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2 CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
3 DISPARITY AND EQUITY
TECHNICAL ADVISORY COMMITTEE MEETING
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12 Via Videoconference
September 6, 2023
13 Commencing at 1:03 p.m.

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Shana W. Spencer, RPR, CRR
22 Court Reporter

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1 **APPEARANCES**
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3 **BOARD MEMBERS:**
4 Jordan Burke, Chair
5 Wanda Figueroa Peralta
6 Julia Richerson
7 Catrena Bowman-Thomas (not present)
8 Patricia Bautista-Cervera
9 Marcus Ray (not present)
10 Kiesha Curry (not present)
11 Jeanine Lubuya (not present)
12 Elaine Wilson (not present)
13 Roger Cleveland (not present)
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1 **P R O C E E D I N G S**

2 CHAIRMAN BURKE: Welcome in,
3 everyone. I think most of you are probably
4 here with these routinely. But for those who
5 don't know, I'm Jordan Burke serving as the
6 current chair for the Health Equity and
7 Disparity TAC for Medicaid.

8 We've got a few topics to cover today.
9 As a heads-up, I am currently on call this
10 week. And so if, for some reason, I have to
11 quickly take a minute, I apologize ahead of
12 time.

13 So I've changed the intro a little bit.
14 I've decided to give Deputy Commissioner
15 Hoffmann a break from saying hello to us
16 every time, so we can just kind of try to get
17 into things. Since we don't have enough for
18 a quorum, we won't be able to approve minutes
19 or anything yet, so we will go ahead and move
20 into old business.

21 One thing we had spoke about last time
22 was a topic that we really hadn't gotten into
23 yet but was looking at the disparities in
24 maternal health. I think that we had
25 mentioned that Dr. -- I apologize if I say it

1 wrong but Dr. Theriot, who is one of the
2 people that -- I believe that you are, like,
3 medical director or something like that --
4 had covered that topic quite in depth before.
5 And so I didn't know if she would be
6 available to speak with us and kind of give
7 some insights into what she's been seeing and
8 working on.
9 MS. PARKER: I do not -- this is
10 Angie Parker with Medicaid. I do not
11 currently see her on the meeting. She has
12 done a presentation for the Medicaid Advisory
13 Council at the last one, so I do know that
14 they are -- she does have some information
15 for that. But she's currently working on a
16 dashboard for everyone that will be on our
17 website. But unfortunately, it doesn't look
18 like we have that present- -- or Dr. Theriot.
19 That's how you pronounce her name. It
20 doesn't look like --
21 CHAIRMAN BURKE: Gotcha.
22 MS. PARKER: -- it sounds.
23 CHAIRMAN BURKE: Theriot.
24 MS. PARKER: Theriot. But we can
25 certainly see about her having that prepared

1 for the next meeting.
2 CHAIRMAN BURKE: Yeah. And one
3 question for -- in sending these agendas out
4 and things like that, would it be easier --
5 so, like, as I'm going through the old
6 minutes and things like that and kind of
7 checking things off that I've seen, would it
8 be easier when I send the agendas out to kind
9 of put the name beside of it of the person if
10 I have, like, a certain question or thing I'm
11 asking for, to have that listed in the
12 agenda? I don't know if Erin or Kelli are
13 around.
14 MS. BICKERS: You're welcome to do
15 that. Some TACs do. I do send it to all DMS
16 staff and MCOs when it's received before I
17 post it on the website. It could just be
18 possible that she had a meeting conflict and
19 couldn't be here today.
20 CHAIRMAN BURKE: Okay. I just
21 wanted -- I didn't know if that was something
22 that's easier to work from your guy's end
23 rather than just guessing at what I'm looking
24 for.
25 MS. PARKER: Well, I can --

1 MS. BICKERS: It's your preference.
2 Oh. I'm sorry, Angie.
3 MS. PARKER: I'm sorry, Erin. I
4 was going to say, for me, sometimes I do have
5 to go back and -- I ask for the minutes, so I
6 make sure that I am addressing things that
7 were brought up at the last meeting. And
8 sometimes I'm a little delayed in seeing --
9 reviewing those meeting minutes, but it
10 doesn't hurt to maybe elaborate under an
11 assigned person.
12 But as Erin said, she does let -- she
13 does provide the agenda to all of us, and we
14 do look at that. But sometimes we may not
15 have -- if we haven't participated in the
16 last meeting, we may not know what exactly
17 the request is.
18 CHAIRMAN BURKE: Okay. Yeah. And
19 I -- that may be something in the future that
20 might be a little easier to work out,
21 especially if I have some specific question
22 I'm trying to get to.
23 Okay. We can move on. If she were to
24 join later on, we can ask. Or if anyone else
25 that's here, you know, that isn't her, has

1 been working on that and can discuss some
2 things, I'm also open to that. Okay.
3 MS. BICKERS: I -- sorry, Jordan.
4 This is Erin. I do have a presentation that
5 she shared with, I believe, the Children's
6 TAC last month that's on our website, so I'm
7 happy to send that to you guys if you would
8 like to see the presentation Angie was
9 speaking about.
10 CHAIRMAN BURKE: Sure. Yeah. It
11 won't hurt to review it. Okay. We can move
12 on.
13 A couple of topics we had talked about
14 last time and we got some information on was
15 interpreter services and the grievance
16 processes. For interpreter services, I think
17 the thing that we had been trying to pin down
18 was a quicker and more accessible way for
19 people to get in contact, you know, with an
20 interpreter rather than going through the --
21 like the entire service line.
22 And I think that was something that --
23 one of the MCOs basically said, you know,
24 that wouldn't be possible given how their
25 setup is. But a couple of others had

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1 commented that might be something they could
2 work on to try to get a more direct line. I
3 didn't know if any discussions have happened
4 with that with the MCOs and if there is
5 anything that they're working on at this
6 point.
7 MS. PARKER: Do any of the MCOs
8 want to speak to that that are on the call?
9 CHAIRMAN BURKE: And if not, that's
10 fine. We had --
11 MS. CLEMENTS: Leslie Clements --
12 oh. Sorry, Jordan.
13 CHAIRMAN BURKE: No worries. We
14 had spoken -- or Dr. Figueroa and I were
15 talking before this one a couple weeks ago.
16 And although we had gotten all that
17 information sent to us kind of -- you know,
18 the background on how the current services
19 are set up through interpreter services, we
20 were wondering if there was a way that we
21 could, you know, get a presentation from the
22 MCOs maybe at the next TAC meeting on both
23 the interpreter services and the grievance
24 processes just because, you know, it's always
25 helpful to kind of review the process they

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1 have in place. And so if they were to
2 discuss them with us, maybe we could look at
3 some things, maybe pitch some ideas on ways
4 to improve.
5 I saw that -- I think it was
6 UnitedHealthcare had tested the actual time
7 to see like, you know, once you call the
8 service and you go through the different
9 directions and things like that to actually
10 get to an interpreter. They didn't put a
11 specific thing down there.
12 You know, I could attest to that myself.
13 But I don't want to, you know, necessarily
14 tie up their lines for calls that end with,
15 you know, I was just seeing how long this
16 would take. But if that was something that,
17 you know, the MCOs could look at.
18 Just -- you know, although they have
19 that line in place, is there -- do they
20 really know how long it takes to get through?
21 Is it a reasonable amount? If it takes 15,
22 20 minutes, that's an entire visit with the
23 patient; right? So that's a long time.
24 And if there is vast differences in how
25 long that takes to access, is there any way

1 that, you know, they could look at other
2 MCOs' ways of how it's set up to kind of
3 hasten that. But yes, a presentation on that
4 would be great. Then obviously --
5 MS. BICKERS: Jordan, I can -- this
6 is Erin again. I'm sorry. I can send that
7 formal request out to the MCOs after this
8 meeting.
9 CHAIRMAN BURKE: Okay.
10 MS. BICKERS: To have that prepared
11 for the next meeting.
12 CHAIRMAN BURKE: Yeah. And,
13 obviously, a direct line like Dr. Richerson
14 has requested would be great. So if they're
15 open to that idea, that would be awesome.
16 MS. CLEMENTS: Hey, I'm back. I'm
17 so sorry. I know I was cutting out with my
18 audio. Are you able to hear me okay this
19 time?
20 CHAIRMAN BURKE: I can.
21 MS. CLEMENTS: Excellent.
22 All right. So we actually do have a
23 presentation at Humana that I've got ready to
24 go if that would be helpful, and it includes
25 a direct line.

1 CHAIRMAN BURKE: Okay. Sure. I
2 don't think we have any other presentations
3 actually scheduled for the day -- correct? --
4 unless someone actually has the GARE tool
5 that's available to present today.
6 MS. BICKERS: No, sir. I had sent
7 out an email to let them know that the
8 presentation would be requested at this
9 meeting, so I was not prepared for anyone to
10 present.
11 So give me just a second and, Leslie,
12 I'll make you a cohost.
13 MS. CLEMENTS: Okay. Thank you.
14 DR. RICHERSON: Before Leslie goes,
15 I have a quick question for DMS. The
16 messaging around easy access to free
17 interpreters through the MCOs is so
18 important, as we've talked about. I don't
19 think I have to go into the disparity issues
20 around language access.
21 Is there a point person within DMS that
22 can organize it and get it all together and
23 then have a communication from DMS instead of
24 trying to get communications from all the
25 MCOs? I think we really want, say -- if we

1 really want people to use it, then I think a
2 communication from DMS with all the direct
3 phone lines, all of that in one communication
4 would be really helpful. Because if people
5 get information kind of piecemeal from all
6 the different MCOs, it's going to not have as
7 big of a potential impact.
8 So who's, like, the DMS point person for
9 language access? Is there one?
10 MS. PARKER: Well, that's a very
11 good question. I don't know that anybody has
12 specifically been assigned to that. But,
13 obviously, within our Equity and Determinants
14 of Health branch being one of those things
15 and why we have this TAC, that could
16 certainly be something that we look at in how
17 to best put that information together.
18 DR. RICHERSON: Thanks.
19 MS. PARKER: Yeah.
20 CHAIRMAN BURKE: I think if Leslie
21 has her presentation, she can go.
22 MS. CLEMENTS: Are y'all able to
23 see my screen?
24 CHAIRMAN BURKE: Yep.
25 MS. CLEMENTS: Great. Thanks for

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1 confirming.
2 Okay. So I did a little digging. I am
3 still new to my role as Humana's Associate
4 Director of Health Equity, so this is a great
5 opportunity for me to learn a bit more about
6 the resources that we provide to our
7 enrollees as well as to the providers that we
8 partner with. And so we do have a direct
9 line.
10 What you see on my screen right now is a
11 very brief explanation of what language
12 assistance services Humana has to offer. So
13 we do have the flyer that you see on the
14 right-hand side of the screen, and I'm very
15 happy to make sure that everybody has access
16 to this deck. So anyone is welcome to use
17 it.
18 You can click on that image, and it will
19 actually take you to the printable flyer in
20 case you want to have that available. And
21 that might be a good resource for the DMS
22 person that's pulling together all of the
23 information for each MCO.
24 We also have a page on our website that
25 also talks about all of the various services

1 that we offer as it relates to our language
2 assistance program, and there's information
3 about it in our provider manual. So we have
4 information published in multiple places.
5 We also have access to an email address.
6 So if you do still have questions after
7 reviewing the materials that we've talked
8 about here, you are welcome to reach out
9 directly to the team at Humana that manages
10 these services.
11 But where you really want to pay
12 attention is that phone number at the top of
13 the screen there in green where it says any
14 provider who needs assistance with over the
15 phone or sign language interpretation, you
16 can call that phone number. They will take
17 the member's ID from you and then they'll be
18 able to get you connected to the
19 interpretation service.
20 The great news is when you call that
21 line, it's going to take you to a Humana
22 associate, a real live human being who will
23 be able to talk to you and help you, so you
24 won't be forced to go through a phone tree.
25 We also put together just a little bit

1 of information on this slide about, of
2 course, what providers also are required to
3 provide. I'm sure everybody here is very
4 familiar with that. And part of why we think
5 it's really important that both we on the MCO
6 side and the providers have access to
7 interpretation services, it really does -- as
8 you've already pointed out, Dr. Richerson, it
9 helps to avoid some of those disparity gaps
10 that we see.
11 I'll pause for just a moment and see if
12 there are any questions folks might have
13 about either of the slides that I've shared
14 here.
15 (No response.)
16 MS. CLEMENTS: Okay. The last
17 slide that I have, I thought this was kind of
18 interesting, just to give you a view of what
19 we're experiencing with our Humana enrollees.
20 Over the first six months of the year, we saw
21 about 2,100 of our members who do not have
22 English as their first language leverage our
23 language interpretation services. So you can
24 see what that utilization looks like on this
25 pie chart.

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1 DR. RICHERSON: Is that available,
2 the number, after hours and on weekends, or
3 is it -- how does that work?
4 MS. CLEMENTS: Very good question.
5 I believe it should be, but I will confirm
6 for you. And I will share that information
7 back with the person that coordinates this
8 meeting.
9 DR. RICHERSON: Thanks.
10 CHAIRMAN BURKE: And,
11 Dr. Richerson, is that type of setup -- and,
12 again, I mean, I haven't accessed it to see
13 how it actually goes. But is that more of
14 what you're trying to get set up for each
15 one? Because, again, you access these more
16 than I do.
17 DR. RICHERSON: So, ideally, it
18 would be less than ten seconds to get an
19 interpreter, so that's -- I think that's what
20 we're shooting at -- shooting for. And I say
21 that for two reasons. One is, for us,
22 because we're so high volume. We're 80
23 percent non-English speakers; right? So
24 we're moving. And if I have to wait two
25 minutes per call, that -- I could have seen

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1 another patient; right?
2 So we want -- but it's also for people
3 that are lower volume that are like, oh, this
4 is going to take, like, too long. I'm just
5 not going to do it. I'm just going to do it
6 without an interpreter because the family
7 speaks a little English. So that speed is so
8 important, and so I think it all depends.
9 So with the Humana line, if I'm on --
10 you know, if I'm on hold, you know, 45
11 seconds at this spot and then 45 seconds at
12 another spot and 30 seconds at another spot,
13 then -- then you're looking at, it's too long
14 because it's a barrier so...
15 CHAIRMAN BURKE: Yeah.
16 DR. RICHERSON: So I think it just
17 depends on testing and internally maxi- --
18 you know, getting it as quickly as possible
19 and decreasing any barriers.
20 CHAIRMAN BURKE: Yeah. It's -- I
21 guess it is hard on both ends, though; right?
22 Like, by the time you call and you give the
23 number or you give the patient's name and you
24 give their, you know, date of birth and
25 they're able to match that and find the

1 interpreter that's available -- because they
2 can't just have 1,000 interpreters sitting
3 there, you know, waiting for one person. I'm
4 sure they're all in use at different times.
5 So currently as is -- right? -- if you
6 have an interpreter that worked at your
7 clinic -- right? -- you wouldn't -- like,
8 there's not reimbursement for that
9 interpreter; correct?
10 DR. RICHERSON: Correct.
11 CHAIRMAN BURKE: The clinic just
12 has to pay them.
13 DR. RICHERSON: Right.
14 CHAIRMAN BURKE: That seems like --
15 like, is there any particular reason why that
16 isn't a service that isn't covered for
17 clinics, like, that having an interpreter on
18 site isn't something that's reimbursed?
19 DR. RICHERSON: That's a good
20 question.
21 CHAIRMAN BURKE: Because that seems
22 like the most direct way to decrease that
23 barrier; right? You no longer need to call a
24 line. They no longer have to see if somebody
25 is someone waiting around. If you have the

1 provider that's, you know, needing that
2 person, they're right there.
3 DR. RICHERSON: I'm assuming all
4 the MCOs are just, then, connecting us to a
5 national interpreter line. I'm assuming it's
6 not really their staff that are answering.
7 You're probably just connecting us to
8 whatever your paid service is.
9 CHAIRMAN BURKE: Yeah. Like a
10 third party.
11 MS. CLEMENTS: That's true. We do
12 at Humana have some Spanish-speaking
13 associates, of course, since that is the
14 primary secondary language that we encounter.
15 But you're correct, Dr. Richerson. For the
16 most part, you're being connected to a third
17 party.
18 DR. RICHERSON: And so -- I think
19 I -- so in a perfect world, we would have one
20 phone number for all of Medicaid; right?
21 That would be a perfect world. We'd dial
22 1-800 number. We could -- whatever. But if
23 we're going through all the MCOs, we just
24 want to minimize that -- the lag, that time
25 to be connected.

1 Because I just called that number,
2 Leslie. So there's music that plays. You're
3 on hold. And then it connects you to an
4 operator and then you're on hold and then
5 somebody picks up. So there's still -- even
6 though it's not a phone tree, which is great,
7 there's still multiple hold spots when I -- I
8 mean, at 1:00 in the afternoon when I just
9 called.
10 So I just think we need to just keep
11 pushing and analyzing and everybody looking
12 at their processes and testing them and
13 seeing what reality is.
14 CHAIRMAN BURKE: Okay.
15 DR. RICHERSON: But your question,
16 Jordan. We have so -- we can't afford to
17 have enough on site. So even if I have four
18 interpreters in the building, I still have to
19 call our outside line. Because there's ten
20 providers, and there's people in the front,
21 and there's people in nursing. And there's
22 people in the provider's room. There's
23 people in the lab.
24 CHAIRMAN BURKE: Yeah.
25 DR. RICHERSON: So...

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1 CHAIRMAN BURKE: Yeah. They can't
2 be everywhere at once.
3 DR. RICHERSON: Yeah.
4 CHAIRMAN BURKE: It looked like
5 Rachel was asking -- oh, sorry. One second.
6 MS. BICKERS: I can read Rachel's
7 question. It said: Could you use a
8 community health worker to help with
9 connecting to the translator while at the
10 provider's office? And then Jonathan Scott
11 also dropped some regulation information that
12 I'll copy and send out to the TAC.
13 DR. RICHERSON: So I guess I'll
14 respond to that question. So if we -- we
15 don't have any community health workers.
16 We're still exploring whether or not the
17 payment rates at FQHCs is -- how that's going
18 to work and all of that stuff. So I'll tell
19 you, if we could afford a community health
20 worker, I would have -- they would be, like,
21 helping people get food and not waiting on
22 hold for an interpreter.
23 I just think that nobody should have to
24 wait. It's not that it's a burden on me as a
25 provider. I think that if we're real -- if

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1 we're really serious about language access,
2 it should be almost immediate, which is what
3 we can get in the office with our interpreter
4 phone. I get the phone. I push the number.
5 We pay for it, and I have an interpreter
6 within three seconds.
7 So I think that's just what we should
8 all not settle for less than. And we're not
9 there yet, but I think we could still keep
10 working toward that. It should be almost
11 immediate.
12 Because you're talking people in the ER.
13 You're talking subspecialists, I mean,
14 dentists. Everybody wants that universal
15 fast access. But baby steps are great, and
16 continuing to look for -- get those lines
17 with no phone tree is a great first step.
18 MS. CLEMENTS: Yeah. Thank you for
19 your feedback, Dr. Richerson, and I really --
20 I'm very intrigued by your good idea that --
21 you know, what if we all had one line that
22 everyone was able to dial and get that
23 immediate access. And I don't have enough
24 familiarity with all of the state regulations
25 in place that I displayed on the second slide

1 that I shared. But, certainly, that is --
2 that's an excellent idea and one that would
3 be interesting to pursue.
4 CHAIRMAN BURKE: Okay. I think --
5 it looks like Tabitha in the chat said Anthem
6 also had a presentation they would like to
7 present if you're done, Leslie.
8 MS. CLEMENTS: Yes. Thank you so
9 much.
10 MS. ROSS: Hi. Good afternoon.
11 Let me share my screen. This is our
12 presentation as well. Give me one second to
13 share. Are you all able to see that screen
14 just yet?
15 CHAIRMAN BURKE: We can now.
16 MS. ROSS: Okay. So for Anthem
17 Medicaid, just a little bit about our
18 interpreter services and line as well. As
19 you see, we have -- I'll go here. As far
20 as -- everything that we are presenting today
21 can be found in the member handbook as well
22 as online. Those services are available
23 for -- our member services line is available
24 7:00 a.m. to 7:00 p.m. Monday through Friday.
25 So anyone who is seeking interpreter

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1 services, they can contact our member service
2 line to be able to get those as well as if
3 they need translation of written materials.
4 So we do have that available. And, of
5 course, any and all of our interpreter
6 services are provided at no cost to any of
7 our members.
8 As far as different types of services,
9 we do have the face-to-face available so that
10 they -- a provider would -- an interpreter
11 would be able to come into the offices, if
12 necessary. That does take some lead time to
13 request that service for an individual to be
14 on site, if needed, as well as sign language,
15 if that's necessary. We do have telephonic
16 interpreter services available.
17 And, also, we have associates who are
18 member speaking as -- Spanish-speaking as
19 well. So if an individual does not speak
20 Spanish or needs an additional language, we
21 do have that available as well as our nurse
22 line, so that -- there's interpreter services
23 available for that as well as for hearing
24 impaired.
25 Our providers are able to also contact

1 our case management department and request
2 interpreter services. There is a form that
3 can be filled out for that or called in as
4 well so that you can request those services.
5 Again, as we were talking about before,
6 we do have different types of alternative
7 formats, so braille, large print, or audio.
8 If those are needed, we definitely can offer
9 those upon request.
10 (Brief interruption.)
11 MS. BICKERS: If you're not
12 speaking, please mute. Sorry about that.
13 MS. ROSS: And then, of course, we
14 are just -- we're able -- our primary
15 language is English. We do also have five
16 percent or more of our population that speaks
17 Spanish, so we do translate our materials
18 both in English and Spanish. And those are
19 available on our member web portal, if
20 necessary, for anyone.
21 Utilization. We had 80 members that
22 were from 2022 to 2023 that had requested
23 translation services, and so there's the
24 breakdown. That's January through July of
25 this year. And then we also had 287 requests

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1 for face-to-face services for our individuals
2 for that.
3 Various different language requests.
4 You see there, we have about 13 or 14 other
5 languages besides English and Spanish that
6 have been requested, and we were able to
7 offer those services utilizing our
8 interpreter language line.
9 And then I think there was a question
10 that was about grievance and how we go
11 through the grievance process, so we've
12 included that as well. Members are able to
13 either call us via our member services line
14 and/or write in a formal complaint. You can
15 submit those to this phone number or an
16 address, and we do respond to those.
17 We have the information that's available
18 as far as how you will receive notification.
19 So within five days of receiving the
20 complaint, we will notify you that we've
21 received that and then we will also let you
22 know how we have resolved it within those
23 30-day time frame.
24 If you -- if, for some reason, a member
25 does not -- is not happy with the information

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1 that they've received or the resolve, then
2 they are able to take this to the Medicaid
3 managed care ombudsman program as well to
4 seek further assistance.
5 And they can also file via a form. So
6 there's another form that all MCOs use, and
7 they can fax this form in to us directly as
8 well utilizing the different modalities. And
9 that's our presentation.
10 DR. RICHERSON: Can you go back to
11 the phone number slide?
12 MS. ROSS: Sure. Absolutely. I'm
13 sorry. Let me share.
14 DR. RICHERSON: And it reads that's
15 what the member calls, but does the medical
16 provider or the dentist or behavioral health
17 call that same number for interpreter?
18 MS. O'BRIEN: That's more for the
19 member calls, Dr. Richerson --
20 DR. RICHERSON: Okay. So who --
21 MS. O'BRIEN: -- when they call in.
22 I know what you're asking for. Most of the
23 things that we get that deal from the
24 provider, actually, they send in the forms to
25 us so that we can get the interpreter

1 face-to-face in the office.
2 DR. RICHERSON: So it -- so we
3 definitely need the option to call in
4 ideally.
5 MS. O'BRIEN: I -- I know we don't
6 have the option right now that you could call
7 directly in and have an interpreter on the
8 phone within ten seconds. I know that for
9 sure. There's --
10 DR. RICHERSON: Is there --
11 MS. O'BRIEN: And I know there's
12 been plenty -- in that Iroquois area, I know
13 you have a lot of refugees in that area that
14 you're seeing so...
15 DR. RICHERSON: So is there a
16 number at all that providers can use, say, if
17 somebody is having a mental health
18 appointment or a dental appointment? Is
19 there a number --
20 MS. O'BRIEN: Most of that, we --
21 most of the ones that were, like, on that
22 list of where it was showing that, where
23 they're face-to-face, most of those are
24 coming from either behavioral health or from,
25 like, speech and OT, PT types of services.

1 DR. RICHERSON: But there's no
2 telephone option right now?
3 MS. O'BRIEN: There's not a
4 telephone option to just pick up the phone if
5 somebody walks into your office, and you have
6 to call and have an interpreter service.
7 DR. RICHERSON: Is that something
8 you all are talking about internally as a
9 possibility?
10 MS. O'BRIEN: It would be something
11 we would have to talk to our subcontractors
12 about because most of the MCOs are -- I'm not
13 sure about Humana. But a lot of them have,
14 you know, subcontractors who actually, you
15 know, do those services. So that would be
16 something we would just have to talk to them
17 and also look at what -- I would be
18 surprised, the ten seconds.
19 I know what you're trying to -- I
20 understand because, you know, I ran the Home
21 of the Innocence. And we saw a lot of
22 different refugees but also our population,
23 and it was tough to always have a
24 face-to-face. Sometimes we were able to get
25 the face-to-face, of course, because we had

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1 the schedule, you know. So we knew who was
2 coming in next week and all of those types of
3 things. But it is a challenge in the
4 offices, I understand.
5 We ended up having to actually get our
6 own contract with Catholic charities and then
7 also with Pacific -- I think it was called
8 Pacific Interpreter Service to serve the
9 members as they came in the door.
10 DR. RICHERSON: Right. That's what
11 people are doing now and we're trying to move
12 away from because there's so -- so much
13 inconsistency among offices. And so we want
14 that -- we want that really simple,
15 straightforward, this is how you get it.
16 MS. O'BRIEN: I understand that,
17 Dr. Richerson. I understand where you're
18 coming from, too. So it's kind of a -- it's
19 a hard balance, I think, between walk-ins,
20 emergencies that come in the door and how to
21 handle that, too, you know, or last-minute
22 scheduling that somebody cancelled. And
23 that's another whole issue within itself.
24 DR. RICHERSON: Yeah. And it's not
25 so -- I just want to be clear. It's not so

1 much mine. We've got it figured out. It's
2 extremely expensive, but we've got it figured
3 out.
4 MS. O'BRIEN: Yes. Yes.
5 DR. RICHERSON: I'm worried about
6 my patients that are at the emergency room
7 and at the dentist and that's at private
8 subspecialty offices that --
9 MS. O'BRIEN: Right.
10 DR. RICHERSON: -- still tell
11 people to bring an interpreter with them. I
12 think DMS needs to know there are still
13 practices that say we will not use an
14 interpreter. They have to bring an
15 interpreter with them. So that is still
16 there, so we want to move away from that,
17 make it so --
18 MS. O'BRIEN: Yes. So if there are
19 some specialties that are doing -- yes. They
20 can -- like, and usually the specialists will
21 have schedules, you know, pretty much set,
22 and we do have a way for them to get a
23 face-to-face person. So I'm not sure where
24 the disconnect is with that piece, but thank
25 you for bringing that up.

1 CHAIRMAN BURKE: All right. If the
2 other MCOs at the next meeting want to
3 present theirs as well, so we can look
4 through at how their things are set up, that
5 would be great.
6 And, again, looking at disparity and
7 equity, as Dr. Richerson said, I mean, that's
8 a key point. Communication is obviously so
9 important with people's health care, making
10 sure that things are clearly informed to the
11 people.
12 The grievance --
13 MS. PARKER: Can we get -- I just
14 wanted to -- sorry, Dr. Burke. We will get
15 that information that the MCOs have been
16 providing and see if we can find a common
17 thread with that as well. We'll look into
18 that.
19 CHAIRMAN BURKE: Great. Same with
20 grievance processes. We had gotten the huge
21 file going through each of the different
22 grievance process setups for the different
23 MCOs. So I appreciate Anthem for showing at
24 least a little bit of theirs.
25 I mean, it seems fairly dense material

1 on how the whole -- the thing is set up and
2 the timelines. And I'm sure that for a lot
3 of members, that's a difficult thing to work
4 through if they are trying to, you know, file
5 a grievance.
6 Sorry. I was reading the chat real
7 quick. Yeah. Leslie was saying that she
8 thinks that goes against some regulations,
9 requiring patients to bring their own
10 interpreters. So that's why, you know,
11 having that grievance process being easy to
12 access so they can bring something like that
13 up if that's a problem they're facing, that
14 would be great for the patients.
15 But yeah, if the MCOs can present some
16 of their grievance processes at the next
17 visit, so we can try to figure out a way to
18 maybe streamline that or make it easier for
19 patients if they are experiencing those
20 problems.
21 Care gaps was something that was brought
22 up at the last visit. I think it was
23 actually Stuart Owen who had mentioned it.
24 He said that -- because Catrena had
25 questioned about, you know, certain -- people

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1 should know going to certain providers and
2 not, you know, experiencing the care that
3 they should and whether that's, you know,
4 just that provider or if there's, you know,
5 possibly, like, an underlying -- whether
6 known or not -- bias for how they're treating
7 their patients, which results in different
8 healthcare outcomes.
9 And he said at one point that they
10 can -- they can see, you know, the quality
11 measures and things like that for patients.
12 But he said, I believe at one point, that it
13 isn't broken down by, you know, race or
14 anything like that.
15 I didn't know if that would be something
16 that could be possible to access data on, not
17 to, like, you know, villianize or demonize
18 providers, you know, if they have large gaps
19 but at least so they -- providers could be
20 shown, you know, the differences in outcomes,
21 whether patients of certain color are having
22 different outcomes at their own clinics
23 versus others. So they can review their
24 processes and try to, you know, improve them.
25 I don't know if that's accessible in the

1 data.
2 I know that you guys had said a lot of
3 the -- a lot of the problem is that, you
4 know, race and stuff isn't put into that
5 information, so I don't know if it would be
6 accessible or not.
7 MS. PARKER: Are you asking this of
8 the MCOs?
9 CHAIRMAN BURKE: So -- so, I guess,
10 yeah. Do the MCOs -- when they look at care
11 gaps for providers, is there a way --
12 MS. PARKER: Is it broken down by
13 race?
14 CHAIRMAN BURKE: Yeah.
15 MS. PARKER: Well, they should have
16 that capability if they have the information,
17 and they are to be tracking that if -- you
18 know, if they do have challenges like we have
19 challenges in the tracking of person's race
20 and ethnicity. But if they're currently
21 doing that -- I would have to defer again to
22 the MCOs, but that is something that they
23 should be able to break down within their
24 systems.
25 MS. ROSS: Yes. This is Tabitha

1 from Anthem. In regards to that, that is one
2 of the things that we're able to do, is look
3 at stratification based on race or age or
4 gender, so different things as we're looking
5 at some of those clinical outcomes to see how
6 we can better improve those as well.
7 CHAIRMAN BURKE: And are you guys
8 looking at that from, like, a region
9 perspective or provider perspective or, like,
10 institution perspective to see if there are
11 areas that, you know, clearly something is
12 different at that institution or place versus
13 others to try to improve?
14 MS. ROSS: Yes.
15 CHAIRMAN BURKE: Or is it more
16 statewide that you're looking at?
17 MS. ROSS: Yes. So we have taken
18 the approach to be -- to look at the member
19 specific, so looking at the member. And then
20 we're also looking at, like, geography, so
21 maybe where they will be, future steps of
22 what we're looking at that -- we would like
23 to -- we have the capability right now, but
24 we're wanting to delve deeper into that as to
25 be able to match those to the providers as

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1 well. So you can kind of see, you know, if
2 there are opportunities within each one of
3 those, how can we best help support those
4 individual providers to help the members to
5 be able to close those gaps?
6 CHAIRMAN BURKE: Okay. Again, I
7 think it's something we've kind of talked
8 about from the beginning, is that, you know,
9 there's a lot of data that you can get or
10 retrieve. But it's how to interpret it or
11 use it at that point, I think, that -- we've
12 seen that a lot between the last meeting and
13 this one. Because we've got different things
14 sent to us, and I'm trying to just figure out
15 the best way to actually reason through them,
16 which, I mean, goes into the next one.
17 We got some information from the
18 out-of-care -- or out-of-network utilization
19 from the different MCOs. Thankfully, it
20 looks like they had given that information to
21 another TAC as well so more accessible.
22 I was trying to look through the
23 numbers, and I don't see any specific
24 patterns necessarily that says that, you
25 know, one area is more of need. There was a

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1 fairly -- like a pretty vast difference,
2 though. One of the MCOs had only had, I
3 think, less than, like, 100 of these single
4 case agreements, and others were, like, in
5 the thousands. I don't know if that was
6 specifically because they have more providers
7 in their network or, for some reason, they're
8 only centered in the middle of the state
9 where people don't go as far. I don't know,
10 but I thought that was interesting at least.
11 I can't remember the exact one at this point.
12 Anything that anyone else had seen when
13 they were looking at that to -- that stuck
14 out to them as far as, you know, what was
15 being accessed out of state?
16 (No response.)
17 CHAIRMAN BURKE: No. Yeah, me
18 either. I thought it would be useful, but
19 when I looked at it, it was kind of just
20 nothing.
21 Okay. So immunization fee adequacy. I
22 know, Dr. Richerson, you had sent me a little
23 bit on this. It was fairly recent, so I
24 didn't get to review it as much in detail.
25 DR. RICHERSON: Yeah. I think

1 we're just communicating back and forth, the
2 team on the email group. I'm still waiting
3 to hear from community -- some
4 community-based providers on what their
5 contracted rates are for vaccines just so we
6 can get some -- the most up-to-date
7 comparisons for some of the more expensive
8 vaccines, so we will keep reporting back.
9 CHAIRMAN BURKE: Okay. All right.
10 And then value-added benefits was, like,
11 another little area that we had discussed at
12 the last meeting. I didn't know if anyone
13 had had any thoughts on, you know, additional
14 ways to try to use those.
15 I know, Dr. Richerson, you had mentioned
16 value-added benefits aren't always something
17 that moves the needle, but is there a way to
18 kind of change those or ways the MCOs can
19 kind of collaborate on what actually is
20 effective? I mean, even though -- you know,
21 I'm sure ideally, they offer different
22 services in order to be, like, more unique
23 and to try to get certain patients to go with
24 them. I mean, it's best if they're actually
25 using those types of things.

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1 So are the MCOs looking at -- you know,
2 like, we've had this information sent to us;
3 right? It looked like the gas cards and
4 things like that were really used, and there
5 were other services that weren't. Are they
6 reviewing those types of things to try to
7 make value-added benefits and stuff more
8 enticing for patients to use to access
9 things, or is that something that isn't
10 currently being looked at?
11 MS. ROSS: This is Tabitha from
12 Anthem. Yes. That is included in part of
13 our strategy, you know, in trying to see, you
14 know, what are those benefits that are going
15 to be the most beneficial to be able to help
16 support those members. How can we best
17 improve their health outcomes? So matching
18 what value-added benefits could support
19 those.
20 So things like you mentioned before, the
21 gas cards. If we can help to be able to
22 provide the gas cards to be able to connect
23 them to get to a doctor's office, that's
24 something that we're going to do. Or is it
25 something that we have as far as maybe an air

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1 fryer or something like that? How can we
2 make sure that that healthy cooking can be
3 connected to chronic conditions, in
4 supporting those?
5 So we do look at what we're offering and
6 how they're actually going to benefit the
7 member and their health.
8 CHAIRMAN BURKE: And I --
9 MS. CLEMENTS: And I'll second what
10 Tabitha said. You know, we at Humana are
11 also evaluating constantly, you know, what
12 does the utilization of our benefits look
13 like and trying to break that down by our
14 enrollee demographic, too; right?
15 So if we were to find out that, you
16 know, only members who are based in
17 Louisville are using a particular benefit,
18 well, then, that tells me there's a gap. And
19 so how can we potentially close that gap for
20 our members who may live in other parts of
21 the state, or whatever that disparity looks
22 like.
23 So we're also, you know, always trying
24 to make sure that we're providing the most
25 appropriate benefits that are going to be of

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1 the best use for our enrollees.
2 CHAIRMAN BURKE: Okay.
3 DR. RICHERSON: I would just add, I
4 think this would be a really interesting
5 thing to really look deeper on. I know it's
6 so hard; right? So we have Medicaid but then
7 we have all the MCOs. And I think that
8 sometimes it's hard to look at it from a big
9 picture perspective because we have all the
10 details of all the programs from the MCOs.
11 But as a tool -- as a Medicaid tool to
12 improve equity, is there anything that we can
13 ask for -- ask the TAC for or something like
14 that to say, okay, let's go up a few levels
15 and say, all right. So let's look at the
16 programs as a whole, and have they had an
17 impact, and what some strategies could be
18 sort of looking at the state as a whole.
19 For example, I love the idea of
20 value-added benefits. My patients don't --
21 I've mentioned this before. No -- like, I'll
22 show them these things I pick up at meetings,
23 and they have no idea that they're available
24 for their children, even for the well-child
25 visits.

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1 So that's just one example of -- you
2 know, as a strategy for the state to improve
3 health outcomes, how do we work better to get
4 it in front of people? I don't know. Just
5 as an example.
6 So I guess my question is: Is there a
7 way to look at it from a higher level to
8 really analyze the impact on equity, using
9 health -- value-added benefits as an equity
10 tool? Because I've gone to meetings, and
11 I've been told that the uptake is less than
12 10 percent across the board for all
13 value-added benefits if you look at
14 everything.
15 MS. CLEMENTS: Yeah. I think
16 you're absolutely right, Dr. Richerson. And
17 I think that sometimes, you know, enrollees
18 are confused about what is something that is
19 covered by standard Medicaid versus what is
20 it that, you know, Humana offers versus what
21 Anthem offers. So I think you're right, that
22 that definitely contributes to low
23 utilization rates.
24 And I really appreciate what you're
25 proposing here about: Could we look at it

1 from a statewide perspective? Maybe some of
2 those value-added benefits should be part of
3 what is covered standard by Medicaid across
4 the board.
5 I think it would also be really
6 helpful -- and this is something that I'm
7 looking into for our Humana enrollees. But,
8 you know, I think everybody would benefit.
9 Do we know exactly what it is that all of our
10 enrollees want and what they need?
11 You know, I've been an employee of
12 Humana for a very long time. And,
13 periodically, our human resources department
14 will survey us and allow us to give feedback
15 on what kinds of benefits are most valuable
16 to us.
17 And so I think it would be really
18 beneficial if the State would be interested
19 in partnering with us as MCOs to also get
20 that kind of broad perspective from all
21 Medicaid beneficiaries. You know, we do that
22 individually as MCOs. We survey members. We
23 talk to members. But I think that seeing it
24 from a statewide perspective really would be
25 helpful.

1 DR. RICHERSON: And then maybe not
2 having it bringing up to DMS paying for it
3 but having DMS mandating certain value-added
4 benefits. I don't know if there's -- any of
5 them are mandated or -- but if we know that
6 access to a cell phone is universally
7 important, then why can't all the -- and
8 maybe all the MCOs do. That might not be a
9 good example. But having some common,
10 more trans- -- easier to understand.
11 MS. MILLER: Dr. Richerson, this is
12 Kate Miller. I'm the whole health director
13 at Anthem. One of the things -- and I don't
14 know. Angie Parker, you might know the
15 answer to this. But some -- I'm wondering if
16 there is the capacity to maybe have a QR code
17 that takes -- that all doctors could hang in
18 their offices that says: Do you have
19 Medicaid in Kentucky? Do you need help?
20 Scan this QR code.
21 And then the QR code then goes to, like,
22 a landing page where, then, they would click:
23 I have Anthem. I have Humana. I have
24 WellCare. I have Molina by Passport, you
25 know, like whoever. United. I'm sorry. I'm

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1 trying to not leave anybody off. Aetna. You
2 click on, then, your particular Medicaid
3 insurer that, then, would take them to things
4 like the community resource page that every
5 MCO has, you know, for their members to have.
6 Has, you know, click here to access your
7 healthy rewards.
8 Like, each MCO would be responsible for
9 doing their own page. But if we could have,
10 like, one landing page that could have a QR
11 code that all providers could hang in their
12 office and then people could be directed to
13 it. I don't know. That's just my vision for
14 the perfect world.
15 MS. PARKER: If we only lived in a
16 perfect world. But no, I -- Kate, that's
17 obviously something to potentially explore.
18 That could be something we would add to one
19 of our population health or quality meetings
20 to kind of discuss.
21 DR. RICHERSON: Yeah. I think --
22 MS. PARKER: I mean, sometimes you
23 have to look outside the box on things so...
24 MS. MILLER: And I think that all
25 the managed care companies would be happy to

1 come together and make that happen. I mean,
2 I think that that's something that benefits
3 all of Kentucky. That's something that we
4 all could, you know, lock arms and play red
5 rover, you know, and make that happen so...
6 MS. ROSS: And I think this goes to
7 speak to -- this is Tabitha, sorry, with
8 Anthem again. I think it goes back to
9 Dr. Richerson's comment about just
10 communication and people knowing about
11 difference services; right? So not only
12 would it be something -- maybe that QR code
13 would be able to be in our provider offices
14 but, you know, maybe our community-based
15 organizations.
16 As we're expanding this, like, putting
17 it in the places in which our members or
18 enrollees are at so that if you do have that
19 opportunity to scan it, then you are made
20 aware of the services that are available to
21 you because that's a place that you frequent.
22 And it's somewhere that's in your community,
23 and you're not having to go outside of that
24 to receive that communication. So just
25 thinking about more awareness in

1 communication that would be broadly to the
2 membership as a whole.
3 MS. PARKER: Well, not all members
4 go to a provider office. But, I mean,
5 there's -- as I said --
6 MS. ROSS: Yes.
7 MS. PARKER: -- this is something
8 that we can explore. Obviously, we do rely
9 and expect the MCOs to communicate with their
10 membership. And if they have the certain
11 programs, that they are alerted to those.
12 Generally, in open enrollment, we do
13 send out to the Medicaid members at that
14 time, it's open enrollment time, and we
15 include the value-added benefit mailing with
16 that open enrollment information. So if
17 their address is correct and it gets to them,
18 they do have -- the members do have that
19 side-by-side value-added benefit page that
20 compares all MCOs.
21 Is it a perfect system? No. But I do
22 appreciate ideas on -- and how we could
23 potentially think outside the box in some of
24 these areas, and we can certainly have those
25 discussions in our MCO equity meetings as

1 well.
2 CHAIRMAN BURKE: Sorry. I got
3 caught up in things for a minute, so I missed
4 part of that. Sorry. What was the
5 overarching theme there? I was dealing with
6 a couple of texts and stuff for the hospital,
7 if someone doesn't mind to recap that real
8 quick.
9 MS. PARKER: Looking for ways to
10 improve education or notification for the
11 members to know what the benefits or their
12 value-added benefits are, I think, is the
13 overarching way to -- how do we improve
14 communication so that they know that they can
15 get a gift card or a gas card if there's a
16 low utilization towards those types of
17 benefits?
18 CHAIRMAN BURKE: Yeah. And are --
19 MS. PARKER: And then I would also
20 say associated with it -- and I apologize
21 Dr. Burke for -- is: What are the outcomes
22 of those value-added benefits?
23 CHAIRMAN BURKE: With how they're
24 set up now -- I know that, like, some of them
25 are, like, if someone has had their well

1 check or if they've done things. Is it they
2 have their well check or they meet some
3 criteria and the value-added benefit is
4 automatically sent to them, or is it
5 something where they do it and then they have
6 to then go and request that they receive the
7 benefit?
8 MS. PARKER: That depends on the
9 MCO, and that is a challenge. I mean,
10 some -- if a claim comes in with the
11 well-child visit, some MCOs will
12 automatically send that value-added benefit
13 to them. Sometimes the members have to go in
14 and do something special.
15 So when I say something special, they
16 have to go to their website and sign into
17 their wellness program or something to that
18 effect. So that could be part of the low
19 utilization in some areas as well.
20 MS. CLEMENTS: Yeah. And I can
21 share an example. You know, from Humana's
22 perspective, what Angela just described is
23 true; right? So if you receive a service
24 that is claims-based, we will automatically
25 issue the associated reward to our members.

1 They don't have to take an action. They get
2 it automatically.
3 But if you are taking advantage of a
4 benefit that's outside of traditional
5 healthcare claims -- so, for example, we
6 offer free haircuts for kids who are going
7 back to school. Obviously, there's no claim
8 for that, so that is a situation where we
9 would require our members to let us know that
10 they took advantage of that and then we can
11 then reimburse them.
12 CHAIRMAN BURKE: Gotcha. Okay.
13 DR. RICHERSON: And then just to --
14 one final word on that. I think the bigger
15 question for us as this TAC is: Is there
16 evidence nationally that value-added benefits
17 promote equity?
18 And so I think if there's a lot of
19 evidence that shows that this is an important
20 equity tool, I think, then, it may give us
21 more -- more strength to the work that, oh,
22 yeah, this is one of the -- nationally,
23 they're saying that value-added benefits
24 really can change the landscape for people
25 around health equity. Then I think -- but if

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1 it's like, eh, it doesn't really work, then
2 it's a nice thing to do but not, like, a
3 priority. So I think that would be another
4 question to continue to ask.
5 Because we know right now, the --
6 despite everyone's best efforts and lots of
7 time and money spent on these, we know the
8 uptake is super low. So it's going to take a
9 lot -- a lot of transformation in these
10 programs to increase uptake. And if there's
11 not a lot of evidence that it improves
12 equity, then -- you know, just thinking about
13 prioritizing.
14 MS. PARKER: You know, we can
15 certainly look into that. I'm not sure
16 specifically equity -- it would promote
17 health equity but potentially health
18 outcomes, but we don't know that either for
19 sure. So something to review.
20 I do know, you know, they do -- in
21 order -- they'll give free diapers if they
22 participate into a maternal health program,
23 and that helps with, you know, hopefully
24 improving outcomes for the birth and pre and
25 post. So there's a lot that falls into that.

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1 DR. FIGUEROA: But I think when it
2 comes to equity, there are two things that
3 continue to be persistent as barriers. One
4 is language. And the other one is the
5 geographical barriers, say, rural communities
6 and things like that.
7 And I think that -- I know that we want
8 to quantify everything, and that would be our
9 first choice. But there are some things that
10 it's difficult to quantify, to look at what
11 is the impact other than the experience of
12 people coming into the program and having
13 regular checkups.
14 A good example of that is domestic
15 violence. We can expand partner violence,
16 prevention, shelters, and all of that. But
17 that is not -- you know, we might not expect
18 to see a drop in the number of people
19 accessing those services because it might be
20 that once the services are available, more
21 people are going to request it. It's not
22 that you have a higher incidence necessarily.
23 So the impact is not necessarily measured by
24 a decrease on something.
25 And so when it comes to language, I know

1 that people are coming to -- are requesting
2 services. But when we don't have the
3 language capacity, that's a huge barrier.
4 Or when we encounter, like, different
5 communities, whether they're the
6 Spanish-speaking or Burmese or many other
7 communities that are dealing with difficulty
8 in accessing services or hiring clinicians
9 who are bilingual, that we have to work in
10 access to services in a way that they feel
11 heard to begin with. You cannot do health
12 care without seeing what people need.
13 And so I think that we should not focus
14 so much in the numbers at this point
15 demonstrating the value of it because that
16 has been demonstrated already. We should
17 look at the impact based on whether the MCOs
18 have that capacity or build that capacity,
19 whether providers are able to get a
20 differential in -- because language is a
21 specialty -- in their reimbursement. When
22 you have someone who is bilingual, I mean, we
23 establish a differential pay in order to
24 attract that. But, you know, someone needs
25 to pay for it.

1 And so, one, I advocate -- and I'm going
2 to continue to do so -- in improving access
3 to language services, and the other thing is
4 to -- valuing the skill of those individuals
5 who are bilingual, so we can retain them as
6 healthcare providers.
7 CHAIRMAN BURKE: Yeah. I mean, we
8 talked about language -- you know, we can
9 talk about it the whole time, the importance
10 of those types of barriers.
11 That was all for old news that I had.
12 There was a couple of things that we got sent
13 recently, but we can touch on those in
14 general discussion if we make it through.
15 I know that the GARE tool presentation
16 has been on here for a few now. Anyone that
17 is able to do that today? Has there been any
18 updates or things? I know it was an
19 ever-changing project the last item we had
20 reviewed it.
21 MS. PARKER: Well, I do know, you
22 know, initially, when this committee started
23 or this TAC started, that our Deputy
24 Commissioner Hoffmann and her staff had done
25 a GARE tool, all of it, and discussed what it

1 was overall. We are looking at and we're
2 hoping to have someone who is an expert in
3 that field to kind of go over it. I mean, we
4 can -- we can show you what the GARE tool is.
5 But hopefully, by the next meeting, we
6 can kind of give you more of a general
7 oversight, again, on what that looks like and
8 how it can be used in health equity. And I
9 apologize it's being kicked down the -- kick
10 the can for another couple of months but...
11 CHAIRMAN BURKE: No worries.
12 Dr. Richerson, that link you had just sent,
13 what's kind of the -- you know, I can't read
14 it all right now. What's kind of the summary
15 for what it's trying to say?
16 DR. RICHERSON: Yeah. It's just
17 sort of -- it's that same question of: Do
18 patient incentives move the needle? And
19 they're like, maybe but not. The evidence is
20 not overwhelmingly positive.
21 CHAIRMAN BURKE: I'll try to keep
22 the link to review it after. As far as the
23 MIC goes, do we have any updates on that or
24 where we're at with how thing are going?
25 MS. PARKER: We do. Danita

1 Coulter, who is the Equity Branch Manager, is
2 going to discuss that, I'm hoping.
3 MS. COULTER: If I can find my
4 unmute button. I'm sorry.
5 Just for the most recent updates for the
6 MIC, of course, we recently had our
7 showcases. So with those showcases, the MCOs
8 showed some interest in transportation as the
9 option. One of the innovators in particular
10 that they expressed interest in was called
11 Kaizen Health.
12 So we did have a follow-up meeting with
13 that particular vendor just to find out some
14 more details about what their transportation
15 option looked like and to just answer some of
16 those lingering questions. Right now, I
17 don't know that we have any of our MCOs that
18 have moved forward with establishing
19 contracts with this vendor.
20 We wanted to make sure that it sort of
21 was not going to be a duplication of some of
22 those barriers that we see with
23 transportation right now. Other than Kaizen
24 Health, I don't think that we've moved
25 forward with any of the other tech-enabled

1 solutions.

2 We do have another funding opportunity

3 that developed from the innovation showcase.

4 So there is going to be additional funding

5 for a pilot that is going to focus on a

6 subset of people that are insulin-requiring

7 diabetes Type 1 population.

8 So there is a potential to fund -- for

9 the MIC to pilot five programs, and that's

10 through Kentucky, Iowa, and New York. So

11 they're -- those applications are pending.

12 They will run through September, is when they

13 will announce who will be -- who will receive

14 those funding. So it will be the potential

15 for 100. It's going to be a small pilot, so

16 it'll be 100 Medicaid members if Kentucky is

17 selected.

18 So right now, for our MCOs, we do have

19 two MCOs that have reached out to us that

20 have expressed interest. So if they decide

21 to pursue the application, again, they would

22 have to choose a vendor that was involved in

23 those -- in the innovation showcase. So any

24 of those vendors, Dr. Burke, that we looked

25 at through that list, those would be the

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1 potential people that we would partner with.
2 Outside of that, the other things that
3 are going on with the MIC are that they are
4 continuing to provide the technical
5 assistance calls, and we continue to have
6 those state calls where we just do our
7 regular check-ins to see where we are and if
8 we have any additional supporting questions
9 for the MIC team.
10 CHAIRMAN BURKE: Great.
11 MS. CLEMENTS: Danita, this is
12 Leslie with Humana. Thank you to the MIC for
13 making it possible for us to connect with
14 some of these groups.
15 We are very interested in being a part
16 of Kaizen's application, and we had an
17 initial discussion with Mindi Knebel, their
18 CEO and founder. And she mentioned that she
19 would be connecting with us and a couple of
20 other MCOs to talk about how we could issue a
21 joint application since we know that those
22 applications would be, you know, preferred,
23 if we had more than one MCO involved. And
24 I'm having a hard time getting Mindi to, you
25 know, help me get back with all the other

1 MCOs and get a date on the calendar for us to
2 chat.
3 So I didn't know if maybe you knew more
4 than I did or if you might help point me to
5 somebody on your team that could help get a
6 group discussion together. But we are
7 definitely interested.
8 Oh, and it looks like you might be on
9 mute. I see you talking.
10 MS. COULTER: Yeah. Sorry about
11 that. If you can include myself, Angie, and
12 LeeAna on your communications, we can look at
13 that and see what we can do to try to connect
14 you to -- she should be reaching out to you
15 directly to help facilitate this. But I can
16 reach out to also facilitate something with
17 the MIC director to see if she can help get
18 things moving with you all.
19 MS. CLEMENTS: Thank you so much.
20 That would be wonderful. You said send a
21 note to you and -- who were the other two
22 folks?
23 MS. COULTER: LeeAna and Angie,
24 just so that we're all in the loop so that
25 we're familiar with the conversation. That

1 would be great.
2 MS. CLEMENTS: Excellent. If y'all
3 wouldn't mind to just drop your email
4 addresses in the chat, I will very happily do
5 that. Thank you.
6 MS. COULTER: Thank you.
7 CHAIRMAN BURKE: Good. We had
8 talked before about health disparities
9 reports and things. Angela, you said that
10 you guys were still kind of parsing through
11 things and trying to put some reports
12 together to see even where to start.
13 What have you guys been looking at so
14 far, and is there anything that you do have
15 data-wise that's starting to stick out or
16 still kind of in the process of getting
17 things?
18 MS. PARKER: Well, you know, we
19 went through the transportation presentation
20 last month. And Rachel had provided some
21 follow-up from that to Erin, and I believe
22 Erin was going to share that with you all.
23 We -- you know, there are so many things
24 that stick out, but we are currently looking
25 at homelessness and see what we could

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1 potentially -- we may or may not have
2 something for you by the next meeting.
3 But in general, we're looking at
4 everything and where we need to target
5 specific areas. But every area needs to be
6 targeted, so it's a work in progress.
7 And also with Danita, you know, she's
8 been the lone person within her branch, and
9 she's getting ready to hire a couple of
10 people. So we're hoping that it will help
11 facilitate a lot more information as well.
12 CHAIRMAN BURKE: Julia, you
13 unmuted. You got something?
14 DR. RICHERSON: I was just going to
15 ask on the -- just the reporting out of the
16 system on health disparities. So is there --
17 can we look at -- do you have anything we can
18 look at maybe next time, even, like, diabetes
19 rates and the race and ethnicity data or, you
20 know, anything just to kind of get our eyes
21 on some of the data even though we know it's
22 not 100 percent?
23 MS. PARKER: We'll see what we can
24 do, Dr. Richerson. I mean, if that's what
25 you're looking at -- until we can get, like,

1 more of a social determinants of health type
2 report, if we want to look at diagnosis
3 specific and what we can pull from that.
4 DR. RICHERSON: Does anyone have a
5 particular diagnosis that they'd like to --
6 CHAIRMAN BURKE: I mean, when you
7 talk about things like -- anything that falls
8 within the metabolic area; right? Whether
9 that's hypercholesterolemia or diabetes or
10 rates of heart attack, strokes. I mean, all
11 those things are what we anticipate we'll
12 look -- you know, like, there's disparities
13 in it, but having some actual numbers is
14 always nice.
15 Let's see. It looks like -- not to put
16 her on the spot, but it looks like
17 Dr. Theriot did join. I didn't know if she
18 would be able to comment on the things we had
19 spoke about earlier, about -- it sounds like
20 she had done something with the disparities
21 in maternal health, if she's there.
22 DR. THERIOT: Hello. I'm here.
23 CHAIRMAN BURKE: Hi.
24 DR. THERIOT: I'm sorry I'm late,
25 but I figured --

1 CHAIRMAN BURKE: No worries.
2 DR. THERIOT: -- you guys would
3 still be on if I got on at 2:00. What
4 questions did you have?
5 CHAIRMAN BURKE: Someone had
6 mentioned at the last meeting that you had
7 previously presented and that you do a lot of
8 work in, like, maternal health. And so we
9 know that one of the areas that's a problem
10 is that women of color experience far worse
11 outcomes in many different areas and have
12 higher mortality rates, and so just seeing
13 what work has been done on that area that
14 you -- things that you guys have already
15 looked at or if there's other questions we
16 could ask to maybe help out, given, you know,
17 what this TAC is.
18 DR. THERIOT: The main thing really
19 that's happening is working with the Kentucky
20 Perinatal Quality Collaborative, and that is
21 trying to make sure everybody gets high
22 quality care in hospitals, so there's no
23 discrepancy between the care one individual
24 gets compared to another.
25 And they've been working on trying to

1 get people to postpartum visits, you know,
2 after they deliver. They've been working on
3 a hemorrhage bundle so that everyone's blood
4 loss is treated the same way and counted the
5 same way. So different things like that.
6 That's kind of like the frontline stuff
7 that's happening.
8 Because the disparities with maternal
9 health, I mean, it's the same hospitals, the
10 same providers, the same staff. Everything
11 is the same except for white women are doing
12 better than women of color. And so the
13 bottom line is the system is treating them
14 differently probably based on the color of
15 their skin.
16 And to fight that, you kind of have to
17 set up protocols that -- and treat everybody
18 the same way. To me, that's a little lame
19 because how is that going to -- it seems like
20 a long haul to do that. But you can do it
21 along with your implicit bias training and
22 other training -- you know, staff trainings
23 and things like that to address the issue.
24 But right now, we're trying to define
25 the problem. We're working with the

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1 Department of Public Health and the PQC and
2 just trying to do what we can do.
3 CHAIRMAN BURKE: Good. Now, you
4 said they're trying to implement these things
5 where things -- people are treated the same
6 across the board. Are there any facilities
7 that have already implemented that, or are
8 there places that have previously implemented
9 that where it had successful outcomes that
10 you guys are basing that off of?
11 DR. THERIOT: It's an ongoing
12 process. But the ARHs are -- all of the
13 ARHs, the -- what's ARH stand for? Area --
14 CHAIRMAN BURKE: Appalachian
15 Regional Healthcare.
16 DR. THERIOT: Appalachian Regional
17 Healthcare. Thank you. They're all
18 participating with the PQC. We have a
19 Norton's Hospital in Louisville
20 participating. So there's different places
21 around the state that are participating.
22 They have to have a leader. They have
23 to be able and willing to start some of these
24 programs in their hospitals. It's basically
25 QI projects in hospitals focused around labor

1 and delivery.
2 CHAIRMAN BURKE: Do you know if
3 Kentucky specific versus national -- how the
4 disparities here compare to other states?
5 Are we about average or worse or better?
6 DR. THERIOT: We're about average.
7 We're not any worse.
8 CHAIRMAN BURKE: Yeah. Which
9 isn't -- still not saying much, I'm sure.
10 DR. THERIOT: Not saying much.
11 Yeah.
12 CHAIRMAN BURKE: Okay. Had you
13 done a presentation for a different TAC or
14 group on this subject before?
15 DR. THERIOT: I think I have done a
16 very short presentation for the Nursing TAC
17 on this.
18 CHAIRMAN BURKE: Gotcha. Do you
19 recall, like, any specific highlights or
20 things like that that you had from that?
21 MS. BICKERS: Dr. Theriot, I have
22 it pulled up if you'd like for me to share
23 it.
24 DR. THERIOT: Sure.
25 MS. BICKERS: I was going to email

1 it to the TAC.

2 DR. THERIOT: We can go through it

3 and see. There's probably some good

4 information. I think when we did it, there's

5 some national comparisons on there.

6 Let's see. Am I able to scroll down or

7 no?

8 MS. BICKERS: I can scroll for you.

9 Can you see it?

10 DR. THERIOT: Yes. We can see it.

11 MS. BICKERS: Perfect.

12 DR. THERIOT: Some of this stuff

13 you guys already know, and this is just in

14 Kentucky. So Kentucky is 87.5 percent white,

15 8.5 percent black. Yet, of course, the

16 pregnancy-related deaths for our black women

17 are much higher than our white women.

18 You can go ahead. Next slide. And,

19 again, this is from our -- the Kentucky

20 Maternal Mortality Review. And it's looking

21 at the difference in maternal deaths from any

22 cause, so whether it's pregnancy-related or

23 not, based on race. And you can see a big

24 difference between deaths for black women

25 versus white women.

1 CHAIRMAN BURKE: Do you know
2 what -- like, what causes are encompassed
3 within that that they're looking at?
4 DR. THERIOT: All cause. So that
5 one was any cause. So if you got in a car
6 wreck, that would be counted in that as well
7 as, like, a postpartum hemorrhage. You know,
8 that was all cause.
9 And so we do have some good news coming
10 up, so if you scroll down a little bit. This
11 one is pregnancy-related deaths based on
12 race. And if you look, still, we have 40 per
13 100,000 versus 13 per 100,000 for the
14 pregnancy-related deaths.
15 So the related ones is you wouldn't have
16 died unless you were pregnant so -- or
17 because of the pregnancy. That includes the
18 postpartum hemorrhage, you know, sepsis, you
19 know, those things that happen because of the
20 pregnancy versus a car wreck. So this is
21 just pregnancy-related, so it's still a
22 difference there, a pretty big difference.
23 CHAIRMAN BURKE: And is that number
24 at the bottom -- it says NF2. So the total
25 number is 2, but the rate puts it at 40.

1 DR. THERIOT: Yes.
2 CHAIRMAN BURKE: Okay.
3 DR. THERIOT: And that's from the
4 most recent maternal mortality review that
5 came out last November. And then this one is
6 looking at the underlying causes of death,
7 and this is from 36 states that submit
8 information to the CDC.
9 And when you have a Maternal Mortality
10 Review Committee, that the CDC wants
11 everybody to use the same form so they're
12 gathering the same data. So 36 states are
13 using the same form to gather this data, so
14 it's more standardized. And we are one of
15 those states, and so that's why it says 36
16 states.
17 But this is looking over, you know,
18 several years. But you can see 22 percent of
19 the deaths -- of the pregnancy-related deaths
20 are from mental health conditions.
21 And then the next slide, if you look
22 just at black moms, what is it? Coronary
23 conditions are the highest, so that's right
24 at about 16 percent as the cause of death.
25 And cardiomyopathy is 13.9 percent. So

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1 looking at black moms, a lot of cardiac
2 issues are causing their death.
3 And then just the flip side, the next
4 slide looks at white moms. And most of the
5 time, the cause of death is a mental health
6 condition, so interesting.
7 And then going back to this real quick,
8 the PQC and why we are focusing right now on,
9 for example, the maternal hemorrhage bundle,
10 you know, if the leading cause of death for
11 black moms is cardiac-related, then that
12 should -- that should help.
13 You know, focusing -- you know, that's
14 an in-hospital thing that happens. And if
15 you treat all the moms the same way, you
16 weigh all the pads, do whatever you do to
17 assess bleeding and help standardize
18 protocols, that should -- that should help
19 address that disparity.
20 And then this slide is just looking at
21 the Kentucky maternal deaths, basically all
22 cause over time, and the rate is still per
23 100,000. And you can see it's just going up
24 a bit. And in Kentucky, we have a lot --
25 about 52 percent of our moms -- of our deaths

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1 of our moms are substance-use related, about
2 half of them.
3 This one is just really showing the
4 changes, you know, again, over the years.
5 And I don't know if you can see it, but as
6 you move towards the gray -- the
7 brownish-gray color, it's, you know, moving
8 towards 2001 (sic). And just looking at it
9 over time and how really it's getting worse
10 over time, but the racial disparity is still
11 the same. Like, that doesn't seem really to
12 be changing.
13 Almost done. Let's see. Oh, and this
14 is just to show -- and this is a CDC slide,
15 too, that as -- you know, if your pregnancy
16 outcomes are different, black versus white,
17 well, then, your preterm births are going to
18 be higher for black women, and your low birth
19 rates are going to be higher for black women
20 because the pregnancies are not as healthy as
21 the white pregnancies. So this is just the
22 pre-term birth rates showing the difference
23 in race and then the next one -- I'm sorry,
24 is the low birthweight with the difference in
25 race.

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1 So Kentucky is kind of right on the
2 national stats, so we just have to improve.
3 We have to keep working on it. We have to
4 address it, No. 1, and then we have to try
5 and figure out ways to address it.
6 CHAIRMAN BURKE: Yeah. It'll be
7 interesting to see, you know, how the
8 postpartum hemorrhage protocol that's
9 implemented for all actually impacts. I
10 mean, I think, at least in theory, that's,
11 like, a perfect example of, like, equitable
12 health care; right? You're doing something
13 that will improve health for everyone but
14 will disproportionately improve it for those
15 that are most affected by it.
16 So, you know, that's -- I think that
17 should be like what we try to think of to do
18 for other things.
19 DR. THERIOT: Thanks, Erin.
20 Thanks.
21 CHAIRMAN BURKE: Thank you.
22 Appreciate that. I think that goes through
23 most of the topics that I had on here. We
24 had recently got a couple of things, so I
25 just had some questions.

1 I see we got something about the 1915(i)
2 SPA. I didn't know if there was anything
3 that you guys wanted to mention about that.
4 Oh, Rachel has got her hand up.
5 MS. ROEHRIG: Yeah. Sorry there,
6 Jordan. Before we get onto that, the report
7 that was sent, just to recall -- because I
8 know it was a holiday weekend, and you all
9 had an influx of emails. But the
10 transportation PowerPoint on that disparity
11 that was done in July, there was a report
12 sent that was an update on the follow-up
13 questions, the covered services, things like
14 that. So that's in your email.
15 But I wanted to ask, in addition to
16 that, for the next TAC meeting -- we can
17 certainly look at diagnosis codes and what
18 have you, but we are already in a project
19 working with different agencies and getting
20 information on homelessness. So it would
21 have a lot more meat on its bones if that's
22 something that you all would like to be
23 presented with. That's a project that we're
24 currently working on that we should have done
25 by the next TAC meeting if you rather go that

1 direction rather than diagnoses.
2 CHAIRMAN BURKE: Yeah. I mean, I
3 think if you feel as if it'll actually be
4 more impactful as far as what it would
5 provide, for us to get, you know, something
6 tangible to do something with, then I think
7 that's reasonable.
8 Yeah. I looked through the NEMT
9 transport thing. I have an interesting point
10 from it.
11 But I was just going to ask about -- you
12 know, if there was anything for this -- this
13 SPA that we had been sent from Erin that
14 was -- just this morning, if there was anyone
15 that wanted to touch on that and exactly what
16 that's going to be doing.
17 Is that one of the ones that we've
18 spoken about before because -- this serious
19 mental illness and substance use disorder.
20 Is there anything new with that?
21 MS. PARKER: I just saw that this
22 morning regarding that. I don't think it's
23 been necessarily discussed here.
24 CHAIRMAN BURKE: Okay.
25 MS. PARKER: We might have some

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1 more information on that at the next TAC if
2 you want to put that on the agenda. Deputy
3 Commissioner Hoffmann or someone from her
4 behavioral health team may be able to address
5 it a little bit more succinctly that I can.
6 But if you have that -- if you would
7 like to participate in that meeting, I
8 believe that's the 25th at 10:00, and listen
9 in on that. It might be a good opportunity
10 if you're available.
11 CHAIRMAN BURKE: Okay.
12 MS. PARKER: The 1915(i) waiver.
13 CHAIRMAN BURKE: Yeah.
14 MS. PARKER: Because there was a
15 senate joint resolution this -- that was
16 passed for us to -- us as in the Cabinet and
17 Medicaid -- to see about submitting a request
18 for a waiver through -- to CMS. So that is
19 being evaluated. That's the limit of what I
20 know.
21 CHAIRMAN BURKE: Okay.
22 DR. THERIOT: And is it --
23 MS. PARKER: Dr. Theriot may know
24 more.
25 DR. THERIOT: Well, I think they

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1 said it was out for public comment in Tuesday
2 morning's meeting.
3 MS. BICKERS: So I sent out two
4 communications for the TAC members. From
5 time to time, I get communications they ask
6 me to send to all the TACs. So on Friday the
7 1st, we sent out one for the Michelle P
8 waiver public comment. And then this
9 morning, I also sent out the 1915(i) SPA
10 informational webinar information, webinar
11 announcement. So both of those
12 communications came out kind of back-to-back
13 to you guys.
14 CHAIRMAN BURKE: Okay. The
15 information we had been sent over the weekend
16 for the NEMT information, a couple of things.
17 Tons of cancellations. That's a -- 529,000
18 cancellations is huge. It did look like at
19 one point -- at the top, it said that the
20 data is based on a one-way trip. If a member
21 scheduled to and from, that would be two
22 trips included for the one date of the
23 service.
24 So if there was a cancellation, did it
25 count as two cancellations for that, or would

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1 the cancellation just count as one since they
2 hadn't went the one direction yet?
3 MS. ROEHRIG: It should be -- it
4 would actually count as twice because --
5 CHAIRMAN BURKE: Okay.
6 MS. ROEHRIG: -- one there and then
7 one back from the provider, whatever service
8 that they had scheduled so...
9 CHAIRMAN BURKE: Okay. And then on
10 the -- it said that the cancellations are
11 mostly -- you know, it says illness or no
12 reason given for no-shows. Is that the
13 transportation provider gets to the location
14 and then that's the reason that's typically
15 given for them not going on the scheduled
16 transport?
17 MS. ROEHRIG: Yes. So the No. 1
18 occurrence that we've been advised for Office
19 of Transportation is when the transportation
20 providers show up to that member's door --
21 they had called and scheduled, you know, a
22 doctor's appointment. They need
23 transportation. Provider shows up at the
24 agreed-upon location, time. Knocks on the
25 door. Either the member forgot about it and

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1 wasn't at the facility -- or at the
2 residence, or they were at the residence and
3 just said no, I don't -- I don't need this
4 anymore. I don't want to go.
5 So there's quite a few things like that.
6 Instead of in advance calling, hey, I don't
7 need to go to this appointment, I have it
8 rescheduled, it's more of last minute, they
9 don't show up. So that's a bit of a problem
10 that we're seeing.
11 CHAIRMAN BURKE: Do the -- do
12 vendors try to contact the patients in the
13 days prior, like one to two days prior or
14 something like that, to confirm, you know,
15 the scheduling of the pickup or of the
16 appointment that they had initially
17 scheduled?
18 Or is it -- if it's -- like, I don't
19 know exactly, you know, how far out they
20 usually plan these. I know it has to be
21 several days in advance anyway. But is there
22 any closer, like, reminder to the patient of
23 the appointment they had set up or --
24 MS. ROEHRIG: Yes. My
25 understanding is that there is a follow-up

1 that occurs a few days beforehand, so that is
2 supposed to stop that issue from happening.
3 So I can definitely get more information
4 from Office of Transportation to see a bit
5 about that process and get back to you on the
6 next one, just to make sure that we have the
7 ins and outs understood.
8 CHAIRMAN BURKE: With so many
9 different vendors across the state as well --
10 MS. ROEHRIG: Yeah.
11 CHAIRMAN BURKE: -- are you guys
12 able to look at maybe cancellation rate by
13 different vendors to see, you know, if
14 there's -- why does this vendor have, you
15 know -- they say they schedule these things.
16 But they say 80 -- you know, 20, 30 percent
17 of the time, when they go there, the patient
18 wasn't available to be picked up. But
19 another company only has it happen, like, 4
20 or 5 percent.
21 Is there anything that we could look at
22 to see if that's happening? And if so, you
23 know, why is there such a disparity? And why
24 are people in certain locations being picked
25 up and actually taken to their appointments

1 versus not others?

2 MS. ROEHRIG: We can certainly

3 request that and give that to you in a report

4 similar to this fashion.

5 One thing that's important to note on

6 there as well is whenever we are talking

7 about the transportation providers, providers

8 are under a transportation broker, and we

9 have 16 different brokers. So it can get a

10 little messy with getting information to go

11 from that end all the way back up to us.

12 CHAIRMAN BURKE: Yeah.

13 MS. ROEHRIG: So that's -- that's

14 something that would be good for us to ask

15 for and really fine-tune that information and

16 give that to you. I think that would be

17 beneficial.

18 CHAIRMAN BURKE: Yeah. Because I

19 am from Knott County, and Knott County has

20 14,000 people. And they had the third-most

21 cancellations for a county in the entire

22 state.

23 MS. ROEHRIG: And this is in a

24 six-month time frame, yes.

25 CHAIRMAN BURKE: Yeah. So there's

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1 Louisville, the county where Louisville is.
2 It's the county where Lexington is. And then
3 there's the towns that -- maybe you guys
4 heard of one of them, probably not even one.
5 So I don't know what's going on there.
6 But when I saw that, I was -- you know, I
7 would love to know why their rate -- and
8 based on a per number, I'm sure that has to
9 be absurdly -- you know, they have a third of
10 the -- a third of the cancellations that
11 Fayette County had.
12 And although -- I mean, I'm sure they
13 request a longer transport far more often,
14 but I'm sure -- I don't know. There has to
15 be a vastly different number. So that just
16 really shocked me, and so trying to dig into
17 what's going on there was most interesting.
18 MS. PARKER: We're doing -- I mean,
19 once we started this project with
20 transportation in general and then, you know,
21 eastern Kentucky and doing -- based on the
22 questions that you all had in follow-up and
23 what we've seen so far, we're doing -- we are
24 doing a lot more digging ourselves and
25 wanting to know. Because when I looked at

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1 the data and I saw that Jefferson County -- I
2 can't remember specific, but they had a
3 huge -- I mean, I know they have the
4 majority -- they have a lot of the population
5 in that area, but still, the numbers were
6 staggering. And I -- and I was like: Are we
7 sure this number is correct?
8 So we did ask them to go back and look
9 at that. But yeah, we're doing a little bit
10 more digging ourselves in this and trying to
11 identify trends and, you know, if it's one
12 particular person or if we can get the
13 Managed Care Organization information, just a
14 lot of different -- there's a lot of
15 different ways to go with this. But yeah,
16 it's definitely something that we need to get
17 to the bottom of.
18 DR. THERIOT: Is it -- like, when
19 they cancel it like that, is it -- are we
20 sure it's being cancelled by the member
21 instead of the driver? I mean, what if they
22 show up and they think they're going to bring
23 mom and a baby to the -- you know, and mom is
24 there with the baby and two other kids.
25 Does the driver say, oh, I can only take

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1 you and the baby, not the other kids. And
2 mom says, well, obviously, I can't go. You
3 know, I mean, how do we know it's the real
4 reason it's being cancelled? Because I --
5 you know, I think that's the rule, that they
6 can bring, like, the parent and the child,
7 but people have more than one child.
8 MS. ROEHRIG: Right. And it's up
9 to each individual transportation provider
10 and at their discretion if they have the seat
11 available for the child to come with them at
12 no cost. So -- but that is definitely
13 something to dive into a bit deeper and to
14 analyze because, yeah, when we got those
15 numbers, we were pretty shocked.
16 MS. PARKER: Yes.
17 DR. RICHERSON: Dr. Theriot, that
18 was my question, too, is: How do we know
19 these cancellations -- because, you know, on
20 our side, we hear the drivers cancel; right?
21 That's all we hear, and I don't see where
22 that data is bubbling up.
23 However, I spoke to somebody in the
24 community health worker world. And they said
25 if you want to put on transportation issues,

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1 talk to the community health workers; right?
2 Because they are working so closely with
3 members, and they may have a perspective on
4 the transportation issue that we can't
5 capture anyway else.
6 And so we could invite somebody from the
7 state office or, you know, the -- one of the
8 representatives sort of statewide from the
9 community health workers if we wanted to get
10 more information, or you all could touch base
11 with them.
12 But I think somehow getting the member
13 or the patient's voices in this conversation
14 as we go forward is really important.
15 DR. THERIOT: And a lot of times,
16 even if they're school-age kids, mom will
17 keep them out of school that day if either
18 they have an appointment or the younger kids
19 have an appointment because she physically
20 can't be at home to either get them on the
21 bus or get them off the bus, so she has to
22 bring them with her.
23 And doing everything right, you know,
24 she might look like a no-show in the clinic
25 and might be cancelled transportation, and

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1 the kids miss a day of school and -- but
2 she's trying to do everything right. And so
3 it's hard to kind of get that kind of stuff
4 out of the data.
5 MS. ROEHRIG: Absolutely. And we
6 will definitely work on getting an updated
7 report with some of those questions addressed
8 for the next TAC meeting.
9 CHAIRMAN BURKE: Julia, you had
10 asked, you know, a week or so ago of a
11 request for the next TAC meeting. But you
12 said there was a new 1115 waiver application,
13 and you had said you had spoken with, I
14 think, some others about it.
15 What had you covered so far, just so I
16 can figure out kind of what you're talking
17 about?
18 DR. RICHERSON: Just the -- just
19 any updates on -- there's a new 1115 that's
20 been submitted; is that right?
21 CHAIRMAN BURKE: That's what you
22 had said, yeah.
23 DR. RICHERSON: Yeah. Angie or
24 Judy or -- is there a new 1115 that was
25 submitted?

1 DR. THERIOT: There's a lot of
2 1115s going on.
3 MS. PARKER: Well, mobile crisis is
4 one, and it's still in procurement. So I
5 can't really talk much about that.
6 DR. THERIOT: Incarceration is
7 another. They're all working through the
8 system.
9 DR. RICHERSON: And so until they
10 are through, we can't really get any updates?
11 Is that what you said?
12 MS. PARKER: On mobile crisis,
13 because it's still in procurement -- we can't
14 talk about things that are in procurement
15 necessarily. So -- but we're still looking
16 at signing a -- hopefully signing a contract
17 in the very near future on that.
18 CHAIRMAN BURKE: You also said you
19 had spoke with someone doing research with
20 the AAP for qua- -- equality and quality for
21 Medicaid.
22 DR. RICHERSON: Yeah. I sent you
23 those reports just to -- just to Jordan, just
24 for your information to see --
25 CHAIRMAN BURKE: Were they the ones

1 you had sent me this morning?

2 DR. RICHERSON: Yeah. Yeah.

3 CHAIRMAN BURKE: Okay. Yeah. I

4 haven't -- I have not looked through those.

5 DR. RICHERSON: So I guess -- no.

6 Just -- I guess, on the 1115, just if

7 there -- if you can update us next time on

8 anything related to our work.

9 MS. PARKER: Yes. I would just

10 make sure you put that on the agenda.

11 CHAIRMAN BURKE: Okay.

12 MS. PARKER: And we'll make sure we

13 have somebody here that can -- that will

14 address it.

15 CHAIRMAN BURKE: Okay. And you

16 said -- which 1115 is that specifically,

17 Julia, or --

18 DR. RICHERSON: I didn't realize

19 there were so many, so I guess anything that

20 pertains to this work would be great.

21 CHAIRMAN BURKE: Okay. All right.

22 Any topics for general discussion?

23 Things people have thought about or seen

24 since last visit or last meeting that they

25 wanted to bring up to maybe have us talk

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1 about in this TAC?
2 DR. RICHERSON: It sounds like
3 transportation will continue to stay on the
4 agenda; is that right? I think that's really
5 important.
6 CHAIRMAN BURKE: Yeah. We tend to
7 get updates about it. I hadn't included it
8 on this one. We had just got the
9 presentation -- or the data, I think, last
10 week or sometime, and I had already submitted
11 it. So I didn't include it but knew I'd
12 bring it up later.
13 Okay. All right. It's a little early
14 this time, but if anyone doesn't have
15 anything going on, any other additional
16 topics -- I don't know if you guys typically
17 adjourn a little early sometimes or not. No.
18 Any of the other TAC members on? Who we
19 got? Dr. Bautista, anything?
20 DR. BAUTISTA-CERVERA: No. I just
21 wanted to request to Dr. Theriot her last
22 three slides. I just missed one because I
23 stepped on my cat, so I didn't see -- I
24 didn't see your slide and then I got lost
25 because she had run away. I am sorry.

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1 DR. THERIOT: Erin, could you send
2 the slides out to the TAC?
3 MS. BICKERS: Yes, ma'am. I
4 already have it in the email, prepped, ready
5 to send.
6 DR. THERIOT: Thank you.
7 DR. BAUTISTA-CERVERA: Thank you.
8 MS. BICKERS: You're welcome. I
9 couldn't find my mute button.
10 CHAIRMAN BURKE: I was trying to
11 see if Wanda was still on.
12 DR. FIGUEROA: Yes, I am.
13 CHAIRMAN BURKE: All right. So we
14 had -- were you here earlier when we had
15 covered a little bit about interpreter
16 services and grievance processes?
17 DR. FIGUEROA: Yes.
18 CHAIRMAN BURKE: Okay. Was there
19 anything -- I know that you had mentioned to
20 me asking for, like, a presentation from the
21 MCOs. Was there anything from them that you
22 were wanting specifically to see or --
23 DR. FIGUEROA: Yeah. I would like
24 to see what is the process for each one of
25 them. And I think that by the virtue of

1 presenting, maybe we could identify how we
2 can create a similar system among the MCOs so
3 people are not lost, whether they have to
4 contact Humana or someone else, you know, in
5 terms of what are the steps. Sometimes it's
6 how to simplify it.
7 So I hope that, you know, throughout the
8 presentation, that the MCOs are open to
9 recommendations in terms of how to create a
10 system that could be similar across the --
11 across their companies.
12 DR. BAUTISTA-CERVERA: I think in
13 this regard, I just support and second the
14 request of Dr. Richerson regarding having
15 one, you know, base page for all the MCOs to
16 contribute and work together, so the process
17 would be easier independently of which MCO
18 the Medicaid patient is seeking assistance.
19 DR. FIGUEROA: Right.
20 CHAIRMAN BURKE: Would something
21 like that be something that we could
22 recommend to the MAC, a way for them to
23 organize, you know, something like that,
24 where there is just one system set up that's
25 more accessible?

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1 Do we have another person with us, or
2 was it just myself, Dr. Bautista,
3 Dr. Richerson, and Dr. Figueroa? I thought
4 someone else was here earlier. I guess not.
5 I know, Dr. Figueroa, you work --
6 primarily, like, your locations are with
7 behavioral health type things; right?
8 DR. FIGUEROA: Yes.
9 CHAIRMAN BURKE: Okay. Anything on
10 that side recently that -- I know that
11 there's tons of things already ongoing. How
12 often do you guys look at, you know,
13 disparities in behavioral health outcomes as
14 far as, you know, based on race and things
15 like that, and what have you seen?
16 DR. FIGUEROA: Well, behavioral
17 health is a bit different than physical
18 health in the sense that language is
19 extremely important. It's not just another
20 person translating because context is
21 everything.
22 And that's why we are advocating not
23 only to have translators but to be able to
24 have a differential in reimbursement. So we
25 can attract bilingual individuals into our

1 staff, into our -- because it helps more the
2 patient when the provider is bilingual and
3 doesn't have to rely on a translation.
4 What are your symptoms and then you run
5 some labs, and you determine whether this
6 person have diabetes or not or whatever.
7 With behavioral health, the nuances of
8 languages are very important. And, also, the
9 clinicians base their diagnosis and their
10 treatment strategies on what they see.
11 And the context of language is -- you
12 know, you don't have a lab test that
13 determine whether a person have depression or
14 not or schizophrenia, for example. So -- so
15 the issue of language is extremely vital to
16 us.
17 We have seen growth in terms of the
18 Burmese population and also Spanish-speaking
19 population. And being in western Kentucky --
20 it's not Louisville, which you have more
21 diversity and probably a higher pool of
22 healthcare providers who are bilingual. We
23 experience the language barrier more so, I
24 would say, in the rural areas and places like
25 the one that we provide services to.

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1 So, you know, we looked at the trends on
2 an annual basis, but we also participate in a
3 community needs assessment. For example, I'm
4 part of the Board of Directors for the
5 Owensboro Health regional hospitals, and we
6 work closely with them. And the issues of
7 language and access has been identified
8 before as well, so they struggle with that as
9 much as we do.
10 I mentioned earlier, a couple of months
11 ago, the need to open the certification for
12 people who are bilingual, that they can
13 become interpreters. I know people that have
14 tried to register for that, and it's very
15 cumbersome. And they have not been able to
16 do it. Maybe that's something that can be
17 looked at.
18 So my first -- the perfect scenario is
19 that we would have clinicians who are
20 bilingual -- right? -- that we're able to
21 recruit in and maintain them. But sometimes
22 perfection is the enemy of good.
23 Let's say that we have to rely on
24 translations. Then I would say that, as a
25 system, we should look into expanding those

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1 opportunities, maybe doing public
2 announcements about people that can become
3 interpreters because that will open the doors
4 for hiring individuals in these areas.
5 I don't know how many translators each
6 MCO has, you know, but how can they
7 coordinate? If they have one, two, five,
8 ten, I don't know. But we definitely need to
9 have more, and it would be great -- I mean,
10 we cover seven counties -- that we could get
11 our own translators or have differential
12 reimbursement.
13 CHAIRMAN BURKE: Yeah. Yeah. I
14 mean, that's -- we had spoke about that
15 earlier. I mean, that seems like the easiest
16 solution, is, you know, paying for that type
17 of skill or for that specific --
18 DR. FIGUEROA: And some states --
19 for example, I come from Illinois. They --
20 like, for the shower fair, for therapies and
21 all of that, there is a differential in pay
22 in the reimbursement and -- because they know
23 that you need to have the capacity.
24 CHAIRMAN BURKE: Okay. So another
25 thing we had had a discussion about in the

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1 clinic a week or two ago. So at least based
2 on the presentation we were given, they said,
3 like, HPV -- throat cancers caused by HPV
4 are, like -- we're No. 1 in the nation as a
5 state for Kentucky on most recent data.
6 I didn't know if -- with Rachel saying
7 that they were going to review stuff for
8 homelessness and things like that rather than
9 rates specific to obesity and other things.
10 But, like, obviously, cancer would be another
11 one to add in the future of rates to look at.
12 And specifically, once I seen that
13 throat cancer -- you know, with having things
14 like Gardasil and vaccines that we use which
15 help, you know, prevent throat cancer, I
16 didn't know if we had any information on
17 disparities and vaccination rates, you know,
18 specifically for Gardasil but obviously for
19 other ones as well.
20 And if there are large differences in
21 vaccination rates -- which, again, I'm sure
22 there are, how do we -- you know, how do we
23 think about improving that or decreasing that
24 disparity?
25 DR. FIGUEROA: Uh-huh.

1 MS. PARKER: Well, you bring up a
2 very interesting topic because HPV
3 vaccinations, it's been a hot topic on our
4 side of things and looking at measures for
5 the adolescents that -- and how or if
6 providers are administering these
7 vaccinations. And we do have a low HEDIS
8 measure that measures this HPV, which is --
9 Dr. Theriot, what is it? Combo 10. I don't
10 know. Combo -- that has the TDAP and HPV.
11 DR. THERIOT: Combo 10.
12 DR. RICHERSON: IOM2. IAM2; right?
13 DR. THERIOT: Oh, sorry. Yes.
14 Sorry. Yes, it is.
15 MS. PARKER: Yes. So we have a
16 very -- we have a low measure as it relates
17 to that and some of the challenges. It is to
18 get to our children by the age of 13 having
19 their immunizations for HPV, Gardasil by that
20 age, so looking into that area.
21 Whether or not, you know, providers are
22 just uneasy about discussing it because of
23 the sexual connotation to it or if we evolved
24 from that or not. So I'll let Dr. Theriot --
25 she's a little bit more well-versed in this

1 than me, but this has been a topic of
2 conversation.
3 DR. THERIOT: We are asking
4 everybody we can to improve their HPV rates,
5 be it universities or MCOs or whoever. But
6 they -- they do push back because of saying
7 it's associated with, you know, sex. I
8 personally don't see that, and you guys who
9 are pediatricians also can't imagine -- I
10 think it honestly is the provider not wanting
11 to take the time to bring it up and to have a
12 conversation with the families. And
13 that's -- that's tougher to get around, I
14 think.
15 So I really think we have to do some
16 provider outreach or education, or whatever
17 you want to call it, to have them, No. 1,
18 accept it as a routine vaccine like polio or
19 diphtheria and treat it like that, like every
20 other vaccine. And, therefore, they would
21 have the conversation with their parent --
22 with the parents and the families to give it.
23 But I'm appalled that it is such a
24 problem. I think it's absolutely ridiculous.
25 It's crazy that you wouldn't want a vaccine

1 that protects you from cancer. And so that's
2 why I think doctors just aren't discussing it
3 with their families.
4 DR. FIGUEROA: That's good.
5 DR. RICHERSON: And just to add --
6 just to add to that, I think there's probably
7 two big -- to me, there's two big arms of
8 opportunity. One is what Judy is talking
9 about. The other is if you look at the
10 people who have had one but just didn't get
11 their second by age 13, that's a huge number.
12 And those parents want it, but we're not
13 making sure they get it -- right? -- as the
14 healthcare community or the public health
15 community so -- and those are the easy ones.
16 They want it.
17 So if we could just knock that -- we --
18 our HEDIS rate would improve tremendously if
19 we could just get that second dose in for
20 people who actually want it. And focusing a
21 lot of energy there, I think, would be really
22 helpful. We don't know -- I can't run a
23 report and find my people who need a second.
24 DR. THERIOT: I guess it gets down
25 to what Dr. Franco always said. You know,

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1 every time a child comes in, you should look
2 at their shot record and give them one if
3 they need it every single time.
4 DR. RICHERSON: I think they're
5 just not coming in; right? So they come in
6 around 11 and a half, close to 12, for that
7 11-year-old checkup. They get their first
8 one. And then they come in when they're 13
9 years, one month, for their second one.
10 So you're -- it's just such a narrow
11 window. Now, we're trying to start at nine,
12 but that's hard to remember to do, so you can
13 get that second one in by 11. But yeah, it's
14 just that the -- so many kids don't come in
15 between 11 and a half and 13.
16 DR. THERIOT: Right.
17 DR. RICHERSON: They may come in at
18 11 and a half and 13 and a half, but
19 it's that -- there's just a little gap in
20 there.
21 DR. THERIOT: Well, we did -- we
22 started it at C&Y at nine, and we had great
23 results.
24 CHAIRMAN BURKE: I don't know if
25 there's -- sorry.

1 DR. THERIOT: No. I was just -- we
2 just have to, you know, get everybody on
3 board in the clinic in case the doctor
4 forgets about it.
5 CHAIRMAN BURKE: I think what you
6 said about education is -- like, some type of
7 campaign or something regarding HPV
8 vaccination. The rate of HPV vaccinations
9 versus the rate that decline when I bring up
10 HPV vaccinations is at least 60 percent;
11 right? What are our rates? Like 20 percent
12 or something like that, if that.
13 And I maybe have 1 in 20 patients tell
14 me, you know, that they are against HPV
15 vaccination, maybe 1 in 10 when I bring it
16 up; right? Because I discuss it as a way to
17 prevent cancer, and that's how it should be
18 presented.
19 And a lot of times, if I have older kids
20 that aren't vaccinated for it and I mention
21 it, it's they were never offered or -- you
22 know, or they just -- they weren't educated
23 on it.
24 And so I think -- I've had some patients
25 tell me, you know, that they had saw a

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1 provider before that had recommended against
2 it; right? And, like, that is -- that is why
3 the number is so low; right? It's not that
4 there is 80 percent of people against
5 preventing cancer; right? It's just -- we
6 know that's not the number; right? If you
7 went out and asked 100 people would you like
8 to prevent throat cancer, I think they're all
9 going to say yeah; right?
10 It's not asking, and it's not having
11 people that are educated who are the people
12 that should be vaccinating them to begin
13 with. And that is a drastic number, and I
14 don't think we realize how many providers
15 aren't educated on the vaccine as well. So I
16 don't know how we could fix that statewide,
17 but that's definitely a problem.
18 DR. BAUTISTA-CERVERA: And then
19 we're considering the kids that come to the
20 offices to see the pediatricians, but we have
21 also to think about all those that don't come
22 to the offices, you know. We still have to
23 battle against the belief that I don't have
24 to go to the doctors unless I'm sick, you
25 know. And even if we talk to the parents,

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1 unless they are sick, they won't bring their
2 kids.
3 So having a family to bring kids just
4 for a well check and then for vaccinations,
5 it's another field that we have to -- we have
6 to really work at, particularly with refugees
7 and also with migrants.
8 CHAIRMAN BURKE: Yeah. I had
9 something else, but it completely slipped me.
10 Oh, for health departments, when they do
11 their vaccines -- because I know a lot of
12 patients go through health departments as
13 well. I'm sure they have the HPV vaccine
14 there.
15 Is that part of, when they go in, just
16 say they're 11-year-old shots? I'm sure it's
17 offered, but I don't know if there's -- I
18 don't know. I don't know -- with who is
19 giving it and things like that, how that's
20 presented as well when they're going through
21 there.
22 Because it's not technically one that's
23 required by the school, I don't know if it's
24 also recommended at the time when they're
25 coming in for their 11-year-old vaccines.

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1 I'm sure at places it is. But I don't know
2 if that's a thing that's actually set up for
3 all the health departments, that, you know,
4 we recommend that at each 11-year-old visit
5 when they're getting those shots or
6 thereafter if -- again, because if they
7 didn't get it offered at 11 and they're
8 coming in for their 16-year-old meningitis or
9 something, it's still -- you know, bring it
10 up again.
11 Just because, you know, they didn't get
12 it at 11 doesn't mean that they said no.
13 They may have never heard of it. So yeah,
14 that's something I see.
15 DR. THERIOT: I hope they are. If
16 not, Dr. White is going to find out about it,
17 and I'd hate to be in their shoes.
18 CHAIRMAN BURKE: Right. It's --
19 yeah. That's a soapbox that we could all get
20 on.
21 Okay. Well, we don't have enough people
22 here to vote for anything. But if no one
23 else has a topic to bring up, I guess we will
24 adjourn for this one.
25 Our next meeting is on the -- or

1 September -- I've got the old thing pulled up
2 that I've been reading from, November 1st.
3 There's also participation in the
4 registry. Yeah. Oh, yeah. That other
5 people -- that's another problem. I feel
6 like most clinics are on board with putting
7 things on the registry now, but there are
8 some that definitely do not, and I have to
9 call and get the vaccines from them.
10 So our next meeting is on the 1st of
11 November. If everyone is good with it, we'll
12 go ahead and adjourn.
13 DR. RICHERSON: Thank you.
14 CHAIRMAN BURKE: Thank you, guys.
15 MS. PARKER: Thank you.
16 (Meeting concluded at 3:01 p.m.)
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2 C E R T I F I C A T E

3

4 I, SHANA SPENCER, Certified

5 Realtime Reporter and Registered Professional

6 Reporter, do hereby certify that the foregoing

7 typewritten pages are a true and accurate transcript

8 of the proceedings to the best of my ability.

9

10 I further certify that I am not employed

11 by, related to, nor of counsel for any of the parties

12 herein, nor otherwise interested in the outcome of

13 this action.

14

15 Dated this 18th day of September, 2023.

16

17

18 *_/s/ Shana W. Spencer_*

19 Shana Spencer, RPR, CRR

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