DEPARTMENT OF MEDICAID SERVICES
CONSUMER RIGHTS AND CLIENT NEED
TECHNICAL ADVISORY COMMITTEE

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OCTOBER 17, 2023
1:30 p.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Emily Beauregard, Chair
Miranda Brown
Melanie Tyner-Wilson
Arthur Campbell
Brenda Mannino
Christy Hardin

MS. BEAUREGARD: It's great to see everyone. It looks like it is 1:30.

Erin, do you know how many of our Consumer TAC members are on right now? I see Arthur.

MS. SHEETS: Hi, Emily. It's Kelly.

MS. BEAUREGARD: Hi, Kelly.

MS. SHEETS: Erin is out so I will be your host today.

It looks like we currently have you, Miranda, Arthur, Brenda, and Christy.

MS. BEAUREGARD: That sounds great.

If everyone can turn your cameras on if you are able, I think technically we don't need them on for the entire meeting, but when we do vote we do need to have the cameras on.

MS. MANNINO: Hi.

MS. BEAUREGARD: Hi. Good to see you.

Why don't we go around and make quick introductions. Just your name and the organization or the population that

you represent and then we will get into the rest of the agenda.

So I'm Emily Beauregard. I'm the Director of Kentucky Voices for Health and I am the chair of the TAC.

MS. BROWN: Hi. I'm Christy Hardin, I am the Youth Service Center Coordinator here at Bullitt Central and I'm here representing the FRYSC Coalition.

MS. BEAUREGARD: And Christy, it's so nice to have you on.

MS. HARDIN: Thank you.

MS. MANNINO: Hi. I am Brenda Mannino, and I represent AARP.

MS. BEAUREGARD: Miranda and Arthur?

MS. BROWN: Hi. I'm Miranda Brown with Kentucky Equal Justice Center.

MS. BEAUREGARD: Arthur might be having some technical difficulties. He represents P&A, Protection and Advocacy.

Kelly, did I miss anyone else? I think this covers it, right? Because we --

MS. SHEETS: (inaudible) is the

only one I don't see.

MS. BEAUREGARD: Right.

So why don't we -- we do have a quorum, and the next item on the agenda is to approve minutes from our previous meeting. That would be August and, of course, the minutes are a transcript, so if you had a chance to look at that, great. Let me know if you've any questions or if you think there's anything that needs to be corrected. Otherwise, I will take a motion to approve.

MS. MANNINO: So moved.

MS. BEAUREGARD: Thank you, Brenda.

Second?

MS. BROWN: I second.

MS. BEAUREGARD: Thanks, Miranda.

All in favor say, "Aye."

ATTENDEES: Aye.

MS. BEAUREGARD: Any opposed?

All right. Then, motion carries. Minutes are approved.

So we will go on to the old

business.

Actually, no. I have to back up here. We are going to go just a little out of order. I think that Angie needs to maybe hop off early, so we are going to cover -- is that right, Angie?

MS. PARKER: I don't. But Angela Taylor, who is going to be do the presenting.

MS. BEAUREGARD: Oh, a different Angela. Got it. Okay, thank you.

MS. PARKER: Yeah. She is (f.) on the old business and she has to leave by 2 p.m. So thank you for allowing us to move her up on the agenda.

MS. BEAUREGARD: No problem.

MS. PARKER: I'm Angie Parker, Director of Quality in Population Health at the Department for Medicaid Services. And the last meeting I talked about a network adequacy reporting that we were working with the Office of Data and Analytics on. It is still not ready for prime time, but I thought that Angela could potentially show you a high level of

what we are working on. So I will turn it over to Angela Taylor. Thank you.

MS. TAYLOR: Hi, I'm Angela Taylor.

Just one second. I'm just trying to get this pulled up. If you could give me just two minutes.

MS. BEAUREGARD: Of course.

MR. CAMPBELL: It looks like this speaker is working.

MS. BEAUREGARD: Hi, Arthur. Thank you. I'm glad that we can hear you. You may have missed the introductions, but I did mention that you are here representing P&A.

MR. CAMPBELL: Thank you. I had a problem with my microphone.

MS. BEAUREGARD: Okay.

MR. CAMPBELL: That's why I was late.

MS. BEAUREGARD: Not a problem. We can hear you great now. So hopefully your microphone will continue to work.

MR. CAMPBELL: Thank you.

(Side conversation.)

MS. PARKER: Emily, is there something you want to go over before she --

MS. BEAUREGARD: We can cover --

MS. TAYLOR: I'm so sorry. I just left another meeting and I didn't have this pulled up. I'm really sorry.

MS. BEAUREGARD: That's okay. I wasn't sure how much time you would need.

We could go over the first (a.) on that item standing data request, which is the number of Kentuckians currently covered under different types of Medicaid.

MS. GRIFFIN: This is Jiordan with the Department of Medicaid Services. I am the Branch Manager of Eligibility and Enrollment and I can go through these numbers.

So currently we have 143,881 individuals in traditional or fee-for-service Medicaid. We have 1,465,477 individuals that are in Medicaid under managed care. Of that population, 565,489 are in Medicaid expansion. For a total member count in Medicaid, this is

individuals, 1,609,358. Emergency time-limited Medicaid, we have 201 individuals. In presumptive eligibility Medicaid we have 923 individuals, and that, I believe, covers the member counts. And I also have the renewal information if you all want me to cover that as well.

MS. BEAUREGARD: Yes. Let's go ahead and do that. Thanks.

MS. GRIFFIN: Sure.

This question was how many people received a renewal notice RFI or a renewal packet in July and scheduled for one in August. In July, these would be individuals with a renewal due date of August 31st. We had 53,278 individuals going through renewal. So for passive renewals with an RFI sent, we had 11,335. Individuals that were sent a -- an actual renewal packet were 14,663 and then individuals that were passively renewed with no RFI needed were 27,280.

MS. BEAUREGARD: All right. Thank you for that. And I realized that I mistakenly did not update that from our

last meeting, I believe. So do you happen to have the numbers for September and October? I don't want to put you on the spot if you don't.

MS. GRIFFIN: Yeah. I can get them really quickly. It just might take a second.

MS. BEAUREGARD: Okay.

And the other thing that was on that standing request is the number of people currently participating in a 1915c waiver. But it may be that Pam Smith is going to share that.

MS. SMITH: Yeah, I've got that.

MS. GRIFFIN: Pam, you can go ahead if you want and I'll try to pull up the updated numbers.

MS. SMITH: Yeah, I can.

So as of right now, total in all six 1915c's we have 31,806 people that are actively getting services. So if you want to I can give you -- of course I don't have the math completely done. If you want me to break them out by waiver I can do that and put it in the chat, but all

together total we have 31,000.

MS. BEAUREGARD: Okay. That's helpful.

Pam, I know that I think at our last meeting we talked a little bit about Medicaid renewals for people with waivers and some of the issues that people have been having and I know that you've been kind of tracking that and trying to make sure that people aren't losing coverage. Do you have a number of people that you've been able to either extend or re-enroll in Medicaid to keep their waiver?

MS. SMITH: I don't have a number, and I will let Jiordan, or I think I saw Deputy Commissioner Cecil on here as well, speak to part of what's been able to be done through part of the unwinding, but what I can let you know is the top concern now that I am seeing is related to individuals that are of an age now where they need to have the SSI disability determination and I can -- we've been able to work with those individuals and make sure they understand they will not lose

their waiver slot, because sometimes we realize that takes longer than the traditional 60 days that you can be without waiver services.

We have the ability to, kind of, override that automatic program closure so we put notes, or it's called an alert so it shows up red on their screen, and that will prevent the case from getting closed. If, for some reason, it gets closed, I can get that slot back, so we can give that person that slot back, so we've been able to ensure anybody who has been experiencing delays because of redeterminations, you will not lose your slot just because of that. As long as you are involved in the process. If I have somebody who is just not responding, we are reaching out to them and doing everything possible to talk to somebody and somebody just is not doing anything, so they are not responding to anybody, and then after a certain period of time, we won't immediately close them, but we do, kind of, have to give a consideration if,

after 90 days or more, we can't get a hold of them despite trying multiple ways, or they are just not responding or not following through. If we give them directions and have somebody reach out and call them and say, "Okay. We are going to call you at this time and you need this, this, this information," Eventually, it could get to a point that we would close them out, but that is the ultimate last resort and that's really because someone has failed to -- despite everyone's best effort -- to comply with that. But that is an absolute last resort and I will tell you I have not had to do that. So I don't expect a --

MS. BEAUREGARD: That was going to be my next question.

MS. SMITH: No. I have not had to do that.

We've had -- with Jiordan's team and our other -- the other teams that help and with the DCBS offices, and just within Medicaid we have not had to do that. We have been able to help individuals through

that process.

MS. BEAUREGARD: That's good to hear.

I will say just one thing before we switch back to Angela. I know of some folks who -- I think one of the things you had shared with us is that a caseworker should be assisting people who may need assistance. We can't assume that everyone with a waiver or in long-term care -- even though that's a separate population -- can complete the process on their own, and that a caseworker should be participating in that and providing them assistance, and I don't know that that is happening all the time. It certainly hasn't been with some of the cases I have heard.

MS. SMITH: Will you let me know? And we will verify with them, but they also -- we have given the case managers the ability to bill an extra unit of case management if they have to assist members in that process because we realize it can be lengthy sometimes depending on -- each case is different. You can't

say it's going to be the same for each one because each individual is different, but if you get any specific examples. And we will work with the case managers, too, to make sure that they a) understand that that is part of their responsibility as the case manager, but b) understand and if it causes, you know, extraordinary work above and beyond what is that normal case manager responsibility, that there is the ability for them to get that additional unit of case management.

MS. MANNINO: I have a question. Can I interject a question here?

MS. BEAUREGARD: How many Kentuckians are currently covered? What was your total? Under traditional, expanded, all of that?

MS. SMITH: Jiordan, do you have that? Do you have those numbers?

MS. GRIFFIN: Yes. So traditional Medicaid we have 143,881 individuals and then in managed-care, we have 1,465,477, for a total of 1,609,358 members.

MS. MANNINO: Okay. And how does this number compare to a year ago? Would you know?

MS. GRIFFIN: I did not come prepared to speak on that so I would have to go back and look that up.

MS. BEAUREGARD: I can only estimate it for you, Brenda, but it's more than 100,000 fewer people have Medicaid.

MS. MANNINO: I just want to know if it was going down.

MS. BEAUREGARD: And there are -- Medicaid has this statistics page. I can send you a link. It's really great. It shows monthly enrollment numbers.

MS. MANNINO: Okay.

MS. BEAUREGARD: And even weekly for some types of reports, and so you can take a look at that and look at fee-for-service and look at that each of the MCOs, and it's really helpful.

MS. MANNINO: Okay. I would appreciate that. Thanks.

MS. GRIFFIN: But just while I have you guys again here. For the

renewals that have a due date of September 30th, 2023, we had 103,515 individuals. Of those, passive renewal with an RFI sent more 7,220. Individuals sent a renewal packet were 16,967 and then individuals renewed as passive with no RFI were 79,328 and for October renewal numbers, we haven't finalized that yet so I can't report on those just yet.

MS. BEAUREGARD: Thank you.

So Angela, if you are ready now, you can skip to the network adequacy presentation.

MS. TAYLOR: Yes, I am. Again, apologies about that.

I'm gonna start. Can you see my screen?

MS. BEAUREGARD: Yes.

MS. TAYLOR: Okay, great.

First, I'd like to explain what we base this on. The MCOs send us a report every month, I think, or every quarter, that basically details their level of adequacy, so the number of providers they have in different

categories and how their panels for each MCO, and whether or not they believe they are meeting their contractual requirements.

So when you are looking at this very first map, you can see that the specialty that I'm currently looking at is laboratory, and I'm looking at quarter one of 2023. This one is Passport Molina and this is the specialist detail that we are looking at. I'm going to switch this to dentist just because -- not to pick on them by any stretch of the -- but they are the easiest to see variations with.

So you can see based on the legend on the right that whether or not they have enough adequacy -- red is that they have 50 percent and then as they get into this oranger color, they have 80 to 90 percent -- less than 90 percent. No one -- Passport does not currently claim to have more than 90 percent capacity per county at this time. And then, there's several dashboards here, so I'm going to kind of go through them quickly. If you

have questions, feel free to stop me, but I will try to get through as much of it as I can.

So -- sorry I went to the same page. Apologies.

I'm going to switch over to this one. And this is the grid detail of what we think in, based on claims data and based on enrollment data, the adequacy actually looks like.

I'm going to switch to dental. And I will switch to the latest quarter. And we are looking at WellCare here. And this population is for all members. Now, to explain how why these look like little squares here, I'm going to flip back over here and explain how we sort of divvied up the population of Kentucky.

So my analyst split Kentucky into 2-mile grids and assigned a dot for every two miles. The address information in Enrollment and Eligibility is pretty good, but sometimes it's not. If we can't map it exactly, it will map to the center of a county, so the cleanest way to do

that was to assign each member to a specific grid dot and then it will populate the grid based on which dot they are the closest to.

So this is what the Medicaid population of Kentucky currently looks like. The darker dots, bigger darker dots mean that there are more people within that 2-mile radius so it is even a little bit smaller than some of the census tracts. And you can see that there are these big, open areas. This is Daniel Boone National Forest, and up here in the Appalachian region, there are less people in those areas because they got assigned to a dot, like, that was somewhere where other people lived.

So this is kind of how Kentucky looks. Based on this grid, we then tried to determine -- sorry, I went the wrong way -- whether or not we felt like we were seeing enough adequacy in those areas based on actual submitted claims. So whether or not providers were submitting claims for the Medicaid beneficiaries that

live in those 2-mile areas.

So if we are looking currently at dental, if we are looking at WellCare, for quarter three of 2022, there is a little bit of lag with claims data and also with getting the MCO data in. For all members, where the provider that is assigned to that square has submitted at least 12 claims in that quarter. We can switch that to 1, and you can see that there is less coloring and it will change that to red here.

So what you have, here, is the ability to, sort of, look and see where there are truly potential issues with network adequacy in this area of dental, because, although there are people that live here, and there are providers that live here, they aren't submitting a lot of claims for those people. Does that make sense?

MS. BEAUREGARD: I think so.

One of the things that I was actually going to ask you about was how you figure adequacy when we know that some

providers maybe only see a handful of Medicaid members versus a larger panel. So if that's what you are kind of getting to there, that would make sense.

MS. TAYLOR: Yeah. That's exactly what we're doing here.

So you can see in this area, in this sort of Davies area for WellCare, this is just for WellCare. Like if you are looking at just any one of these single dots, it's Davies County near Owensboro, there are 8,000 children in Medicaid who are within this 2-mile district and 9,000 adults, which is a total of about 17,000. There are six pediatric dentists and seven family dentists within that range, so you can see that the ratio does not meet -- it's a 2,000 to 3,000 per doctor based on the number of claims. And these providers are submitting at least 12 or more claims within the quarter.

If you are looking at this, it looks like WellCare for dentists are well covered in the southeastern area. We are

not seeing any issues with a) the number providers or b) the number of Medicaid patients that they are seeing. It looks like they have pretty good coverage. They do not have as good of coverage here, even though they may have dentists paneled and may be meeting the contractual requirements, those doctors are not seeing WellCare patients -- in this area, and then up here in northern Kentucky.

And if you wanted to look at a different one, say maybe -- we will look at Passport. That's Passport Molina, now. They are not super great up through the northern area, but pretty good in the southeastern area.

This Owensboro area is again a problem -- a potential problem.

And we will switch over to Humana just to see what they look like. Decent coverage. A couple small spots here where they don't have great dental coverage, but for dental, you know, people actually seeing dentists and the dentist actually seeing beneficiaries, but the

rest of the state looks pretty good.

So based on, again, what the MCOs say they have as paneled providers, but we are actually seeing in Medicaid through the claims and encounter system, this is a way to sort of pinpoint, or maybe look for more opportunities for better -- for better adequacy.

MS. BEAUREGARD: You know, using claims data is interesting. Of course, it doesn't -- it still doesn't capture people who don't have claims data because they haven't been able to find a provider so there is no claim. There's been no service. And I know there is that secret shoppers survey that IPRO does -- that third-party quality review organization, but is there any other way that you are able to capture demand that this supply isn't meeting?

MS. TAYLOR: We haven't currently added in -- I mean we know that adults are covered twice a year and kids have always been covered twice a year. We haven't quite added in people who aren't

seeing the doctor at all in this dashboard. That's certainly a really interesting way to --

MS. BEAUREGARD: Well, particularly with dental, I feel like if I were to show that map to a dentist in Eastern Kentucky, or really any Medicaid member in Eastern Kentucky, they would disagree. They would say that is not the case on the ground. And it may be that these providers are enrolled with MCOs but either don't have the capacity to see enough patients or, for whatever reason, because of billing, because of prior authorizations and other, you know, barriers to participating, they don't necessarily provide a lot of services to Medicaid members. And I know that that's the challenge of all this work, but --

MS. TAYLOR: I think -- I think --

MS. BEAUREGARD: I think it would be fantastic to have a panel of both beneficiaries and a panel of providers, kind of, work through these maps with you

and we could, kind of, think through ways of capturing what you don't have access to in terms of the data.

MS. TAYLOR: Yeah, I think that -- absolutely. That would be great.

And to your point -- which is a great point -- we have set the bar very low. We've basically said the qualifying claims has to be 12. So within this quarter, they only had to submit 12 claims. That could be for one patient, five patients, we set the bar very low as far as what the adequacy threshold is. We could certainly add to that, right? We could say you have to see a certain number of people, not just submit a certain number of claims. So there are definitely ways that we can enhance this and make it more useful, but this is our first shot at attempting to do it this way based on what the MCOs have reported and what we are actually seeing.

MS. BEAUREGARD: Well, I really appreciate the work you have put into this, and I think its fantastic to have

this kind of dashboard. So I definitely appreciate you developing it and also giving us a demo whenever it is still kind of in the works. But, yes, I think it would be very helpful to just get some input from providers, from beneficiaries, as you continue this.

And one other thing I wanted to ask, and I'll see if any of the other TAC members have questions. I know that the network advocacy standard in Kentucky is 95 percent. That, 95 percent of the time a Medicaid beneficiary should be able to access a service that they need within time and distance standards that are in statute and regulation. Is that how you have also built -- have you built that into this dashboard?

MS. TAYLOR: Only on the level of the MCOs.

So if we go back -- sorry -- I went the wrong way. If we go back to the MCO dashboards -- but that's based on their reporting. We have not done that based on what's actually being shown in

claims data. So this is the MCO reporting to us, their providers, and what they say their adequacy is.

For here, for laboratory for Passport in this quarter, they have told us that they don't have adequate coverage in Fulton County, and they are close to adequate in both Christian and Calloway, but according to Passport, for this quarter, they meet all of the requirements of the contract.

MS. BEAUREGARD: I think there's a little bit of a disconnect in -- or maybe it's just a crude way of MCOs reporting adequacy. I think it's one thing to have providers and network. It's another thing to really meet the network adequacy requirement, as I understand it. To say that every member is receiving the services that they need within time and distance standards. Those are just two different things. So having a provider in your network doesn't necessarily guarantee that they are seeing the patient within those time and distance standards. And

so, I feel like that's where this is -- there still a lot of work to do.

One of the things that I had recommended or at least brought up on one of our last calls, was that there be a reporting mechanism so that when a beneficiary is looking for a provider in-network, and within these time and distance standards, that if they can't find one, of course, it's important to go through the process with the MCO and maybe the MCO can help you to identify someone, perhaps, they will approve out-of-network care, but that seems to be relatively rare. But that Medicaid, DMS would be able to capture those times when it doesn't happen, so that we have a better handle on how many people are looking for care and not getting it within those time and distance standards. So that is something that, if I didn't make that as a formal recommendation before, we might want to do that -- might want to consider that as a TAC.

Do any of the TAC members have

any questions or comments here?

Well, it looks like it's just about 2 o'clock. One other thing, Angela, do you have an idea when this will be ready to share? When it will be available for someone to, actually, seek out and take a look online?

MS. TAYLOR: I believe that our goal is to get one more reporting cycle in with the MCOs to make it available to DMS and production, so Angie Parker and the commissioner, and whoever else in DMS would require it. As far as making it public, I don't know that there are any plans for that.

MS. BEAUREGARD: Okay.

So who would have access to it once you publish it?

MS. TAYLOR: Angie Parker, the Commissioner of DMS, the Deputy Commissioner of DMS, and whoever else they want to give access to.

MS. BEAUREGARD: I see.

So if the MAC wanted to request a presentation, they could get a

presentation, or if there was, like, an open records request.

MS. TAYLOR: Yeah, yeah.

And I think we can do a presentation for the MAC whenever they ask for it. I just can't publish it on the web.

MS. BEAUREGARD: I see. Okay. All right.

MS. PARKER: Probably, Emily, what we would do, I mean, of course we need to fine tune things and, as you mentioned, network adequacy and access and availability time, you know, it's a drill-down type of situation. We've been working towards this for a couple years now, actually. So we are closer than we have been, and I was a little hesitant in showing this today, but I think we've made a lot of great strides, and I wanted to show to assure you that we are working to be able to better define what network adequacy is, as well as ensuring that it is adequate. So it takes a little time to do that, but we appreciate your input.

MS. BEAUREGARD: Yeah. Thank you all. We appreciate being able to see it and give you feedback.

Anything else before we move on?

All right. Thanks, Angela.

MS. TAYLOR: Thank you.

MS. PARKER: Thanks, Angela.

MS. BEAUREGARD: All right. Well, I think if we go back to the usual order of the agenda. We've gone through (a) and the next item here is the Home and Committee-Based Services rate study and specifically the PDS rate increase.

We had two questions here for you, Pam, if you're still with us. We've asked before, and I think just want to know if there is an update on the number of participants who have increased their PDS rates, and then how DMS is complying with the directive to make sure that 85 percent of the increase is going to go directly to people who are doing direct support.

MS. SMITH: So let me do -- I'll do the first one first about the how many

have increased their PDS rate.

This one I've been struggling with and I'm still thinking about how I can capture it, because I don't know how many people want to versus how many people are struggling to. So I'm still trying to work through and see if maybe there is a survey, or how we can maybe capture that data. But I will tell you, and just being completely transparent and honest -- because you all know that's how I roll -- it has kind of taken a lower seat, because I want to make sure I'm helping people actually get the increases when they need them. So it's not fallen off my radar. I'm trying to think about how to capture that, but I don't know since I don't know that beginning number of how many people want to increase the rates. And you would think, right, that that would be all of them, but I actually spoke to someone earlier this week and she may be in -- she may be in the low number -- but she had found a way through PDS, you know, as the employer, to have a rate that was actually

below even what the increases were for fiscal year '23, so, but it worked for her. It paid all of her employees, agreed to that rate, it allowed her to maximize the number of services she was able to get, so it's hard to define what that starting group is to say, "Okay. Fifty percent have or 75 percent have." So I'm still thinking about that. So I haven't completely forgotten about that request, so I will continue to think about how to do that.

And we are continuing to work with individuals that call us or email us and say, "I've tried to do this. My person is not responding to me, or I don't know how to do this." And we are reaching out and helping to navigate those relationships and help that to happen as quickly as possible.

The second piece. So I need to clarify that 85 percent directive is actually was our directive if they bill the 50 percent. The attestation they sign -- the attestation -- and they're

billing one of those services that they can bill the extra 50 percent instead of what was mandated in the budget increase, and so we are currently -- we collect -- we are collecting reports on claims and we are looking at that, and we will be going back as part of our billing audits, and we will be looking at that information and gathering that to look at to make sure that that 85 percent, we are looking at the attestations, how the providers that they are planning to pass that through, because there where several options they were given to do. A lot of it was pay increases, but some of it was through benefits or bonuses. Some of them actually provided necessary supplies like uniforms that weren't normally provided, or they weren't normally -- they were a smaller agency and they didn't normally provide scrubs to their individuals, but they found that was of a benefit to be able to do that to increase the employees. And the story they told was they had someone that really wanted to start

working, but she didn't have the money to buy a set of scrubs, and so, before this came through and she was able to do that, she actually went around doing odd jobs for her neighbors to be able to buy her first pair of scrubs so that she could become a direct service provider.

MS. BEAUREGARD: So I guess the right way to phrase that question, then, is, how is DMS assuring compliance with the directive? Does that sound --

MS. SMITH: Right. So we will be doing that through the auditing. And as part of the attestation, the providers, when they sign it, if we found that they did not pass that on, then that could potentially be recouped. Or they could be put on a corrective action plan. There could be multiple consequences for that, but we are looking at that as we go back and audit, now, as we are starting to bill those services.

MS. BEAUREGARD: That's helpful.

And Pam, I have to apologize because I forgot that Veronica also may

need to leave early.

MS. SMITH: That's fine.

MS. BEAUREGARD: So we can go out of order. Would you be willing to give us a PACE update in a little?

MS. SMITH: That's fine. Absolutely. She's my boss. So I can't really say no.

MS. MANNINO: Can I ask, what is the PDS rate?

MS. SMITH: It is -- so I don't have them all memorized -- but that's the -- that's the rate that an individual can pay for participated directive services. It's the -- up to a max amount that an individual can decide to pay their employees.

MS. MANNINO: Okay, thank you.

MS. BEAUREGARD: Did that answer your question, Melanie? Or Brenda? I'm sorry.

MS. MANNINO: Yes. Okay thank you.

MS. BEAUREGARD: Excellent. Okay.

Veronica, sorry about that.

MS. CECIL: Oh, no. That's okay. I'm not sure what it is you want me to address.

MS. BEAUREGARD: Oh. Okay. Well, I figured any of the items on the agenda that you were going to speak to, I thought we could cover now before you have to hop off. And if there aren't any specific items, then we can certainly hop back to PACE.

MS. CECIL: Yeah. I think Team Medicaid has it ready well-covered. If there is something that pops up after I drop off I'll be sure to follow back up on, but thank you. I appreciate you.

MS. BEAUREGARD: Okay. All right.

Well, then, Pam, I guess we are back to you.

MS. SMITH: Okay. Let me --

MS. BEAUREGARD: Sorry for jumping around, everybody.

With the PACE program rollout, you've just been giving us updates on how

that's been going.

MS. SMITH: Yes. So let me have -- I have some kind of exciting steps to share.

So these are as of 10/1. We now have 129 active participants enrolled in PACE. We have three providers that are serving 17 counties. We have seven new providers that will be serving an additional 41 counties that are in the process of CMS approval. Six of those are on track to begin providing services in 2024. The sixth one is in 2025. That onboarding process is very extensive. The on-site reviews that are required -- and some of these providers are also building from scratch. So they are buying land and they're actually building their PACE centers, or they are doing extensive renovations of existing buildings that they have purchased to meet the requirements to be a PACE provider.

Very excited with how PACE is going. The feedback that we have received from participants has been overwhelmingly

positive. We have had a few that have said, "You know what, this isn't for me. I would rather do Waiver," and have kind of come and left. But for the most part, we've heard nothing but just satisfaction and have seen a lot of success stories from the PACE providers and from the members that are getting those services.

I have some links that I will put in the chat that you all can go out to and see where the counties or agencies are serving, and some of the other just general info about PACE. I think I saw the "What Services are Covered" portion of that.

So the interesting thing about PACE is that it is designed to cover any service that the individual needs that is determined medically necessary by their interdisciplinary term. So it includes preventative care, it can be acute care, can be long-term care. It can be services that meet their social needs. So it can be around nutrition, it can be recreational therapy. It is really

anything that the individual needs that that interdisciplinary team, when they meet, that they believe is medically necessary for that individual. So it is a great addition, I believe, to our long-term services and supports, so I'm really excited to see how it continues to grow.

MS. BEAUREGARD: Yeah. That's fantastic.

Anyone have questions about PACE?

And in terms of enrollment or really promoting the program, are you doing that in a pretty targeted way, Pam?

MS. SMITH: We've done, so there's been - we have put a lot out on the website. We've talked and developed the relationship with our Money Follows the Person team, as well as just encouraging the collaboration between the case managers and the PACE organizations and connecting them, so, really, they can be referral sources for each other because one service might work better for somebody

than a different one. So we've been really targeting the communication between the agencies and helping them. Making nursing facilities aware and making providers aware and we have some -- as we go and speak about PACE we have some just general, really quick pamphlet-type things, just easy to read and we send out. And hopefully in 2024, as we expand out to more counties, we are going to expand that sharing of information as well since we will be starting to serve so many more people. I like to talk about it any time anybody asks me about it. If you can't tell, I'm kind of excited about PACE.

MS. BEAUREGARD: Well, it's nice when you have a bright spot whenever --

MS. SMITH: It is. Exactly. It's nice when there is a sunshine.

MS. BEAUREGARD: All right.

Are there any other items on this agenda that would be yours to report on?

MS. SMITH: I can talk about --

MS. BEAUREGARD: I guess the

1915i.

MS. SMITH: The 1915i. Yes. I can talk about the 1915i.

So the 1915i state plan amendment for serious mental illness, as well as addressing homelessness, so it's providing supported housing and employment to individuals with SMI and SUD. We had our town hall on September 25th. The recording and the slide deck have been posted to that so I am going to -- I will put that link in the chat.

We will be doing in-person sessions, I believe there's five -- there are five areas scheduled throughout the state. We are working on getting the locations right now, but those are going to happen in early- to mid-December, so we will get that posted as soon as -- we are working on getting all of the locations nailed down right now, but there will be placeholders that will go out to tell people these are where we are targeting to have them. Look for more information soon. Those will likely go out with in

the next couple of weeks.

If anybody knows -- just a plug -- if anybody knows of an area that likes to have town halls, or that would offer up space for town halls, or where, you know, would be a central location and be easy for individuals to have access to, if you would reach out to me or Kelly Clay, I would appreciate that. So shameless plug for help finding locations if anybody has any good ideas for places to have them. We try to target places that are easiest for people to get to. We've done a lot of libraries. We've done some schools have let us use gyms, so that type of thing. But more information coming very soon on those and we are targeting to have that waiver application coming -- submitted to CMS by the end of December or beginning of January.

MS. BEAUREGARD: And that's the 1915i, right?

MS. SMITH: That is the 1915i. I will have to -- I don't know if Leslie is on, or if one of the other behavioral

health staff to speak to the 1115c., but that is the 1915i which will be in my -- will fall in my group.

MS. HOFFMAN: Pam, this is Leslie.

The 1115 is currently with CMS for SMI and includes the recuperative care and the expansion of IMD for SMI for parity-related, just like we do for SUD. And that's at CMS now.

MS. SMITH: Thank you, Leslie.

MS. BEAUREGARD: Leslie, can you remind me, I know there was public comment, you know, and that period ended, and the next step is that you basically wait for CMS, right?

MS. HOFFMAN: That's correct. And I don't have a timeframe yet, but they will be approving that.

MS. BEAUREGARD: Have you summarized those comments? Is that something that's been published and I may have missed --

MS. HOFFMAN: Yes. They're on the website. Let me -- I'll send you a

link later. Is that okay?

MS. BEAUREGARD: That would be great. Thank you. If you could just send it to Kelly or Erin and get it out to the group, that'd be great.

And Pam, we will be sure to share the town hall -- whatever sort of save the date that you all put out.

MS. SMITH: Also, just real quick, Emily, I want to remind everybody that the six 1915c waivers are posted for public comment right now. It is actually the same link as the -- where you can go to get to the recordings. It's right above that in the link that I just posted for SMI but each application is posted with a summary of updates beside it and that we've got about -- a little less than two weeks left. We've got to 10/27 and we will be closing public comment on that.

MS. BEAUREGARD: Okay. Thank you. So one other thing, I know that Arthur has asked to have that item on the agenda -- the proposal to overhaul the Michelle P. and other waivers and, I

think, Arthur, just correct me if I'm wrong, I think that we're going to put that off until perhaps December or another month when a guest speaker can join us. I do think that is the case, Pam.

MS. SMITH: Keeping me on the edge of my seat. I'm excited to hear, Arthur.

MS. BEAUREGARD: We are building up the anticipation.

MS. SMITH: Exactly, yes.

MS. BEAUREGARD: It's really a health-related issue that has delayed this individual from being able to join us.

MR. CAMPBELL: I am sorry. I am sorry, but the person who wants to talk, he can't get out of his home right now.

MS. BEAUREGARD: Arthur, that's completely understandable. We will just wait until he's ready.

MS. SMITH: Absolutely. And Arthur, if there's anything that we can do to be able to help him be able to participate, let us know. If there's anything that we can do to help.

MR. CAMPBELL: Thank you for your patience.

MS. BEAUREGARD: All right. I know we have kind of jumped all over the place, but I think the next item --

MR. CAMPBELL: By the way, if I have my video on, it will break up.

MS. BEAUREGARD: Arthur, that's all right. When we vote at the end, if you can maybe try to turn your video on, but I think we might have a problem even without it.

MR. CAMPBELL: Okay. I know that. Thank you.

MS. BEAUREGARD: All right. Sounds good.

Angie Parker, are you going to be telling us or giving us an update on the DMS report from the Hospital Rate Improvement Program?

MS. PARKER: I am. I don't have anything to report yet, though. It's still being audited so hopefully by the next meeting I will have something for you.

MS. BEAUREGARD: I will keep it on there. Thank you.

The next item here is certified CHW reimbursement implementation. Just an update on that and where things are at with the regulation.

MR. DEARINGER: Yes, hi. This is Justin Dearinger, Director for Division of Healthcare Policy.

So the administrative regulation is moving right along in the promulgation process. We have some comments that we are going to insert after working with a couple of groups, including yourself, so we are going to make some changes to that regulation.

Implementation is going well. We are seeing an increase in providers billing every month. I think we are still waiting for the system to, kind of, catch up on the fee-for-service side, but the MCO numbers are increasing. I think they increased 40 percent from last month, so we are having a lot of providers bill for CHW services, and we are trying to

finalize the last piece of the dental CHW billing issue that we have been having.

So we've sent six different options to the contractors with MCOs to make sure that those options would work in their systems, and they've sent us back a couple of options, so we are trying to narrow it down to one with them and we will have that done soon, but it's going really well, so far, and we are excited to get that payable in every system and Venus billing and I think it will just continue to increase from there.

MS. BEAUREGARD: That's fantastic. Well, good. Thank you for that update.

One thing I've heard recently, still, from some CHW's is that they are a little unclear on what documentation is necessary. I know there isn't, like, real specific guidance. They've kind of generally been told that there has to be something documented in the chart, but I think people want to know that they are doing it correctly, honestly.

MR. DEARINGER: Ma'am, I think we clarified a little bit of that language in the regulation. So hopefully that will help.

MS. BEAUREGARD: Okay. Great.

Does anybody have any questions about that? And if I didn't say, if I didn't kind of spell it out, its community health worker for anybody who is not familiar. I say CHW too often.

All right. Thanks, Justin.

So now we are back down to our new business items, and I guess it really -- the MAC and TAC orientation packet shouldn't necessarily be new business still. That's something we discussed in the past, but I just wanted a status update on where that's at.

And I skipped the Get Contacted option. So why don't we touch on that first? This is something that we also discussed on the last call. There is a new option for people to kind of select Get Contacted, either when they are online, on Connect, or even now, I think

they can -- somebody on the call center can facilitate that process. There is even a new form that people will get in the mail if they are no longer eligible for Medicaid, then they can select Get Contacted and an agent can reach out to them to help them with shopping for a qualified health plan and enrolling. Originally, when this was being discussed, before it was ever live, we had been told that connectors were going to be added in 2024, and I've heard some different things. Some people weren't aware that connectors were being added and didn't think that that was happening any longer so I just wanted to really verify if that's still the plan and if there's, kind of, a general date in mind for when that will happen.

MR. VERRY: Hello. It's David Verry from DMS, the exchange.

Yeah, we're definitely looking at having that option be available for connectors as part of an -- either an SOW next year with Deloitte, or a change

request. And we're looking at doing something that no one else in the nation is doing and having a battery of 2, 3, or 4 questions -- really short -- to try to help the individual who says they want help to get either to a connector or to an agent, whichever is going to be best to help the individual. So it's --

MS. BEAUREGARD: So directing them a little bit more?

MR. VERRY: Yeah. You know, like, if someone says, "I know I want health insurance and I don't want financial assistance." That's a no-brainer. You need an agent.

If someone says, "I want to explore options for food stamps or SNAP or any other programs," that's obvious, that's a connector.

And then, maybe, just one or two really quick questions on income family size. Not anything that looks even as complicated as the prescreen, but just to get them pointed in the right direction.

MS. BEAUREGARD: I think that

would make a big difference in accuracy or getting people to the right place the first time rather than accidentally referring to someone to an agent who needs a connector or even needs help with a totally different program.

I do still have a slight concern -- I think there should at least be the acknowledgment that not all agents sell all products.

MR. VERRY: All agents sell all of the plans that are on our exchange.

MS. BEAUREGARD: Is that the case?

MR. VERRY: Yes. All agents sell all plans that are on the exchange.

MS. BEAUREGARD: Okay.

MR. VERRY: They might not be appointed -- they only need to be appointed to one to sell for all, but they can sell for all.

MS. BEAUREGARD: They have the ability to?

MR. VERRY: Yes.

MS. BEAUREGARD: I think there

has just been some concern --

MR. VERRY: Sorry for that confusion.

MS. BEAUREGARD: -- there, that they're directing people to a particular product.

MR. VERRY: Oh, that would be horrible --

MS. BEAUREGARD: Connectors are little bit more neutral.

MR. VERRY: -- if you got sent to -- connectors are neutral, which is a huge advantage. It also is a slight disadvantage when an insurance agent is the only person who can look at someone's circumstances and then recommend what they think the best plan might be. There are advantages and disadvantages to both scenarios, obviously.

MS. BEAUREGARD: Which is why I think having both is a great idea.

MR. VERRY: It's a great idea. Like we usually do with the exchange, we mirror what the FFM is doing. And then -- which is what it's doing now -- behaves

exactly the same way, but then, because we are a state-based exchange, we always need to be thinking about what we can do to innovate and do it better.

MS. BEAUREGARD: But the advocates that we know in other states and some of our national partners, we have not heard great things about that, unfortunately. So we want to make sure that we are doing it better than the way the FFM is doing it.

MR. VERRY: Of course. That is what you are here for, Emily; to yell at us in a great way.

We've had about 6,000 referrals since it began and, right now, it's hard to line up for referrals-led to an enrollment, because it starts out with such little information.

We are adding an innovation next year to where they can at least self-report that it led to an actual enrollment. So we can get some better data, but it seems to be working along with everything else and all the hard work

the whole community is doing, because we're continuing to gain enrollments in the period of time that, if it weren't for the unwind, we are actually seeing enrollments go down.

We started the unwind at about 58,000 active enrollees and then that plummeted by almost a thousand -- actually over a thousand -- because people went to Medicaid. I think we're the only state in the union that does that -- that gets people over to Medicaid early if they are qualified, even if they were on a QHP.

But then, we've been gaining ever since and we are approaching 62,000, so all of these tools seem to be working to get people enrolled. But we are definitely, definitely open to anything that can be done to improve things, Emily, and everyone else.

MS. BEAUREGARD: Yeah.

So just one other question. I know that you've been trying to, kind of, rein this in just for qualified health plans, because originally it was people

who were looking for Medicaid enrollment were getting sent to agents, and agents were referring them, so there were some changes made so that it was more clearly -- like specifically targeting QHP eligible. That's how I -- at least what I remember hearing. But now, the agents are being paid for Medicaid applications. Are Medicaid eligible folks also being, like, put through that Get Contacted?

MR. VERRY: They can choose that, of course, but as far as being transferred from the contact center, which is the primary flow, no, of course not, because it wouldn't make any sense. Because once you become eligible, you are automatically enrolled. The agent really has very little to do with finding an MCO for someone.

MS. BEAUREGARD: Oh no. It's not about that. I mean, it would be the application or being paid for the application. You have to apply to be found eligible.

MR. VERRY: Yeah.

Right now, the primary flow to connect on demand is -- so it's done the application at the contact center and they are ready to enroll, and instead of having that rather complicated back and forth over the phone with someone who's not an insurance agent, about deducting people's co-pays and everything else online, they just send them over to --

MS. BEAUREGARD: Okay. So there's not a plan to start directing Medicaid, potentially Medicaid-eligible folks who want to apply over to agents.

MR. VERRY: No. Heavens, no.

MS. BEAUREGARD: I wasn't sure, because now agents are being paid to do Medicaid applications, so I wasn't sure if that was part of the plan. So thank you for clarifying.

MR. VERRY: Again, a double-edged sword. The great thing about connectors is they have to help anyone that comes to them, which is wonderful. If I was smart, I would be a connector. For sure. Insurance agents are running a

small business, and as long as they don't discriminate, they, unfortunately, do not have that same legal requirement. So by offering them this small, one-time fee, at least it compensates them to the point of, "Hey, I'll help you out and if it goes the wrong way and I don't get paid, don't get a commission, then at least I got something out of it," to try to broaden the net that we're casting to try to help people.

Just for clarification there, too, they don't double dip. If an application leads to a QHP, they are not going to get paid a commission and get paid the $50.

MS. BEAUREGARD: So they get a commission instead of the 50. Yeah.

MR. VERRY: It is a lot higher than that fee, but we wouldn't -- I know I wouldn't feel comfortable with paying someone and then having Anthem pay them on top of that.

MS. BEAUREGARD: It's really helpful to know that this Get Contacted is

going to be really targeted to QHP enrollment.

MR. VERRY: Yeah. The only thing that is not targeted -- anybody who clicks on that from the public can then choose to use whatever options are available.

MS. BEAUREGARD: Sure. Okay. Thank you.

Miranda, do you have any questions about that? Or any of the other TAC members?

MS. BROWN: I really appreciate all of the updates, David.

You said that there was a change going in for -- well, the only thing I wasn't clear about is you mentioned the two to four questions to help direct people and also adding the option for connectors. Would those go into effect at the same time? And do you have a timeline?

MR. VERRY: Timeline, to be honest, is probably third quarter of next year. I'm just being honest.

MS. BEAUREGARD: You said fourth quarter?

MR. VERRY: Third quarter.

MS. BEAUREGARD: Third quarter of next year. Okay.

MR. VERRY: And that's just a really rough sketch given everything else that is going on.

MS. BROWN: Thank you.

MR. VERRY: Yeah. Absolutely hear you, but I can only answer what I can answer.

MS. BEAUREGARD: No. We appreciate --

MR. VERRY: I think it will be a great idea. I mean, nowhere else can you go to one place -- it will get us closer to that magical no wrong door, no wrong platform.

MS. BEAUREGARD: That's what we're looking for.

MR. VERRY: And it should cut down on traffic at DCBS, too.

So thank you all.

MS. BEAUREGARD: All right.

Well, we will look forward to more updates on that as it gets closer. And if you can tell us in the future how Get Contacted is working if you do start to get a sense of how many people are enrolling and if there is any sort of data that you can report from that, that would be great.

MR. VERRY: Yeah. If we get the holy grail of going through this virtually anonymous tool of how many are getting through to enrollment, which we are working on, making it -- trying to trick them into telling us the information that we want. That would be a helpful tool as well.

MS. BEAUREGARD: Well, now I think we can move on to the MAC and TAC orientation packet and, Kelly, is that something that you have been working on?

MS. SHEETS: Yeah, Emily. That's something that I've actually put together and I have submitted it to upper management for review and they are still reviewing.

MS. BEAUREGARD: Okay. Is there

any kind of input that we can provide at this point?

MS. CECIL: Emily, this is Veronica Judy Cecil with Kentucky Medicaid.

We are just reviewing it, but then happy to send it out and certainly it could be an iterative process if you all take a look at it and see if there's anything we need to change then we will welcome that. It's still undergoing internal review and we will try to kick that out as soon as we can.

MS. BEAUREGARD: That sounds good. Thank you.

MS. CECIL: By the way, they've done a fabulous job of pulling it together. So we are excited to launch it.

MS. BEAUREGARD: Yeah. I'm looking forward to seeing it. I do think it will be really helpful for new members and even for current numbers, honestly. We can all brush up on some things.

MS. CECIL: Yes. Agreed.

MS. BEAUREGARD: Brenda?

MS. MANNINO: No. I just said, yes, that would be helpful.

MS. BEAUREGARD: Okay. Gotcha. I try to keep an eye on the boxes whenever I can see them.

All right. Anything else related to that or anything we have covered so far? I just want to make sure that I'm not going too fast.

We have a couple of other new discussion items. The first is language access and this is an area or an issue that Miranda and I have discussed quite a bit, and she wanted to put this on the agenda to have a larger discussion with DMS and the MCOs.

MS. BROWN: Yes. Thank you, Emily.

I wanted to put this on the agenda today because I heard from a couple different community partners about issues they were having with getting interpreters for Medicaid patients for their appointments, and one of them, I believe, is on the call.

Jennifer, do you want to share? Thanks.

MS. BALLARD-KANG: Hi, my name is Jennifer and I'm the Refugee Health Promotion Coordinator with the Kentucky Office for Refugees.

We provide funding for programming directed at supporting the health and mental health of refugees around the state. And some of the funding that we provide goes to support community health workers -- I heard you all talking about community health workers before. And we have regular meetings with our community health workers, and they often report back that they experience challenges when helping their clients connect with providers that are accepting Medicaid, but are resistant to providing language access and, often times, there seems to be a misunderstanding of the roles and responsibilities around providing language access.

Sometimes they've reported to me that a provider may explain through the

community health worker that their understanding is that that is the responsibility of the MCO, and then they're explaining to the community health worker, to explain to the patient, that they need to contact the MCO and schedule an interpreter for that service. And so it just seems like there is a lot of confusion around, like, what's the responsibility of the patient to make sure that there is an interpreter available? What's the responsibility of the MCO? What's the responsibility of the provider? And then, how that can be communicated clearly to folks, especially folks who, you know, our medical system is very new to them, and then how community health workers can help explain that when it doesn't seem to be quite fleshed out, maybe. So we thought if we could help get some clarity around that and then communicate that to our partners, then that would be great.

MS. BEAUREGARD: Yeah. I appreciate you being here today, Jennifer.

Miranda, did you have anything else that you wanted to add before we just open it up to DMS and MCOs? I think we're basically looking for some guidance, here, and just clarification, and it sounds like there's been a lot of inconsistency at best.

MS. BROWN: Yeah. I was concerned to hear Jennifer's story and heard from an interpreter provider who also had a similar experience that they had to work through the MCO rather than through the healthcare provider, and so I was -- yeah, I was concerned about that, because I wasn't sure that that was the correct process and, yeah, so I'm not sure if there someone on today who can address this.

MR. OWEN: This is Stuart Owen with WellCare.

Not somebody from DMS, but the requirement as providers is if you get federal Medicaid funds, you are required to provide interpreter services. That's an Office of Civil Rights Law. But we at

WellCare, you are required, if you don't or can't, for whatever reason, notify us, we have a customer service member or provider, or summary on behalf of the provider, we will arrange for it. We can arrange it. We have locally-contracted vendors for interpreter services. We will arrange it, but you got to tell us. The provider is required, but they can't -- they have to tell the MCO, so the MCO can arrange it.

MS. BEAUREGARD: I think it's great, on the one hand, that WellCare would do something that WellCare isn't really required to do. Like, you are saying it is the provider's responsibility, and that is how I've understood it, and I ran a language access program at a family health center years ago. But I wonder if that's, maybe, adding to some of the confusion where providers who are technically responsible are now kind of putting it off on the MCO saying, like, "Don't go through me. The MCO will pay for it," and maybe that's

creating some of the delay in the confusion because, then, otherwise the provider would really be expected to provide it. Is that --

MR. OWEN: Yeah. I mean, that probably is the case. There's probably providers who don't know -- who don't know that -- they honestly don't know, and they think it's the MCO's responsibility.

MS. BEAUREGARD: Yeah. And I don't know when DMS makes this expectation clear to providers, or if there is an opportunity to remind providers of their responsibility, but that may be part of the solution here, to make sure that providers understand that this is something that is required of them.

MR. OWEN: Now, I don't know -- I'm sure all of the MCOs do -- we have a Diversity and Equity Council, and this is one of the things that we are targeting this year.

We are looking at this and gaps. We're looking at the most prevalent languages and gaps and lack of individuals

getting interpretive services and why they are not getting. And so, we are definitely looking at that and will be doing provider education and outreach regarding that, which will help, and then -- I just forgot. There's something else.

Anyway. I mean, we definitely -- MCOs can educate providers about this, as well.

MS. CECIL: Yeah. This is Veronica with Medicaid.

It's always good to know and understand when there are challenges, and I think we always discover there is an opportunity to reeducate and to make sure everyone understands what requirements are.

So I appreciate you bringing this to our attention, and we will certainly take this back and see about what we can do to clarify requirements and make this easier on the member, because it really is about the member understanding what they need to do next and making it

very clear and accessible. So we will take this back and see what we can do to improve upon it.

MS. BEAUREGARD: And I just want to add, like I said, I think it's great that an MCO like WellCare would want to offer this, even though it is truly required of the provider.

I just remember that the provider should be the one making the request. If they do -- if they need that financial assistance, if it really is a financial burden to provide or if they just don't have access to an interpreter, because sometimes when you don't have a large population of patients who speak other languages, you may not have those contracts set up in advance, so I can see some circumstances where it might be really helpful to have WellCare's assistance, but maybe not put on the consumer to make that request, but the provider, so that it is always going through the provider.

MS. CECIL: Yeah. I agree with

that, Emily.

And I do think -- and I'm not going to speak for the MCOs, but I believe they all offer some type of service like that. Primarily, because they have to -- they are responsible -- that if someone calls into customer service, or needs help navigating the benefits, they are required to have those interpreter services available, so --

MS. BEAUREGARD: Just like to get past the call center.

MS. CECIL: That's correct. We will take it back and see what we can do.

MR. OWENS: I just remembered what I forgot. So if this happens, we would also encourage the member to file a grievance, and that way we will know -- we will capture it on the grievance. What is the problem? They didn't provide interpreter services. So that would help, as well.

MS. BEAUREGARD: Yes. Absolutely. To know the scope of the issue and be able to do some intervention.

Jennifer --

MR. CAMPBELL: I have much to say about this issue at the next meeting.

MS. BEAUREGARD: All right. Arthur, I will leave language access on the agenda.

MR. CAMPBELL: Yeah. I appreciate it.

MS. BEAUREGARD: Sure.

Jennifer, did you have any other questions, or anything you want to add?

I know I just kind of suggested the change in process, but I want to make sure that that sounds like something that would be more beneficial for the clients that you are working with.

MS. BALLARD-KANG: Absolutely.

And I think what you all were mentioning about how to file a grievance, because I think that some of it is a misunderstanding about process, but, then, we have had some providers who, they are made aware, and then they still will not comply. So I think, at that point, to understand what the grievance process is.

Would you say the first step is through the MCO and then to Medicaid? Or is it always first through the MCO?

MS. CECIL: Right.

For the managed-care member, the grievance would go through the MCO. But I do want to just clarify that we do not enforce the Office of Civil Rights requirements. So ultimately, a complaint can go to the Office of Civil Rights if the provider is in violation of the federal rule.

MS. BALLARD-KANG: Okay.

So the first step, though, is with the MCO?

MS. CECIL: Yeah. Certainly.

And, you know, it always is helpful for us to have examples, because it's that evidence that we have to use to take to go and ensure compliance with whatever the requirements are.

So I kind of echo Stuart, in that I know it is a burden to do, but anytime that something can be escalated in the form of a grievance helps us have the

information necessary to take action. But if it is a managed-care organization, then it goes through that managed-care organization and then fee-for-service goes through the customer service typical process.

But I think one of the things, again, that we can take away, is probably providing a very simple visual on the process about language access and just put all of the information in one flyer-type format, and what to do if somebody is not in compliance and what those steps are.

MS. BALLARD-KANG: That would be fantastic. And probably very helpful for all our partners.

MS. BEAUREGARD: Would you say almost a decision tree, Veronica?

MS. CECIL: Right.

MS. BEAUREGARD: Okay. All right. I'm just making some notes.

MS. BROWN: That sounds great, Veronica. I would be really excited to see that.

Regarding -- so if someone does

have managed-care, it sounds like the first step is to go through their MCO. If it should ultimately be the Office of Civil Rights complaint, would the MCO escalate that, or is it up to the individual to do so?

MS. CECIL: It is the individual who has had the challenge.

MR. OWEN: But let the MCO know, you know, the provider --

MS. CECIL: It's first step. First step.

MR. OWEN: We will address it with the provider.

MS. CECIL: Yeah.

But I do believe most of the MCOs in their contract with providers require -- they make that very clear that the provider is responsible.

MS. BEAUREGARD: That's good to know. Thank you.

Anything else on that topic right now? We will keep it on the agenda so we can address this again next month. Not next month -- at our next meeting.

MS. BROWN: Thanks for coming and speaking to the issue, Jennifer.

MS. BALLARD-KANG: Thank you all.

MS. BEAUREGARD: Our next item is open enrollment messaging and the value-added benefit side-by-side, which is always something that we like to promote as part of open enrollment.

I know that open enrollment is very different this year because of Medicaid renewals so, Veronica, are you going to tell us a little bit about this, or someone else on your team?

MS. CECIL: Now, I might phone David. David is prepared to go. I know he has been working on open enrollment.

MR. VERRY: Hey, again.

I assume, now, you are talking about MCO open enrollment, right?

MS. BEAUREGARD: Yes. Medicaid MCO open enrollment.

MR. VERRY: My cousin is a QHP. We love them, too.

MS. BEAUREGARD: Not Medicare,

not QHP.

MR. VERRY: Yeah, right.

All of our agents would duck and cover because its Medicare season.

But MCO open enrollment. That side-by-side is coming. We're hopefully going to get it to you all and posted on our website and the QHP site and the Medicaid site January 1, and hopefully before, because we know how valuable that is. It's such a valuable document that the MCOs really like to go through with a fine tooth comb. Maybe January 1st, hopefully sometime in December, and somebody else on the call can correct me if I'm wrong. Hopefully wrong in the right direction.

MS. CECIL: Yeah. We will obviously try to align it with the communication that is going out January 1st to notify them of the ability to change MCOs during 2024 and refer them over to the website so they can make an educated decision about whether or not they want to change.

MS. BEAUREGARD: Now, it -- I think I've heard a different plan. Is there going to be a notice, like, an actual mailed notice that is sent?

MR. VERRY: Yeah.

MS. BEAUREGARD: Okay. I thought, before, that I'd heard that there wouldn't be, so that's good to know.

MR. VERRY: And then December the 16th will be when persons can use SSP to request a change of MCO without reason. And that can be any SSP user, so connectors, people at home, agents, contact centers, whoever. We have taken away regular open enrollment and we've added something better.

MS. BEAUREGARD: Veronica, are you thinking that notice is going to go out by December 16th or before?

MS. CECIL: Yes. On.

MR. VERRY: December 2nd, I think.

MS. CECIL: Yeah.

One other thing to note. So in terms of the notice, anyone who is

currently enrolled will receive that and, then, as new enrollees come on, they will receive after their notice of eligibility, they will receive the letter letting them know they can change their MCO at any time in the letter that notifies them about the MCO. So we are doing a catch up for everybody who is currently enrolled and then going forward to 2024, new enrollees will get a notice as well.

MS. PARKER: I just wanted to add on the side-by-side that someone on my team is working with the MCOs getting all of that together. We had hoped to have it late by this week, but we are going to have to get it interpreted into Spanish, too. So it should be, hopefully, in the next few weeks.

MS. BEAUREGARD: Okay. That sounds good.

Will there be a messaging toolkit for social media that connectors and other will have, or are you just expecting -- was that a yes?

MS. CECIL: We will release it

out. We will release it out.

MS. BEAUREGARD: Sounds good. All right. Well, thank you.

And I also saw in the chat that Anthem, Humana, and UHC all mentioned their interpretive services. So thank you all for that. We appreciate it. Any extra education with providers and reminders would be great.

David, did you have anything else related to open enrollment?

MR. VERRY: No.

Just that we are improving the open enrollment toolkit, and every other week there is something new that we have added to help connectors or agents or both. And they are really looking forward to Fridays at 1:30 when we send out our blast of what the latest and greatest is. When it comes time for that MCO change, it will be all over. The world will know.

MS. BEAUREGARD: Sounds good.

Miranda, or any other TAC members, do you have questions about open enrollment?

Okay. I'm looking forward to seeing how this new type of open enrollment over a longer period of time goes. And definitely planning on sharing that information about it whenever it's available.

I think, even though we have jumped around a lot on the agenda, I'm almost certain that we have covered all of our items.

Anybody, if you notice that I skipped over something, please, let me know now, or if there's anything else that you want to bring up, this would be a good time to do it.

All right. Then I think we can move on to recommendations, which is our next item here.

I had, kind of, jotted down from our discussion about language access a possible recommendation that DMS send out a letter to providers to clarify their responsibility to offer interpretive services and create a visual decision tree to explain how a beneficiary can access

language services and what steps to take when an interpreter is not provided. Does that sound, like, right? Did I get the wording right here? Do we want to make any changes to that?

MS. BROWN: So the second part was to create a visual decision tree for members?

MS. BEAUREGARD: To explain how a beneficiary can access language services and what steps to take when an interpreter is not provided.

And if you want to work on this, Miranda, and bring something back to the next meeting, we can do that, too. Whatever you all feel comfortable with.

MS. BROWN: I think this is good for now.

The only other thing on my mind is just how members will get that visual decision tree. Like, how it will be sent to members. But, I think, probably to focus on creation of the material first.

MS. BEAUREGARD: We can make another recommendation later.

MR. CAMPBELL: May we table this one --

MS. BEAUREGARD: Until the next meeting?

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: You want to table the recommendation until the next meeting?

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: Okay. All right.

Well, Veronica, if that is something that DMS is still willing to do, I would say with the visual move forward, and we are happy to provide input there, but we will make a formal recommendation later.

MS. CECIL: We don't need a recommendation.

MS. BEAUREGARD: Since you already kind of offered. Thank you.

MR. CAMPBELL: I want to write out my thoughts on this because it will take too long if I try to explain my issue right now. Thank you.

MS. BEAUREGARD: Absolutely.

So we will have that on the agenda, Arthur, and you can come prepared with your thoughts --

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: -- and any potential recommendations.

And the same to you, Miranda, if you want to take some time to kind of work that out.

Then the other recommendation that I had in mind around network adequacy, because there has been good progress on that dashboard and good conversation there about that access piece, and how we really get to -- not just saying that there are providers in-network, but that the beneficiary is able to access services within the time and distance standards.

So the recommendation that I would put forward is that the Consumer TAC, or that DMS, create a process for beneficiaries to report when they are unable to access an in-network provider

within time and distance standards. That way, I feel like we would have a much better sense, a comparison of here is the network of providers that are enrolled with the MCO; here is the access to services; and we would be able to see where there are gaps in there, and also there may be some opportunity for DMS to intervene in certain cases when someone needs out-of-network care. So that would be my recommendation. I will repeat it since I kind of explained it as well.

So this is what I would say that would be our official recommendation: That DMS create a process for beneficiaries to report when they are unable to access an in-network provider within time and distance standards.

Can I get a motion?

MS. BROWN: I motion to recommend.

MS. BEAUREGARD: A second?

MS. MANNINO: I second.

MS. BEAUREGARD: Was that you, Brenda?

MS. MANNINO: Yes.

MS. BEAUREGARD: And I heard you too, Arthur, but I think Brenda might have beat you. It was a tie.

All in favor say, "Aye?"

ATTENDEES: Aye.

MS. BEAUREGARD: Any opposed?

All right. Motion carries. Thank you.

MS. SHEETS: Emily, would you mind sending me that in writing, please?

MS. BEAUREGARD: Yeah, absolutely. I did write it down, so I will get it to you.

And then, are there any other recommendations? Okay.

Well, for the next meeting, language access is one area where I would like to hear some recommendations. Of course, always come prepared with ideas for other recommendations. That's one of the benefits of participating in this TAC.

And then the next meeting -- well, November 8, MAC meeting representation. I will be at the MAC

meeting to represent and to report on our work, and as far as the next meeting goes, we do need to reschedule. I was originally planning -- our Kentucky Voices for Health, our annual meeting was going to be on December 5th. It was originally going to be on the 4th and then we had to move it. So probably the easiest thing to do is just work with you, Kelly or Erin, on finding another date. Maybe a few options that DMS is available and then I can poll TAC members.

MS. SHEETS: Yeah, we can do that.

MS. BEAUREGARD: I apologize for that.

So then our MAC meeting schedule, that's when our entire advisory council comes together. Those are always the fourth Thursday at 10 a.m. Although that might be with the exception of Thanksgiving. So, but that schedule is usually up on the MAC website if anybody is interested in attending. I do represent our TAC there, but everyone is

welcome. It's a public meeting. And it is now fully virtual, so that's a nice thing, and recorded if you want to catch up on it later. So we have really appreciated that. That was one of our Consumer TAC recommendations that those meetings be recorded so people can access them later, and that has been really helpful.

All right. Well, I think we have covered everything, so I will ask for a motion to adjourn.

MS. BROWN: I motion to adjourn.

MR. CAMPBELL: Second.

MS. BEAUREGARD: Arthur?

MS. MANNINO: I think he seconded.

MS. BEAUREGARD: He beat you to it that time.

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: All in favor say, "Aye."

ATTENDEES: Aye.

MS. BEAUREGARD: Any opposed?

All right. Sounds good. We are

adjourned.

Thanks everybody. It was good to see you. Have a good day. Bye.

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C E R T I F I C A T E

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

Dated this 27th of October, 2023

__/s/ Stefanie Sweet_____

Stefanie Sweet, CVR, RCP-M