting members going through renewals. So we do plan to maintain the flyers and information.

And, you know, as we always mention, if there's something that we don't have that you all need to help support members, just let us know. We're happy to create anything, anything new or tweak our current flyers and informational bulletins to meet the need. So never hesitate to reach out and let us know if there's something we can create.

With the declining number you see for Medicaid enrollment, we also are tracking the tremendous increase in our Qualified Health Plan enrollment. So, again, just to remind folks, when a member does terminate from Medicaid, they have a special enrollment period.

You know, normally, you have to wait for an open enrollment period for -- to choose and enroll in a Qualified Health Plan. But with Medicaid termination, that triggers their ability to do that at any time between that original March of 2023 date to December of 2024.

So at any time during that period of time, if a member has terminated, they can go and choose a Qualified Health Plan. They just have to check the box for the special enrollment period.

This is actually an older number. We have exceeded 80,000, which is very good news, you know, as we see people that are terminated from Medicaid enrolling in Qualified Health Plans. So you might see that shift in your offices as well.

And always a reminder, you know, our website is full of information. All the CMS monthly reports are on there. The flyers are on there. Our stakeholder meeting that we have the third Thursday of every month is recorded and posted including the presentation we do.

Starting in July, I wanted to mention -- because we are coming out of the unwinding -- that we're going to shift our monthly stakeholder meeting to also include other Medicaid updates. So we'll continue to report on renewals. As we have sort of the lag of extensions and processing and pending cases from the unwinding, we're going to start just providing some general Medicaid updates to keep our stakeholders informed about what's happening.

So it's going to be a new opportunity for people to engage in, you know, what's happening with Medicaid on a monthly basis, and that's something else we'll continue to record and post for folks.

We're always interested in agenda items for that as we embark on this sort of new

stakeholder engagement. So if there are particular updates that you all want to see in those monthly meetings, let us know.

One of the -- I think the biggest agenda items is going to be all the final rules that CMS has issued over the past couple of months. I think there's nine in total that Kentucky Medicaid is going to have to comply with, and they're for all various -- you know, I mentioned the eligibility. There's going to be changes to managed care. There's changes to the home and community-based waivers.

So lots and lots of changes that are going to have to occur over the next couple of years, and we want to be able to report out on where the program is with implementing those and keeping folks informed. So, again, just, you know, shifting the regular monthly stakeholder meeting to a general update.

So I'm going to stop sharing and happy to take any questions about unwinding or renewals. I know your head is probably hurting.

CHAIR MOORE: No. I think that

that's always helpful. And, you know, I think that it's important for us to see what's happening at the state level because, you know, certainly, we're dealing with the day-to-day implications every day. So we appreciate that update.

MS. JUDY-CECIL: Okay.

CHAIR MOORE: One of the things that we were really hoping to include in the TAC -- the Primary Care TAC this year is greater integration with some of the other agencies and organizations within the state and adding representation from DPH and DBHDID to this meeting.

And I believe that Commissioner Marks has joined this meeting as well. Good morning.

COMMISSIONER MARKS: Morning.

CHAIR MOORE: And you have time constraints. And, Veronica, maybe you have a time constraint today; is that correct?

MS. JUDY-CECIL: I'm okay. But certainly let -- yeah. Let's let Dr. Marks go.

CHAIR MOORE: So, Dr. Marks, thank

you for joining us today. And, you know, we wanted to just give you some opportunity to share priorities and how we as primary care providers can support behavioral health initiatives as well.

COMMISSIONER MARKS: Yeah. I really appreciate the invitation to this meeting and continuing to join future meetings as well and just having a presence for the Department for Behavioral Health.

I am coming off of a little bit of sickness, so I apologize if my voice is not a hundred percent today.

So if I haven't met you, I just want to give you a little background about myself first. I have served in the commissioner role for the past year, but I've been with our department for the past seven years and might have interfaced with folks through the Kentucky Opioid Response Effort, which I served as the project director.

And so KORE, the Kentucky Opioid Response Effort, is focused on addressing the overdose crisis in the state by increasing access to a full continuum of services:

Prevention, harm reduction, treatment, and recovery.

So my background is in behavioral science and addiction research originally and formerly assistant professor at the University of Kentucky. But I'll just tell you coming into a full-time role as the commissioner has been an amazing transition and opportunity to think about the work that we did in KORE and the work in substance use and expand my passion and compassions in the space of mental health and also developmental and intellectual disabilities.

And so I just wanted to share some of the primary initiatives that we are thinking about right now and the ways that we intersect with primary care specifically and also some of the other broad domains that we are prioritizing in our work.

We have a strategic action plan that's laid out our priorities and our strategies for the next two years, and so this is just a bit of the highlights of those. But a theme throughout is a commitment to integrated care, addressing -- thinking about

integration in multiple ways, obviously, physical healthcare alongside behavioral healthcare, and also becoming more co-occurring capable in the co-occurring treatment of substance use in mental health disorders.

So an example of the partnership that I really enjoyed taking leadership on was with the Kentucky Primary Care Association and expanding medications for opioid use disorder access through our FQs and rural health clinics. And so this has been a strong pilot that's been going on for several years. We'd love to see this new model throughout primary care in Kentucky.

And it's a simple concept; right? For folks that are appropriate to treat opioid use disorder in a primary care setting, the capacity to prescribe buprenorphine to treat opioid withdrawal and craving, the ability to partner with community partners for behavioral health or to collocate those services, whatever makes sense for the resources and capacity of that community.

And then to provide some really basic

harm-reduction training on how to reduce the likelihood of an overdose, from making sure folks have naloxone, the overdose reversal medication, to also understanding how to reduce risk if continued use is the path at that moment. And so -- can talk ad nauseam about how we expand that model across all primary care.

Another initiative that the Department has been working to expand, we call this the Kentucky Integrated Care Grant, and we're on our second version of this. And it's just a comprehensive healthcare integration framework that thinks about how we build bidirectional and collocated primary care and behavioral healthcare within the same setting. Our priority for this are adults with SMI, serious mental illness; SUD; or the co-occurring of those two.

And we've got a pilot going in two locations right now, our community mental health centers LifeSkill and Pennyroyal and two FQHCs that are also participating in that in Warren and Christian County. Really -- just really strong model, sustainable in how

it's funded, and we are working to hire a project coordinator so that we can support replication in the future.

We have also partnered -- in gratitude to KPCA for helping us with this -- with UC, Irvine, on a Training New Trainers program for primary care psychiatry and have a small cohort of folks that are currently going through that training right now and in ongoing talks about how we could expand our capacity for primary care psychiatry in future years.

Something that's a priority that I wanted to mention for folks right now is promoting screening and early identification in our primary care settings. There's such an opportunity to reach folks earlier in -- obviously, in any stage of disease, and that includes our behavioral health disorders.

This is particularly poignant to me at this moment. We are seeing a cluster of suicides in Pike County right now and in that region. A cluster that exceeds the total number of suicides in the past year has already occurred in these first six months.

And one of the interventions that we think would be critical is if we increased our capacity for screening and early intervention in primary care settings for folks.

We are working on an epidemiological analysis of what might be driving that cluster. But one of our first things that we turned to was: How could we be maybe catching a few of these cases earlier on? Happy to have more discussion about that.

And then I'll just list -- I could go on, but I'll list some of the other kind of broad priority domains that our department is thinking about right now. One are individuals with criminal legal involvement and both services while they are incarcerated, prior to incarceration, deflection from incarceration.

But a key emphasis of the governor right now is also on reentry population and our ability to seamlessly transition, obviously, coverage of health insurance but also back into behavioral health and primary care services upon reentry.

I know there was a significant grant that was just submitted around doing some in-reach on HCV and then connection to community resources. Really excited for that opportunity.

Another space is behavioral healthcare for children and transition age youth. I'm sure you see, at minimum in the media, discussions of some of our DCBS kids that are having to sleep in child welfare offices because there is no theoretical location for them to be placed. The language some folks say is that they're too acute for the acute settings, yet we find that we are caring for them in a child welfare office, which is an absolutely inappropriate and insufficient setting to take care of their needs.

And so I bring that to this because I bring it everywhere to just say that behavioral healthcare and services for our children and transition age youth is an urgent matter. We're seeing an increase in the acuity of symptoms and of the needs for treatment. And, again, early intervention and opportunities to set a new course earlier

on in their development would be significant -- make significant impacts for Kentucky.

Obviously, I mentioned KORE, our Kentucky Overdose (sic) Response Effort. But I'll just emphasize again FDA-approved medications for opioid use disorder alongside overdose reversal medications are the gold standard of changing the trajectory of the crisis.

I hope you saw the governor's announcement -- I believe it was last month -- that showed a 9.8 percent reduction in opioid overdose deaths -- or all overdose deaths in Kentucky from '22 to '23. This was wonderful to see. It's the second year in a row that we've seen a reduction. And it was three times larger than the national reduction, which is really demonstrating that we're doing something particularly right.

We still lost 1,984 individuals, though, last year alone, and so the work is far, far, far from being finished. And our ability to have OUD screening, treatment, and also screening for stimulant use disorders,

methamphetamine continues to grow in prevalence.

And the other data point that I'm not sure folks hear often enough is that black Kentuckians have a higher rate of overdose death than white Kentuckians. That's been the case for several years now. And in postmortem toxicology reports, 25 percent of fatal overdose deaths among black Kentuckians, the second-most-common substance in their system was cocaine.

So it's fentanyl. It's obviously No. 1. Cocaine is No. 2. And so just being aware that it's not just fentanyl, and it's not just methamphetamine but cocaine as well in Kentucky.

Building out our system of care for folks with developmental and intellectual disabilities continues to be a priority. We've seen significant retractions and shifts in our capacity for community care for folks with IDD in the communities.

And this has put pressure on a lot of other systems to care for these individuals, the acuity of needs increasing in them as

well. And so reestablishing, improving waiver alignment and access is a priority in obvious partnership with Department for Medicaid.

And then three more I just want to list really quickly. I already spoke to suicide prevention, intervention, and postvention. This is critical for Kentucky. We are really excited about the rollout of 988. We continue to see it grow month over month.

If you haven't heard about this, please have resources in any setting that you're involved in that tells people that just like we have 911 for a physical health emergency, we have 988 for behavioral health emergencies now. 24/7, free, anonymous call, text, or chat.

And then primary prevention, reaching earlier and upstream into school services, early childhood development.

And then I'll finish with the importance -- I know you all see it -- of having a strong housing continuum. So much of the services and supports that we give are contingent upon stable, safe, quality housing

for a vast array of individuals, from just family housing to recovery housing to housing for folks with IDD. And so that is also a priority for us in partnership with others.

Happy to talk about any of these initiatives specifically. As I said, we'll continue to be an active member of this group moving forward. Really grateful for the existing partnerships and particularly our partnerships with our cabinet partners and Medicaid. So thank you.

CHAIR MOORE: Thank you, Dr. Marks. We appreciate you being here, and I think, certainly, there is a lot of overlap with the work that we're doing in our clinics every day. So appreciate the way your actions past and your future plans to make that alignment as cohesive as possible.

Any questions from the other TAC members for Dr. Marks?

DR. MARTIN: Just, Katie, thanks for all your hard work. Things are running pretty seamlessly now with your all's department, so it's good.

COMMISSIONER MARKS: That is the

highest compliment, Barry. Thank you so much. Good to see you.

DR. MARTIN: Thank you.

COMMISSIONER MARKS: We can't hear you, Stephanie.

CHAIR MOORE: My mute button doesn't like me today. If there are no additional questions for Dr. Marks, we'll move back up to old business.

Veronica, I think you're probably back up with an update on WRAP reconciliation.

MS. JUDY-CECIL: Absolutely. And thank you, Dr. Marks. We really appreciate you being here.

So I was unable to attend the meeting -- the last meeting which was on June 18th. But just to let folks know sort of some of the issues that are being discussed, you know, there's always historic crossover issues. So we continue to try to identify with specific claims what's happening with the crossovers and, you know, examples are always helpful. So I think there's still some work along those.

We were -- we were asked to provide an

updated list of codes and services that are subject to a WRAP and those that are not, so I think that's being worked on. I'm not a hundred percent sure if that's been sent out yet, but it is on our radar. And it is being worked on so hope to get that to providers as soon as possible.

We also are working on -- for those of you who may be struggling with global codes, I know that we've had a couple of examples of some problems around the global edits so trying to work through those and provide some long-term solutions on improving those submissions.

And then I think the other thing is issues with dental claims. You know, we've done a lot of work around dental claims, but I think there's still some additional work that's needed. So we're focusing on -- with some examples that have been provided and trying to figure out, again, long-term resolutions to processing those dental claims.

And it -- you know, it does take the Managed Care Organizations working with their

dental subcontractors and, you know, trying to make sure that we're all processing the same and consistent so that providers don't have those problems.

So those were the -- I know the subject items on that agenda and still working through those. Happy to take any questions, and I might -- I'm hoping other DMS folks are on that could assist with response.

CHAIR MOORE: Any questions? Brandon? Barry? I think Dennis joined as well.

(No response.)

CHAIR MOORE: All right.

MS. JUDY-CECIL: Well, and let me -- if it's okay, let me mention. So the other thing is folks know that we are moving from our current Medicaid Management Information System, MMIS, to the brand-new MCAFS because we love our acronyms, which is the Medicaid Claims Administration and Financial Solution.

Just letting folks know. We did, I think, a brief presentation that that's going to be happening, and there will some changes

in the WRAP payment process. We are still not yet at a place to share more in-depth kind of walkthrough of what that's going to look like, but I just -- I do want to note that it's on our radar. And as soon as we're able, you know, we'll continue and, on a regular basis, provide updates for that implementation.

It has been delayed. So I don't want folks to be really worried about not having enough time to shift what they might have to do, or providers have to do. We plan a very -- we want to get it right, not fast.

So we do plan -- you know, in working with providers and finding out what their needs are in terms of timeline when we're ready, that we feel like our system is ready to go, you know, giving them enough time. So we'll be communicating with providers, making sure that they know what's happening and give them sufficient time to implement.

You're on mute. It's causing you problems today.

CHAIR MOORE: It is incredibly. So moving -- if there aren't -- are there other

questions about WRAP? I was not able to join that call either.

(No response.)

CHAIR MOORE: Okay. Hearing none, moving on to the 72-hour documentation rule. So I know that there was some work that happened last year or so about clarifying this for the RHCs. But I think that there's been another question that has kind of been pervasive for a number of years, which is around whether or not a 72-hour requirement is actually necessary.

You know, I know in an environment where providers are no longer oftentimes working five days a week, you know, as we try to address provider burnout and use virtual scribes and various other technologies, sometimes 72 hours doesn't create enough actual time for all of those elements to take place.

And so, you know, that puts an organization in a position where if you are submitting a claim that was signed or billed out after that 72-hour window, then, you know, technically, you're violating the

contract terms that you agree to as a Medicaid provider.

And so, you know, while I think that all of us recognize the importance of timely documentation, we also need, you know, to create space for these supports that make it doable for providers to see patients in Kentucky.

So thoughts? You know, there's also some sort of various, like: Is that really enforced? Is it not enforced? If it's not enforced, can that reg be changed so that organizations aren't in a place where you're having to just sort of decide whether or not you want to be compliant?

MS. JUDY-CECIL: And so I think the challenge is -- and by the way, the 72 hours is the recommended -- so the requirement -- and we have to follow federal requirements, too, is that it's in a timely manner.

And 72 hours, I think, has been the -- kind of the go-to as the definition for timely. I know it's what most, if not all, states use. I think it's what's recommended by the -- oh, the coding -- AAPC. I can't --

I'm missing how -- the names of the acronym but -- and so it's the standard.

If we're wanting to consider going off the standard, you know, I think that's just -- we can -- happy to take that request back. If you all want to recommend that, you know, we can look into it. I just -- I'm a little concerned because that is the standard, you know, across the country and I think with Medicare, too. And so we'd be an outlier if we did something different, and we'd have to really consider that.

CHAIR MOORE: Okay. I don't know that we have to, at this point today, make a formal recommendation, but I think it's important for us to take that information back and share with our members and have conversation about that. And then, you know, maybe we'll leave that on for some additional discussion in October if that feels okay to the group. Barry? Brandon?

MR. HURLEY: I think that would be appropriate, yeah.

CHAIR MOORE: Okay. All right. Are there any updates on crisis

stabilization?

MS. JUDY-CECIL: So, unfortunately -- it's always regrettable to report us maybe going backwards. But, you know, we had hoped to roll out a new mobile crisis including a 23-hour crisis stay utilizing an administrative service organization. And, unfortunately, that did not get funded by the legislature.

So we are -- we are in the process of trying to determine how we're going to shift from that and hope to be able to share that with providers, you know, in the next couple of months on how maybe we can move forward with, you know --

We had filed regulations, but they've been withdrawn. They were withdrawn earlier in June. And so, you know, right now, we're just sort of seeing what's -- what can we do going forward.

CHAIR MOORE: I think that from the provider's side, we all very much see the need for this work, so we look forward to those updates and certainly are prepared to work on the advocacy side to help our

legislators understand that.

MS. JUDY-CECIL: I appreciate that. Yeah. We thought there were some really good changes we were making. The rate was increasing and, you know, we were excited to really engage other providers in the whole mobile crisis continuum. So, you know, we'll -- I think the goal is still to try to move that direction but just having to sort of, again, you know, just sort of re-evaluate how can we do that.

But I really appreciate those comments, Stephanie.

CHAIR MOORE: Absolutely.

Utilization trends from 2023.

MS. JUDY-CECIL: I am -- definitely, I think, have someone else on here for that. Is that Angie Parker?

MS. PARKER: Hi. Yes.

MS. JUDY-CECIL: Thank you.

MS. PARKER: I'm Angie Parker. I'm the Director of Quality and Population Health. I realize this has been on the agenda from last time.

From a quality and population health

standpoint, we look at trends through the HEDIS measures, Healthcare Effectiveness Data and Information Set, and we do not have 2023 measurement year results yet. So I would expect to have that by the October meeting just so that we can compare those measure sets to 2022 and previous years that I can -- would be able to share.

As far as any other type -- like utilization management type trends, Dr. Theriot and myself just recently completed a review of all six of the MCOs' utilization management program from 2023.

I would like to suggest that maybe that would be something that each MCO present on what they are seeing within utilization management trends at your next meeting. I could -- when you have six MCOs and you're reading them all, they're all pretty similar in what they're identifying. But I think it might be good for you all to hear it from them and what efforts they are doing as far as what they're seeing in those trends.

CHAIR MOORE: Thank you very much. I'll make a note of that, and as we put

together the October agenda, we can identify what the best structure for that presentation would be. So thank you.

MS. PARKER: Thank you.

CHAIR MOORE: All right. So moving on to new business. The 1115 waiver. Veronica, I think we're back to you on that one.

MS. JUDY-CECIL: I am also going to phone a friend on this one.

CHAIR MOORE: Okay.

MS. JUDY-CECIL: I think we have Angela Sparrow on who can provide an update.

MS. SPARROW: Good afternoon. Again, Angela Sparrow. I'm one of the behavioral health supervisors within the Department for Medicaid Services. So I wanted to provide an update in terms of our overall department 1115 demonstration initiatives.

And let me pull up the slides here. Just a moment.

MS. JUDY-CECIL: And while Angela does that, just to remind folks what an 1115 waiver is. So 1115 waivers allow a state

Medicaid program to waive certain requirements. You know, we're -- we are mandated to cover populations and services. But if we want to do something that -- it's called a demonstration waiver. If we want to do something different, then we can do an 1115.

And so, Angela, I'll let you take it --

MS. SPARROW: Well, no. That's -- I was going to say when we said one-on-one today --

MS. JUDY-CECIL: Yeah. Perfect.

MS. SPARROW: -- I'm not exactly sure how in depth we wanted to get. So I did want to provide some slides and, again, an opportunity to -- a brief overview of what the Section 1115 demonstrations are. Because, again, I think there's a growing reference to 1115s. You may hear that term often and especially moving forward as the 1115 and Medicaid continues to grow. And so, again, it is a great opportunity for states.

Let me switch to slide --

Okay. And, again, like Veronica mentioned, it is an opportunity for states

really to be able to pilot or demonstrate to CMS flexibilities in our typical allowance in Medicaid programs in terms of state plan covered services, models to deliver services. But really, again, to be able to demonstrate the use of evidence-based interventions and practices to better the health outcomes and quality of services for individuals in the Medicaid program.

And so many states, again, have been operating under some of type of Section 1115 demonstration even for decades. And so the 1115 demonstrations can grow, expand, change over time. With those flexibilities, they can be amended. And so, again, it is an opportunity for states to seek authority from CMS, again, to receive a federal match or -- again, on services that we would not otherwise be able to obtain through our normal state plan covered services.

But with every demonstration opportunity, again, states must demonstrate to CMS budget neutrality. So, again, that means that our request to CMS, again, the expenditures that Medicaid would spend both

federal, again, would not exceed the cost of what we would spend on those services otherwise or for those members otherwise, so without that demonstration.

So our with demonstration expenditures cannot exceed our without demonstration expenditures. So that can get a little tricky when you're adding new services and expanding services, so a lot goes into that. But, again, states continue to have to demonstrate budget neutrality to CMS in our monitoring and reporting.

And so with that being said, about 1115 demonstrations, again, CMS does issue, when new opportunities arise, formal state Medicaid director letters which, again, is really an in-depth guidance that outlines what the opportunities are, what the needs are, and really, again, what the states would need to do to comply in order to obtain approval for these demonstrations and maintain approvals.

And so within those state Medicaid director letters, most of the full demonstrations, again, have prescribed, if

you will, demonstration goals and milestones. States obviously, again, can make those goals and milestones specific to their states as well as add additional goals and milestones. But that, again, is a large component of the waivers.

And so in order to seek approval, states, again, typically, before submitting any request to CMS, conduct stakeholder engagement. So, again, interviews, focus groups, conduct research from what other states have done. And often, again, you know, we may be referred to California has obtained this, or Arizona has obtained this. Can Kentucky do that?

So, again, extensive research into what those other states are doing. How did they obtain those authorities? And what does the landscape of their states look like? Again, we know Kentucky is very different than other states. And so, again, what would this look like specific to Kentucky?

And so all of that information, again, is then gathered to draft the demonstration application. Then states are required to

conduct public forums prior to submission, certain time frames before that, seek that public comment about the application. States then have an opportunity to review those public comments, respond to those public comments, and revise and adjust the application as needed, and then actually formally submit the request to CMS.

And post-submission to CMS, there are several deliverables states have to meet under each demonstration request. And so, again, we do undergo, you know, a completeness check. Did we meet the requirements that the state Medicaid director letter required of the state to do?

Again, states also then go under a federal public comment period, 30-day public comment period before CMS can begin to review our application.

At that point in time, CMS will complete their initial review, and that really kind of starts the waiver negotiations between CMS and the state. So, again, that can be -- that time period is unknown. It can be months and then, in cases, even years.

They have implemented a new approach, more of a fast-tracked, expedited approach for approving state waiver requests. And so this is really the first of its kind. We'll get to discussion about reentry. But, again, really, if states fit into that, the guardrails of that state Medicaid director's letter, they may, again, fit into more of a fast-tracked, expedited approach, more standard terms and conditions that CMS will issue to states to help expedite these approvals.

Because as we talk through this, again, you can see it's a very cumbersome process, to obtain authority and then maintain authority. So once CMS agrees to approve a demonstration for states, states then have to complete an implementation plan that has to be then submitted to CMS.

We -- it is new for states to have to also now, for our reentry demonstration, develop a reinvestment plan. But we have to, again, meet monitoring protocols and requirements. We have quarterly/annual reporting to CMS. We also have an

independent evaluator to evaluate our demonstrations, our progress. Are we meeting our goals, our milestones, the requirements of the waiver?

And so, again, we're required to -- most waivers are approved for five years at a time. And so we do submit midpoint assessments and reviews to CMS, and those have to be reviewed and approved as well as the evaluation design. So lots of deliverables that are required, again, like I said, to obtain and maintain the demonstration.

So just to kind of give you an overview of what Kentucky's Section 1115 demonstration currently looks like. Again, our overarching demonstration is titled Team Kentucky. It was, again, formerly known as the -- excuse me, the Kentucky Health (sic) -- oops. Sorry -- to Engage and Achieve Long-Term Health.

And our initial 1115 was approved in January of 2020 -- excuse me, 2018. Currently, the demonstration includes our substance use disorder Section 1115. And

that is approved through September of this year.

So we are anticipating a five-year extension. We did receive a temporary extension. We're anticipating another five-year extension to this demonstration to be obtained before September, so the end of September, to extend that out.

The Section 1115 demonstration, really, the authority allows Medicaid to reimburse for our SUD residential treatment programs at a statewide average length of stay of 30 days. So without the authority, Medicaid, again, could only reimburse up to 15 days.

So, again, we have the authority to reimburse beyond 15 days to -- up to a statewide average. So all of our residential facilities together, their length of stays, again, cannot exceed 30 days' length of stay.

It also, again, waives the Institution for Mental Disease, the IMD exclusion, which only allows, again, a reimbursement up to 16 beds in a facility. So with the waive of the exclusion, Medicaid can reimburse for SUD residential up to 96 beds per location. And

that's for programs that meet the qualifications and standards that were put in place under the demonstration.

So I just want to provide an example of the milestones that the states are required to meet, again, to maintain the authorities. And so often, again, providers, you may have questions. You know, why is it that states are requiring specific licensure or requirements? And, again, a lot of the requirements are placed into our regulation changes -- can be done through regulation changes or SPA changes.

But this is just an example. Again, wanted to share. In order for Medicaid to maintain these authorities, we have to meet this milestone which, again, requires Kentucky to use a nationally-recognized, SUD-specific program standard to set those provider qualifications for residential treatment facilities.

So, again, we did adopt the ASAM criteria, so the American Society for Addiction Medicine criteria, when we first initially implemented the SUD in order to

meet, you know, this milestone specifically. But states are required to ensure that we set provider qualifications for providers to meet the criteria. And then, again, there's examples of requiring certain types of services, hours of clinical care, credentials for staff.

So, again, when we, you know, often get those questions from providers or concerns, there are certain things that the state -- that CMS requires the states, again, to meet under these demonstrations to maintain these authorities.

And so, again, also through -- some of you may be familiar with or aware -- I think some of your programs, I know, may be connected to our residential treatment programs. So, again, the -- there's an attestation process for our residential programs to ensure that they're meeting the ASAM criteria, meeting our Medicaid regulations. And so programs can obtain the DMS provisional certification and then are required to obtain the ASAM level-of-care certification.

So, again, that process is a part of ensuring we're meeting the milestones, to review our residential treatment providers to ensure that they're compliant, again, with those -- with the criteria, implementing and utilizing the criteria.

And then, again, the other requirements under the milestone is to ensure that individuals in a residential treatment facility have access to MAT, and so medication-assisted treatment defined in Kentucky. Currently under the waiver and to meet CMS requirements is that medication for substance use disorder, again, along with those therapies. And so we have to, again, be able to ensure that our programs at least have access to MAT. So if they're not providing that on site, that they're facilitating that access to off site.

So I just wanted to provide an example, again, of some of the milestones under the waivers. Each waiver, again, has a certain set of milestones that we're required to meet to obtain these authorities.

And, again, our current 1115 also

includes coverage for our out-of-state former foster care youth. And so this, again, extends Medicaid eligibility -- and there's an error. Sorry. I'll fix that before we send those slides over -- to our former foster care youth that are aged 18 to 26 that were in former foster care under another state.

So if they were in former foster care -- or excuse me. If they were in foster care in Ohio, moved to Kentucky, and are within that age frame -- age group, again, they can -- they do have eligibility for Medicaid coverage under the out-of-state former foster care youth.

Part of this, again, has been moved to state plan. But for -- for the youth that fall out -- outside of that time frame when it was initially effective under the state plan, the authority, the 1115 authority, again, remains in place to ensure that they have access to that coverage.

Kentucky, again, we currently have several pending requests, authority requests to CMS. And so in May of 2023, we submitted

a request for a serious mental illness, SMI, 1115 demonstration. And, again, this is to mirror the SUD in terms of the IMD exclusion.

So, again, this will define as a statewide average length of stay no more than 30 days, allow for a reimbursement in our inpatient hospital settings, reimbursement beyond that 15 days up to the statewide average of 30 days for our adults with serious mental illness.

And along with that submission, we also requested authority to reimburse for a recuperative care service. And so, again, you all may also be familiar with that. It's also known as a medical respite. So, again, this is going to be for our adult beneficiaries that are at risk of homeless or homelessness. Then, again, those individuals may require or need additional medical support and care before they are able to transition back into the community.

This is also going to be offered and available for individuals that may not be following a stay but may need to actually be in a -- in a setting prior to a surgery or a

procedure and, again, ensure that they are able to even access that. And so, again, it won't be just for individuals that are leaving hospitalization and needing additional medical care.

And then we also, again, in December of 2023, submitted our Reentry Section 1115 demonstration. You may or may not be aware. Again, Kentucky, in 2020, submitted an amendment to our SUD 1115, and that was referred to as our incarceration.

And so based on guidance that CMS provided the states through those state Medicaid directors letter regarding reentry opportunities, the State did need to make amendments and adjustments to our pending application. So we did resubmit to ensure that we are really in those guardrails of that letter to be able to obtain approval.

And so, again, this is to request Medicaid coverage for certain transitional services. So, again, this is not full state plan Medicaid services pre-release. It is just initially, again, to be a certain set of services for individuals that are soon to be

released back into the community.

And so the focus of the Reentry 1115 opportunity is really to ensure that we are continuing healthcare coverage when that individual is released so that there is an opportunity that they'll select -- that their eligibility, again, is reinstated before that individual leaves the correctional facility and that they have access to those pre-release services; that, again, that they are able to maintain and continue that coverage and it is already reinstated at the time that individual enters back into the community.

And so really, again, ensuring that we facilitate those linkages to the services that that individual needs upon release. And so the emphasis on the reentry demonstration is really around the case management component and the service.

And so Kentucky, again, has requested 60 days prerelease to be able to reinstate the selected benefits. The individual can be connected back into their -- with their health plan or be able to select their health

plan that they choose.

But that case management component is to really -- service is to really identify what are those medical, behavioral health, and those health-related social needs of that individual and family when -- for our youth when they are released and reenter into the community.

And so, again, we want to be able to identify those needs, develop that plan, make those referrals, ensure that they have those connections to those healthcare providers, behavioral health providers. At the time that they're released, those appointments are already made. How are they going to get to those appointments?

Address what those barriers are and then also ensure that we have -- facilitate the handoffs in terms of health records and, again, that -- the data exchange to ensure that we have -- we are able to continue that care. So that, again, are the large components of the reentry demonstration.

And along with the reentry demonstration, we also requested authority to

reimburse up to 90 days for our Recovery Residence Support Service. And so this would be for our individuals with SUD that fall into our Reentry 1115 and for also -- if you're familiar with the Kentucky Behavioral Health Conditional Dismissal Program, or Senate Bill 90, which is piloted in a few of the counties across the state.

Again, that is more of diversion from our justice judicial system for those individuals that are -- that meet certain criteria for charges, are screened to determine if they have mental health or substance use disorders, again, can seek and obtain treatment for that before. Again, and if they complete that treatment program, their charges may be dismissed as opposed to, again, serving out, you know, their sentence, et cetera.

So for those individuals that are participating in that program, they would be eligible for this service as well. Again, this is not reimbursing for recovery residence. It can -- the Recovery Residence Support Service can be provided and will be

provided by approved recovery residence.

But, again, they are required to meet certain standards and qualifications. But, again, this is more of those supports and services that that program does provide for that individual to help them, again, obtain and maintain their long-term recovery.

Just to go back, again, around the reentry demonstration, just to give you an overview. I think we covered most of it. But the reentry demonstration, again, does include our adults in our state prisons currently, just our state prisons, and our juveniles in our youth development centers.

And, again, the benefit package that we spoke to, the benefits will include that case management service, medication-assisted treatment for those individuals with SUD. So, again, that's the medication plus the therapies.

They're eligible for those services 60 days prerelease. And then at the time the individual is released, a 30-day supply of all of the medications. And so that would be prescribed and over the counter.

And then, again, our Recovery Residence Support Services is just going to be for our adults and then that will actually -- that authority will be under our SUD 1115. Services, again, for the reentry can be in person or telehealth.

And we will talk about -- so just to -- and, again, a high-level overview of what Team Kentucky Section 1115 demonstration will look like and walk through when we're expecting, you know, approvals for these demonstrations. So I just wanted to let -- again, here, you can see that we have the reentry, the SUD, the components that we walked through, out-of-state former foster care youth, SMI recuperative care. These are the components and will be the components of the overarching 1115.

Our Recovery Residence Support Service. This new service, again, is going to fall under our SUD demonstration. We are anticipating approval for our Reentry 1115 the end of this month, next week hopefully. And with that approval -- again, once we obtain approval, that does not mean that we

can begin to implement. We, again, will still have to complete our implementation planning, submit that to CMS for approval, and receive approval before we're actually looking at any type of go live, being able to provide services during that prerelease service -- excuse me, prerelease time period.

And then, again, the other components of the 1115, our extensions and our other pending approvals, those are anticipated to be approved by September 30th of this year. And very similar, again, implementation plans, monitoring protocols have to be approved and submitted to CMS before we are actually implementing and go live.

Sorry. I'll stop there. Like I -- I know that's a lot of information and, again, happy to provide -- if anybody -- I stopped sharing before I got to the questions slide. So I'll put in the contacts -- drop those into the text box and, again, will share the slides.

But if you have any questions about the demonstration and the authorities and, again, more in depth as to what that means. That's

just an overview of what Medicaid is required in order to obtain these authorities and maintain and be able to extend moving forward.

But, again, it's -- states have the opportunity to request -- to demonstrate new services, expansion of services, delivery models, et cetera, to CMS. And so we -- it continues to grow, and we have opportunity to still grow, again, addressing some of the health-related social needs, looking at some of those opportunities as well and some of our children's services.

But if you, again, do hear 1115, hopefully, you have a little bit more background as to what they are and what that means.

CHAIR MOORE: Thank you, Angela. We appreciate that. I think Kentucky has done a good job of using the flexibilities that waivers provide to meet some really important needs for key populations.

Dennis, Brandon, Barry, questions for Angela?

DR. MARTIN: No. That was pretty

good.

DR. HOUGHLAND: Stephanie, this is Steve Houghland. It did look like there was a question that came in through the chat, and it may not be the best venue to -- for the question. But there was a question about if there was an understanding of how many Kentucky foster children are out of state at this point.

MS. JUDY-CECIL: We're happy to provide that number. I -- we don't have it at the top of our head.

DR. HOUGHLAND: Okay.

MS. JUDY-CECIL: I will say that that is a last resort. We -- we did have a large number. We worked really hard to get that number down. So now I think it's a much smaller number, which is always good.

And, you know, some of the things we've been doing is our -- Aetna has the Supporting Kentucky Youths, SKY program. And they've been really, you know, working with local or Kentucky providers including, you know, single-case agreements to adjust rates to try to keep those kids in the state. So yeah,

happy to provide that number.

CHAIR MOORE: So if there are no more questions about the waivers, we'll move on to the pharmacy reconciliation process.

MS. JUDY-CECIL: Okay. I think that is me. So it's been a bit of a challenge for us to implement our changes to the 340B program. We did have a change in vendors for our -- who performs the fee-for-service pharmacy benefit manager activities that includes rebate. So that was -- MedImpact won that procurement, and they are -- so they are now both our managed care and our fee-for-service PBM.

MedImpact has been in the process of creating that program and sort of kind of picking up where the previous vendor was. There was some recent testing of files, and so we've been going through that process. And -- you know, and that did flag some issues. Obviously, we don't want to go full steam without us knowing that it's going to work.

So we're working through those test file challenges, and now I think the date has

moved to October maybe for implementation. But, certainly, we'll keep providers updated and give them enough time to be able to shift.

CHAIR MOORE: So one of the things, I think, has been really difficult is that -- and believe me, I appreciate the commitment to trying to make something right before rolling it out. But, you know, even within just a few weeks ago, it was maybe it's July. Maybe it's October. You know, if we could just really work to improve the communication. And if it's punting -- you know, like, if at this point we know that October doesn't look realistic, let's just say January.

Because the problem is, is that we're having -- you know, last year, I know our organization spent considerable sums of money to try to be prepared to meet a deadline that kept getting pushed back. And at some point, you know, we're racking up the equivalent of partial FTEs that we're spending on a deadline.

So, you know, is it possible, Veronica,

to say that once we get the file correct, then we're going to give pharmacies X number of days to build their file? Because it makes no sense for us to be working on building a file if the file format is going to continue to change.

MS. JUDY-CECIL: Absolutely. And I think that is our goal, is to work through the kinks of the file and then provide the information and give an implementation. So I can certainly, you know, commit to 90 days if that's what folks need.

I think that's a very reasonable request, and I -- I appreciate the request and the information about the, you know, burden on the providers. We certainly want to take that into consideration.

CHAIR MOORE: Yeah. I think 90 days is very reasonable.

MS. JUDY-CECIL: Okay.

CHAIR MOORE: I've been ignoring emails about who our TPA is, you know, really because, at this point, I don't have an answer to that.

MS. JUDY-CECIL: Right. Sure. I

know that's difficult. Yeah. Thank you.

CHAIR MOORE: Our pharmacy team gets a little twitchy, and I'm like, no, no. I think it'll be fine.

MS. JUDY-CECIL: Yes. I know. I'm so sorry. Certainly not ideal, but I think we can absolutely commit to a 90-day implementation to give folks -- you know, once we know and we're ready, is to give providers the opportunity to then do what they need to do.

CHAIR MOORE: Okay. Thank you. I appreciate that.

MS. JUDY-CECIL: Yep.

CHAIR MOORE: All right. Is there anyone on the call from DPH this morning?

(No response.)

CHAIR MOORE: If not, we'll move on. But just for the record, we have invited DPH to also participate in this call with us, so perhaps they'll be able to have a designee at the October meeting.

MS. JUDY-CECIL: Yeah. Apologies. I think the person who they would like to send was just -- had a conflict today.

CHAIR MOORE: Okay. Great.

MS. JUDY-CECIL: Thank you.

CHAIR MOORE: So we'll move on. One of the first updates from the PCA is a presentation that we would like to walk through regarding child wellness visits and immunization compliance. So if we could get that -- I don't have that, but I think -- B.J., are you sharing that? Yeah. Perfect.

MS. BUSSELL: All right. Can you see it, Stephanie?

CHAIR MOORE: Yes. Thank you. Thank you.

MS. BUSSELL: Just let me know, and I'll advance.

CHAIR MOORE: Okay. Great.

So the purpose of this presentation today is very much -- you know, we know that there are a number of measures related to child health and, you know, all of us are working towards creating healthy kids in Kentucky from a variety of different perspectives.

And so we wanted to speak today from the perspective of the provider and really talk

about what those challenges are and how we could collectively create solutions to address some of those challenges.

Do you want to hit me with the next slide, please?

So -- and first of all, we just want to share and kind of level set regarding common language. So, you know, I think that a lot of times -- you know, is a well child a sports physical? Is a sports physical a well child visit?

You know, but really what those visits should include from a clinical perspective is a comprehensive, preventative visit, you know, where we are addressing a variety and looking to identify a variety of diseases but also doing health promotion and anticipatory guidance. You know, I think most providers work off the AAP and Bright Futures Recommendations for these visits.

And so as we think about completing those visits, you know, we have challenges presented by, you know, families. You know, we have individual challenges created by us as providers and then also by the regulatory

environment.

So we're first going to dive into some of the ones from families. You know, so certainly, there are many challenges to families when it comes to completing their child's wellness visits. You know, those social drivers. Do they have transportation? You know, I think that there are a lot of transportation pilot programs, but in rural communities, there aren't as many options. So some of the Uber pilots that have happened don't work in communities that don't have Uber available.

And the reality is access and timely appointments, work, and competing priorities make, you know, arranging Medicaid transportation three days in advance really challenging. So, you know, that in itself is a huge challenge. You know, all of my competing social drivers preventing me from being able to access the resources that are supposed to help me be able to get that appointment scheduled.

You know, I think that there is a fair amount of health literacy challenge in terms

of understanding what that well visit is, you know. I think that, oftentimes, families are really aware that they need to bring their infants in for periodic well visits.

But as kids progress and, you know, you see a nine-year-old versus a ten-year-old, there's not a lot of change in development that's happening in that age. And so families think, oh, it's not that important, or I was just there at the office for this. If there was something wrong with my kid, they would have already told me.

But then also things like sports physicals complicate that as well. So families are like, well, my kid had a physical for his soccer team or his football team, so I've probably already completed that.

You know, and then like I said, you know, if you're a family who is living on, you know, a really fixed income -- maybe you're working a job where you don't know what your work schedule is going to be until a week in advance or even a few days in advance or perhaps you're having to work

multiple jobs, it's really difficult to get a timely appointment in a way that meets your schedule but then also allows you to bring that adolescent in.

You know, I know, from my own experience, I have three teenagers, and I'm the CEO of their pediatrician's office. And it's still -- trying to get their well child visits scheduled within everybody's competing priorities is a huge challenge.

You know, I think there are a lot of value-added benefits that are created to try to entice families to come in and complete those well child visits, but those are sort of theoretical. Those are things that come in the mail on a piece of paper. They feel really inaccessible to families. So we have found them not to be motivating to increase people's engagement in well child visits.

And then lastly, I think in some areas of the state, there's variability about whether or not a vaccine is going to be available. We would like to think that in most our FQHCs and rural health clinics, that we're keeping those appropriate vaccines in

stock. But, you know, some providers don't participate in the Vaccines For Children program. Other providers only keep select, you know, number of vaccines in stock because they have seen that the uptake doesn't make sense in their community. So if a family goes in, is the vaccine going to be available?

We've also seen that in other facilities, you know, a lot of the retail-based clinics, that they may not keep vaccines at all. And at a minimum, they may not have access to vaccine records.

You know, when we start to look at the challenges facing the healthcare provider team to completing those, you know, certainly, do you have enough capacity to see those patients? You know, do you have an appointment at the time that the patient needs to be seen?

You know, this is probably one of the highest areas for no shows. So, you know, as a provider who has lots of patients calling in asking for appointments, it's really hard to fill your day with outreach calls and have

those patients not show up.

I know in our office, we did a test of this a few years ago, and I think we made 100 calls. We reach, you know, less than 20 patients, scheduled less than 10, and maybe 2 showed up. And so the time it takes and the staff effort and wages that we're paying staff to make those calls to yield two visits is not a sustainable ROI for us.

I think that, you know, there are opportunities to do well visits when you see a patient for a sick visit. That's one of the really popular strategies, is can we switch this visit when a family is in our office to a well visit?

But trying to bill both of those and use the 25 modifier at a time that people are already overburdened with regard to documentation is really not sustainable. So even if they do the work, you know, doing the documentation to get paid for both visits is not, you know, likely something that a provider in an employed setting is going to do.

You know, trying to align those

evidence-based guidelines and visit frequency with the quality measures and reimbursement. So, you know, we just had the conversation in our office this week. You know, I was like, I think that that payer will let us do calendar year well visits. And, you know, my team pushed back a little bit because they said, really, it's so variable across the board that it's impossible for us to set a standard and use calendar year because there are also situations where it's 365 plus one. And so we are at the risk of, you know, not getting paid for that visit, which is also really challenging.

You know, there are also other plans that really want that aligned to a specific birthday. You know, one of the other questions is: If you have a kid who's in the office and you're trying to convert a visit and they're in the gap, at what point do you rope -- round up versus what point do you round down?

Certainly, post-COVID, we have seen immunization hesitancy continue to reach all-time levels. You know, we've even seen

families that prior to COVID were willing to get flu shots be completely unwilling to even discuss flu shots because they're afraid that the COVID vaccine might be slipped in with the flu shots.

You know, continuity of care. You know, with so many options to get care, you know, different people doing care different ways, it's really hard to get the information that you need and feel confident that you're going to get paid for that visit. So some of it might be with the primary care provider. Pieces might be at a pharmacy. School clinics are doing pieces. And that really is challenging to really know what a child has had and not.

You know, we've already kind of talked about that productivity piece. You know, and then just from a provider perspective, it's not feasible in offices to help patients figure out what their log-in is to their various platforms to help them access those value-added benefits. So we feel strongly that addressing that challenge related to value-added benefits is something that would

help engage more families.

And then finally, from a regulatory environment, you know, obviously, people live really busy lives. You know, people live really busy lives no matter what their life circumstance is, so trying to engage families in the importance of this. You know, it's not just enough to suggest that they have a well visit. It's not even just enough to do marketing around, hey, call and come in. You know, we really have to create an incentive strong enough that will draw them in. Because, otherwise, we're just really -- we don't have a winning opportunity to engage them.

I think we have lots of challenges, both on the payer side -- you know, certainly, DMS has faced it as we've seen during revalidation efforts. And then, certainly, even from the provider side, we see it where patients change their contact information so frequently that, you know, it doesn't matter if you call them, text them, mail something, send a pigeon. You know, probably a good portion of that is coming back to you.

You know, we're not seeing a whole lot of uptake on those value-added benefits, so we feel like from a regulatory perspective, that's something that there's opportunity to change.

Duplicative claims. You know, are you -- you know, getting lots of claims for a well child visit from a variety of different care providers is going to result in claims getting denied.

And then, you know, really, as we start to look at working off care gap lists, by the time that data comes to the provider, it's already so dated that in that time, somebody potentially could have had a well child visit and you don't have that information.

You know, and I know there are lots of opportunities to log in to payer platforms, but the reality is there are too many platforms, and there's too many places where information is kept for any sort of busy patient access team to be able to check all of the places to feel confident that that kid really still hasn't had that care gap -- or had that well child visit.

And so we wanted to kind of really talk through a case study, and I think that this is a case study that feels very, very similar to a lot of us. So we have Braden who is a ten-year-old at a middle school, and he has started soccer practice with his team. And Coach said, "Hey, hey. If Braden wants to continue playing, he needs this sports physical." And I can tell you he needs this sports physical today, not tomorrow, not in two weeks. When that happens, it's I need it right now. You need to go right now and find a place to get a sports physical.

And so Mom sees that a local independent clinic, instant care facility, retail facility is offering sports physicals for $25. So she's like, sure, I'm going to go take care of that.

That provider did, you know, encourage Braden to establish with a local primary care provider, but Braden's parents are busy. They have five other kids in the house. They're both working. And so, you know, establishing that care with a primary care provider just fell to the bottom of the

priority list.

So he's not had an annual well visit since he was five years old because that's the last time he had required vaccines to enter school. So he's within a value-based, and, you know, his payers reached out to him. But, you know, nobody has been successful in reaching Mom.

In September, the nurse at his middle school calls Mom to say that since he's reached his 11th birthday and is in sixth grade, he now needs to update his immunizations to remain in school. So, again, Mom is getting a call, you have to do something right now today, or your kid can't do what he needs to do or wants to do.

And in that call, teachers also report that Braden has really been struggling with attention and behavior in class and recommends, you know, talking with a primary care provider about those needs. And so Mom schedules an appointment with the after-hours provider at the local pharmacy to get the vaccines because she can remain at work. He can remain at school. They can get the

vaccines late in the evening.

And so she'll make a well child visit a little bit later because Braden just had a sports physical. So if something was wrong, surely, that would have already been discussed.

And so, unfortunately, when she gets to the pharmacy, the staff is hesitant to give him the vaccines as they don't have record or access to any other records of immunization that Braden has given previously.

So here we have a really, really busy family who's trying to respond to all of the competing priorities. And they're choosing care based on convenience, but they're not getting coordinated care in that fashion.

So I think that that's a really typical scenario. I think that we fully recognize that, you know, families aren't intending to not take the best care of their kid that they can. There are just lots of reasons that that gets complicated for families.

I think providers are, you know, trying to do what they can to engage families in getting well child visits and vaccines. But,

again, we have to have an ROI that allows our businesses to be sustainable.

And I think from a regulatory environment, they are trying -- you know, both from the MCO and from the Department of Medicaid, you know, there's lots of energy happening to try to help increase engagement. But, you know, for us, we felt like it was worthwhile to have a conversation about some of these realities. Because simply telling our members to do better, if you call these families, they will come, that is just not the reality that we're practicing in right now.

So at this point, we wanted -- you know, Barry, Brandon, Dennis, you have anything to add to that? Do you feel like that's the scenario that you see in your practices as well?

DR. MARTIN: I think this is a common theme across the board, most of these. We see them every day.

MR. HURLEY: Yeah. I mean, we struggle with exactly these type of scenarios so -- and, you know, I do empathize with the

families and the kids and stuff like that. But you're still not getting true, quality care. We're not tracking these kids appropriately. And we're not dealing with, you know, good healthcare concerns, chronic health issues, any of the things that's impacting these families in this strobe light environment where, you know, you're just trying to deal with the here and now without tracking true quality health concerns.

CHAIR MOORE: And I think that's such an important point, Brandon, because I think it's hard for families to evaluate what quality care looks like, you know. I took my kid to a doctor. They signed a form that said he could play soccer so, you know, I have to trust that provider that they, you know, were doing what they need to do. And families don't understand the limitations that we have on the provider side, you know, if we don't have that continuity.

MR. HURLEY: Well, the other side of it, too, I think, Stephanie, is the fact that, you know, if they don't establish with a primary care provider who could track them

over time -- let's just face it. We get a lot of providers sometimes that, you know, even if you're doing a sports physical, even if it is a primary care provider, you know, that's -- we oftentimes wedge those in between appointments.

And you hope your provider is doing a good assessment; right? But at the same time, it's not the cure-all. That's why the ongoing engagement in that relationship in the long term provides quality care.

Because, you know, in a one-off sports physical, I don't know that I've caught the heart murmur appropriately or those types of things that could impact them in the long term. Whereas, if you've established long-term care and you're monitoring that same child and family over time, you're able to identify those issues because you've tracked them over time, or you may have made a -- you know, we've got something in a patient chart, that we noticed something weird last time and they showed up again and things of that sort so...

CHAIR MOORE: And there's such

pressure on providers to sign that sports physical form when somebody is in the office. Like, there's no family scorned like a kid who gets sent to cardiology before they're cleared for soccer.

Dennis, you've been off mute for a little bit.

DR. MARTIN: You know, one of the things that I found is most parents try to -- try to coordinate their sports physical along with their well child visit. But where it has to be at least 366 days after the fact, a lot of times, that gets out of whack with their either soccer timing, football timing, baseball timing, whatever.

I mean, if there was maybe some way that we could say, you know, 15, 20 days, whatever, within that 365-day time frame. Maybe we can expand that window a little bit. I know everybody is afraid that, you know, we'll try to -- you know, so if we snuck one well child visit in, it would take us the whole adolescent time of the child to sneak another one in if you just give us a 15-day window.

But I know that it's -- you know, I know that when my kids were smaller and we tried to do that, we always had to make sure that it was 366 days after the last sports physical or last well child physical. That makes it easier if you can kind of correlate those two or do them at the same time.

DR. THERIOT: You know, this was spot on, very realistic. One thing that we -- this is Dr. Theriot. One thing that we did is if anybody was 11 years of age and up and they are coming in for a checkup, they -- the providers are instructed to do the sports physical at the same time, not necessarily the paperwork but the physical part of it and document that they did it.

So if the kid comes back in six months and says I need it, that sports physical form is good for a year. And you can have Mom fill out her part and then do the other part, and they're good. They don't have to come back in.

And, of course, this is asking, you know, are you sure you don't need it now? And before I give you this form, let me scan

it into the chart in case somebody loses it.

But, I mean, it is a big problem, and people don't understand and nor should they. But yes, it's so much better if they go have continuity with their providers.

But I'm a mother of four kids. You know, if you can go to a pharmacy and you can pay 25 bucks and get that done and they can not have a break in their soccer practice, you're going to do that any time so...

DR. MARTIN: Dr. Theriot, another issue that our pediatricians are having is, you know, trying to get the parents -- their confidence in the pharmaceuticals with immunizations. There's just a lot of the parents, they don't -- they don't trust immunizations anymore. I think Stephanie actually broached on that conversation.

So if there's some kind of a promotion that we can have to kind of endorse or promote the immunizations as being safe and sound, that would be good as well.

DR. THERIOT: We are working with our public health department on that because it's true. We -- Kentucky used to be one of

the highest -- have the highest rates of immunizations, for childhood immunizations in the country back 15, 20 years ago. And, you know, vaccine refusal was something that happened on the west coast, and we never had to worry about it.

And now we -- you know, it got worse, you know, with the -- I think, first of all, the MMR/autism stuff and then with the -- just not seeing those diseases. You know, if you don't see somebody with tetanus or pertussis or diphtheria, you know, it doesn't really exist. It's not a real thing. And so people weren't -- you know, were like, oh, that's not really a problem anymore.

And so things were waning and then we got hit with COVID. And the people that were getting the shots, suddenly, they don't trust any vaccines. So -- and so it's made it a whole lot worse.

So we're really working with public health to do social media campaigns. We are -- we've added incentives within our value-based program for MCOs regarding the vaccines, like the metrics for vaccines, as

well as our teaching hospital. So we're really trying to come at it from different angles.

And then also, with hopefully having the pharmacies -- now that they can immunize down to five years of age, you know, including our pharmacies in hopefully getting some of those, you know, older kid vaccines or catchup vaccines done even if they're not part of VFC. You know, so having the parents have another avenue to get those done versus the pediatrician's office. So we're trying.

DR. MARTIN: Have we thought about working with the department of education as well and getting back to having them enforcing -- having some of the immunizations before they go back to school?

DR. THERIOT: That is a wonderful idea. They are members of some of our task force that we're working on.

And, honestly, some providers, even pediatricians, only carry -- like Stephanie was saying, only carry vaccines that are required for school. And so that nixes the HPV.

So even though the CDC and the ACIP, you know, recommend it, because schools don't recommend it, they don't carry it. And so those kids will have to go to the health department or somewhere else to get that HPV vaccine.

And I think it's crazy that you're not carrying, you know, recommended vaccines, but they don't want to argue with the parents. They -- you know, and they don't want it sitting on their shelves and going bad. So -- so we -- yeah. It's a problem.

But we're -- so the point of that was that if it was required by the schools, they would carry it. And more kids would be vaccinated with -- you know, against cancer.

DR. MARTIN: Yeah. I think that's one of the key areas that we're missing, is because before COVID, that was a requirement. After COVID, with all the remote learning and stuff, I think people, they've become lax with that.

So if we could get a push from the top of the Department of Education for the schools to enforce that, that might help us

as well.

DR. THERIOT: That's a great thought. Thank you.

CHAIR MOORE: Dennis, I think you've been trying to jump into this conversation a little bit. Is your audio -- yeah. There you are.

MR. FOUCH: Yeah. Can you hear me? Okay. Great.

No. Your presentation is spot on. The other issue that we run into is communication with the school health programs. And when there was a preventative visit done at the school and then we bring them in in their normal time and then we go -- we get all the way down the road to -- you know, to billing of the claim, and it comes back that it was already done.

So we've tried to work on that. It would be great if we could -- if, you know, we could work on communication as well or have some kind of repository where we could see those things, similar to our vaccine -- ability to see vaccines in pretty much real-time.

So yeah, it's a major issue, especially this time of year for us as well so...

CHAIR MOORE: So I think that, you know, in terms of solutions, we've kind of hit on a number of the ones that we had sort of collectively generated from a variety of sectors but trying to create alignment and, you know, to keep the time frame as broad as possible, you know. I think that, you know, we've talked a lot about the convenience for families. So, you know, if we know that well child rates are pretty low in general, could we just open it up to be any time in the calendar year so that, you know, we don't have to worry about whether it's 365 plus one, whether or not it's their birthday but just having that broad spectrum open.

You know, I think that there's opportunity from a regulatory standpoint for DMS to hold people accountable, that if you are going to be doing well child visits, that you need to be prepared to vaccinate kids or that you -- if you're doing those things, that you have to have access to check vaccine records.

So, you know, one of the things that I think is difficult for us is -- you know, particularly the KPCA members that are in the CIN, we've all been working on innovation in this space and, you know, have our teams prepared to try to -- to capture these opportunities to the greatest degree possible.

But we can't control when that family chooses to go to Kroger or to Walgreens or to wherever. And so, you know, that creates that expectation that my kid has what they need, and so I don't need to respond to the outreach from the payer. I don't need to respond to the outreach from the pediatrician.

So we would just like to have continued conversation around this, you know, in the coming months, you know, whether it's -- you know, as the MCOs are developing their plans.

You know, we do believe that the incentives need to be available at the time that the patient is in the office. And I realize that that's complicated and thorny, but I think we're going to have to solve

thorny things if we really want to engage families differently.

Because it's really easy to say, oh, I'll get that HPV visit -- or HPV vaccine the next time I'm in the office. But if you can look at a kid and say here's a 25-dollar Doordash card that you can have today if you get this shot, suddenly, kids are a whole lot more interested in getting a shot. Or, you know, you can have a PlayStation card if you, you know, get this shot today.

So we just would ask that, you know, all of the various stakeholders, you know, really give thought to what reality is. Because I think if we're going to move the needle both on well child rates and on immunizations, we're going to have to be very frank and very real about what's happening in families, the challenges that they're facing and, you know, what truly is going to motivate them to make a different behavior choice.

Any additional thoughts or ideas for discussion?

(No response.)

CHAIR MOORE: Dr. Houghland, do you

think that that captured all of the other collective pieces that we had from the other folks that we had talked with?

DR. HOUGHLAND: I do and much better said than I could have.

CHAIR MOORE: I'm not sure about that, but we shall -- we shall see.

So moving on. You know, I know we're running short on time. Do you have an update from the CIN?

DR. HOUGHLAND: Sure. Just to be brief, a couple of things. Many stakeholders on this -- in this meeting have heard some of this information, so I apologize.

But an update on the data aggregation project. Obviously, the members are more aware than some of the other people on the call. But we -- the Kentucky Primary Care Association and the CIN have been working on a data aggregation tool to pull together the disparate sources of information that come in both from payers but then also the HIE and other sources.

So today, work with the Kentucky Health Information Exchange is ongoing, and it's

very promising that that connectivity will be in place in the next month, we believe. Five of the six Medicaid MCOs are contributing information into the data aggregator to date, and work is occurring with the sixth.

And over half of the members of the Clinically Integrated Network are now in different stages of connectivity and implementation. So really excited about that.

We're also moving quickly towards the timeframe where the data validation for NCQA data aggregation validation is occurring. And so once that happens, the groups that are connected, the file feeds between the -- between Azara and the health plans will be deemed as being certified, so it takes a lot of the manual work out of the process.

So we're really excited. We actually set out with the goal of having 30 to 35 groups at this stage by the end of 2024. And so we're actually -- knock on wood -- a little ahead of schedule. It's been a lot of work from a lot of different groups and really appreciate the providers and

leadership putting priority on this. So, again, that's good information to share. It's still a lot of work to be done, though.

And then, I guess, the other thing I just wanted to hit upon was that -- were the clinical priorities that the network has set out. Some have heard this. But, again, I apologize for plowing some of the same earth again. But the networks set out with four large areas of priority: Increasing patient engagement, increasing well child and adolescent wellness visits and preventative services, also increasing adult annual wellness visits, and decreasing avoidable ER utilization.

Underneath those middle two, we unpacked a little bit and set out three specific things for well child and adolescent visits which line up a lot to the previous conversation. One of them is increasing just that, child and adolescent wellness visits. The second is increasing childhood immunization, Combo 10s. And then the third is immunization for adolescents, so the famous Combo 2s.

And we're putting a lot of effort, working with the members of the network, to move this needle further faster and just wanted to share those, especially in light of the previous conversations.

For the adult annual wellness visits, we -- we decided to focus on a couple of specific components of adult wellness. One is focusing on improving glycemic control for individuals living with diabetes.

And the second one is actually enhanced focus on breast cancer screening. And we had a lot of conversation. We thought that having a focus on cancer was going to be really important, considering where Kentucky is in the -- in its current state of incidence and prevalence of oncologic issues.

There's a lot of debate between breast cancer and colon cancer screening, and we decided to look at breast cancer screening or highlight it, a lot because while the population that can be subjected to colon cancer screening is much larger because it's male and female. Kentucky has moved a long way in the last decade on screening rates for

colon cancer screening.

But breast cancer, it seemed like we still had a lot more opportunity. And then, also, with some of the guidelines changing about the age for screening to begin, we thought that it would be important for the next year or so to put some enhanced focus on screening women for breast cancer.

So those are kind of the -- you know, taking those five and then the two others at the bookends, those are the seven priority goals of improvement for the network for 2024, and we'll reassess in 2025. But likely, there will be a lot of similarities in '25 to '24 knowing how long it takes for clinical measures to change when you start taking action on them.

So with that, I'll just stop and see if there's any questions from the -- from the members of the committee.

(No response.)

CHAIR MOORE: Hearing no questions for Dr. Houghland, we'll move on.

Any other business from committee members today?

DR. MARTIN: In regards to old business, I just wanted to bring up the need for us to start really focusing on the MCOs getting our panels cleaned up. I know we've talked about that in the past, and I've talked to some of the MCOs to help us out. But I think we need to really make a concerted effort.

We keep sending in the PCP adjustments or changes, and they don't really get processed. So we're -- it just seems like we're spinning our wheels. And for us to really be effective and manage people's care, we've got to be able to contact them. We have to have some kind of a relationship with them. And it's hard to do whenever you've never even seen the patient, or you don't know how to get up with them. So if we could kind of re-emphasize that.

And -- and maybe somewhere down the road in our contracts look at more of a -- like the way Medicare attributes them by where they've been seen the most so...

DR. HOUGHLAND: So, Barry, it's a great point, and I think we can -- I'd love

to have some additional conversations offline with this. I think in so many of the arrangements with the MCOs -- for those that are in the network, we have a mechanism to be able to address that directly with the MCOs. And many of the mechanisms that they utilize for attribution beyond member assignment does have a factor related to most frequently seen PCP. And, in fact, algorithms breaking down, that's something that we can address from the network level with the MCO in question.

Now, if it is someone that is not a member of the network, then there's -- that's more of a direct relationship that they would have with the MCO. I think, you know, as it relates to high-level, policy-related things, getting some consistency in how an attribution model works, I think, yeah, it does have some merit. Similarities decrease confusion and sometimes can become more replicatable in a good way.

So that may be something that's worth having some conversations about as well, is: How do we drive out some of the variation that is not adding value and is actually

causing confusion in the system.

DR. MARTIN: Okay.

MS. JUDY-CECIL: And I think, you know, if there are issues with the MCOs and we'll have to take -- I'll have to go back and look at the MCO contract to see how this is even mentioned or addressed. And, you know, if we need to -- I agree consistency might be helpful in this area. Always good to identify areas you can be consistent. You know, we're happy to take that back and work across the MCOs for some consistency, either voluntarily, or we can look at what we might be able to do in the contract for January 1 to create consistency.

CHAIR MOORE: I mean, I think creating -- you know, to Barry's point, creating some expectation about response to those change forms. Because it is, like, a -- you feel like you're sending the work into the wind for it to never be --

DR. MARTIN: You feel like you're a rat on a wheel.

CHAIR MOORE: Yeah, yeah. Like, we found -- we had, at one point, started saving

them because we wanted to do some tracking to see if they were productive, and so we had big stacks of them. I was like, we can just shred them because that data exercise will yield no positive results for us.

DR. MARTIN: Yeah. It's kind of a multi-tiered issue. One is, you know, processing the change forms. And the other is just the initial attribution of it as well. Because, you know, if you get somebody -- if you're in Hazard or Hindman or Hyden or Vicco, Whitesburg or wherever, and you get a patient from Frankfort or Lexington, it's kind of hard to manage their care. So I know that shouldn't happen, but sometimes it does. So just a point of emphasis.

CHAIR MOORE: Any other business from other committee members today?

(No response.)

CHAIR MOORE: Okay. So are there specific recommendations that we would like to send to the MAC today?

(No response.)

CHAIR MOORE: I think most of the

items we've discussed are sort of things that wouldn't be applicable to change until the next year, you know, so Barry's comments. But even things around consistency on some of the well child vaccine conversation, I think it's probably impossible to change, you know, time frames and things like that midyear but, certainly, as we move forward. And, you know, I would ask -- not for the MAC, but I would ask the MCOs just be mindful of those things as they have conversations with members.

So hearing no specific recommendations, our next meeting is October 24th.

Is there a motion to adjourn the meeting?

DR. MARTIN: Stephanie, maybe we could ask the MCOs to come back to our next TAC and just provide a brief report on their process, and maybe that would get it as a point of emphasis back throughout the MCO.

CHAIR MOORE: On attribution?

DR. MARTIN: Yeah. Well, not on attribution but on processing change forms.

CHAIR MOORE: Okay.

DR. MARTIN: Just the re-emphasis on it. That's not enough for a MAC recommendation, but maybe it's a follow-up TAC recommendation.

CHAIR MOORE: Okay. I made that note as we put together that next agenda, Barry.

All right. Is there a motion to adjourn?

DR. MARTIN: So moved.

MR. HURLEY: So moved.

DR. MARTIN: I'll second it.

CHAIR MOORE: All right. Thanks, Barry. Thanks, Brandon.

Thank you all for your participation today. We appreciate it.

DR. MARTIN: Thank you all.

(Meeting concluded at 12:05 p.m.)

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C E R T I F I C A T E

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

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

Dated this 9th day of July, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR