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

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Via Videoconference
March 2, 2023
Commencing at 10:00 a.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Mike Caudill, TAC Chair

Yvonne Agan

Chris Keyser (Not present.)

Barry Martin

Dr. Raynor Mullins

MR. CAUDILL: All right. It's 10:02, and we'll call the Primary Care Technical Advisory Committee to the MAC to order, at this time, for our regularly scheduled March meeting. At this time, I guess it's a good place to start; anyway, this is basically the last meeting of the members of this committee, with the exception of Barry Martin. The rest of us will be replaced, and --

(Interruption.)

MR. CAUDILL: Does somebody have a comment? Okay. So for introductions, Teresa, could you introduce the board members that will be sitting at the next meeting of the TAC?

MS. COOPER: Sure, Mike. That would be Barry Martin, Stephanie Moore, Patrick Merritt, Michael Hill, and Stephanie, did I miss anybody with that?

MS. MOORE: Teresa, honestly, I don't have that list in front of me right now. I'm sorry.

MS. COOPER: Okay.

MS. MOORE: I'll pull it up and --

MR. MARTIN: There is one more. I can't remember --

MR. MERRITT: Is it Dennis Fouch?

MS. COOPER: Yes.

MS. MOORE: Okay.

MS. COOPER: I apologize. I didn't get the final copy.

MR. CAUDILL: Did you mention Barry?

MS. COOPER: Yes.

MR. CAUDILL: Okay. Would any of the new members that will be coming up next time like to say anything at this time?

(No response.)

MR. CAUDILL: All right. So, Teresa, would you care to call the quorum or establish a quorum by calling the members for presence and absences?

MS. COOPER: Sure. Mike Caudill?

MR. CAUDILL: Here.

MS. COOPER: Raynor Mullins?

MR. MULLINS: Here.

MS. COOPER: Chris Keyser?

MR. CAUDILL: I believe Chris is going to be absent today.

MS. COOPER: Barry Martin?

MR. MARTIN: Here.

MS. COOPER: Yvonne Agan?

MS. AGAN: Here.

MS. COOPER: You have a quorum.

MR. CAUDILL: Thank you. The next item on the agenda is for the approval of the agenda, and let me point out a couple of typos I've seen. On page 50, line No. 7 and line No. 19, it refers to the DeBusk, D-e-B-u-s-k School of Medicine, and that was misstated in there. And on page 31, line 15, it uses the word "counters," and the correct word is "encounters," as in "medical encounters." Those were the only things I saw that needed to be correcting. Do any of the members have anything else that they saw?

(No response.)

MR. CAUDILL: If there's no other corrections, is there a motion to approve the agenda as corrected?

MR. MARTIN: I make a motion to approve the agenda.

MR. CAUDILL: Motion by Barry.

MS. AGAN: I'll second it. This is

Yvonne.

MR. CAUDILL: Seconded by Yvonne. Thank you. All those in favor, say aye.

(Aye.)

MR. CAUDILL: That's unanimous. All right. Next, Item No. 4, or excuse me, that was the approval of the minutes. No. 5, an update on provider signature regulation, 907 KAR 3:005. Veronica, would you like to update us on that?

MS. CECIL: Mike, I think Jonathan Scott might be on to provide an update.

MR. CAUDILL: Okay. Jonathan, are you on?

MR. SCOTT: Good morning. Jonathan Scott, Kentucky Medicaid.

MR. CAUDILL: Yes, sir. Could you update us on the provider signature regulation and change?

MR. SCOTT: Sure. There is not a change to this regulation, but you're going to be able to rely on it to delay your provider signatures. So that's the thing that you're going to use before 907 KAR 1:082 is in place. So what 1082 -- my

understanding of the greatest interest from this committee was about how that reg would extend some time that you all had to provide a signature. So we wanted to let you know that you can use 3005 Section 2, and I think it's 4 A or B to go from a 24-hour same-day requirement to a 72-hour requirement. So that's something that we brought up in other TAC meetings, and so I think that might be what we were wanting to talk about here.

MR. CAUDILL: Okay. And that's Subsection B2?

MR. SCOTT: Yes, I don't -- I think that's right. It's Section 2 of that reg, 3005 Section 2, because they use the term provider instead of physician.

MR. CAUDILL: Excuse me, it's the lawyer in me. I wrote it down. Not from memory, I promise you.

Okay. So that's a done deal, and we can take this off of the agenda for the next meeting as being settled. Is that right, sir?

MR. SCOTT: To me, yes. That is a long-standing -- that's language we've had

in that reg for a long time.

MR. CAUDILL: All right.

MS. CECIL: Mike?

MR. SCOTT: And I'm not trying to change it.

MS. CECIL: Yeah, Mike? So you also had on new business B, an update on the regulation that makes the actual change to the RHC from 24 to 72. So we weren't sure if there was additional discussion, and certainly, we can wait until that time, but we weren't sure if that was part of this question as to, you know, when does that reg become final.

MR. CAUDILL: You're talking about under new business, Item B, 907 KAR 1:082?

MS. CECIL: That's correct. Yeah.

MR. CAUDILL: Okay.

MS. CECIL: That's the regulation that we've amended to change -- there's a lot of amendments in it, but particular to the provider signature, that's where we've updated it in your all's regulation, specifically.

So we were -- if there's additional

things we want to talk about, or you all want to talk about with regard to that regulation, happy to do so. But if it was also having to do with the provider signature timeline, then I think that's been addressed.

MR. CAUDILL: Okay.

MS. CECIL: I just wanted to know that.

MR. CAUDILL: That's -- under that is title for coverage provisions and requirements regarding rural health clinic services. That's the one we're talking about?

MS. CECIL: Yes, sir.

MR. CAUDILL: Okay. All right. So then, does that put this to rest so that Item B no longer needs to be discussed, also, or is there any desire to discuss it from many members of the committee in light of Veronica's statement?

MS. AGAN: This is Yvonne. I just wanted -- so this is in effect now? It's not a future something, or is it going in effect in the future? Is there a date for

the change?

MR. SCOTT: So 3005 is in effect now. 3005 Section 2 in our use of the term provider, they're to include primary care providers. Yeah, RHCs and FUHCs, so you all would be included in that.

MS. AGAN: Okay.

MR. SCOTT: So 1082 will, hopefully, be effective at some point in the future. You know, I hope that we move forward with it this month on ours, and then at some point in the future, it will be heard by either the interim joint committee on health services or if they were to have meetings on it this month, you know, it's a little bit less clear at what point an ordinary administrative regulation will become effective over the next few months just because of subject matter committee meeting issues.

MS. AGAN: Okay. Thank you.

MR. CAUDILL: So we'll drop this from the agenda. And when that change takes place, Mr. Scott, could you see to it, or maybe Veronica or somebody else you would

want to see to it that it's brought back up at that time and update us?

MR. SCOTT: Sure.

MR. CAUDILL: All right, thank you. Okay then, let's go to the update on the public health emergency wind-down process and launch of a new website dedicated to the wind-down. And I know we've got a lot to go over here, so Veronica, you're on.

MS. CECIL: Thank you. And I apologize I did not introduce myself. My name's Veronica Judy Cecil; I'm the senior deputy commissioner for the Kentucky Department for Medicaid Services. I am going to share my screen. We've got -- hold on. I'm going to -- we do have some things to talk about, and we will provide -- I will provide this -- well, I say, "I" -- Medicaid will provide this to the MAC, and it will get posted on the -- sorry, TAC, and it will get posted on the TAC's website sometime following the meeting so everyone else can have access to it.

This is a very similar presentation that I have been giving to a lot of the

TACs, just to give them an update on what's going on with the public health emergency and unwinding and the restart of renewals.

Just very quickly, so we're talking about this because the federal law that was passed in December and signed by the President, the Consolidated Appropriations Act, is requiring states to return to normal eligibility and enrollment operations. I'm going to talk a little bit more about that in a minute, but that is effective March 31st. And after that date, states have to resume normal operations and restart annual renewals.

In addition, since our last meeting, we got notice from the White House that the public health emergency is ending, that will be May 11th. What is somewhat confusing, I'm sure, to people is that now there are kind of two timelines that are moving forward. When the new federal law removed the continuous coverage and kind of de-linked it from the public health emergency, so now there's kind of two timelines moving forward. And we're going

to do our best not to confuse folks but keep them informed about what's going on.

So the new law that passed in December did make several changes to the Medicaid program as it relates to the public health emergency, and as I mentioned, one was ending the continuous coverage. So during the public health emergency, we've been keeping everybody covered, regardless of any change in circumstance. So, you know, people, if they had a change in income or they were categorically eligible, so they were on social security or in foster care, even if they no longer had that categorically eligible reason, we continued to keep them covered. We could only remove somebody from coverage if they specifically requested it, they moved out of state, or they passed away. So we've been keeping a lot of folks covered.

The new law also phases down our enhanced FMAP. So during this time, to help states offset the cost of keeping people covered, we've had a 6.2 percent enhanced FMAP, and that certainly has helped

Kentucky's budget when it comes to the expenditures for Medicaid. And so that has been a really good tool for us to keep people covered and offset those additional costs.

That is going to phase down over this year down to zero by December 31st. So that's obviously a reason why it will be important for us to go ahead and remove folks who are no longer eligible because we won't have the enhanced funding to cover those expenses.

The new law required a whole bunch of new requirements for the state, including reporting requirements, and so that's -- we've been working on that. CMS is still sending us guidance as early as last week, and that's been a bit of a challenge because, you know, we have, over the course of the public health emergency, been continually preparing for the unwinding and the restart of renewals, but CMS guidance keeps changing on us. And with the components of the new federal law, we're having to make changes at the last minute.

That concerns us, and, you know, it does put us a little bit at risk in ensuring the system is fully ready to restart renewals and to be in compliance with CMS requirements.

So this is a very high-level timeline of the renewal, just focusing on the renewals. So in accordance with CMS requirements, on February 15th, we were required to file what's called a renewal distribution plan and system artifacts. So the renewal distribution plan is how the state is going to allocate the caseload across the 12 months of unwinding.

So it's important to note that even with the restart of annual renewals, not everybody's going to be renewed immediately. It will occur over a 12-month period, and so not everybody is going to lose coverage all at once. Those cases are being allocated across that 12-month period.

As soon as CMS approves those documents, we will post them on our website, which I'll talk about in a few minutes because we want to be transparent about what

we're doing. We want everybody to have the information that they need. We understand the kind of anxiety that's being created as part of the unwinding and the restart of renewals, so we really want to be transparent and provide that communication available to anyone who might want to take a look at that.

As I mentioned, March 31st, 2023, is the end of continuous coverage. So that means that starting April 1, anybody who does join Medicaid and is covered by Medicaid no longer has that continuous coverage requirement. They won't be part of the unwind. They'll be a new enrollment that comes in under our normal eligibility and enrollment rules. For anybody prior to the March 31st date that has been covered by Medicaid, those are the folks that will be part of our unwinding plan and our renewal distribution plan.

April 8th is the date that we have to provide a baseline report to CMS. This will -- there are certain data metrics that CMS is going to monitor from the states --

all states have to follow these. It will be a snapshot of what our population looks like that will be under the unwinding. So it will reflect how many renewals that we have to do across the 12-month period, how many per month, how many have been renewed, how many have been discontinued, how many have moved over to other coverage, like a qualified health plan on the state-based exchange, Kynect.

So this is a baseline report we'll file on April 8th, and then every -- the 8th of every month thereafter during the unwinding period, we have to provide an update -- updated report to CMS to reflect what happened in the previous month. These are also reports we're going to post online for folks to be able to access.

We are actually doing a little bit more granular than required by CMS, and we'll be posting on our website more information than required based on population, so we can look at population specifically by age, by gender, by category. So we'll be -- in Kentucky, we'll be

monitoring the renewal process in a little bit more detail than what's required by CMS, and again, that information will be posted.

So May 2023 will be the first month subject to an annual renewal and a redetermination. So anyone with an end date of May 31st, 2023, will have an annual renewal. So those notices, and I'll talk about this a little bit more in a minute, will go out in early April, so they'll be the first to receive notices. Again, just remember, this is a 12-month period from May 2023 to April 2024, and so not all the population will be renewed in May. Just a certain caseload will.

So speaking of caseload, we have over 900,000 cases. And a case is done at the head of household level, so we've got 900,000 -- over 900,000 cases, we have over 1.5 million people, individual people that will have to be redetermined.

As part of our distribution plan, we looked at our workforce; we looked at external impacts to develop what that caseload plan is going to look like. For

example, we have a smaller caseload in the first couple of months of the unwinding period, so May, June, and July will have fewer caseloads than towards the end of the unwinding period.

The reason we're doing that is so that we can make sure the system's working correctly, the workforce is building up an understanding because there's a lot of training that's having to go on because this hasn't been done in three years. And so it gives us time to be able to monitor that and make any necessary tweaks or changes that would help improve the process.

We also have probably our lowest caseload in December. We have fewer workdays in December, and open enrollment starts then, and so we wanted to make sure that our workforce was not overwhelmed during that period of time. So that's another month where we change the caseload allocation to reflect what all these external impacts are.

This shows you -- there are three populations that we also are redistributing

differently than taking the caseloads and just distributing them across the 12 months. The first one is there on the far left; that's our what we call special circumstance. There's about 14,000 people that were set to discontinue at the very beginning of the public health emergency. They had already been determined ineligible based on our rules, and they were set to lose coverage, but we kept them on as part of the continuous coverage requirement. We've been doing what's called a special circumstance, so every month, we've just been renewing them and keeping them covered. We do plan to redetermine that population in the month of May to try to see if -- and focus on them -- to try to see if there are other -- is there other circumstances that we may not be aware of for them to be able to reenroll into Medicaid and continue their coverage or move to other coverage because they're eligible for some other coverage.

The second population you see there in the middle is the Medicare-eligible population. So folks who turn age 65 or

older are required to sign up for Medicare or be penalized. We do have several folks who, during the public health emergency, did not take that step because they had Medicaid coverage, but now, they will have to go ahead and sign up for Medicare. We've allocated this population from May to October because we're going to have additional supports for them to help them understand what they need to do -- what actions they need to do to sign up for Medicare.

We do believe, in looking at our system, that there's only about 800 folks who did not take that step to sign up for Medicare. So there is a special enrollment period; they get six months after they're disenrolled in Medicaid to sign up without a penalty. So again, we're really going to be focused on these folks to make sure they understand the need to take that action so they won't get penalized.

And then, the last special population there on the far right is what we call our QHP, or qualified health plan-eligible

population. So our system, and I'll talk about this in a little bit more in detail, but our system has been able to identify some of the population that we can verify is over the Medicaid federal poverty level limit. So these folks are eligible for a qualified health plan on the exchange. We want to make sure they know this and understand it that they have assistance to shop for a healthcare plan on Kynect, on the exchange, and our goal is not to have any gap in coverage. So the month that their Medicaid eligibility ends, the next month their qualified health plan eligibility begins.

So we are, right now, doing some system changes and some process changes so that we can support this population and get them connected to folks who can help them shop for that plan, as well as enroll and ensure no gap in coverage. So we'll be allocating them starting in July through the end of the unwinding period.

So this looks overwhelming, but it's sort of a reflection of what the process

looks like to us. And it shows that in one month, we're going to be doing several months of processing. So the darker green boxes represent things that are associated with -- actions that are associated with May. The light blue are actions associated with June. The lighter green is actions associated with July, and the darker blue is action associated with August.

So just talking to this at a very high level looking in March, we will send out a notice, either e-mail or text, to an individual who has a May renewal. So anybody with a May 31st, 2023 end date will receive some communication from us in March to say, "Hey. Your renewal's coming up in May, and you're going to need to take -- you may need to take action."

So we, again, are just trying to make folks understand when they are -- when it is their renewal period --

(Interruption.)

MS. CECIL: -- when their renewal is up and to keep an eye out for additional communications from Kentucky Medicaid.

In April, you'll see -- so the first thing that will happen is May renewals will start processing on April 1st. What our system will do is try to, what's called ex parte, or passively renew all of our members with that May renewal. Our system will go in and try to verify electronically the information that we need to make that determination. And if we're able to do that, the person's done. They get renewed, they'll get a notice of renewal, there's no action -- additional action they have to take.

If we can't get them renewed, they will receive a request for information, an RFI, and then others will receive a renewal packet. That renewal packet is generally for those whose eligibility is determined by resources, so there's additional information that we need that we're just unable to verify through all of our databases.

So those folks, on or about April 2nd, because they haven't been able to be renewed on April 1st in a passive or automatic way, they will -- those will be

sent out to them because they'll have to take action, and we call these active renewals. So there is something that person has to do for us to be able to complete that redetermination. If they do not take that action to provide us the information we need, they will be discontinued on May 31st and no longer have coverage starting June 1st. Of course, somebody could appeal that, and they will have -- we do have 120 days for members to appeal.

The other important thing to note is that members will have 90 days after they're discontinued to provide the information, and we will reinstate them back to their end date so that there is no gap in coverage. So there are things that members can do and actions that members can do once they're discontinued. And that information is provided to them in a discontinuation notice.

So in April, while we're doing the May passive and active renewals, we'll send out the notice for anybody, a text or e-mail for anybody with a June renewal -- a June

end date. And it's important to understand that, again, nobody gets disenrolled until that end date. So even if we determine -- let's say, somebody sent their information to us with a May end date, and on May 11th, we've determined that they are no longer eligible, they still have coverage through the end of May. So we are a month pure coverage state, so that means regardless of when your ineligibility comes within the month, you still get that month of eligibility.

And then, the system continues on from there, but like I said, you all can take this back and look at it and try to see how that process is going to flow over the 12-month period.

So just two things I always want to remind folks of: We are going to send a notice about 90 days prior to their end date so that they know when the renewal is. And if we haven't received a response from them by the 15th of the month of their renewal, we will also send a notice to them saying, "You gotta do something, or you're going to

be discontinued." So we're trying to provide a lot of communication to our members.

Our managed care organizations are going to help us with outreach. They will be also reaching out through phone or text or e-mail, trying to reach members, especially as the end of the month approaches and they haven't taken action; our managed-care organizations will be trying to find those individuals and just figure out if there's some help that they need to take that next step. It may be that they're no longer eligible, they know they're no longer eligible, and if that is the case, we do want to make sure they know that there is other coverage available, either as the qualified health plan on the exchange or perhaps, they're employed, and they now have access to employer-sponsored insurance. Medicaid disenrollment is also a qualifying event for you to be able to access your employer-sponsored insurance in Kentucky. They may be Medicare-eligible, and so maybe they need help moving over to

Medicare, but we do plan a robust outreach campaign around those individuals to ensure no gap in coverage.

MR. MULLINS: Veronica?

MS. CECIL: Yes?

MR. MULLINS: It's Raynor.

MS. CECIL: Yes, sir.

MR. MULLINS: This is very helpful. I'm -- I have some confusion about the potential implications of Senate Bill 65 and what that may do to this whole process because, obviously, the Medicaid expansion extended eligibility for a lot of adult Kentuckians. So what happens if that bill passes? Will you have to re-tool this entire process, or how will it -- what is your best -- I know it's speculation, but it's also based on what's going on in the state right now; is this likely to change?

MS. CECIL: No. Senate Bill 65 is only referencing the dental, vision, and hearing benefits that we added for adults. It has nothing to do with our expansion population, just for the services that we added to adults.

MR. MULLINS: So the adult -- the 900,000 or so adult Kentuckians that were determined to be eligible would still be eligible, just not for the dental, vision, and hearing. So they're not challenging the budget authority for the expansion itself?

MS. CECIL: That is --

MR. MULLINS: That was the point I wanted to get clarified.

MS. CECIL: That's correct, yes. That is correct. It doesn't affect our coverage of the expansion population for Medicaid coverage, just for those added services.

MR. MARTIN: Hey, Veronica?

MS. CECIL: Yeah?

MR. MARTIN: This is Barry. We need to really get this information out to our kynectors throughout the state, as well. How do we --

MS. CECIL: Yes. So we are -- so, Barry, there is information that's streaming to kynectors. There's training that's going to be happening very soon --

MR. MARTIN: Okay.

MS. CECIL: -- to talk through the system and the different changes that we're making and how best to support somebody. So all that's going to be happening over the next couple of weeks.

MR. MARTIN: Okay, good. Because those are the boots on the ground --

MS. CECIL: Absolutely, yep.

MR. MARTIN: -- that gets that information out --

MS. CECIL: Yeah, and providers are, too, and so we do have some extensive communication plan for providers because we know that you, also, are the boots on the ground and see the Medicaid member, and so we'll be providing some additional information there.

So this snapshot -- and I want to -- I at least want to caveat this: This is just a snapshot that our system, as of February 6th, where we can go out and verify folks or not verify them, this is a snapshot that tells us there's about 243,000 people that may lose coverage. May. I say "may" because until we do their actual

redetermination over the 12-month period, whenever their renewal month is, their circumstance could change. So while our system today might show them as no longer eligible based on income, they could lose their job, you know, their income situation could change, and at the time of their renewal, they could still be eligible for Medicaid. But we're using this as a tool for us to try to gauge how many folks really need that support -- that extra support through an active redetermination or that might lose coverage and move to other coverage.

This notes that as of February 6th, we could confirm that 76,000 people are over the Medicaid income limit. So these are folks that we will reach out to and help them understand about choosing a qualified health plan on the exchange, or ask them, do they have employer-sponsored insurance available to them, but these are the folks that we're going to really focus on over the 12 months when their renewal month happens to make sure that there is no gap in

coverage.

And then, that box on the bottom is just a reflection of the age group of these 243,000. Again, we're going to be closely monitoring the demographics of this population so that we can understand who's being impacted.

I'm almost done. Just a reminder, so with the public health emergency ending on May 11th, flexibilities end. We are still working on more robust information around the flexibilities and what's ending. There are some flexibilities that we're allowed to extend for a limited period of time, and then there were some flexibilities that we were able to permanently put in place. But we are going through and preparing a more substantive document on these to provide to primary providers because you all really are the stakeholders that will be mostly impacted by that.

For example, one of the flexibilities that ends is the suspension of provider revalidations. During this period of time, some providers have gone ahead and just

voluntarily done their revalidation, but if they had not, we will restart them, and we will give providers an opportunity to come into compliance. So you're going to be receiving a lot of communication from our provider enrollment folks about when your revalidation is due and when you have to take that action.

We also, based on CMS requirements, have temporarily enrolled some providers. Those are providers who did not go and want to become a full-time Kentucky Medicaid provider. They will have up to six months to actually fully enroll, or they will be discontinued -- or they will be terminated from the program and no longer eligible to provide Medicaid services.

So the other, I think, important part here for members is that we will be losing the second presumptive eligibility period that we had during the public health emergency. That has given folks up to four months of time to file a full Medicaid application and become a permanent Medicaid-eligible member. And so we'll be

losing -- on May 11th, we'll be losing that second PE option.

One of the flexibilities we did permanently put into place is a lot of our telehealth flexibilities. We had filed an updated regulation, 907 KAR 3:170, that incorporated some state legislation that was filed, and that, thankfully, I think, gives us some permanent seed to those flexibilities in Kentucky. I do want to note that one of the flexibilities, which is the platform in which somebody can utilize for telehealth that are non-HIPAA compliant -- the new federal law in December did extend that capability through December of 2024, so right now, we'll still be able to allow those platforms to be utilized. We'll certainly keep providers updated as that date approaches to see if there's an additional extension. If not, then everyone has to return to the HIPAA-compliant platforms as required by the Office for Civil Rights.

So just real quickly, what we're telling people now, primarily our members,

is to say, "Please update your information. We want a current phone number and e-mail address and address so that we can contact you when you're -- it's your time to renew." The worst thing that can happen is that we can't reach somebody and they are eligible, but we just can't verify it before their discontinuation date. So making sure those individuals keep in contact with us, keep their information updated is helpful.

So how to stay informed: We did launch a website, MedicaidUnwinding.ky.gov. That is going to be our source of information for all things unwinding, both the flexibilities and the restart of renewals. We are posting everything on our social media, so if you have the opportunity -- choose one of them because we'll post the same thing on all of them. And you can do all of them, but monitor at least one of our social media platforms during this time. It will be the quickest way for us to send information out about what's happening. Because we do expect, you know, it's a complex process and complicated, and we do

expect that we'll have to make some changes throughout the unwinding period, and we want to keep folks informed about what's going on.

We have March stakeholder meetings. I will send out after this meeting -- oh, no. I think -- I'm sorry. I think Kelli already sent out information to the TAC members about how to sign up for one of those. And then, we'll be posting this on our social media and our website so people can sign up. It is generally going to be the same information at each meeting, so don't feel like you have to come to all three, but coming to one of them would be great. If you can't, we'll have a recording posted so you can go watch it at your convenience, but we will take questions during that time.

And then, following March, during our unwinding period, we'll be holding at least one monthly stakeholder meeting, giving people opportunities to hear us about what our efforts are and how it's going; if there are any changes, they can ask questions. So

we really want that interaction with our stakeholders to stay on top of everything.

And that is it. I'm sorry I took a little longer than I had intended, but there's a lot of information.

MR. CAUDILL: No, thank you. That's one of the important things about this committee is getting the information we need, and allowing DMS a platform to help distribute that, so thank you very much. It's something we're all interested in, and we hope to see more of it.

Let me ask a couple of questions. First off, in the chat room, it shows that your estimated lose eligibility is 243,131, and your total age breakdown total is 234,131; discrepancy there is about 10 -- $11,000. Which one would be the correct number?

MS. CECIL: The number up at the top.

MR. CAUDILL: Okay. All right. And to the comment by Dr. McKee, thank you, I'll get to you a little bit later with that information. I do have you down under the Item D: Dental workforce recommendations.

Having said that, are there any other questions by this committee -- oh, wait a minute. I'm sorry. I've got a couple. Will there be reinstated a co-pay for Medicaid?

MS. CECIL: Excellent -- thank you for that question. No, we, as part of a previous year's legislation, Medicaid did update our state plan amendment regulations. There are no cost-sharing or co-pays in Medicaid now.

MR. CAUDILL: Great. Also, if you know, under the telehealth update, will telephone-only encounters still be acceptable?

MS. CECIL: That is correct. Yep, our regulations will allow for telephone-only.

MR. CAUDILL: Okay. Thank you. Let me ask the committee, is there any questions from any of the committee members for Veronica?

MR. MARTIN: Veronica, these slides will be provided to the TAC and the future TAC members, as well, right?

MS. CECIL: Yes, we can do that. Absolutely.

MR. MARTIN: Okay.

MR. MULLINS: Veronica, just a quick point of clarification on the dental side, I assume that Senate Bill 65 relates only to the expanded dental benefits. If the members were eligible for the adult dental benefits that were in place before the expansion, then they would still be eligible for those same dental benefits; is that the correct interpretation from that?

MS. CECIL: Yes, that's correct, Raynor. And then the other piece to that is our emergency reg. While Senate Bill 65 makes its way through the process, our emergency reg does still cover the period of time until that goes into effect. So it's still all covered. We're not going to go back and recoup for any services that are being provided right now because we have the authority to do that under our emergency regulation.

MR. MULLINS: Yeah, I want to ask a little bit more about that later, but that

was -- I wanted to clarify the eligibility. There still are some dental benefits that will be available to the adult Kentuckians from the expansion?

MS. CECIL: Yeah, those small limited benefits that are still available, yeah.

MR. CAUDILL: All right. Any other questions?

(No response.)

MR. CAUDILL: Okay, then, let's -- thank you, Veronica, on that very informative presentation. And let's go down to old business, C: Discussion on returning to in-person meetings. And this is something that has been hanging around for a year or more now, and we've kicked the can down to this month. And to be honest, it's been so long that I may not remember all the details, but it is my understanding we all are in agreement that virtual meetings are here to stay, but that we're wanting the option to do it in person. And if we do it in person, then there is a difference between what the DMS has available to do that and what our needs would be. So can

anyone chime in on that, and let's see where we are?

MS. SHEETS: Veronica, do you want to take this, or --

MS. CECIL: Yeah, I'm happy to. Well, okay. So since the last meeting, and I'm not sure if we conveyed this, but the CHR building, where we are, is under construction. So Medicaid has moved off the sixth floor, and most of our staff are telecommuting, and we've been moved to temporary residence on the second floor.

The construction that's going on at CHR is removal of -- oh gosh, why am I blanking on the word? The escalators -- I mean, not -- the --

MR. CAUDILL: Elevators?

MS. CECIL: Yes, escalators. Thank you. Sorry, I'm having a senior moment. And so that's creating, in terms of us being able to do anything at our building, that is no longer an option. We remain open, and I know KPCA has offered their facility. The only caveat to that is wherever we go, we have to have a sufficient amount of space to

accommodate any -- anyone from the public who wants to attend the meetings because these are subject to public open meetings. So -- or an overflow room.

So, I think -- you know, again, we had -- I know Erin had checked with LRC, and we're not allowed to use their facilities anymore. So, you know, Frankfurt is extremely limited in access to a conference room that's large enough. The Transportation Cabinet conference rooms are not available to us, so I think we're back to the original problem, Mike, of, you know, finding a space that can accommodate.

We are more than happy to facilitate an in-person meeting if it's the desire of the membership and, you know, continue to look for -- if you all want to set a time, a date certain in the future of when you want to do that, then we can work towards seeing if we can make that feasible.

MR. CAUDILL: All right. Do I have any comments by the committee members?

MS. AGAN: Veronica, when the construction work is finished, will there be

more available meeting spaces that would accommodate a return to in-person?

MS. CECIL: Yes. So what's exciting is that we, at least on our floor, we are planning for a space large enough to be able to host. It will be adaptable to how many people, but here's the bad news, that's two years. They tell us a year, but that's not true. It will be two years before that gets renovated.

MS. AGAN: Okay.

MS. CECIL: Now, I will say, so public health, which is also another area that we've utilized prior to the public health emergency, they're in the process of finishing their construction. I think they're still several months away from that, so that's a potential option, but it's just a little unsure on when that can become available to us.

MR. CAUDILL: Molly Lewis, do you have anything you'd like to comment on this?

MS. LEWIS: No. That sounds good, Mike. Thank you.

MR. CAUDILL: Okay. So the

practicality of it is we cannot meet in person at this time, and that may be upwards of two years before DMS is available, and there may be the alternative here in a few months. So let's kick this can down the road till the November meeting and revisit it at that time. Does that sound appropriate to everybody? And I see head nods going on, okay.

MR. MARTIN: Mike, I really think for right now, even if we just took it off the agenda -- I mean, it seems like this is the most effective way to get more participation. And it looks like our intent was to try to have maybe one meeting out of the year where we get together and actually, you know, converge. I think, under what Veronica was just saying and the fact that this is the most effective way for all of us to get together. I'd say the other TACs are in the same boat; is that not right, Veronica?

MS. CECIL: Yeah, this is a problem across the MAC and the TACs.

MR. MARTIN: Why don't we just take

it off the agenda, and at an appropriate time, we can put it back or revisit it? I mean, there's no sense in keeping it on the agenda when we know what the end result is.

MR. CAUDILL: Right. That's why I wanted to move it out to November, when it might be an end in the construction that Veronica was talking about and the alternate space. There is no need to keep it on, and I like to clean this agenda up as much as I can.

MR. MARTIN: Yeah, let's do that. I'm -- I'll suggest -- let's just remove it. And we can add it whenever it's appropriate.

MR. CAUDILL: Okay. I don't think that requires a motion or anything; it just is.

MR. MARTIN: Okay.

MR. CAUDILL: We can strike it out, or you can strike it out when you get the next proposed agenda. Okay. So this next one is a follow-up on dental workforce recommendations, asking for Veronica to do that. Are you up for that one, Veronica?

MS. CECIL: Yes. So I -- and just

want to clarify, is D and F similar?

MR. CAUDILL: Yes.

MS. CECIL: So I think D -- part of our conversations after our mine and Dr. McKee's presentation on dental was to -- you know, we had the recommendation to create a workforce, and I had mentioned that, as it turns out, a workgroup had been already established -- fairly newly established, that involved the different dental schools, including the new one in Pike -- Pikeville. And Commissioner Lee was asked to be a part of that, Dr. McKee is a part of that. And so rather than recreating the wheel in a separate initiative, we kind of, I think, all discussed it might be a benefit just to have a MAC or TAC member be part of that, and then they could report back on those activities.

So Commissioner Lee has made that request, but we've not heard back on -- she feels fairly certain that that's not going to be a problem and we can identify who that individual is, but she was going to get back to me, and let me know that that's been

accepted and we can propose a person. So I don't know if you all want to make a recommendation. I know Raynor's been the most vocal on this, but if you all want to make a recommendation on who that individual should be when we have that opportunity to provide a name to the group.

MR. MULLINS: Veronica, let me make a comment about that as you might've expected I would. First of all, let me say, it's been a privilege to serve on the TAC, and I'm completely supportive of the recommendations, you know, and the revisions that are being made. I'll still be serving on the executive board for KPCA, and I've assured Molly and Steve that I would still be providing input, and they've asked me to continue to do that, and I will.

But I did want to ask about a point of clarification, and I think we can put both D and F to rest. I was unclear on which coalition was being referenced. Earlier, I thought it was the Dental Coalition that was part of the Kentucky Youth Advocates group, the long-standing

Kentucky dental health coalition. And then, I understood just by a comment there was some question if that was not another coalition that I was not aware of. So I think it's important to clarify who the stakeholders are and what particular group was being referenced in the last minutes. And I'm unclear about that, and I apologize; I haven't followed up with Julie on that. She may want to weigh in on that, too.

MS. CECIL: Is she on?

MS. MCKEE: Yes, she is on.

MS. CECIL: Oh, there she is.

MS. MCKEE: I think that in F, that this was a loosely constructed term. There is an official Kentucky Oral Health Coalition that is based out of the Kentucky Youth Advocates. I don't think this is what this meant. It is a loose group of interested people working on access. They don't have a charter. They don't have a name. They just hammer out possible solutions. So I don't know what to call them, but it's not the official Oral Health Coalition. It's a group of, yes, the dental

schools, some other dentists, things like that.

MS. CECIL: Thank you, Dr. McKee. I think they call it -- I think you guys were calling it, like a workforce because it is very much focused on, you know, access, yes, but when you dig deep into that, it's about how do we graduate more dentists and keep them in Kentucky? So I think we'll probably be focused on those workforce issues.

MS. MCKEE: I think --

MR. MULLINS: So you're -- you have advanced a proposal then, Veronica, to set up an official group or to have this open-ended with a loosely defined group? I'm unclear what's going on.

MS. CECIL: Our proposal was to utilize the workgroup that's been created that Dr. McKee described. It's to utilize that workgroup and ask that maybe they include somebody from representing the MAC and TACs so that they -- so you all can kind of present that Medicaid perspective.

MR. CAUDILL: When we talked before, we were talking about a Kentucky Oral Health

Coalition made up of the three dental schools: UK, U of L, Pike University, and some other stakeholders.

MS. CECIL: Mm-hmm.

MR. CAUDILL: Is this an official group or an informal group?

MS. CECIL: It is an informal workgroup. As Dr. McKee mentioned, there's not a charter or -- but it is a workgroup working on these issues.

MR. CAUDILL: Okay.

MR. MULLINS: So that --

MS. MCKEE: So then, the thing is, if we called it access to care workgroup, that kind of suggests it's not that formal, and workforce is part of access to care.

MS. CECIL: Yep.

MR. MULLINS: Well, I guess the recommendation that we made earlier from the TAC and the MAC group specifically asked the Secretary of the Cabinet to convene a workforce. And so it just seems to me this one is a little open-ended right now, and it doesn't reflect my personal interest. I'll have input into the process; that's not

where I'm coming from. Particularly with the implications of SB 65, this even further complicates the concerns that we all had earlier. So I'll just make that observation, Veronica --

MS. CECIL: Mm-hmm.

MR. MULLINS: -- this is something that's going to need attention because if SB 65 passes, and it's passed the Senate, I guess, and is in the House for a referral for committee with the expectation that it's going to be a political football. For sure, this is going to have consequences that ripple off of the MCO networks and the entire dental care system for Medicaid beneficiaries.

So it's something that I would just like to personally state that I believe needs formal attention because it's going to be a real, real, real problem. In my belief, it goes much further than just workforce -- well, it does go to workforce, but it goes to the integrity of the MCO dental networks and the maintenance and sufficiency of those. So you know why I'm

concerned about it. I haven't been shy about that, but I think it's troubling that oral health and vision and hearing have become political footballs, and it's actually that there's no other way I can see to describe it than that.

And so, I'll just leave my comments to that, but I would hope that the cabinet would clarify and get behind a group with an official charter and formal things rather than a loose coalition. I don't think that will serve the Commonwealth well, and so I'll just stop there.

MS. CECIL: I appreciate those comments, Raynor. When you all made that recommendation, and I took it back to and spoke to the secretary and the commissioner about it, the commissioner made us aware of this other workgroup. And as I mentioned, rather than have two groups working on the same issue, we felt like if the other workgroup has the necessary stakeholders at the table, which includes the dental schools, we felt like maybe we can just leverage that. But happy to take, again,

take back, you know, and renew the desire of you all having the cabinet formalize a workgroup.

MR. MULLINS: Julie, what are your thoughts? Doesn't this need a clear charter and instructions on how to proceed?

MS. MCKEE: I hesitate to give my opinion. One of the -- okay, so this is Julie's opinion only. So write this down that it is Julie's opinion. One of the beauties of this particular workgroup is its informalness. Medicaid representation, usually from Commissioner Lee, is incredibly important, and the dialogue has been priceless. But it is not a Department of Medicaid services-driven group, and I think that that's one of the reasons we're getting really, really good dialogue. I don't think they want to become formal. I think they just want to be heard, and they feel like they're being heard.

They are quite involved with the potential of Senate Bill 65. I mean, as far -- their interest is involved. I don't know how they're working it legislatively.

But they're quite interested in that, but I think the loosey-gooseyness of it makes it pretty effective. And I hope I didn't step on any toes.

MR. CAUDILL: Okay.

MS. CECIL: And Dr. McKee, is there, I mean, I guess a recommendation -- you all would have recommendations that you would encourage Medicaid, or this -- our original conversation to this, is this is not a Medicaid-only problem. This is a state problem with access to dental services. And so elevating it to, you know, a state approach makes sense. But, Dr. McKee, is there -- I mean, if you all had recommendations that came out, you know, I assume you would, that --

MS. MCKEE: You're right. This is a state problem. Even people without Medicaid are having a hard time accessing appropriate dental care throughout the state. Is it magnified in the Medicaid population? Mm-hmm, it sure is, but the recommendations are informal, and they're made with whoever the Medicaid representative is during our

meeting. So like I said, I think this group feels like they're being heard.

MR. MULLINS: I guess I would suggest then, if that's the direction that everyone wants to take with this, then there ought to be some regular reporting back to the TAC and KPCA about what those deliberations are. Because they have a lot of involvement in this process with a million and a half covered lives dentally, that's a very important policy -- set of policy considerations.

So right now, I haven't had any feedback. I haven't sought it through that mechanism. I'm sure I can get some, informally, from knowing all of the -- most of the actors, but it seems to me that there needs to be regular communication on what's going on to address this matter; otherwise it will get dropped off the table.

MR. CAUDILL: Okay. Thank you, Dr. Mullins. I'm going to switch on you a little bit here. Dr. McKee had talked last time. She was going to present us with a study results on a retention rate for

dentists graduating in Kentucky dental schools. And she's indicated today that she has that ready, so at this time, I would ask Dr. McKee to give us her findings.

MS. MCKEE: Thank you. I am really horrible at screen sharing, so I'm just going to click this share screen thing and see where it takes us. And if it works well, you should see a white screen with two charts: One for U of L and one for UK. Oh, I need to be --

MS. SHEETS: Yeah, Dr. McKee, Donna will have to make you the cohost.

MS. MCKEE: Okay. Just let me know when that might happen.

MS. SHEETS: Okay. You should be ready to go now.

MS. MCKEE: Let's see -- no, that's not what I want. I want this. Do you see that now?

MR. BRUNNER: Yes, we do.

MR. HADLEY: Yes.

MS. MCKEE: Okay. Okay, good.

MR. HADLEY: I see the University of Louisville and the University of Kentucky.

MS. MCKEE: Okay, got it. Thank you. This is a rudimentary collection of data, and we have ideas to do it better. But it gives us kind of a screenshot on how many students stay in Kentucky and what percentage. So the look -- the thing is, these are not exactly comparable, but enough for our particular wondering right now.

The University of Louisville -- and the reason I put them first is because they're the older university -- is this number here, the 30, 23, 18, 30, 18, 119; those are the number of Kentuckians that graduated from their dental school and that stayed in Kentucky. And so that's what these numbers are, the 81, the 55, the 42, 65, 50.

The University of Kentucky did not give me that exact number, but I happen to know that out of 63 to 65 students per class, 40 are designated as Kentuckians. And so that's over each year, and this, the 21, 19, 14, 28, 23 represents the Kentuckians that are in practice the year after they graduated.

So you can see, it's kind of all over the place, but bottom line, over the past five years, we have 59 percent of U of L doctoral students staying in the state to practice. This does not include residencies per se, but it could -- but that's phase two. And then at the University of Kentucky, it's 53 percent. You can talk about them being statistically significantly different. I really don't. These are kind of almost the same to me.

Now, I'd like to see more Kentuckians stay. I'd like to see which Kentuckians stay put after going away for military obligation and going away for residency training. So we're going to be getting an intern this summer and fall probably, and one of their jobs is going to be to take the names of the graduates -- because I'm surprised that both of the schools said, "You know, we really don't know. We're just kind of making a guess. We don't keep up with them." I'm like, they hold their debt. They know where to go to get money. They ask them for alumni donations. So I don't

know about that.

But anyway, so we're going to ask our intern to take the names of the graduates per year, compare them to the current Board of Dentistry roster on do they have a Kentucky license, and further that, are they practicing in Kentucky. Because you can have a Kentucky license and still practice in Missouri, for that matter, but we can check all that, and that will give us a better -- now, do I think it will change much? I really don't, but it will give me more peace of mind that these numbers are as accurate as they can be.

Just to remind you, we have a loan repayment program in place right now that will have students graduate -- 2023 graduates that we will award them money to reduce their educational debt to the tune of $200,000 over four years of service in a community of need. And so that happens at both dental schools, and we're having a pretty good uptake on it. I would like to expand that if we could.

Studies show -- now, you all have

heard me say this before -- and the reason I don't have my camera on -- I'm really sick and I look really bad, and it would be an insult to my mother. Studies show that if you -- if a licensed professional stays in a community between four and five years, they stay in a community for 25 years, and that's what we want. We want people to go to communities of dental need -- they have to take Medicaid, but they don't have to take all Medicaid -- communities of dental need to establish themselves as part of that community, and we think that would help promote that.

So we're doing that. We hope to continue that year after year after year to make a difference because if we could put four to six dentists in a community, in our communities in Kentucky -- you can look at these numbers down here: We had 18 in '22 from U of L, and 23 from the University of Kentucky to plant their roots in Kentucky, and we could add to that.

I am willing to take questions because that's all I got.

MR. CAUDILL: Any questions for Dr. McKee?

MR. MULLINS: A couple of observations from Raynor: I'd change the title, Julie, to I think you're talking about in-state dental graduates practicing in Kentucky. I think it's not students, it's the graduates, and it's the in-state residents.

MS. MCKEE: I think you're right; thank you.

MR. MULLINS: Okay. And then, the other observation that I would make, just to inform people about this: Since 1992, there has, in fact, been a cap on in-state enrollment in the Commonwealth of Kentucky that's contributed in a major way to this. And that restricted the University of Louisville to 45 in-state students and the University of Kentucky to 40. Just -- the percentages I just am kind of ignoring in this as I look at this chart. It's the actual numbers that are of consequence. Julie, do you have any sense of, for example, in 2022, what the enrollment was at

the University of Louisville?

MS. MCKEE: It was not -- it was not 45. It was, like, maybe 120.

MR. MULLINS: I'm talking about total enrollment, in-state and out-of-state.

MS. MCKEE: Yeah. 120 per class size.

MR. MULLINS: So they -- I mean, the numbers from UK --

MS. MCKEE: U of L --

MR. MULLINS: -- but the numbers from U of L also just doesn't -- both those numbers are woefully low for state-supported institutions. And I guess the other observation I'd make is to really understand the dynamics of dental workforce, these need to be separated out for general practitioners versus dental specialists.

MS. MCKEE: Well, and that's one thing we did not have. If I can get an intern on it, we can tell that from the Board of Dentistry registrations. We can do that; that won't be hard. We did not get that. The thing is, as just a reminder, that U of L, several years ago, had goals of

doubling their enrollment through their dean at that time, John Sauk. And the doubling included not one extra Kentucky student; they were all out of state.

MR. MULLINS: And it's -- this is a multi-decade problem that's -- we're now beginning to see. So, Veronica, I'd just like to make one more observation for the TAC, and then I suggest we move ahead -- these data are what they are -- and that is one of the unfortunate consequences of a lot of the changes that related in some of the earlier partnerships with Medicaid, was the loss of the dental information initiative.

I started with Dr. Rich in 2012, tracking this over time -- these outcomes, and so those have all, unfortunately, been disrupted. And it seems to me it's going to be really hard to make sense of this unless you go back, Julie and Veronica, to the basic parameters that were in that dental information initiative and try to get those up-to-date so you can really understand what's going on in Kentucky.

So I'll just leave it at that. I

think both of you understand where I'm coming from on that. And so, I'll stop and not take any more of the time of the members, but I think this is a very important policy issue for the Commonwealth of Kentucky.

MR. CAUDILL: Okay. Thank you, Raynor. And as you pointed out, we do need to move on. So let's go to 5E, establishment of core quality indicators uniform between all MCOs, and Angie Parker, I see that you're on here. You talked a little bit last time about plan and timetables and so on, so could you address that, then?

MS. PARKER: Absolutely. Angie Parker, with Medicaid. I know that you all have been wanting to discuss and finalize some core clinical indicators with the MCOs, and I can say that we're very close to that. Actually meeting with the MCOs on Monday to kind of go through what we are looking at.

I believe I did state last time that we are looking at and focused on childhood

immunizations, diabetes, maternal health, and social determinants of health. So that will be our primary focus on core clinical indicators. So we should have some additional information at the next Primary Care TAC.

MR. CAUDILL: All right. Thank you.

MS. PARKER: Mm-hmm.

MR. CAUDILL: No questions for Angie -- I'd like to move on, then, to G, update on mobile crisis response unit. And last time, I believe Veronica, you were telling us that it's a model that you set up for a 24/7 number to be called for a crisis team to meet with the caller, handle whatever the caller is struggling with, and connect the caller with the appropriate services, and to connect the caller to the providers, and if needed, for integrated care, and hope to launch it in October. So do you have any update on that?

MS. CECIL: I am happy to say we have Leigh Ann Fitzpatrick with our behavioral health team, who's just going to provide an update and maybe some additional information

of what that model looks like.

MR. CAUDILL: Okay.

MS. FITZPATRICK: Sure, thank you. And as you mentioned, 988 is a number that has been in effect since last July 2022. It's a call line -- we have 12 call centers in the state that is managed by the Department of Behavioral Health. I am on that state implementation team, so I can give you information that I know.

And so that has been in effect, and there's 12 call centers within the state of Kentucky for 988. So anyone in a behavioral health crisis, if you ever have a question, can call 988, and they can get -- they can get appointments set up at that time, they can get referrals at that time. If the caller and the call-taker deems that that is a -- that they cannot de-escalate that call at that point, there can be a mobile crisis team to be dispatched out.

So Medicaid did receive a mobile crisis intervention services planning grant from CMS along with 19 other states. And with that planning grant, we looked at our

mobile crisis services, our definition of those services, the rates that are involved with those services, and what types of providers that can provide those services.

So we have -- one thing that came from that is a 265-page needs assessment. That we met with several providers -- several community stakeholders, and from that needs assessment that we did, that is where we focused all discussions, decisions, and determinations that we made. So it was kind of just determined that we needed to somehow better -- sorry, somehow better determine those services and make sure that those services are being implemented to the definition of CMS.

So yes, as of October 1st, 2023, we hope to have that in place. We should have an organization that's going to be able to monitor those calls, and they will subcontract with providers, and they will guarantee to us that they have coverage through the state of Kentucky -- that once the call-taker determines it is a mobile crisis dispatch that that mobile crisis team

can get to that person within 60 minutes.

Now, if they're traveling to that person and they can't get there in 60 minutes, and it's going to be, you know, they can call them and say, "Hi. My name is such and such. I am on the way to you." So there's going to be guaranteed communication within 60 minutes.

Once that mobile crisis team is there with that person and they assess that person and de-escalate, and if they can solve that crisis at that point with a referral or with a follow-up the next day, wonderful. If that assessment is done and it is deemed that that person needs to go to a higher level of care, we are starting at 23-hour crisis observation, so it's not residential, which we have right now, but 23-hour, we don't -- sometimes that person just needs to get away, take a break, talk with a counselor or talk with a case manager, or appear and just take a break, which is great. And if they need to go to a residential where they have to stay longer than 23 hours, or if, unfortunately, they

need to go on to the hospital, that can be done there, as well.

MR. CAUDILL: Okay.

MS. FITZPATRICK: Did I answer your questions, or do you have more questions?

MR. CAUDILL: No, I have no more questions. You did a good job. Thank you, Leigh Ann.

MS. FITZPATRICK: Okay, thank you.

MR. CAUDILL: All right. That's the last thing under old business. Is there anything that needs to be addressed under old business before we move to new business?

(No response.)

MR. CAUDILL: All right. Not hearing anything, we're going to move through agenda Item No. 6, new business, and under A, this is where we give Deputy Commissioner Veronica Cecil an opportunity to share with us anything that she wants to that may have not already been discussed. And so, Veronica.

MS. CECIL: Thank you, Mike. I think because we've talked about legislation, Senate Bill 65 is of concern to us, and

we're monitoring a lot of other pieces of legislation that may impact Medicaid. So we'll, you know, maybe report back on that at the next meeting.

But I did want to mention some of you may have heard that CMS approved California for an 1115 around juvenile incarceration. Just as a reminder, we, in December of 2020, filed an amendment to our 1115 that was very expansive to cover incarcerated individuals, but that was focused on adults. But we would have covered treatment inside the facility, those in prehearing status, and then connecting those getting ready for release, about 30 days prior to their release, with a managed care organization to help coordinate their care upon release.

So what we are doing we've already -- CMS reached out to states that had a pending incarceration waiver, and are encouraging us to amend ours because we do want to -- we do plan to mirror what California's been approved for the juvenile population. Because this is an area where CMS already feels comfortable with approving those,

we're going to continue to still work on an alternative option for the adults. We may have to kind of move back to something less expansive and just focus on the pre-incarceration and trying to help folks pre-release, to try to focus on those individuals.

The big piece there is that we just want -- we want people -- to support them to be as successful as possible, and part of that has been access to necessary medications, access to a community provider. So we're still looking at that, but I'm sure folks have probably heard that that was on the horizon, and we wanted to address that.

But I won't take any additional time. I think we've talked about, you know, the unwinding was sort of our big piece of information, but happy to take questions.

MR. CAUDILL: Okay. So for the committee members, this is our last shot at Veronica, with the exception of Barry. So do you all have any questions you'd like to pose to her?

(No response.)

MR. CAUDILL: Okay, Veronica --

MR. MULLINS: I'd just like to thank her for the transparency and for the initiatives that the administration has taken to try to address some of the concerns. Thanks, Veronica.

MS. CECIL: Thank you, Raynor.

MS. AGAN: This is Yvonne. I'd like to thank Veronica and all the people that work with her for, again, her openness and willingness to work on issues together and collectively. And I appreciate that very much; thank you.

MS. CECIL: Thank you. Well, and I'd like to recognize you all for your service. This is a, I know, a voluntary position, and we welcome the interaction. I think we all have the same goal in mind, but I want to thank you for the time and energy that you all have put into the TAC. And I'd like to think that we'll continue to work with you all even if you're not a member.

MS. AGAN: Yeah.

MR. CAUDILL: Does that mean we can keep your personal cell number in our

directory?

[Laughter]

MS. CECIL: Of course; always available. Always available.

MR. MARTIN: Veronica, is Jonathan still around? In regards to the 907 KAR --

MS. CECIL: I don't know if he stayed on. For that piece, it's just that --

MR. SCOTT: I'm here.

MS. CECIL: Oh, good. Okay.

MR. SCOTT: Sorry. I'm going to focus you on my smaller screen.

MR. CAUDILL: We'll move on the agenda then under new business, Item B. We've had a prior discussion on 907 1:082, but there's some additional questions I think Barry would like to pose at this time.

MR. MARTIN: Yeah. We've gotten your responses back. How is it going? What is the progress on this?

MR. SCOTT: I have been working with our behavioral health team, and I hope that I will be able to just either send an older version that we had prepared on through or just make some really small changes. We

were originally pausing to allow the behavioral health associate to be something that you all can do. We're going to introduce that, especially for people that are still trying to get some training and things like that, but we have to introduce it as a new regulation in Chapter 15, so we wanted to give you all kind of a cross reference and ability to use that. So that was the initial delay.

But then we found a couple of other just maybe nitpicky things that we needed to do to it, as well. Just updating some definitions and things like that, so giving it one more quick review. But I hope I can have it through the process next week.

MS. CECIL: Yeah, Barry, we just -- we kept it open because we thought we'd make some other updates to it during the time.

MR. MARTIN: Okay.

MS. CECIL: But no substantive changes in terms of what, you know, the version that you all can see out on our -- on the reg site.

MR. MARTIN: Okay.

MR. SCOTT: That's right.

MR. CAUDILL: All right.

MR. MARTIN: And sorry for cutting you off, Veronica. We really do appreciate all the help. We have a better working relationship with Medicaid now than we have in a long time, so we do appreciate it.

MR. CAUDILL: Couple of points then, as it -- well, let's go ahead and do 6C, community health worker reimbursement. Who will be presenting on that?

MS. CECIL: Well, you still get another chance at me. We have submitted our state plan amendment for coverage of community health workers. It is pending with CMS, so as soon as we get the -- we don't think there's any issues with it. We're pretty optimistic about it, so as soon as we get that approval, we'll start sending out more information and guidance on reimbursement. It will be a reimbursable service for an FQHC and RHC, but we'll provide more guidance as soon as we have that approval.

MR. CAUDILL: All right. Looking at

our chat box, Veronica wanted to make a correction about the presentation she did on slide seven. The correct number is 234,131 -- both at the top and the bottom of the slide.

And I believe the other questions have been answered. There is a question about whether or not there is the mechanism to recommend more in-state slots be approved for the dental programs. Would anyone like to speak to that?

MR. MULLINS: I would just say that issue is much more complicated than that because it gets into the whole structure of how dental education is financed in the Commonwealth. And it'd probably take an hour to really do that justice, so I'll just -- I was just typing a note to Barry, but I'll just add this comment into the minutes.

MR. CAUDILL: Okay. I'll be honest, the dental schools --

MS. MCKEE: This is Julie. I was --

MR. CAUDILL: -- have let us down, in my opinion. If you look, the University of Louisville did about 10 percent of the 120

students that are practicing in Kentucky, and this is consistent with what I've seen with professional schools, medical schools, the same way. And it probably is a reason why they hem haw around about what the numbers are, is because it's probably embarrassing to them that so few people end up being Kentucky dentists, or physicians for that matter. And that's my personal opinion.

MR. MULLINS: I'd like to add a comment to that, Mike, somewhat in defense of the colleges, as you might expect I might. Because my belief is they were forced into privatizing their budgets by state policymakers, and so they've had to contend with that. We can argue about the proportions of those things, but it is a much more complicated issue than just it might appear to be on the surface. And I'm happy to elaborate. As a matter of fact, my plan was to do a little piece on that and submit it to this ad hoc workgroup and others for their consideration. And I'll be sure and share that with you and others.

MR. CAUDILL: Okay. Thank you. And now we'll move to Item 7 on the agenda, reports from the MCOs. It starts out with United. Last time, Chris Kern and Dr. Cantor presented. Who will be presenting for United today?

MS. CANTOR: Good morning. This is Dr. Cantor with United Healthcare. Thank you for the opportunity to speak again.

MR. CAUDILL: Good morning. Please go ahead.

MS. CANTOR: Yes. Can you hear me? Good morning --

MR. CAUDILL: Yes, ma'am.

MS. CANTOR: Oh, good. Okay, thank you. A couple of updates from the hospital-to-hospital transfer. We had spoken about this at the EMS TAC. But we are working towards a process to make it easier for the transfer from one facility to another without a prior auth, or it's actually auto-approved, and then within 30 days, receive the physician-certified statement in order to validate the need for that transfer. So we're proceeding with

that implementation.

And the other point that I wanted to bring is just a reminder about using Z codes when submitting documents and claims. That helps us understand your patients, our members' needs and helps better position us to identify any gaps of patient care. And we can then connect with your patients to help them with resources and any treatment referrals. So those Z codes are super, super important, and just would like to encourage that utilization.

If there are any other questions or concerns from United Healthcare, I'm happy to take those.

MR. CAUDILL: Is there any questions for Dr. Cantor?

(No response.)

MR. CAUDILL: All right. Let's move to WellCare. Johnie Akers presented last time. Johnie, are you on?

MR. AKERS: Yes, sir. Good morning, Mike. So we have upcoming provider summits that we're scheduling for May. We're going to have those in Prestonsburg, Lexington,

Owensboro, and Louisville, and we'll be sharing and posting on the web more details this month about those provider summits.

Also, we do have a plan in place to help provide educational content about redetermination, and that will include future offerings during our biweekly webinar series that we host every other Friday at 1:00, that WellCare information forum.

So when we get that information finalized, we'll be able to share. And that's all that I have for today.

MR. CAUDILL: Thank you, Johnie.

MR. AKERS: Thank you, sir.

MR. CAUDILL: Humana. Last time, Darryl VanCleave and Jeff Hadley presented. Who will be presenting today?

MS. TRIGILIO: Hi, Mike. This is Pam Trigilio. Myself and Jeff Hadley will be presenting, and we do have a few slides if I could be granted access to share a screen, please.

MS. SHEETS: Okay. You should be able to share now.

MS. TRIGILIO: Thank you. All right.

Again, my name is Pam Trigilio. I'm the associate director for the provider relations team for Humana Healthy Horizons. We just have a few announcements and reminders for today.

First, we're welcoming two new provider relations representatives to my team this month. One of those will be serving some of the eastern counties, and the other one is serving some of our western counties. Once those two new associates are officially on board with my team, we will be sharing a new updated provider relations representative list with all of you, and it will also be posted to our website.

Over the course of this year, the PR team will be conducting PCP on-site visits to some of your office locations. And in those visits, we will provide education on important topics and then ensure compliance around some of the ADA and HIPAA requirements. Your PR rep will be reaching out to you for scheduling these, and we do ask that you partner with us so that we can meet you in person and provide some great

information to you.

Our newest addition of the new horizon provider newsletter will be published soon. This is a wonderful resource for some important provider topics, so please be watching from our PR team to share this to your e-mails. And as always, past editions of this newsletter can be found on our website.

And then lastly, providers will also soon be receiving a reminder, via fax, for your yearly compliance training requirements. Our preferred method of completing these trainings is the Availity, and the steps to access that training are outlined on this slide here.

So that is all I have for provider relations, and I will turn it over to you, Jeff.

MR. HADLEY: Thanks, Pam. Yeah, if you can, go ahead and advance the slide. I presented in our last TAC about -- I did a comprehensive, I think, overview of our value-added benefits and our rewards, so I kind of consolidated the things that I

thought were most applicable to primary care, just to kind of, you know, replant the seed for, you know, care for our members, let you know how we are trying to promote health and wellness.

We do have incentives that are around -- our Humana new beginnings is basically our maternal care program, and we do have incentives for our members that participate in screenings and wellness visits to address those issues. We have incentives around our health risk assessment that we conduct with our members. I don't know if there may be opportunities for us to do better sharing of information around what we get from those health risk assessments. I can explore that stuff internally.

We also do the incentives around what we call a level of care education, which is how we educate our members on when to go to the emergency room versus when not to go to the emergency room. And then what is the appropriate, I think, strategy or process to address whatever healthcare needs that our members have that could be better addressed,

as opposed to going to the emergency room?

Pam, would you click to the next slide? And then we also have incentives around our well-child visits. So, you know, we just want to make the primary care centers know that when dealing with Humana members, that when there is a new kid in the mix, that we do provide some significant incentives for those well-child visits that kind of accumulates. So there's up to $100 in rewards for our new mothers or new parents -- I guess I shouldn't isolate that to mothers -- new mothers and fathers that bring their kids in for their well-child visits. Based on the age of the kids, 0 to 15 months, there's up to $100 in rewards for those families; and then, 16 to 30 months, up to $40 in rewards for the families who bring in their kids and try to address the healthcare needs of their new family members. Next slide, please.

And then, just general wellness visits. We just want to make sure that we're making everybody aware that there are incentives and that we are actively

promoting health and wellness for our members to address those needs in relation to, you know, just going in for a general, once-a-year annual wellness visit. And then, wellness -- or, I'm sorry, weight management programs, and we have other incentive programs, which I kind of hit on in the last meeting, so I won't try to duplicate everything.

I think -- is that the last slide? Oh, and then, our Quality Member Access Committee. During the last meeting, there was some discussion around just engaging members and getting feedback from them. This slide and I think it will go to everybody, but it contains a lot -- this is kind of a summation of what we glean from feedback from our community advocates and our members as far as barriers to healthcare and accessing those things, as well as -- the map basically shows the locations of our 2023 scheduled enrollee feedback sessions that we're going to be hosting with folks.

And Mike, I really appreciate your suggestions during the last meeting. We've

reached out, and my reps in the different regions are connecting with folks. Your participation in those meetings and having our community advocates and having folks with the primary care centers attend those meetings and give us feedback on what the barriers to healthcare is, is essential to us in creating -- eliminating some of the barriers and creating greater access to healthcare. So I just wanted to express appreciation for all of our community advocates and our providers in attending those meetings because it really does help us, I guess, design our value-added benefits for the next planned year, as well as establishing what rewards will promote and incentivize healthy behaviors.

So this information will go out, and I'll be talking with you, Mike, and with other folks and inviting you guys to attend our enrollee feedback sessions, which also includes our community advocates, so I appreciate your participation in that. That's all -- that's all that I have, Pam.

MR. CAUDILL: Okay. Thank you, Jeff.

There's a question rolled up: Is the HRA value-added benefit of $20 for each member or per Medicaid household?

MR. HADLEY: It's per member. So, yeah. So for each member that completes our health risk assessment, they get the $20 benefit. And they don't have to do anything to generate that benefit. Once they complete that assessment, then it automatically generates that reward within our Go365 system.

MR. CAUDILL: Okay. Thank you very much.

MR. HADLEY: Thank you.

MR. CAUDILL: Moving on to D, Passport by Molina, and last time, Yolanda Cowherd was the speaker. And I see that she's on there; will you be talking today, ma'am?

MS. COWHERD: Yes. Hello, everyone. I'm Yolanda Cowherd with Passport by Molina. And today, I'd like to speak a little bit about our women and children's reward program. This program is for members who are identified as pregnant at 35-weeks or

later or report they have delivered with outreach by the screening team. They are referred to our supporting healthy moms and babies program, which, you know, for outreach.

This team is comprised of two community kynectors and an RN and CM with maternal-fetal experience. Once engaged in care, the member is followed until 12-weeks postpartum with the focus on education, addressing any barriers to care for mom and baby, social determinants of health-related needs, and ensuring mom attends her postpartum visit and baby gets off to a healthy start in life with appropriate preventative care.

The supporting healthy moms and babies team also completes screening assessments and a screening for postpartum depression. If the mother or child need ongoing CM support after 12 weeks, they continue with the program, or they are referred to a CM for longer care.

I do have a flyer if I can drop that in the chat, and I welcome any questions.

MR. CAUDILL: Is there -- any questions for Ms. Cowherd?

(No response.)

MR. CAUDILL: Okay.

MS. COWHERD: Thank you.

MR. CAUDILL: Let's move, then, from Anthem. Last time, it was Ken Groves filling in for Brian Richardson. I don't see Ken on here, but I do see Brian. Will you be speaking today, Brian?

MR. RICHARDSON: Hello, Mike. How are you?

MR. CAUDILL: I'm fine. Thank you, sir.

MR. RICHARDSON: Good. Just wanted to share eight different tutorials that we have coming up throughout the remainder part of 2023. And its -- I can give them to you.

Remaining in the first quarter, we have two more left, and they're titled advancing health equity by reducing disparities. That's going to be on March 15th at 11:00 a.m. and March 23rd at 1:00 p.m.

Another one that we're going to have

in the first quarter is 2023 annual coding updates, and that will be offered on April 13th at 11:00 and April 20th at 1:00. And I also want to state that all of these are out on our provider website, Anthem.com, and I direct you to go there so you can sign up for it if you feel you want to join one of these.

In quarter two, we have pregnancy and women's health, the HEDIS measures, and that will be on May 3rd at 11:00 a.m. and June 14th at 1:00 p.m.

The next one will be SDOH screening and measuring the impact, that's on May 17th at 11:00 and June 29th at 1:00.

The next one is substance use disorder overdose awareness, May 23rd at 11:00 and June 21st at 1:00.

In quarter three, we have diabetes management on July 6th at 11:00 and again July 20th at 1:00.

The next one is HEDIS ECDS quality measures. That's offered on August 9th at 11:00 and August 17th at 1:00.

The next category would be CPT

category, quality, and documentation. That's offered on September 14th at 11:00 and again on September 21st at 1:00.

And quarter four, we have two more, understanding risk adjustment, mood disorder, and suicide. That's on October 11th at 11:00 and October 25th at 1:00, and again on November 2nd at 11:00 and November 16th at 1:00.

So you can go to Anthem.com to find any of these that anybody would want to sign up for and go through the tutorial education. That's all we have this time, Mike.

MR. CAUDILL: Okay. Thank you so much, Brian.

MR. RICHARDSON: You're very welcome.

MR. CAUDILL: We're going to move to Aetna. Let's see, Ken, did you have anything you wanted to add before I did?

MR. GROVES: I'm sorry, are you asking Ken Groves?

MR. CAUDILL: I'm sorry?

MR. GROVES: I don't have anything, thank you.

MR. CAUDILL: Okay. Didn't want to leave you out there.

MR. GROVES: No problem.

MR. CAUDILL: Okay. Let's go to Aetna. Krystal Risner presented last time. Would you have a presentation this time, please?

MS. RISNER: Good morning. Krystal Risner, provider relations with Aetna Better Health of Kentucky. And I just have an update to share today in regards to our current ERA EFT enrollment process. In an effort to better streamline a way for providers to access enrollment and electronic payment, Aetna Better Health of Kentucky is partnering with Change Healthcare. We introduced a new ERA EFT enrollment system. The new enrollment process actually takes effect on March 31st '23. After this date, enrollment submissions or changes will no longer be sent directly to Aetna Better Health of Kentucky as they are today. Providers will begin to submit those new enrollment changes or new enrollment forms or changes directly

through Change Healthcare. If providers are currently enrolled in ERA or EFT, there is nothing additional that needs to be done.

Details about this communication were actually sent out yesterday afternoon to all providers that are currently enrolled in our constant contact communication platform. The notices can also be found on our website, as well as other newsletters or anything that is sent out throughout the month, and that can actually be found under the newsletter and notice tab.

And lastly, if you're not already enrolled in the constant contact platform, you can reach out to your network provider relations manager and request that your information be added to our list.

And I believe that's all. Thank you for the time.

MR. CAUDILL: Thank you very much, Krystal. Moving on to Item 8 on the agenda, recommendations to the MAC. We've not discussed one during the meeting, but is there a recommendation to be considered?

(No response.)

MR. CAUDILL: Hearing none, let's go to MAC meeting representation, whose next meeting is March 23rd at 10:00 a.m. I've been asked by KPCA to go ahead and make a presentation at that time, and I have accepted in doing that.

We'll go to next meeting, May 4th, 10:00 a.m. The KPCA will send out the information for you all to get on.

Let me say at this time, before we adjourn, that it's certainly been a pleasure to be on this committee, and it's certainly been a pleasure to serve in the capacity of chair for the last couple of years.

I think that we have accomplished several things. I think that one of the simple things with MCOs is getting cheat sheets, if you will, of all the COVID benefits that was available, and, lately, the addiction benefits that was available to be able to give out to our members in one place.

I think that this issue, the dental shortage that the MAC committee has adopted, is extremely important and shows a great

need in the Commonwealth that needs to be overcome.

We've talked about same-day visit payment, and again, that was adopted by MAC. The department is still considering that, and I certainly hope that they carry on what started here and help correct that issue.

Autism awareness, if you remember, Tal Curry made a presentation back in January. This is an area that affects 1 in 44 people in this country and is becoming more and more prevalent. It's like doubled in the last 20 years or so. There's a lot of discrepancy, it's a labor-intensive thing with a low reimbursement, and the focus needs to be on it to help so many of our citizens, both in treatment and accessibility. And I think that we've made a good start with that.

The thing that's being worked on about core quality measures uniformity is something that we, as practitioners, need. It helps simplify it so that we can have a better effect on these quality measures by

being able to concentrate our resources and not have them spread out so much.

And in this meeting, I've noticed over the last years that the managed care organization representatives are much more vocal and bring together -- and bring us a whole lot of information, much more so than when I started this.

And to end it, I'm going to read something that the KPCA CEO said last time in her minutes. It says, "I really appreciate Medicaid listening and helping to address issues, but I think that also shows where the TAC comes into play with us sharing where the issues are. So I think that the future looks bright for continuing these discussions and using the TAC to help develop better policies."

And I think that very well sums up, and I hope that during my tenure here and the board members' tenure, we've been able to live up to that. And I sincerely hope that the group that will be replacing us on this board will carry on, both on the issues that we've raised and develop them on their

own.

So that having been said, the next meeting is May 4th at 10:00 a.m. And is there a motion to adjourn?

MR. MARTIN: I make a motion to adjourn.

MS. AGAN: I second.

MR. CAUDILL: All right. We will adjourn at 12:00. Have a good day, everybody.

(Meeting adjourned at 12:00 p.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

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

Dated this 20th day of March, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR