CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
CHILDREN'S HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
March 8, 2023
Commencing at 2:00 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Donna Grigsby, MD, TAC Chair

Alicia Whatley

Michael Flynn

Courtney Smith, Vice Chair

Cherie Dimar

MS. SHEETS: Please remember to turn your camera on so that we can comply with all open meeting laws. So please have your camera on while you're voting. And with that, Dr. Grigsby, I'll turn it over to you.

MS. GRIGSBY: Okay, thank you. I can't see all of the participants, but I can see that we have at least one other member of the TAC -- how many members of the TAC do we have on currently?

MS. SMITH: Courtney Smith is here.

MS. DIMAR: And Cherie Dimar's here.

MS. GRIGSBY: Okay.

MS. WHATLEY: Alicia Whatley is here.

MS. GRIGSBY: Great. Okay. So we are currently one member shy of a quorum; is that correct?

(No response.)

MS. GRIGSBY: I believe we had a quorum last time, and we had Michael with us, correct?

(No response.)

MS. GRIGSBY: Okay. Let's go ahead and get started. I apologize for any background noise that you guys may hear.

There is a new member of my family who's quite rambunctious and noisy, so I apologize in advance for any unusual noises that may come through during this meeting. So I will try to stay muted as much as possible.

I believe the first order of old business is the data request we had from DMS on school-based mental health resources. Does anyone have a report for that?

MS. DAVIS: Hi, this is Erica Davis. I do have a report for that. And, Kelli, will you let me know if I'm able to share my screen now?

MS. SHEETS: You should be able to share your screen. I'm having a lot of technical difficulties, so let me know if you can't.

MS. DAVIS: Okay. Are you able to see the PowerPoint?

MS. GRIGSBY: Yes.

MS. DAVIS: Okay, great. Okay. So we'll go ahead and get started. The request was for some updates on the school-based behavioral health services. And the mouse wanted to lose me there.

Okay. So I'm not sure how much you all know about the school-based services, so I'm going to give a little bit of background. Since 1988, Medicaid has reimbursed schools for any services that have been provided to children that have an individualized education plan and that are also members of Medicaid. And schools are not required to participate in the school-based Medicaid services, but they are required to provide all the services that are listed in a child's IEP. And so whether or not they get funding from Medicaid, they're still having to provide those services, but Medicaid would provide some reimbursement for them to help them cover those expenses.

Then in 2014, Medicaid did a rule reversal for free care, which meant that as long as a child was a member of Medicaid, any service that is provided to them that is a covered Medicaid service that school could be reimbursed. And Kentucky submitted a state plan amendment and had that approved in 2019. So any service that is provided to

a Medicaid member that is medically necessary, that's a covered service provided by a credentialed practitioner, can be reimbursed to the school. And there's one additional requirement, and that is that whatever that service is, has to be offered to all students in the school at no cost to the students.

And the Medicaid in schools program in Kentucky is, we contract with the Department of Education to administer the program, so they take care of all the administrative functions, the Random Moment in Time Study, those sorts of things. And the school districts themselves are the ones who enroll as Medicaid providers. And the way that the reimbursement is done in the schools is through a cost settlement process. So the schools will submit claims throughout the year, and they are given an interim rate, so it's not the full reimbursement. It's an interim rate just to provide funding to them to -- it's a cash flow. It provides funding to them so they can continue to do the services. And then

at the end of the year, there is a cost settlement, and that's where all of the claims are tallied up, and we make sure that any service that is done they get the full reimbursement for.

And the year 2021 through 2022, there were over 400,000 claims that were paid for the Medicaid in school. Of those, only 10,945 were in the expanded access. And remember, the expanded access are the ones that provide a greater number of services to all students in the school.

And I will not belabor the point: We know there is a mental health crisis among the youth in Kentucky. These are just a few of the example stats that we have out there just showing how bad the situation is. And the thing is that most students, their first resource for getting any sort of mental health services, are going to be in school. That is -- they all have access to school, but they don't all have access to mental health services, which is why it's important that we make sure that those are provided there.

And additionally, the recommendation is that there be no more than 250 students to every one school counselor, and that's the national recommendation. When the LRC did their latest assessment in 2021, Kentucky's rate was -- or ratio was 457.8 students to every one school counselor.

And so because of that, we have -- of course have the School Safety and Resiliency Act, which was passed in 2019, which did make that recommendation that -- well, requires Kentucky schools to have that 250 students to one counselor ratio, but it did not provide any funding for that to actually occur. So in 2022, that same statute was revised to require schools to provide the Department of Education the number of mental health service providers that they have, what their credentials are, what their duties are, and then the amount of time that they are in each of those duties, and additional information like that, but still no additional funding for those mental health service providers in the school.

Kentucky's Medicaid program can

provide additional funding. And with that funding, that could employ additional mental health service providers. So what we are hoping to do is with those 171 school districts that we currently have, 165 are participating in school-based Medicaid services. But of those, only 57 are participating in the expanded access program. That's only one-third, but it is up from 34 the first year. But again, only one-third are participating in that expanded access. And if you think about that, that's going to be where those counselors or school psychologists are going to be able to say, "These are the services we have -- the mental health services that we have." And have it open to all of the students to make them comfortable to come in and make sure that they're getting those services.

So that makes our priorities within the Maternal and Child Health branch to increase the school district participation in expanded access, to bring it up from that one-third rate. We also want to recruit behavioral health professionals for

school-based services, and there's some ongoing initiatives for that. But also to promote the behavioral health services that are available to students to make sure students know that they do have a resource within the schools to get those services.

And if you need any additional data or information on that, Joe is our school-based services coordinator, and I have his contact information there. And you can also reach out to me, and my e-mail is there. And I wanted to open it up if anyone has any questions on anything that I've presented today.

MS. GRIGSBY: This may seem like a silly question, but is there any possibility that this mandate is going to be funded by the legislature?

MS. DAVIS: I don't know, but I would speculate that asking for the number of mental health service providers and for the schools to report that, that that could be a very -- it could be a possibility that that would lead into some potential funding if they saw that there is a low number of

mental health service providers, and that there would be no way to reach that ratio of 250 to 1 without funding.

MS. GRIGSBY: Okay. And is there anything this group can do to help make them aware -- I'm sorry, is that a recommendation that we need to make from the MAC -- or to the MAC, so that they can take that forward, or how can this group help with that?

MS. DAVIS: I will leave it to leadership on what should be taken to the MAC. For this group, I would say whatever we can do to assist in making sure that any mental health service providers know that there's a need within the school systems. And could maybe contract with schools if they're not already doing that.

Not all mental health service providers are employees of the school districts. In some districts, they are just contracted. And so as long as mental health service providers know that that's an option as well, that would be great.

MR. OWEN: This is Stuart Owen with WellCare, and I don't mean to crash in, but

a note, as far as making a recommendation -- you're talking about making a recommendation to the MAC that the legislature, I guess, would appropriate funds. Just to note that next legislative session, the 2024, is an appropriation -- is a budget session appropriation where they do stuff like that. So, you know, you could be setting the groundwork for next year basically; just a note.

MS. GRIGSBY: Okay. Thank you --

MR. OWEN: Sure.

MS. GRIGSBY: -- for clarifying that.

MS. THERIOT: And just keep in mind, the program itself, the extended care in schools, is a way to bring money into the schools for those services. So it's -- it will theoretically pay for itself. So getting somebody, you know, getting the legislator to appropriate funds is not necessarily a barrier if they haven't because school systems, just like Erica said, can hire behavioral health people that will, you know, see kids and then bill Medicaid for the kids, and then cost share

to round out the money.

MS. DAVIS: Okay. If there aren't any additional questions, I will turn it back over to you, Kelli.

MS. GRIGSBY: Thank you, Erica. Thank you for that presentation. I think the next part of old business is the reports from the MCOs on vaping, e-cigarettes, prevention and treatment resources available. Would anyone like to get that started?

MS. PULLEN: This is Kelly from Aetna. I don't mind for Aetna to go first, but I do need to have the ability to share my screen, pretty please.

MS. SHEETS: Okay. You should have it.

MS. PULLEN: All right. So we put together just a brief presentation. We are going to walk through a little bit of data that we have pulled from internally here at Aetna, but also other sources. And then we'll just quickly kind of highlight the resources that we have to help serve our youth who may be using e-cigarettes or who

may be using tobacco.

Right here, we really cited some data that we had from our partners, Kentucky Youth Advocates, and their partnership with the Foundation for Healthy Kentucky. They actually surveyed middle and high school students in November and December of 2020 to gauge the youths' beliefs around tobacco use and how recent policies are impacting tobacco use. And they surveyed about 400 youth from 22 different counties in Kentucky, and that included our far eastern western and southern parts of the Commonwealth. And so the bullets that you see on the screen are really from that survey that really noted that there may have been a decline in the use among children and teens in the survey, but we know from data, right, that some of that usage has actually doubled. And according to the survey, students said that the pandemic actually led to an increase in vaping.

More than 14 percent of youth in Kentucky said they believe that e-cigarettes are actually safer than traditional

cigarettes, which we think is important to note. And then in addition to that, there was a 2019 Youth Risk Behavior Surveillance Report, and that showed that 26 percent of Kentucky high school students and 17.3 percent of middle school students used a vape product for at least one day in the 30 days prior to the survey. Nationwide the results for that were 32.7 percent.

In terms of internal data that we had, we were able to pull some data -- this is from encounters and claims, and we always like to give a disclaimer that there can be a lag in our claims data. Providers do have quite a bit of time to submit those to us, so I always try to let folks know that before we present it. But we are looking at claims report by year from 2018 to 2022. And this is showing us whether or not e-cigarette usage was noted on the claims. So we saw in the review of claims only 57 children or adolescents that had a claim with a diagnosis of a vaping-related disorder or a nicotine dependence disorder or other tobacco products has actually been

received through us in the last five years. So that's an incredibly low number.

What this slide reflects is our healthcare encounter data that may be related to e-cigarette or vaping usage or products that are associated with a lung injury. And this means that the claims had one of the diagnoses associated with the lung injury due to vaping on the claim. So it was kind of the best way that we could pull some data for folks to look at. We did use the ICD-10 official coding guidelines that are related to e-cigarette or vaping or product use. And we just want to again call out this data may not be exhaustive, and it may not represent all of the possible reasons that a youth may have an encounter that's related to e-cigarette or vaping or product use.

And then, we wanted to note that claims data for 2022 is likely not yet comprehensive because there is that lag, and providers still have time to submit those claims; they have up to 365 days. So looking at relatively low cost, but again,

that really is probably likely due to the mechanism that we have to pull that particular data from our claims and encounter.

In terms of the resources that we offer for our youth, all of our youth do have the ability to be assessed by our care management team and our SKY program in particular. All of our kids are actually assigned to a care manager, and they complete a health risk assessment and an outreach questionnaire that does drill down and ask those youth whether or not they are using tobacco products or whether or not they are using a vaping product. Pending the results of the HR, our care managers then deploy interventions.

So our members have access to psychoeducation. They have access to additional care management services, which may be to direct members to resources, such as the quit line. We've also got Krames education materials that we review with our youth, and then we also have some formalized psychoeducation programs. One, in

particular, is called CATCH My Breath. I'll review that -- details of that are on the next slide. And our care managers will refer our kids that do screen that they are using tobacco products and refer them to that psychoeducation program.

All of the members, right, that are in Medicaid have access to covered services. So if there are services out in the provider community, care management will refer members to those that may be provider-driven.

And then I'll walk through really quickly our CATCH My Breath program. This is actually an evidence-based e-vaping education program that provides teachers, parents, and other health professionals with up-to-date information that helps really equip our students with knowledge and skills they need to be able to make informed decisions about the use of e-cigarettes. Our partner company, CVS, has a national partnership with CATCH My Breath so that everyone can access this information and this program at no cost. So we're able to

provide this to all of our Medicaid youth here in Kentucky.

In addition to referrals coming from care management, our outreach staff actually reach out to schools throughout the state and other community-based organizations that have after-school programs, and they're offering to facilitate or support that community-based organization facilitating the CATCH My Breath program. And the overall goal of this curriculum is to prevent the initiation of e-cigarette use amongst our preteen and our teen adolescents.

The program is designed to help students discover that non-use of e-cigarettes is the norm, right, for adolescents, helps them identify reasons why they might start using e-cigarettes, and then recognize those subtle or not-so-subtle messages that we may see in e-cigarette advertising. Then it's teaching them to practice skills for resisting peer pressure and that advertising pressure to use, and help them decide on their personal reasons,

their personal commitment to not use e-cigarettes and set goals for future non-use.

The outcomes that we see from this program and that we're able to gather are to ensure that these students resist their own curiosity, peer and advertising pressure to experiment with e-cigarette usage, and that we're hoping that they understand that e-cigarettes are addictive, that they are unhealthy, and not an as popular product as they think.

And then, we want to help equip them with the skills and see an intended outcome that they're influencing their friends and their peers, as well to not use e-cigarettes. So really spreading the word of the curriculum.

I will pause and see if you all have questions from us. I know that's incredibly brief. I wanted to be respectful of that five-minute time limit. And we've sent this presentation over to DMS to share with the TAC members, but happy to take any questions and send any follow-up information that you

all may need.

MS. GRIGSBY: Thank you. Just a quick question from me. How would a provider be able to refer a patient to this program, or would we just go through a care manager?

MS. PULLEN: The easiest way I tell folks is yes, to go -- is really to go through care management, but the quickest way to do that is if they know who their care manager is, of course, they can have those conversations in real-time and ask for their care manager to make that referral. If providers are not sure who the care manager is, I always tell folks to call our member services line. It's, you know, one phone number that's easy for folks to remember or have access to, and they can actually warm transfer people over to care managers.

In addition to that, all of our providers have a provider relations rep, and so they may already have an established relationship with that person. So if they've got members that they think would be

good candidates for that, they can work through their PR team also to make that connection point.

And we are --

MS. GRIGSBY: Okay, thank you.

MS. PULLEN: -- we noted in here we do work with community-based organizations. That there are folks that, you know, that are interested in us hosting one with, you know, with a provider group or other community-based organization, please let us know. We're happy to expand access to this evidence-based program.

MS. GRIGSBY: Thank you. Would another one of the MCOs like to present?

MS. BROSHEARS: Anthem's happy to go next. Let me -- sorry. Okay. Do you have our PowerPoint, or do I need to share my screen? I believe we sent it to Kelli earlier.

MS. SHEETS: You did send it to me. I'm having some technical difficulties and can't get to it, so I'll make you cohost, and you should be able to share.

MS. BROSHEARS: Okay, terrific.

Okay. Is everybody able to see our screen?

MS. SMITH: Not yet.

MS. BROSHEARS: Okay.

MS. SHEETS: It looks like she's frozen. It might be easier and more time-sensitive if we move on and come back to Anthem, if that's okay.

MR. COX: This is Stuart Cox from Anthem. Yeah, she just messaged me. She had a severe computer restart issue in the middle of this, so if we can come back to Dr. Broshears, we'd appreciate it. Thank you.

MS. SHEETS: Absolutely. This is the day for technical difficulties, I'll tell you that.

MS. KOENIG: Hey, this is Stephanie Koenig from --

MS. MCFALL: Hi. Paula McFall with --

MS. KOENIG: -- oh, go ahead.

MS. MCFALL: I'm sorry. This is Paula McFall with WellCare. We're happy to go if I can share my screen.

MS. SHEETS: Okay, I have made you

cohost. You should be able to share.

MS. MCFALL: Okay. All right. Can you see the screen?

MS. SMITH: Not yet.

MS. MCFALL: Okay.

MS. SMITH: Now we can.

MS. MCFALL: I always forget, with Teams, you only have to click once. With Zoom, you click twice, sorry. So Shannon Jones from medical -- senior director medical management is also on the call, and she will be talking as well as I am. And so we put together some PowerPoint and we'll send after the meeting.

Let's see, so Centene Institute, of course, is our corporate owner, and they have what's called a Youth Impact Award that challenges students to learn more about specific health issues, and vaping was one of them.

In 2021, they had a Prevention Youth Impact Award Campaign where they focused on ages 14 through 19, where they were challenged to raise awareness about vaping and e-cigarette use and take action to

promote prevention with their peers and community. So they had a PSA contest. Communication about the contest was completed through social media, e-mails, and flyers. Students learned about dangers of vaping by developing and submitting a 30 to 50-second public service announcement video. And then, current educational details are provided at all community relation events, given to providers to educate members, providers at schools and community organizations. The winner was the Ohio -- Centene's Ohio plan, and I've included the YouTube video related to that, and it was a very powerful PSA if anybody wants to take a look at it.

WellCare's prevention program encourages enrollees to actively commit to healthy lifestyles and support those who are ready to quit, including vaping and e-cigarettes. Enrollees choosing to quit have access to custom quit programs and supports. The program aggressively works to prevent anyone from becoming a user of tobacco, including e-cigarettes and vaping.

We actually use QUIT NOW for our online, as well as health coaching product.

Additional resources are we have an online resource called MyStrength. It's a self-directed online therapy program to help enrollees deal with tobacco use. It also deals with people with co-morbid conditions, such as anxiety, depression, and other SUD disorders. We have access to non-nicotine prescription meds, care management access with personal engagement and coaching, and peer support.

We do motivational text messaging for people. We have incentives driven by HEDIS. Tobacco screenings in dental, vision, and mental health settings. We engage providers to raise awareness to enrollees through the provider manual newsletters and website alerts of enrollees participating in the tobacco program. We have community engagement coordinators who provide enrollees information at WellCare-sponsored community events.

Now, we have a physician on the line, Dr. Melissa Hancock, who's part of this

Children's TAC for WellCare, and she has some real-life examples of success. So Dr. Hancock, do you want to talk through some of those?

MS. HANCOCK: Sure. Sure. Hey, Dr. Grigsby, it's good to see you on there today. I am a clinical pediatrician, as well as medical director with WellCare, but, you know, we screen all kids 11 and older for smoking and vaping. And I have to agree with what Aetna said, you know, it seems like it's universally thought in kids' minds, adolescents' minds that vaping is much safer than traditional smoking. So, you know, the marketing departments for the vaping have done a good job on the kids with that misconception.

So, you know, as a clinician, I have used some nicotine replacement therapy for older adolescents in conjunction with frequent, if not weekly, visits for follow-up for older adolescents and teens. Probably the biggest and saddest story I have is a parent and child that both were very motivated to quit smoking, and I

managed the child's therapy and met with them weekly. And, you know, I think obviously support is a big piece.

So we also use the 1-800-QUIT-NOW in the office where we have the tear sheets, and our office manager and everyone are familiar with the MCO representatives where we can refer kids to the various programs. And just, you know, super positive reinforcement for the younger kids who haven't started smoking or vaping yet.

And then, WellCare's program for, you know, helping with smoking cessation in pregnant mothers. So you get super important, right? The immediate benefits for the neonate without having nicotine withdrawal and the potential side effects of all that, but also then having potentially a parent who doesn't smoke themselves, which is a big influence on kids starting smoking or vaping, you know, during their adolescent years, as well.

But, yeah. That's pretty much all I had to add.

MS. MCFALL: Okay. Well, thank you.

I think we'll just dive back into like the other ask, which was pregnant women and teen smoking cessation.

We have treated 1,367 members in 2022 who were managed through the smoking cessation program. And with pregnant women, all moderate to high-risk pregnant enrollees are referred to case management. The smoking triggers at least a minimum of the moderate risk. Many fall into the high-risk case management program.

Education is provided to smoking caregivers of infants to protect the infant's health. We provide how second and third-hand exposure can exacerbate respiratory illnesses among already compromised NICU babies, asthma, and complex peds population. We advise the guardians to wash their hands, wear hair coverings, smoke outside, never in a closed space, such as a car, change clothing or wear a raincoat-type material when they smoke outside so that clothes do not need to be changed.

Continued education includes examples of ways secondhand smoke exposure can impact

ear infections and other respiratory infections, even if the child does not have a diagnosis of respiratory issues. Review vaping as a concern for chemical exposure for child and guardian due to lack of regulations. Advise caregiver to keep the devices out of reach of kids, and vaping is not a fix for keeping the children away from dangerous chemicals. Advise on the dangers of smoking in the vicinity of any oxygen equipment that is in the home.

So Shannon, did you want to add some information on this piece?

(No response.)

MS. MCFALL: Or maybe she lost connection. So additional --

MS. JONES: Sorry. I was talking on mute.

MS. MCFALL: Okay.

MS. JONES: Can you hear me?

MS. MCFALL: Yeah, yep.

MS. JONES: Technology. Yeah, so earlier, there was a question around referrals for smoking, and Kentucky has its own line, which is monitored in the state of

Kentucky with their care management team. So you can call the 800 number, or we also have a mailbox that's set up specifically for providers who can send that into us.

The other thing about WellCare that's special is that we have an OB, NICU, and a complex peds team that all work together. So if we're working with a member -- I was just talking to one of my care managers this morning. So she worked with a member during the pregnancy who smoked. She wasn't ready to quit, so we advised her to smoke less, and she did. Once the child was born and put in NICU, she had a conversation, you know, with the case manager following through NICU, and she was at the point of wanting to quit. We knew the stress was going to be difficult for her having the child in NICU. And so the NICU nurse continued to work with the mother after she left the OB case manager, and continued through that.

And then again, not necessarily in this case but with other cases, once they come out of NICU, then we hand them off

internally to a complex ped. So I think that continuity of care is really important, especially in talking about the smoking cessation and being able to, other than just giving them a 1-800-QUIT, we're able to follow through and provide that education to the mom and the family.

MS. MCFALL: Thanks, Shannon. So then again, we want to make sure that teens are also included in our prevention, and so we have the QUIT NOW for assistance. And we also do have -- for pediatric behavioral health care managers that work with families and can provide this as a resource. And of course, in our assessments of case management, we look for gaps in care and needs, and so we make sure we include that in our assessment and recommendations to help people with their desire to quit.

And then we also provide counseling through that program. And the program many people are probably familiar with it, but they have a phone and online program for people that want to do both technology-based coaching support, including e-mail, text,

and chat. Educational materials, quit planning materials, and progress tracking. And then access to community resources online.

And then some people who may not have access to a computer will do phone coaching only. And that's -- we provide information by e-mail or mail -- quit planning materials, as well as quit progress tracking. And then some just prefer to do online only, and they can have many access to resources, the quit planning tools, the progress reporting, access to online community, and chat with the coaches.

There was an agenda item in the Children's TAC on future topics, and we know that Centene has done the same as they did for vaping. They have a contest on anti-bullying, and so we have provided information on this to schools, as well as community support. I have not found the PSA that won yet, so when I find it, I will communicate that with folks. But that's kind of the process in which we're looking at some future trainings for education

around bullying and cyberbullying.

And that's what we have.

MS. GRIGSBY: Okay, thank you.

MS. MCFALL: You're welcome.

MS. GRIGSBY: Any questions for them?

(No response.)

MS. GRIGSBY: I think we've had several folks offer to go next. I think Dr. Broshears from Anthem is back after having a little IT glitch. So if you want to continue and then we'll go to United and then to Humana --

MS. BROSHEARS: Perfect, thank you.

MS. GRIGSBY: -- if that's okay.

MS. BROSHEARS: And I apologize for that. Of course, I got the blue screen of death in the middle of everything, so all right. Can everyone see my screen now?

MS. GRIGSBY: Yes.

MS. BROSHEARS: Okay. All right. Well, I'm Danielle Broshears from Anthem. I'm one of our medical directors. I'm going to talk to you today about our different smoking and vaping supports that we offer --

MR. COLLINS: Dr. Broshears, you're

showing the wrong screen again.

MS. BROSHEARS: No -- well, is it? Okay, because the one that's up is supposed to be --

MS. SMITH: It was there, now it's not. It looks like your e-mail or chat or something.

MS. BROSHEARS: Okay. Let's see.

MS. JUDE: Do you want to --

MS. BROSHEARS: Yeah, let me exit and let either --

MS. JUDE: Would you like me to share mine?

MS. BROSHEARS: Yeah. Let's let Victoria or Stuart -- I apologize for having all kinds of problems today.

MS. SHEETS: Okay. Who's going to share so I can make you cohost?

MS. BROSHEARS: Victoria Jude.

MS. SHEETS: Okay. Give me just a second.

MS. JUDE: Okay.

MS. BROSHEARS: I apologize for the delay.

MS. SHEETS: Okay, Victoria, you

should be able to share now.

MS. BROSHEARS: Perfect. Thank you, Victoria. So we have multiple different outreach and programs we have at Anthem to try to help our various ages of members, either one, prevent them from starting smoking and vaping, and two, to help them quit.

We have a member program, a tobacco cessation program through the Truth Initiative, which is a partner for us. They aim at 18 plus through this program, and so obviously, pregnant moms would fall, those that are 18 plus would fall under this category. And I'll talk more about this program specifically later.

The Truth Initiative also partners with us on This is Quitting Program, and that is a text-based program that is aimed at ages 13 through 24. So there is some overlap in that age 18-to-24 range, but this program provides a little bit more anonymity because it does aim at children. And a lot of them are concerned about parents finding out that they quit -- if they're vaping,

that they're afraid to reach out through other ways. So this one, we do not collect data through this program. So we do not necessarily have data on how successful the program is, but I'll talk about that a little bit more. There have been studies done, but it is our specific help to quit vaping for this teen age.

We also have a health education program. We have an infrastructure of team members who are able to go out into the schools and provide, you know, boots-on-the-ground education to different schools. Again, I'll go through these programs a little bit more in-depth in a moment.

We offer a healthy reward, which is $75 for anybody who completes the tobacco cessation program. And so if they can successfully complete that, they'll get a $75 health reward.

We additionally have a value-added benefit, and this is actually providing a smoking distraction kit. They get things such as gum, mints, fidget spinners, stress

balls, just anything to try to keep their hands and mouth busy for not smoking or vaping. And this is available to anybody who enrolls in the tobacco cessation program. Next slide, Victoria.

All right. So as I mentioned, we have a boots-on-the-ground education program where our Anthem associates are going out into the schools. We target elementary, middle, and high school students. There's different programs available based on the age that we're trying to reach out, but in general, we're trying to educate on the dangers and consequences of vaping, reduce the number of people who start vaping, increase the number of people who quit, and then also, you know, making them feel that they can resist peer pressure and understanding it's not the normal thing to vape, and helping them understand the negative consequences of vaping. Next slide.

We have three sessions, and they can be mixed and matched or based on what either the school wants or the age appropriateness.

A few of the things that we go over are vaping and what chemicals they contain, consequences of vaping, there's a refusal skills workshop where our team members can work with the kids on learning how to say no to help increase their resistance of peer pressure, and recognizing the marketing traps of vaping, and helping them stop vaping if they already are. Go on, Victoria.

Anybody who attends one of these gets handouts. We have them in English and Spanish. Here are just a few examples. We try to provide more education to those. Hopefully, they'll take them home, and if there's a family member who's vaping or smoking at home, they can share with them. So we can reach more than just the student, we can also reach the family. Next slide, Victoria.

As I mentioned before, we've partnership -- we have a partnership with the Truth Initiative. They're a nonprofit. They're basically a tobacco cessation program and partnership with the Mayo

Clinic, and they've done a lot of research and evidence-based stuyding of the problem to come up with two different programs. One of which is the This is Quitting program. The This is Quitting program, as I had mentioned before, is aimed at ages 13 to 24. It's text-only. They text a keyword to a number. The only thing they have to provide is their age. They can provide more information to get it more personalized, but that's not needed. They can set a quit date if they want, and then get up to 12 weeks of daily text messages to help encourage them. And then they can also get on-demand support if they feel like they're having stress or cravings to either vape or traditional smoking. Next slide, Victoria. Keep going, please.

Okay. So the ex program is self-paced, self-guided. They have multiple different ways they can reach out. Like I said, it's mainly for those 18 plus -- or it is only for those 18 plus. They can get chatting with either a coach, they can chat with other members who are trying to quit

smoking in their community section. They can also get text messaging and quit medication. All of these things are available through this program, which is free to them.

Other things that we have for pregnant moms is we also have an OB-QIP program, and the OB-QIP program is for provider-based incentives, but part of that part of the incentive program is for the providers to increase the quit rates of pregnant moms who are smoking. And so by doing so, they get measured on that and that goes into their incentives. So that's another way we're reaching out. We also are waiting for our 2022 data; we don't have that yet, but we have -- we do know that our members are using the state quit line, so I feel like we have various resources, and we're really trying to reach our members through various different ways. Does anybody have questions? Concerns?

MS. GRIGSBY: Thank you. Any questions?

(No response.)

MS. GRIGSBY: It's really positive that there's so much very good work going on. It's nice to hear all the work that everyone's doing around this issue.

Okay. If no questions for Anthem, United Healthcare, please.

MS. KOENIG: Sure. If I can get access, I'll go ahead and share my screen -- Stephanie Koenig.

MS. SHEETS: Okay. You should be good to go.

MS. KOENIG: Great. Thank you. I'm like somebody else; I'm so used to using Teams. Can everybody see my screen, okay?

MS. GRIGSBY: Yes.

MS. KOENIG: Okay. Great. Similar to what Anthem kind of -- I'm sorry, Aetna presented earlier, our approach really was specific tobacco use. And so what we have found, and kind of the way that we are addressing in the Kentucky market, is the approach to tobacco use. And so specific to use, I think that it is showing up in vaping, and I think the campaign for tobacco -- the tobacco campaign, Free, did poll

Kentucky, and we were obviously above the national average at like 26 percent for vaping.

And so, in addition, the next slide that you'll see really kind of extends further, and when we look at the billing codes that are suggested for vaping, the nicotine dependence is the code to use.

We also wanted to include and try to understand our prevalence within cannabis use. As we know, that while it's not legalized in the state of Kentucky, there is use of vaping with marijuana, and wanted to kind of try to understand as we are doing more of our HRA core assessment. So this is our overall universe for 2021 and 2022 and the CPT codes that are tied to this.

As Aetna also pointed out, I don't believe this is a true representation of vaping specifically. It's hard to quantify when there's many different methods to use of tobacco, even in the form of using marijuana, and if that is through vaping. So I don't think this truly represents the actual market in which -- or the population

in our membership, but this kind of gives you the breakdown of these codes, and kind of the high utilization of how providers are billing to treat these diagnoses.

We did break it down a little bit further. For under 18 for the use of tobacco -- and again, using those same codes. And while being newer to the market, our numbers, I think are lower, as well as kind of trying to quantify -- there were multiple positions on the claim line to really understand, is this their primary diagnosis, or if they're just being treated for this.

In addition, I do want to add in reviewing and trying to form a true representation of this population with zero to three population that showed up on the claim lines for secondhand smoke, breastfeeding -- so this was kind of how we quantified our population. And our current approach right now is through our HRA, and so there is the core assessment through the screening.

We did implement this year the youth

HRA assessment, and so the screening question is asked at the top, screening for the nicotine and are discussed with member's usage. If a member does desire, then we do -- similar to all the other MCOs, we do have case management that offers -- and we do have partnerships, as well as with Quit Now for the individualized coaching and smoking cessation.

What our case management team has found, is obviously some of the barriers, especially with that youth HRA and for those youth that may not want to disclose or a parent is completing the assessment for that youth. So we are truly able to connect to those services and trying to take that into account.

So currently, that has been our approach and how we are screening for tobacco use with our membership, and kind of looking at where we are and have been for the last year is evaluating additional opportunities. So our approach is assessing, partnering with Quit Now, with case management, referring to community

resources. We also leave one-pagers, leave-behinds at community events, provider packets that kind of go over, again, the consequences to vaping and quit smoking -- or quit smoking, and I'll show you the flyers that are left behind at our community events.

Over the course of the next year, we are evaluating a few different opportunities similar to some of the other MCOs. So provider incentive smoking cessation programs -- that is in evaluation right now to implement within our market, as well as a specific tool that assists youth to quit for life. And it's technology-based, and then the other one was an evidence-based high-touch virtual care service, and there's a kind of three-tier module depending on the severity or the need. There's an immediate financial incentive for both the youth and the adult if they do participate. And again, those are three different programs we are looking at implementing.

Some of the outcome consideration -- I already discussed earlier when we were

evaluating kind of our data and our encounters to our data, as well as our claims, it's really hard to quantify this data and become specific to the population. So having to look at, not just youth vaping, but looking at tobacco use. And so if we remove or come hard on vaping, what is another method that those youth might use?

And moving forward, these are the leave-behinds or one-pagers. So it does walk through kind of the effects. And again, I think Anthem and Aetna both stated, you know, they're based on our research, and I think youth do believe that it is a safer method to vape, and so giving some additional education on this.

And so kind of the next point of contact, and I think that was a question that was also asked, how do you connect a youth to these resources? And so we kind of outlined the steps to get connected with your PCP, calling member services to get connected, and that's when that HRA would be completed. And then this is the additional quit smoking that kind of connects you to

the Quit Now program.

Any questions for me? I know many of these programs --

MS. GRIGSBY: Any questions?

(No response.)

MS. GRIGSBY: So it looks like in your slide, you talk about the resources available for adults, but fewer resources available for children. Are you also -- I mean, it looked like that was certainly a handout that was appropriate for adolescents.

MS. KOENIG: Yes, and this is left behind in the school settings. This is one-pagers that are left behind at the community events. Obviously, we do have the youth HRA and we are meeting with the parents.

Part of the challenges and barriers that were pointed out is, you know, in that assessment, is the youth going to be open to disclosing their vaping, and just, you know, trying to assess what may be the challenges or barriers to get a true kind of -- Quit Now is predominantly for 18 and older.

There is limited resources for the younger population. Obviously, that is with the guardianships' agreement, but in our evaluation of opportunities, the second bullet, population specific, this is a smart technology tool that is specific to youth that we're hoping to look to implement this year.

MS. GRIGSBY: Okay. Good, thank you.

MS. KOENIG: You're welcome.

MS. GRIGSBY: Humana is ready to present, I hope.

MS. MUELLER: I am; if I could just get sharing, please.

MS. SHEETS: Okay. You should be set.

MS. MUELLER: Okay, thank you. All right. Okay, I'm Diana Mueller. I am manager of Humana's health and wellness coaching team. I was asked to come today and talk a little bit about our tobacco and vaping cessation health coaching program. Health coaching can include quite a wide variety of health wellness topics. And in Kentucky, we do support tobacco vaping

cessation, as well as weight management for youth ages 12 to 17.

Humana's health and wellness coaches are highly skilled in many different evidence-based behavior change theories, models, and methods. We facilitate a nonclinical and non-prescriptive coaching program. This allows us to support behavior change, meeting the member where they are and flexing between different strategies until we find what best supports each member.

Health coaching creates a very dynamic relationship between the member and the coach that supports the creation of new lifestyle habits and long-term behavior change. We do gladly support members with implementing providers-suggested action steps, too; that's always welcome.

Health coaching recognizes that each person has unique motivations, values, needs skills, current behaviors and challenges, in addition to varying levels of readiness to change. And no two behavioral change paths or cessation attempts will be the same.

Coaching incorporates all of the items listed to support the member with enhancing their abilities to enact change. The coach is going to get to know the member, asking about their unique circumstances and their future visions, and we help them to set their cessation goals, create small action step plans, and help them to stick to those plans.

All right. This is an overview of our tobacco vaping cessation program for the youth. Our program does include all forms of tobacco products: Cigarettes, cigars, vaping, spit dip chew, doesn't matter, we'll work with them. Kentucky Medicaid members ages 12 and up with any history of smoking or nicotine use are eligible for participation. The youth program includes eight health coaching sessions meant to be completed within a 7 to 12-month time frame, so they're spaced roughly a month apart. The program does support people in all stages of change through to maintaining complete cessation of tobacco use.

Enrollment in our program begins with

a phone call from the member or a care manager referral. And program contact information is on the Humana Healthy Horizons Kentucky website. We do schedule the first coaching session at that enrollment phone call, and it's scheduled with both the parent or guardian and the child. That parent or guardian is required on the first call in order to give verbal consent, and then optional on remaining calls. And we do also e-mail out an enrollment packet to the parent or guardian that includes the COPPA direct parent notice and the coaching consent form, but these don't need to be returned. So COPPA is referring to the Children's Online Privacy and Protection Act.

Completion of the first two coaching sessions within 45 days of enrollment will earn the member a $25 e-gift card, and completion of all eight sessions will earn them another. And these e-gift cards are rewarded through the Humana Healthy Horizons mobile application.

We have had 304 enrollments in 2022,

and to our coaching program, with 66 completions of all eight coaching sessions. The expected timeline is about 7 to 12 months, so those completions lag a little bit behind the enrollments. In addition, as of March 1st, we had -- still have 183 active participants engaged in the coaching program.

All right. The next couple pages are some flyers that we send out to program participants upon request or as an educational need arises during the coaching conversations. This first one is our general program flyer. It does contain our phone number for the Kentucky program -- I thought it contained the phone number for our Kentucky program. And we do have a dedicated line so that members can call in. The information is on the website.

We have an example of a trifold with some facts about vaping, and a youth and tobacco information sheet, an example of one of the items that we hand out during coaching calls.

Okay. Any questions on our health

coaching program -- and then, we have a couple other Humana associates who might fill in some more information, too.

MS. GRIGSBY: Any questions?

MS. HARRISON: Thank you, Diana. This is Samantha Harrison. I wanted to also incorporate Megan Hofmann into our conversation with the TAC regarding how, much like the other MCOs, our care management team works with membership to refer. So, Megan, if you don't mind to open your mic.

MS. HOFMANN: Yes, can you all hear me -- good afternoon, everyone. Thanks for having me on. Again, my name is Megan Hofmann. I'm one of the managers with care management at Humana Healthy Horizons in Kentucky. Just to give a little bit more info on how care management plays into how closely we work with our wellness coaches.

So our HRAs, when they go out to all the members or if any of our care management staff is on the phone with a member, we're going to try to get an updated HRA or health risk assessment on file if not already. One

of the questions on that assessment does ask if they're using any tobacco or any tobacco-like products, so we can get some more information. If the member states that they are using tobacco, we will explore with them the wellness coaching options. We also, like I said, have members that maybe were diagnosed with something else, and so that's triggering an outreach from a care manager or a care management referral. And then when the care manager looks over that health risk assessment before making the call, they may see that the member checked that they are using tobacco or they are vaping and they would like help quitting. And that triggers for us that we need to have that conversation with them and try to get them linked up with a wellness coach.

Also, for anything else, like I said that members are going to be referred to care management, we have care management support assistants. They run our care management inbound line, so members calling wanting a care manager for any reason, wanting more information, wanting to get set

up with a program, on each and every call, our care management support assistants are going to also go through all of the value-added benefits that we offer for our members. And part of that is going to be Go365 and wellness coaching. So they're going to be talking to them about Go365 and their Go365 benefits, how they can get gift cards. A lot of times, those conversations will lead to tobacco cessation.

So these are just some different ways that we can get the member talking about things they may be interested in. We do always let them know that the wellness coaching, especially for tobacco cessation, is completely voluntary. It's not going to affect their benefits, so we do have a pretty good outcome of members wanting to be involved.

Once the member lets us know that they are interested in learning more about wellness coaching, that they want to be matched up with a coach, it's a very easy process for us. So at that point, all the care manager -- or care management support

assistant has to do is we send an internal secure e-mail to the wellness coaching mailbox. We just include member name, ID number, which wellness coaching program they're interested in, and then the best phone number, time of day, or day to reach them. And at that point, a wellness coach will get back to us very quickly; I would say usually same day, let us know, "Hey, I received your referral. I'm going to outreach this member."

After that, when we do our follow-ups with the members, we've heard great things about how they love working with their wellness coach, we can also follow back up with that mailbox and find out who the wellness coach is that is set up with our member. The care managers can then collaborate with them so that everyone's on the same page and we're working together. That's been working really well.

And then vice versa. If a member was somehow, you know, set up or called the wellness coaching line, they're set up with a wellness coach, they're having some more

medical issues, maybe they're in a tobacco cessation program, but they're telling the wellness coach their main motivation for quitting is because, you know, they've been diagnosed with asthma or they've been diagnosed with COPD, and for some reason we haven't been able to reach them on the care management side for that yet. Then the wellness coach can send a secure internal e-mail to our care management mailbox. And we will have a care manager outreach that member within a couple of business days and see if we can enroll them in care management and continue that collaboration process.

So that's just a little snippet of how we're all working together and making sure we are reaching all of these members, looking at their total health needs, and getting them in the correct program. Any questions?

MS. GRIGSBY: Okay. Thank you. Thank you, guys, all for your presentations thus far. There is, as I said earlier, there seems to be a lot of great work going on out there.

Does anyone from PassPort have --

MS. BEAL: Yeah.

MS. GRIGSBY: -- a presentation?

MS. BEAL: I'm here. It's Jessica.

MS. GRIGSBY: Okay.

MS. BEAL: I'd like to be able to share a screen, and I'd love permission not to be on camera. Someone's still without power.

MS. SHEETS: You should be able to share your screen.

MS. BEAL: Thank you. Give me one second because, without power, I am operating in a unique location, making it a little hard for me to -- I don't have multiple screens today like I normally do, so give me just a minute. Can you all see my screen? If so, I'll go ahead and blow this up.

MS. GRIGSBY: Yes.

MS. BEAL: Great. So I'm going to keep this as short and sweet as I possibly can. I think we've heard a lot about care management programs and other things and health management programs that we all seem

to have in common.

As a quick reminder, the original question that we heard at the TAC was really around the relationship between behavioral health and nicotine use. That was what was brought up at the last meeting, specifically a belief that -- or at least somebody had brought up the possibility that if we could help adolescents stop using vape products in particular, but I think we would all just assume nicotine products in general, that we might see behavioral health improve. This was brought up as part of the continuum for behavioral health needs.

So I just wanted to remind everyone there's really just a correlation, not a causation, related between nicotine use and behavioral health. But we do know that there's a likelihood that some of our youth who begin using nicotine products may have a behavioral health underlying diagnosis, but that the -- kind of that cyclical process of use, the constant cycle of use withdrawal, use withdrawal, use withdrawal, can definitely exasperate anxiety and depressive

symptoms in any population. So that was part of the question; I wanted to make sure we answered it.

Like the other MCOs, we know that claims is not always the best way to look at things, so I thought a point in time. This is representing 12 months of claims with full claims run out for those 12 months based on date of service. Just looking at our EPSDT members, age 10 to 19 and looking at the diagnostic breakdown as a clinician myself, the youngest person I was ever asked to treat for cessation was six years old, but when I looked at our data, I can tell you that really we start to see actual denominators that are greater than two or three when we hit age 10, so that's why I started at age 10. But you can see that, in general, we're just not seeing a lot of vaping-related disorder diagnoses coming through, but we're definitely seeing a lot of nicotine dependence, unspecified, etc., that may be including some of those vaping issues, but it's just not coming through real clearly in our data set. But you can

see we definitely have a lot of nicotine use in our adolescents in the Commonwealth, which we know. This isn't surprising.

So I was curious to see of all of these claims how many of these were actually a primary diagnosis, which might indicate that this was a -- somebody who was actively engaged in treatment by a provider related to it, and you can see that that number radically decreases; we're looking at around 44 members total in 12 months, half of whom were 20 years old. So we don't -- we see a lot of secondary diagnoses when we look at our data for this population. We see a lot of secondary diagnoses with a behavioral health diagnosis first or substance use disorder diagnosis first, but we don't often see it in the primary spot, which tells us we aren't seeing as much direct cessation work, but I can appreciate that. Because again, as somebody who worked in pediatrics a long time myself, you know, this -- pediatricians, we see them do some coaching around this, but they don't always necessarily only bring a patient in for

coaching, right? It's part of the continuum of care that they're offering during a well-child visit or a sick visit, etc. So it's not terribly surprising to me that we're not seeing that.

I didn't put it in the slides, but I was again, always curious about my data, and it was nice to see that we get really great coding from our pediatricians, too, related to tobacco exposure, and that we're able to kind of look at that if we want to for our youngest members. Because I'm going to assume that while I saw a couple of zero-year-olds with a nicotine dependence diagnosis that was probably a misnomer; it might be more related to a parent. But when I pulled for codes related to exposure, it was pretty high, and I'm really appreciative of providers kind of giving us that heads up and letting us pull that into our stratification when we're looking at children's needs.

Again, we have our care management process. We have a health management process, as well. All of our care managers

are trained to address tobacco cessation and nicotine cessation in all age members. We try to have them set that as a goal if the member wants to, but of course, we're always member-centric. So if the member is not interested in addressing cessation or harm reduction, they are going to persistently engage in motivational interviewing throughout the course of their care management process to try to move that member into kind of more of an action stage of change around nicotine use. We, of course, refer to the Kentucky Quit Line, and then we can also send teens to My Life, My Quit, or sometimes Smoke Free Teen, which is a great resource because there's a text option there, as well.

Our CMs have a unique opportunity to refer members that want additional support around cessation innovation interventions to our community health workers. And what makes that extra special is not only are they trained to address tobacco cessation and nicotine cessation, but depending on the location of the member, they can meet them

in the community, or they can meet them in their home if they need a little bit of extra help and support, which is really of value for -- especially working with caregiver and teens sometimes. So that's a little added bonus that we have as an option for some of our members again, depending on their location and if we have one of our community health workers in that area of the state. So that's kind of the care management process as a whole.

Our community engagement team has health educators on it, and our community engagement reps are also trained. We partnered with Stanford's tobacco prevention program, and we present those materials in middle and high school some of which are vape-specific. And we work also a little bit with the local health departments, too, to try to help kind of -- not all local health departments have the bandwidth to always do that for schools, and so we are partnering with local health departments to find out where they don't have as much bandwidth and really directly offer to

schools the opportunity to do some of that prevention work in the schools through presentations, etc.

And then, like the other MCOs, we have plenty of nicotine cessation materials. We provide education at our one-stop health centers. So any member that walks in can get some education and actually has manipulables and other things like sitting on tables to learn more about nicotine cessation, but also the damage that nicotine can do. So pretty similar across the MCOs, I think, in general. Any questions?

MS. GRIGSBY: Okay. Thank you. Any questions for any of our MCO presenters -- thank you all so much for this very helpful -- all of these helpful presentations.

MS. SMITH: Yeah. I agree. They were great, thorough, and lots of good information that I didn't know about.

MS. GRIGSBY: Thank you.

MS. SHEETS: I just wanted to say if any of the MCOs have not sent in their presentations if you'll send those to me, and I can put my e-mail in the chat. It

just goes to me, if you have not already. I will make sure I get those out to the TAC members.

MS. GRIGSBY: Okay. Thank you all so much. Kelli, can you get our agenda back up, please?

MS. SHEETS: Yes, ma'am.

MS. GRIGSBY: Thank you.

MS. SHEETS: You also have a quorum, so --

MS. GRIGSBY: Oh, okay. Okay, so I guess if we have a quorum, let's go back and look at -- we have approval of the minutes from the January 11th meeting.

MS. SHEETS: Again, members just need to turn your cameras on.

MS. SMITH: Should I motion for the approval of the minutes?

MS. GRIGSBY: Yes, please. And then we need a second. Am I allowed to second as the chair?

MS. DIMAR: I'll second.

MS. GRIGSBY: Okay.

MS. DIMAR: After we have a motion.

MS. SMITH: Oh, I'm sorry; I thought

I did. I motion to approve the minutes from January 11th.

MS. DIMAR: I second.

MS. GRIGSBY: Okay. And then all in favor, say aye.

(Aye.)

MS. GRIGSBY: Any opposed?

(No response.)

MS. GRIGSBY: And any discussion of the minutes?

(No response.)

MS. GRIGSBY: Okay. Thank you to all the MCOs. Looking at the new business again, I think we put this under new business because -- I'm not sure why we put it under new business because it looks like we -- it's the same that we had under old business. So skipping through new business since we will not have those presentations again in May, on to the general discussion and future topic suggestions. Any discussions among the members about topics or requests for data that we need to make for the May meeting?

(No response.)

MS. GRIGSBY: Are there any of these topics that we feel like we need information on from the MCOs or from DMS that we want to discuss in May?

MS. SMITH: I'm going to ask a silly question as someone who's rather new, I mean, or hasn't ever been to an in-person meeting, and only ever done these sorts of virtual meetings. So what other types of formats do we have other than having the MCOs present something, like if we just want to discuss as a group one of these topics? I mean, I know that maybe we need data, or I don't -- that's all that's ever really happened in the meeting since I've been a member.

MS. GRIGSBY: Mm-hmm.

MS. SMITH: And maybe that's what we do --

MS. GRIGSBY: Mm-hmm.

MS. SMITH: -- but what other formats, or is that typically what we like to do, is just get them to give us updates or thoughts or what each is doing for some of these problems?

MS. GRIGSBY: I can tell you I go back long enough that I was actually involved in in-person meetings, and sometimes we would invite specific content experts to come and talk about certain topics, particularly if there were topics that may not be being addressed by the MCOs.

MS. SMITH: I assumed, yeah.

MS. GRIGSBY: Yeah. So again, several of these topics I don't think the MCOs will be doing anything about the juvenile justice issues and I don't know if that's something we want to visit or we want to wait until after they've had a chance to kind of address some of their issues. You know, certainly bullying, I think, would be, you know, something that we would get information from, you know, schools about. You know, I think of all of those topics that I see, obesity would be the one that we may be able to get program, you know, programmatic information from the MCOs, but perhaps we want, you know, a content expert to talk about poverty and homelessness and, you know, reviewing those statistics. But

really the presentations that I've seen in the past, were either content experts or reaching out to the MCOs or DMS about programs that are in place --

MS. SMITH: To address them.

MS. GRIGSBY: -- to address some of these issues.

MS. SMITH: Okay. Thank you. That just -- that helps me.

MS. GRIGSBY: Okay.

MS. DIMAR: Yeah, I think it'd be good to have maybe a content expert about the poverty and homelessness situation to learn more about that and if there's anything we can do, and --

MS. SMITH: Yeah, that would be good.

MS. DIMAR: Yeah, that's kind of always an urgent need.

MS. SMITH: To give -- maybe take a break from the MCOs having to make presentations, but also to, you know, so that we can target areas of need from those content experts on that topic.

MS. GRIGSBY: So, Alicia, are you still with us?

MS. WHATLEY: Yeah, I'm here.

MS. GRIGSBY: Okay. Anyone from your shop or you that could kind of give us some information on this on a state level?

MS. WHATLEY: I can ask internally if anybody feels that they would have kind of the right expertise. When it comes to homelessness, we certainly have been trying to look into this issue, but I would definitely not say we're the experts on it.

So there are a couple of other groups that we work with closely on some issues around housing, so I wonder if I could do a little outreach to see if maybe they have somebody that can come and present sort of a broader look at the problem, and then, obviously, specifically around children in Kentucky, I'm assuming would be of most interest to this group. If that sounds good to you all, I'm happy to do some outreach and see if I can find the right person just based on some of the partners I know that we work with.

MS. DIMAR: That sounds good.

MS. SMITH: That's be awesome.

MS. GRIGSBY: Yeah. That sounds good, thank you. And then any -- so do you think that's something that we could get information on for the next meeting in May?

MS. WHATLEY: Yeah, I mean, that date's already set, right? May 10th --

MS. GRIGSBY: May 10th.

MS. WHATLEY: -- is that what I'm seeing?

MS. GRIGSBY: Yeah.

MS. WHATLEY: Yeah, with that, I mean, it's still two months. I would assume that we could probably get somebody there. I think that's probably plenty of time. But I can try to reach back out to you, Dr. Grigsby, probably in the next couple of weeks after I get an answer, and we can --

MS. GRIGSBY: Okay.

MS. WHATLEY: -- see for sure on that.

MS. GRIGSBY: Okay.

MS. WHATLEY: Can you remind me -- when do we need to have the May agenda set?

MS. GRIGSBY: I believe it's supposed to be set 30 days ahead of time; is that

correct, Kelli?

MS. SHEETS: Um --

MS. GRIGSBY: Wait, no. It's like a week ahead of time.

MS. SHEETS: Yeah, I like to get them ten days ahead of time, but a week is acceptable.

MS. GRIGSBY: Okay.

MS. WHATLEY: Okay. Give me a little time. Yeah, I'll definitely try to get an answer in the next couple of weeks if somebody would be available and willing to kind of come and present to the group. But I'll follow up with you if there's any additional questions or other details for that --

MS. GRIGSBY: Okay.

MS. WHATLEY: -- here in the next couple of weeks. Yeah.

MS. GRIGSBY: Okay. Good. So it sounds like, in terms of the next meeting, we will not have an ask for MCO partners. We're going to give you all a break for the next meeting, but thank you for your presentations today.

I don't think there are any recommendations that we need to make from the MAC since this is not a budgetary year in terms of the funding for mental health resources. If that's -- I mean, that was the one thing that came to mind. Is there anything in terms of recommendations to the MAC that any of the other members identified?

MS. SMITH: I can't think of anything.

MS. GRIGSBY: Okay. So MAC meeting representation, I believe, Kelli, do you have the date of that next meeting -- I believe these meetings are typically on a Thursday.

MS. SHEETS: I had trouble getting off mute. It is March 23rd.

MS. GRIGSBY: Okay.

MS. SHEETS: Which is a Thursday.

MS. GRIGSBY: Which is a Thursday, which takes Dr. Smith and myself out of being able to attend since we're both involved --

MS. SHEETS: That is an issue.

MS. GRIGSBY: -- clinically those days. Would any other member of the TAC like to be our representative for the MAC meeting?

MS. SMITH: Remind me what time they are, Kelli.

MS. SHEETS: It begins at 10 a.m.

MS. SMITH: Yeah, I can't do that, unfortunately.

MS. GRIGSBY: Okay. If any of the other members look at your schedule and realize that you have availability and are willing to sit in on that meeting, please reach out to me and let me know. Any other comments or thoughts about -- do we all want to stay on the line and just come up with the -- or do we want to touch base maybe later about the agenda for May? I guess we have to wait and see if there's anyone that can present, so perhaps we can touch base in the next couple of weeks about the May agenda.

MS. DIMAR: Okay.

MS. GRIGSBY: Okay. Any other comments?

(No response.)

MS. GRIGSBY: Do I have a motion to adjourn?

MS. SMITH: I'll motion to adjourn.

MS. GRIGSBY: A second?

MS. DIMAR: I'll second it.

MS. GRIGSBY: Okay. All in favor -- I've never heard anyone object to --

(Aye.)

MS. GRIGSBY: Aye? Yeah, I've never heard anyone object to adjourning a meeting. So thank you all for your time today. Thank you, especially to DMS and the MCOs for your excellent presentations. I learned a lot today. I learned there's a lot of good work going on out there around vaping and smoking cessation and tobacco use and cannabis use, so thank you all for all of your good work. Kelli, thank you for taking care of the group.

MS. SHEETS: Absolutely. Happy to do it.

MS. GRIGSBY: Will you be with us in May or will Erin be back?

MS. SHEETS: Erin will probably be

back, but I might be with you, as well.

MS. GRIGSBY: Okay.

MS. SHEETS: We haven't quite worked out the logistics of who's going do what once Erin gets back, but I'll probably be on, I just may not be your host.

MS. GRIGSBY: Okay. Well, thank you, again. And Alicia, if you can just e-mail the crew when you get some information, and then maybe we can work on the agenda for May and share that with Kelli. Okay?

MS. WHATLEY: Sounds great, thanks.

MS. GRIGSBY: Thanks, guys. Have a good rest of your day.

(Meeting adjourned at 3:30 p.m.)

* * * * * * * * * * *

CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim 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 2nd day of April, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR