1 CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
9 July 28, 2022
Commencing at 10:00 a.m.
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Shana W. Spencer, RPR, CRR
16 Court Reporter

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1 APPEARANCES

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3 ADVISORY COUNCIL MEMBERS:

4 Elizabeth Partin - Chair
Nina Eisner (not present)
5 Susan Stewart (not present)
Dr. Jerry Roberts
6 Teresa Aldridge - Secretary
Dr. Garth Bobrowski - Co-chair
7 Dr. Steve Compton
Dr. John Muller (not present)
8 Dr. Ashima Gupta
John Dadds (not present)
9 Dr. Catherine Hanna
Barry Martin
10 Kent Gilbert
Mackenzie Wallace (not present)
11 Annissa Franklin (not present)
Sheila Schuster
12 Bryan Proctor
Peggy Roark
13 Eric Wright (not present)

14 Commissioner Lisa Lee
Senior Deputy Commissioner Veronica Cecil
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1 CHAIRMAN PARTIN: Let's go ahead
2 and call the meeting to order. And, Teresa,
3 are you on? Would you take the roll call?
4 (No response.)
5 CHAIRMAN PARTIN: So I guess she is
6 not on. So, Veronica, I think you said that
7 Dawna was the staff person today?
8 MS. CECIL: Yes. I don't know.
9 Dawna, do you have --
10 MS. CLARK: I'm here, and I can go
11 ahead and do roll call.
12 CHAIRMAN PARTIN: Okay.
13 MS. CLARK: Okay. Elizabeth
14 Partin.
15 CHAIRMAN PARTIN: Here.
16 MS. CLARK: Nina Eisner.
17 (No response.)
18 MS. CLARK: Susan Stewart.
19 (No response.)
20 MS. CLARK: Dr. Jerry Roberts?
21 MR. ROBERTS: Here.
22 MS. CLARK: Teresa Aldridge.
23 (No response.)
24 MS. CLARK: Dr. Garth Bobrowski.
25 DR. BOBROWSKI: Here.

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1 MS. CLARK: Dr. Steve Compton.
2 DR. COMPTON: Here.
3 MS. CLARK: Dr. John Muller.
4 (No response.)
5 MS. CLARK: Dr. Ashima Gupta.
6 DR. GUPTA: Here.
7 MS. CLARK: John Dadds.
8 (No response.)
9 MS. CLARK: Dr. Catherine Hanna.
10 (No response.)
11 MS. CLARK: Barry Martin.
12 MR. MARTIN: Here.
13 MS. CLARK: Kent Gilbert.
14 MR. GILBERT: Here.
15 MS. CLARK: Mackenzie Wallace.
16 (No response.)
17 MS. CLARK: Annisa Franklin.
18 (No response.)
19 MS. CLARK: Sheila Schuster.
20 DR. SCHUSTER: Here.
21 MS. CLARK: Bryan Proctor.
22 MR. PROCTOR: Here.
23 MS. CLARK: Peggy Roark.
24 MS. ROARK: Here.
25 MS. CLARK: Eric Wright.

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1 (No response.)
2 MS. CLARK: You have ten MAC
3 members here.
4 MS. HANNA: I apologize. I am
5 here. I apologize. I'm on -- my father's
6 caregiver didn't show up, so I apologize. I
7 had to jump away for a minute. Thank you.
8 This is Kathy Hanna.
9 MS. CLARK: Okay. That brings us
10 to 11 MAC members present.
11 CHAIRMAN PARTIN: Okay. So we do
12 have a quorum, so we can go ahead and move
13 forward.
14 Peggy, I saw that your hand was raised.
15 Did you need to say something?
16 (No response.)
17 DR. SCHUSTER: I think she had it
18 up originally, Beth, to indicate that she was
19 here.
20 CHAIRMAN PARTIN: Okay. Thanks,
21 Sheila.
22 DR. SCHUSTER: Yep.
23 CHAIRMAN PARTIN: Okay. So next on
24 the agenda is approval of the minutes for
25 May. Would somebody like to make a motion?

1 DR. SCHUSTER: I'll move their
2 approval. This is Sheila Schuster.
3 DR. BOBROWSKI: Garth Bobrowski
4 seconds.
5 CHAIRMAN PARTIN: Okay. Any
6 discussion?
7 (No response.)
8 CHAIRMAN PARTIN: All in favor, say
9 aye?
10 (Aye.)
11 CHAIRMAN PARTIN: Anybody opposed?
12 (No response.)
13 CHAIRMAN PARTIN: Okay. Minutes
14 are approved. Next, we'll move on to old
15 business. And, first of all, I would like to
16 extend a thanks to the Department of Medicaid
17 Services and the commissioner for updating
18 the Rural Health Clinic Reg, 907 KAR 1:082.
19 I think those updates to that regulation are
20 good and important, and I thank you for
21 moving forward on that.
22 So having said that, we'll just move
23 into the old business. First up is: When
24 will Medicaid regulations promulgate -- I'm
25 sorry. When will Medicaid promulgate

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1 regulations to reimburse Certified
2 Professional Midwives?
3 MS. LEE: Good morning, this is
4 Lisa Lee, commissioner for the Department For
5 Medicaid Services. At this time, we have
6 several projects that we're working on, and
7 many of them from legislation that was passed
8 in this session and last session. And so
9 while we understand the request for -- to
10 include Certified Professional Midwives, at
11 this time, we are not considering adding it
12 and nor will we be doing that in the near
13 future.
14 But as you know, Dr. Partin, just from
15 the conversation and just acknowledgment of
16 the rural health clinic changes, you know, we
17 do continue to listen to the MAC
18 recommendations, and we'll work with you all
19 to make sure that we're making policy changes
20 that are very pertinent to the program and
21 that will enable our members to be seen and
22 receive the services that they need.
23 But right now, at this time, given our
24 workload and the stretching of our staff
25 based on all of the projects we have that

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1 we're working on, we are not going to move
2 forward with reimbursement -- regulations to
3 reimburse Certified Professional Midwives at
4 this time.
5 CHAIRMAN PARTIN: Okay. Thank you.
6 And just as I continue to do, I'll continue
7 to keep that on the agenda, and maybe one of
8 these days, it'll be a yes.
9 MR. GILBERT: Madam Chair, may I
10 raise a question? I'm new to the MAC, of
11 course, so I'm trying to gain my feet here,
12 and perhaps Ms. Lee can help me.
13 So though it has been enacted in law
14 that it's okay, what's the consequence of not
15 promulgating regulations? Does this mean
16 that nurse midwives will not be paid or
17 reimbursed?
18 CHAIRMAN PARTIN: No. Nurse
19 midwives are currently reimbursed. This is a
20 new category. They're Certified Professional
21 Midwives. They are not nurses. They are
22 regulated by the Board of Nursing, and they
23 must pass national certification exams in
24 order to be certified and be able to practice
25 under the regulation of the Board of Nursing.

1 But they're not reimbursed for their services
2 by Medicaid.
3 MR. GILBERT: But I thought the --
4 wasn't there legislation this year that
5 enacted their reimbursements?
6 CHAIRMAN PARTIN: No.
7 MR. GILBERT: Isn't that what 575
8 did?
9 CHAIRMAN PARTIN: No. They're not
10 reimbursed for their services. They are
11 recognized, and they are able to practice.
12 They're just not able to be reimbursed by
13 Medicaid.
14 MR. GILBERT: I see.
15 DR. SCHUSTER: Madam Chair, I think
16 Kent is thinking about the community health
17 workers which was House Bill 525. And that
18 was --
19 MR. GILBERT: Yeah. Thank you.
20 DR. SCHUSTER: And that was in
21 legislation, Kent.
22 MR. GILBERT: Thank you, Sheila.
23 DR. SCHUSTER: Yep.
24 CHAIRMAN PARTIN: Okay. Next item
25 is continuing Zoom meetings. We had talked

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1 in the past about meeting in person in
2 September. And so I just wanted to bring
3 this up again with the group to see if you
4 are comfortable meeting in person in
5 September, or do you want to meet by Zoom?
6 So any -- any discussion on that? Any
7 thoughts?
8 MR. GILBERT: I would likely think
9 it would have to do with where we are
10 numbers-wise which are not currently good. I
11 know that it would be lovely to see everyone
12 in person, but I think maybe if we are not
13 out of the red, as a substantial number of
14 our counties are, I'm not sure that both
15 travel or meeting in person is as wise as it
16 might be otherwise.
17 CHAIRMAN PARTIN: Thank you, Kent.
18 Anybody else have any thoughts on that?
19 MR. MARTIN: Yeah. If we don't do
20 it in September, as the year progresses and
21 the winter hits, we might as well just
22 postpone it until next summer.
23 CHAIRMAN PARTIN: So are you in
24 favor of meeting in person or by Zoom, Barry?
25 MR. MARTIN: If we can't meet in

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1 September, we probably should just put it off
2 until spring or attempt to do it in the
3 spring.
4 CHAIRMAN PARTIN: Okay. Any other
5 thoughts?
6 DR. BOBROWSKI: This is Garth
7 Bobrowski. I would recommend just going with
8 the Zoom for our September meeting. And just
9 like Kent said, just maybe wait and see what
10 the numbers are looking as the year goes
11 along for the in-person meeting. I know we
12 had agreed to go to once a year to try to do
13 an in-person. But I think this September
14 might be too early.
15 CHAIRMAN PARTIN: Okay. So I -- as
16 much as I would love to meet in person with
17 everybody -- because I miss seeing you and I
18 miss that interaction. I miss our little
19 side conversations before and after the
20 meeting. But I'm inclined to also agree that
21 since we've got counties in the red, that it
22 might be wiser to meet by Zoom.
23 So we haven't heard from all the MAC
24 members. So if there's any MAC member who
25 would like to meet in person, please speak

1 up.

2 MS. ROARK: I think the Zoom

3 meetings are the best for our gas prices, and

4 I'm trying to work and with the COVID. And I

5 just feel like it's the best for me.

6 CHAIRMAN PARTIN: Okay. Thanks,

7 Peggy. Well, then, I don't hear any

8 objections, so I think we'll go ahead and

9 meet by Zoom in September.

10 MR. MARTIN: Sounds good. I still

11 think that we should have it as a goal for us

12 to meet in person once a year but find an

13 opportune time to do that.

14 CHAIRMAN PARTIN: Yes. Yes. I

15 agree. And we can -- we can revisit that

16 again in September if you like. We should --

17 November should still be okay for travel. If

18 COVID numbers are down and people are feeling

19 comfortable, we could change our mind. But

20 for now, let's just say that we will continue

21 Zoom meetings until next spring.

22 MR. MARTIN: Okay.

23 CHAIRMAN PARTIN: Okay. Next up --

24 and I see myself on the screen now. I just

25 got a little hesitant. Okay. Anyways.

1 Okay.
2 Update on missed and cancelled
3 appointments. How is the reporting going,
4 and is there a common thread as to why
5 patients are not showing up for appointments?
6 I guess this would go to commissioner or
7 somebody from DMS.
8 MS. LEE: Yes. Thank you. Lisa
9 Lee again. We have been monitoring reports.
10 For example, we pulled up the latest
11 quarterly report in this last quarter ending
12 in June. We do show 10,640 logged missed
13 appointments in the system. And, again, our
14 information is only as accurate as the
15 provider's report.
16 Of those 10,640, a little over 7,000, or
17 67 percent of those, were just a no-show, no
18 reason provided. We also are showing that
19 about 11 percent, or a little over 1,000,
20 individuals rescheduled their appointments.
21 Transportation issues are low on the
22 list. Only 73 of those 10,000 reported as
23 transportation issues, 12 childcare issues.
24 But, again, the biggest was the no-show and
25 the no reason provided at 67 percent.

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1 And I believe that the MCOs that are
2 presenting today, they may have more
3 information on some of the no-shows specific
4 to their population.
5 CHAIRMAN PARTIN: Okay. That's
6 kind of concerning, that they're -- and it's
7 kind of what we thought, too. People are
8 just not showing up. They're just not
9 showing up. There's no reason.
10 MS. LEE: And I think we could put
11 it into perspective, too. But, again, though
12 all we know are those no-shows that are
13 logged. But we could also go back, and for
14 this same quarter, we could run a report
15 showing the actual total number of
16 individuals who didn't show up to get a
17 percentage of Medicaid population that's not
18 showing up for their visits.
19 Because when we look at the 10,000, you
20 know, in a quarter, that does sound like a
21 lot. But when we compare that to the, you
22 know, the claims and the individuals who did
23 show up, you know, we'll see what the actual
24 percentage is per quarter. And we may need
25 to start looking at it in that lens, also.

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1 CHAIRMAN PARTIN: Okay.
2 MR. COMPTON: Madam Chairman, Steve
3 Compton. I think the no-show is probably
4 underreported, though. So when we start
5 looking at those percentages, we need to keep
6 that in mind. We know who showed up, but the
7 no-shows are not -- not every practitioner is
8 reporting.
9 MR. MARTIN: Not only that, but if
10 you use overall utilization, that will
11 include walk-ins.
12 MR. COMPTON: Good point.
13 MS. LEE: Yeah. And thank you,
14 Mr. Compton, for that observation. We do
15 know that the information is only as accurate
16 as we have in our system and if it is logged.
17 So something that we, you know, still want to
18 keep an eye on.
19 And I think at the last one -- at the
20 last MAC meeting, Dr. Bobrowski, you may have
21 even mentioned somebody who had missed 11
22 appointments. And if we can find those
23 individuals and reach out to them just to see
24 what we can do to help get them into the
25 office, to their appointments.

1 Because that's going to be -- that's the
2 overall arching goal of this project, is to
3 try to identify those individuals,
4 particularly those that miss one or more
5 appointments, so that we can find out why
6 they're missing, help them get in to their
7 appointments, and make sure that they're
8 adhering to their medication protocol and
9 other measures to make sure that their
10 health -- that they're taking care of their
11 healthcare needs.
12 MR. MARTIN: I think we also need
13 to stress to the providers that that's there,
14 and they need to use it. And if they don't
15 use it, then it doesn't give you good numbers
16 to -- to leverage.
17 DR. SCHUSTER: Yeah. I'd like to
18 follow up on that. We discussed this at the
19 behavioral health TAC, and we were going to
20 ask for a report on who is it that is
21 reporting.
22 I know that you all can break that down,
23 Commissioner, by behavioral health versus,
24 you know, different specialties and so forth.
25 And I think it would be really helpful to

1 have that information as well. We'd sure
2 like to get after our behavioral health
3 providers to make sure that they're using the
4 portal. Thank you.
5 MS. LEE: And I think keeping in
6 mind the overarching goal of we're trying to,
7 No. 1, reduce the number of no-shows but,
8 No. 2, make sure that individuals are getting
9 to their healthcare appointments and taking
10 care of their healthcare needs.
11 So I think -- I don't know that we have
12 had enough information about the no-shows
13 out. I know we have trained providers it's
14 in the system, but I don't know that we have
15 communicated widely enough the importance of
16 logging those no-shows.
17 So maybe we can do something in the
18 department to kind of help get the providers
19 to go ahead and start logging those no-shows
20 so that we can help them bring their members
21 into their offices for treatment.
22 DR. GUPTA: This is Dr. Ashima
23 Gupta. I know that our office, for example,
24 we've had so much turnover since COVID that I
25 know that reporting is not happening at my

1 office. It's just with the turnover, it just
2 gets -- you know, that's like the least on
3 the priority list to take care of. So maybe
4 even just like a quarterly email that's sent
5 out to the providers, I think, will really
6 help.
7 MS. LEE: Thank you for that
8 recommendation.
9 CHAIRMAN PARTIN: I think, also, it
10 will be good to look at the overall patients
11 that are showing up comparing to the ones
12 that don't. But I also would want to temper
13 that by saying that even if it's just two
14 patients a day, for a practice, that's a lot.
15 Because that's two slots that could be filled
16 by somebody else who wants an appointment
17 that day and who's put off because there's,
18 you know, an appointment scheduled.
19 So looking at that, I think, is
20 important. But, also, I think we need to
21 keep in mind that it may not get to the crux
22 of the problem.
23 DR. SCHUSTER: Madam Chair, I think
24 Dr. Theriot has her hand up.
25 DR. THERIOT: Thank you,

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1 Dr. Schuster. I was just wondering -- well,
2 it would be nice to know what the providers
3 are doing when a patient no-shows or misses
4 an appointment. Because that's the point in
5 time that it would be nice to intervene, you
6 know.
7 And I wonder if there's some best
8 practices out there, you know. So if a
9 patient doesn't show, reaching out to that
10 patient right away to, you know, see what's
11 going on to try and get them in. And, again,
12 it might be a reminder, but it also might be
13 a car problem, you know, whatever else.
14 But I'm just wondering what the
15 providers themselves are doing at -- you
16 know, on that day to help patients attend
17 their appointments.
18 CHAIRMAN PARTIN: That's a good
19 idea.
20 MR. MARTIN: Well, we're finding
21 across the board -- dental, behavior, and
22 medical -- that a lot of it is just common
23 offenders, the same offenders with multiple
24 no-shows. And then you spatter in a few that
25 doesn't do that on an ongoing basis. But

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1 across the board, it seems like there's a
2 constant population that does that.
3 DR. THERIOT: Well, that's even
4 better. So knowing that ahead of time, you
5 know, what's being done to reach out to those
6 patients in particular to help?
7 MR. MARTIN: I think we're all
8 trying to call, confirm appointments. And
9 even when you confirm them, they still don't
10 show up. And even our registration clerks,
11 it's gotten to the point where they already
12 know, okay, we're scheduling them, but
13 they've not showed the last three or four
14 visits. They're not going to show again.
15 So that's where we need help from the
16 MCOs and Medicaid and other insurance
17 companies to help target those that we know
18 that we're wasting time on. And the ones
19 that doesn't show because of whatever
20 sporadic reasons, then those are ones that
21 may have legitimate reasons or not. I think
22 it's a targeted population we're looking for.
23 DR. THERIOT: Thank you.
24 CHAIRMAN PARTIN: Yes. I would
25 agree with that. At our clinic, we've

1 purchased a reminder, a text reminder through
2 our EHR which added quite a bit of expense.
3 So far, I can't say that it's made a whole
4 lot of difference.
5 We do call people when they miss their
6 appointment and try to reschedule. Sometimes
7 they will schedule another appointment.
8 Sometimes they just tell us they'll call
9 back.
10 DR. BOBROWSKI: Sometimes at our
11 office, if they miss several appointments
12 like Commissioner Lee alluded to, we finally
13 just get to the point and say, on a day you
14 can come, you call us first thing in the
15 morning. And if we get an opening, we'll
16 call you. Otherwise, you can call on another
17 day.
18 Because at some point as a business, we
19 just -- and these are adults. Enough is
20 enough. Act like an adult and be responsible
21 for these appointments. I hate to be -- we
22 don't mean to be mean or crude. But, you
23 know, some offices, you miss a couple
24 appointments, and you're just dismissed.
25 Now, we haven't done that.

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1 But it's just like last Thursday night
2 about 7:30, I got a phone call. A lady
3 called. I don't know how she got my personal
4 cell phone number but called my personal cell
5 phone number and said -- well, she messaged
6 me on Messenger first. Then she called me
7 five minutes later. Oh, I'm in pain.
8 Well, she's already missed four
9 appointments this spring and summer. Well,
10 you know, I didn't come in on that night. I
11 already was into something else and then
12 she -- and she didn't call Friday to be seen.
13 We had to call her Tuesday to be seen, and we
14 got her in and took care of her.
15 But, you know, these are adults, and I
16 just think we just need to sometimes just
17 quit spoon-feeding them and just say, well,
18 this is the reality of you missing your
19 appointments.
20 You know, yes, it's just like Dr. Partin
21 says, we've got that text reminder system,
22 and that adds an expense to your office
23 running. And I think a lot of these ideas
24 are good. But at the same time, you've got
25 to be really careful of all the

1 administrative burden that we put on our
2 front office staff or assistants and nurses
3 and whoever helps to keep up with this
4 paperwork.
5 Because that's kind of one of the common
6 things that we hear, is that the
7 administrative burden is just getting
8 unsustainable for some of these programs.
9 DR. GUPTA: This is Dr. Ashima
10 Gupta. I totally agree. I mean, on
11 Monday -- we're in a private practice,
12 totally independent. I had ten no-shows on
13 Monday. And with decreasing reimbursement
14 from insurance companies, it just -- it makes
15 it very difficult to sustain a practice,
16 especially with inflation. And we have to
17 pay our employees so much more than we did
18 three years ago just to keep them.
19 MR. MARTIN: I agree. It's
20 just Medicaid has given us a tool to use, and
21 if we don't use it and give them the
22 information, we can't get them to hold our --
23 hold our patients accountable.
24 I think if we can give them the
25 information, then it's up to Medicaid to

1 help, with the MCOs, hold our patients
2 accountable that are missing these.
3 I think we're just going to keep
4 struggling. At least they've given us a tool
5 to use. We need to try to use it and give
6 them the information somehow.
7 MR. DUKE: Commissioner, just to
8 your question related to: What are MCOs
9 doing? Jeb Duke from Humana.
10 I will tell you we're doing the best of
11 our ability to take action. So any member on
12 a report is getting a letter, just ensuring
13 that we're stressing the importance of
14 coordinating and communicating with
15 providers. Any member in case management,
16 either behavioral health or physical health,
17 is getting a phone call to ask about barriers
18 to their appointments.
19 And then members who are frequent
20 flyers, members who hit the report more than
21 once, are also getting live phone calls to
22 try to understand why our members aren't
23 maintaining their appointments. But we hear
24 the frustration, and we're willing to
25 innovate and do any recommendations. But

1 we're taking action with the information we
2 do have.
3 CHAIRMAN PARTIN: This has been a
4 really good discussion, and I think we've hit
5 some points here. I think providers need to
6 work harder providing this information to DMS
7 and then DMS can, in turn, work on the
8 information that they receive to help us come
9 up with a solution for this.
10 So I appreciate everybody's input. It
11 helps a little bit, you know, when you're
12 dealing with a problem, to hear that you're
13 not alone. So thank you for everybody
14 speaking up.
15 Next up on the agenda is update on
16 reimbursement for multiple visits on the same
17 day.
18 MS. LEE: I think I'm going to turn
19 it over to the Senior Deputy Commissioner,
20 Veronica Judy Cecil. She's been working on
21 this topic, so Deputy -- Senior Deputy
22 Commissioner.
23 MS. CECIL: Thank you. So this is
24 something the primary care TAC brought up,
25 and we are continuing to do our deep dive in

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1 this. We're working with Myers & Stauffer
2 who does all of our rate development for our
3 FQHCs and RHCs so that we can really
4 understand the impact to the program.
5 Part of their -- their work is to
6 research across states what other states are
7 doing. The challenge there is that every
8 state is different. I think you always hear:
9 When you see one state Medicaid agency, you
10 know one state Medicaid agency. So we're all
11 different in how we administer the program.
12 But we're still gathering that
13 information, and we will be presenting that
14 to the primary care TAC so that they can take
15 that information and utilize it as -- you
16 know, whether or not they want to present a
17 recommendation from that.
18 CHAIRMAN PARTIN: Okay. So do I
19 need to keep this on the agenda for the next
20 meeting, then?
21 MS. CECIL: I -- my recommendation
22 is to, you know, allow the primary care TAC
23 to -- because it's on their agenda, to allow
24 them to review it since that's where it came
25 out. But I certainly will defer to the MAC

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1 on how they want to handle that.
2 CHAIRMAN PARTIN: Okay. I think
3 that it's an issue with primary care. But if
4 I'm not mistaken, it's also an issue with
5 other specialties. Because people have a
6 primary care appointment and they have a
7 specialty appointment on the same day, and
8 that's where we're running into the issue.
9 MS. CECIL: Yeah. But it's
10 specific to the three entities that receive a
11 supplemental payment, the FQHCs, the RHCs,
12 and the CCBHCs. And you've got to love
13 acronyms.
14 CHAIRMAN PARTIN: Yeah, right.
15 MS. CECIL: But the specialty --
16 that's what we're diving into, so it's not
17 just behavioral health or medical, physical
18 health appointment. It would also include,
19 you know, whether or not a specialty -- you
20 know, some other specialty like dental or,
21 you know, just some other provider type
22 service. So that's what we're looking at.
23 CHAIRMAN PARTIN: Okay.
24 MR. SHANNON: This is Steve
25 Shannon. The four CCBHCs are just new to

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1 this world since January, but it clearly is a
2 question that's come up amongst ourselves as
3 well. How does this play out? And so -- and
4 is there a disincentive to scheduling
5 multiple visits on the same day for a person?
6 MS. CECIL: So I just want to
7 remind everybody how the rate gets developed.
8 It's about the scope of services that are
9 provided. So it includes, you know, all the
10 services that are provided, all of the
11 practitioners that provide those services.
12 And that gets utilized to develop the rate.
13 And so that's why it is a -- you know, a
14 daily rate. And if there's a change in
15 scope, then there's -- then, you know, that
16 can trigger a change in the rate. So, you
17 know, it's supposed to be contemplated in the
18 development of the rate for all services
19 delivered on that date. That's the model.
20 But, again, we're taking a look at it.
21 We understand and have heard the concerns of
22 the providers on this, and we're going to
23 take a look and see what we can find out and
24 work with the providers on if there's, you
25 know, a different model that they're

1 interested in adopting.
2 There are -- I will tell you there are
3 good and bad with each model, and there are
4 winners and losers with each model. So that,
5 I think, all has to be taken into
6 consideration.
7 MR. MARTIN: This is Barry, and I'm
8 on the primary care TAC. And Medicaid has
9 been working with us, and we are reviewing
10 the information they're giving us. And I
11 think just leave it on there, and I think,
12 hopefully, we'll come to a resolution or a
13 recommendation to either take it off or
14 recommend some action.
15 So we're working on it. I would
16 recommend just to keep it on this agenda, and
17 hopefully we'll be able to address it.
18 CHAIRMAN PARTIN: Okay. Thanks
19 for --
20 MR. MARTIN: Is that all right,
21 Deputy Commissioner Cecil?
22 MS. CECIL: I defer to you all.
23 MR. MARTIN: Okay.
24 CHAIRMAN PARTIN: Okay. Thanks,
25 Barry. So I will keep that on the agenda,

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1 then.

2 Okay. Next is Hepatitis C prenatal

3 screening. Number of cases and number

4 treated. This issue came up at a previous

5 meeting, and I think those numbers were going

6 to be presented today.

7 DR. THERIOT: Hello. This is

8 Dr. Theriot. I surprisingly was having

9 trouble getting the numbers, and I think I'm

10 pulling them wrong. The numbers I got were

11 less than one percent of our pregnant women

12 were being screened for Hepatitis C, and I

13 really don't think that's correct.

14 I looked at one of our state university

15 partnerships, and their number was 11 percent

16 of pregnant women in Kentucky Medicaid

17 getting screened for Hepatitis C. I was very

18 happy with that number because it was much

19 more than one percent. But as you know, it

20 really should be 100 percent. So we're still

21 looking into that.

22 Just to give people background, Kentucky

23 is the second-leading state for adults with

24 Hepatitis C. About two percent of our adults

25 have Hepatitis C in the state, and we lead

1 the nation in pregnant women who are positive
2 for Hep C. About eight percent of babies
3 that are born to moms who are Hep C positive
4 will end up becoming positive themselves for
5 Hepatitis C.
6 And we have a wonderful treatment, so
7 it's easy to treat, honestly. And so we
8 really need to screen and find out every
9 single person that has it so we can treat
10 them and cure them.
11 So that's a long way to say I don't
12 really have specific numbers right now and --
13 but I have been working on it, and I will try
14 and get those for next meeting.
15 CHAIRMAN PARTIN: Okay. Thank you.
16 So we'll put that on the next meeting, then.
17 That's -- if that's correct, that's alarming
18 because isn't that mandated, that that
19 screening be done?
20 DR. THERIOT: It is. It is. Yes.
21 And I'm actually very scared that the number,
22 the 11 percent, is actually accurate so...
23 CHAIRMAN PARTIN: Wow. Okay.
24 Well, hopefully we'll have better news next
25 meeting.

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1 DR. THERIOT: Hope so.
2 CHAIRMAN PARTIN: The next item on
3 the agenda is just a reminder that our next
4 update on maternal/child health will be in
5 November.
6 And then before we move on to updates
7 from the Commissioner, I wanted to just say
8 that for our election today, we have one
9 candidate for each position. And so at the
10 end of the meeting, we will do our election.
11 But if anybody is interested in running,
12 please let us know, so you can be added to
13 the slate. Otherwise, we'll just do a voice
14 vote of approval.
15 Okay. Next up is reports from
16 Commissioner Lee.
17 MS. LEE: Hello. Thank you. So
18 I'm sure, as many of you may have been
19 watching the news today and to see the
20 devastating floods in eastern Kentucky, we
21 have seen on the news several people losing
22 their homes. Some people are missing,
23 definitely just devastation due to all the
24 flooding.
25 We have been in touch with our MCOs

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1 relating to some of the actions that they're
2 taking to make sure that individuals have
3 access to their medications. Dr. Fatima Ali
4 is also working with MedImpact to make sure
5 that individuals who may need emergency
6 prescription pills can get them, focusing on
7 individuals who may be in case management or
8 in in-patient, looking at, you know, some of
9 our long-term care facilities to see if
10 there's any impact there.
11 But, again, just trying to do everything
12 we can to make sure that individuals in the
13 eastern part of the state that are being
14 impacted by these floods have access
15 particularly to their medications and
16 healthcare services if they need them.
17 So we'll -- you know, more to come on
18 that but definitely are working with our
19 MCOs. And I would like to definitely thank
20 all of the MCOs who have initiated contact
21 with the department to see what they can do
22 in order to help individuals in the eastern
23 part of the state.
24 Our MCO partners, as you know, were very
25 critical in western Kentucky during the

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1 tornados in helping ensure that not just
2 Medicaid members but other members in the --
3 other individuals in the community had access
4 to health care and the supplies that they
5 need. So we'd just definitely like to thank
6 the MCOs for all they're doing right now for
7 the communities in eastern Kentucky.
8 One update, a little bit of sad news, is
9 that those of you who may know Lee Guice and
10 work with her, her last day will be tomorrow.
11 She is retiring effective August the 1st. We
12 definitely hate to see her go.
13 She has a wealth of knowledge and has
14 been -- as you know, been very instrumental
15 in many of the TAC meetings. In her -- as
16 she leaves, Justin Dearinger will be acting
17 director for a while. So if you have any
18 questions for Lee, you can reach out to
19 Justin.
20 The other bit of news that we have, I'm
21 going to turn the conversation back over to
22 Senior Deputy Commissioner Veronica Judy
23 Cecil, and she is going to give you an update
24 on Medicaid reorganization activities that
25 have been taking place. Veronica.

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1 MS. CECIL: Thank you,
2 Commissioner. Dawna, I'm going to share my
3 screen. Okay. Hopefully you all can see
4 that. It might be a little hard to -- I'm
5 going to Zoom in, but can you all see the org
6 chart? Yep. Okay.
7 So what you're seeing here is, at a high
8 level, what changes have been made to
9 Medicaid. And we reorg'd as of -- we had a
10 reorganization as of July 14th. Two of our
11 divisions are unaffected, and that's Program
12 Integrity and Fiscal Management. We renamed
13 three of our divisions, and I'm going to go
14 through those. And then we created two
15 brand-new divisions.
16 So let me Zoom in. So the Division of
17 Information System is a new division. What
18 we did last year is we did move over staff
19 who works on Medicaid systems, and we have a
20 lot of them. And it's very complicated and
21 complex, and we decided to bring those over
22 from our sister agency that handles all of
23 the information systems for the Cabinet. We
24 brought them in-house so that we could better
25 prioritize Medicaid's needs and the system's.

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1 Several of them will be going through
2 procurement, and we have to get approval from
3 CMS on our financing of the system. So we
4 really wanted to bring those folks in-house
5 and work, so policy and our IT experts can
6 work hand-in-hand and more closely to ensure
7 that those systems are reflecting what
8 Medicaid needs in those systems.
9 So as part of that, we moved -- well, we
10 made that transfer last year. We created two
11 new branches. We just moved them over into
12 the Division of Information Systems and have
13 created a third branch called Data
14 Management.
15 So health -- the Division of Health Care
16 Policy was renamed. It was formerly Policy
17 and Operations, which was Lee Guice's
18 division. We've made some major changes
19 here, the biggest of which is creating a
20 Maternal and Child Health Branch. We're
21 super excited about this opportunity to focus
22 our staff and our efforts on these two
23 critical areas of health.
24 As you know, you know, with Dr. Theriot
25 leading us, we're doing a deep dive into

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1 maternal health and trying to figure out ways
2 that we can improve outcomes. So now we're
3 going to have a branch dedicated to that.
4 Our Benefit Policy Branch will become
5 the Physical Health Branch and, again, solely
6 focused on policies around healthcare
7 services and how those are reimbursed. So
8 we'll be looking forward to, you know, being
9 able to do a better job of keeping updated on
10 trends and innovation and healthcare policy
11 through that.
12 The division of -- our new division --
13 new-named Division of Quality and Population
14 Health was formerly Program Quality and
15 Outcomes. Program Quality and Outcomes used
16 to do both quality and managed care
17 oversight.
18 And we felt like it was really needed
19 to -- we needed to break those out into
20 separate divisions. Because, again, our goal
21 here is to drive outcomes. I think you've
22 heard Commissioner Lee mention on several
23 occasions we want to be more than just a
24 payor of claims. We want to be a driver of
25 healthcare policy to improve the outcomes of

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1 our members.
2 So this division is being refocused to
3 do that. We've created an Equity and
4 Determinants of Health Branch. This branch,
5 as it says, will be focused on: How do we
6 address the inequities and disparities across
7 the state that affect our members?
8 You know, CMS, the Center for Medicare
9 and Medicaid Services, our regulatory agency,
10 is very much focused on how can we better
11 address the determinants from the Medicaid
12 program. It's allowing MCOs to utilize, you
13 know, funding for those determinants, and
14 it's housing and food and clothing and jobs.
15 And so how can we improve the overall health
16 of our members, not just for healthcare
17 coverage.
18 The former Disease and Case Management
19 Branch has been renamed Population Health
20 because we want to look through that lens as
21 we develop our policies. We want to be able
22 to focus on those chronic conditions. You
23 know, we really need to be -- we just
24 understand we need to do a better job of
25 ensuring that we're -- our policies and our

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1 programs can address those across the
2 program.
3 And then our quality -- our MCO Quality
4 Branch has just become the Quality Branch.
5 Again, focused on -- we have a quality
6 strategy we're working on right now. It's
7 going to be looking at and doing more reviews
8 of the services, of the coverage, and
9 ensuring that we're paying for quality
10 services.
11 And then a Research and Analytics Branch
12 that will provide us the necessary data so
13 that our policies are data-informed, we're
14 making changes based on that data, and
15 ensuring that the data is usable, is quality
16 data and actionable.
17 The Division of Health Plan Oversight is
18 the other new -- brand-new division. This
19 will be the division that takes over all of
20 the oversight of the Managed Care
21 Organizations. But I'm also happy to
22 announce that the Health Benefit Exchange
23 which does the Marketplace, the qualified
24 health plans, it has moved into this
25 division. And the director for Health

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1 Benefit Exchange has come over, Edith Slone,
2 and she is now the new director for the
3 Division of Health Plan Oversight.
4 We wanted to do that because this
5 division is going to help us ensure
6 consistency and continuity of care across the
7 different plans, from Medicaid to Qualified
8 Health Plans and potentially in between.
9 If there's a -- I know you all are aware
10 that we're talking about a Basic Health Plan,
11 so all of that would fit under this one
12 division so that we have people that can see
13 across that continuum and understand it and
14 help people navigate it.
15 So as a result, we've created a new
16 Appeals and Complaints Branch, so all of the
17 appeals and complaints related to the
18 Medicaid program and for MCOs and for
19 Qualified Health Plans will fall in that
20 branch.
21 We renamed the MCO Contract Management
22 to just Contract Monitoring. So they will
23 be, again, enforcing the MCO contract but
24 also looking at the agreements with the
25 Qualified Health Plans to make sure that

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1 everybody's in compliance.
2 And then we moved -- from Policy and
3 Operations, we moved Eligibility and
4 Enrollment under this branch, again, because
5 we want that continuity and consistency in
6 understanding how eligibility is affected by
7 all the programs and be able to seamlessly
8 move people across.
9 So I think the other really great change
10 here is our former Community Alternatives
11 Division has been renamed the Division of
12 Long-Term Services and Supports. We decided
13 to align all of the long-term and community
14 programs into this one division. And that,
15 again, is part of our logic of making sure
16 there's consistency and continuity.
17 People often move from long-term care
18 into community programs and community
19 programs into long-term care. So now we have
20 all of that under one division. We created
21 the Long-Term Care Facilities Branch. That's
22 the nursing facilities, the ICF/IDDs. And
23 so -- so those folks -- anything related to
24 nursing facilities or nurse-aide training,
25 all of that will -- has moved over to

1 Long-Term Care Facilities Branch under the
2 renamed division of Long-Term Services and
3 Supports.
4 What we're hoping is that this is
5 seamless to providers and to members. You
6 know, again, some of it has just been a
7 change in name and -- but a refocus for the
8 department. And what we're hoping to gain
9 from this is bringing on additional staff.
10 You know, our -- our resources have
11 always been limited, and we have a fabulous
12 staff that's -- fabulous employees here under
13 the department. But because our day-to-day
14 is -- we're so overworked and overwhelmed,
15 this will give us the opportunity to bring on
16 some additional staff with different skill
17 sets; for example, bringing on people who are
18 familiar with population health, you know,
19 bringing on some diversity in the skills that
20 we already have, and being able to focus
21 where we should which is, you know, improving
22 the lives of our members.
23 So that is a really quick and high
24 overview. I'm happy to take any questions.
25 CHAIRMAN PARTIN: Veronica, the

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1 columns in white, are those still there or
2 are --
3 MS. CECIL: Yes. Right. There was
4 no change to the Division of Program
5 Integrity and to the Division of Fiscal
6 Management.
7 CHAIRMAN PARTIN: Okay. And then,
8 secondly, could you send all of the MAC
9 members a copy of this flow sheet?
10 MS. CECIL: Absolutely. Happy to
11 do that.
12 DR. SCHUSTER: Veronica, this is
13 Sheila Schuster. Two questions. One is: At
14 some point, can you tell us who are in those
15 big boxes that head up those divisions?
16 MS. CECIL: Absolutely. So I'll
17 just go real quick, but we'll add the names
18 for the version we send.
19 DR. SCHUSTER: Okay.
20 MS. CECIL: John Hoffmann is acting
21 director for Division of Information System.
22 John has been with Medicaid for a long time.
23 He was previously the assistant director in
24 the former Division of Program Quality and
25 Outcomes. But he's now acting director of

1 Information Systems.
2 Angie Parker, who was over Program
3 Quality and -- Program Quality and Outcomes,
4 remains the director of the new -- of the
5 renamed Division of Quality and Population
6 Health. So Angie Parker will still be there.
7 As we mentioned, Lee Guice was formerly
8 Health Care Policy leaving August 1st, so
9 Justin Dearinger will be acting director
10 there.
11 Edith Slone from the Health Benefit
12 Exchange has become the new director for the
13 Division of Health Plan Oversight.
14 And then Pam Smith remains the director
15 for the renamed Division of Long-Term Care
16 Services and Support.
17 DR. SCHUSTER: And who's in that
18 Division of Program Integrity?
19 MS. CECIL: That's Jennifer
20 Dudinskie.
21 DR. SCHUSTER: Oh, yeah. Okay.
22 MS. CECIL: She hasn't changed, and
23 then Amy Richardson is the director of Fiscal
24 Management.
25 DR. SCHUSTER: Thank you. And then

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1 I have one more question, and that is at the
2 very top. And, of course, I love seeing
3 behavioral health right up there at the very
4 top of your chart, but I'm a little confused
5 about what that means. Because you've got --
6 MS. CECIL: Yes. Sure. I'm
7 happy -- yeah. I'm happy to explain that.
8 So behavioral health does not have its own
9 branch. It's just -- it's basically a unit.
10 It's a program, and it does come under the
11 Commissioner's office. Leslie Hoffmann, the
12 other deputy commissioner, heads that -- that
13 program.
14 DR. SCHUSTER: Okay. I knew that
15 she was there. I guess I was thinking that
16 it would go under, you know, where you have
17 physical health and the other categories.
18 MS. CECIL: Yeah. So I will share,
19 Dr. Schuster, that we had lots of
20 conversations about whether to create a new
21 branch for behavioral health, but we really
22 want to keep it under the Commissioner's
23 office.
24 DR. SCHUSTER: Well, we like having
25 the Commissioner's clout up there with

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1 behavioral health, so I'll take that. Thank
2 you. Appreciate it.
3 MS. CECIL: You're very welcome.
4 Are there any other questions?
5 (No response.)
6 CHAIRMAN PARTIN: Okay. Anything
7 else from the Commissioner?
8 MS. LEE: I do not have any
9 additional updates at this time, and I do
10 apologize. I'll have to be dropping a little
11 early today, but you all will be in very good
12 hands with the senior deputy commissioner and
13 the rest of the Medicaid staff that are on
14 here. I will be on for a while longer, but I
15 will be dropping maybe around 11:30 or so.
16 So no other updates at this time.
17 CHAIRMAN PARTIN: Okay. Thank you.
18 And then next up, then, is an update on the
19 Basic Health Plan and unwinding.
20 MS. LEE: So we are on pause right
21 now with the Basic Health Plan. As you know,
22 we had started out with an original start
23 date of 1/1/23. We did listen to some of the
24 concerns, particularly potential carriers who
25 were concerned about maybe being able to

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1 develop an adequate provider network. So it
2 is on pause right now, and we will give
3 further updates as we get them.
4 Related to unwinding, we -- as you may
5 know, the Public Health Emergency has been
6 extended again. We have a communication plan
7 that is ready to go. Our main concern and
8 focus for unwinding is going to be on our
9 members, making sure that we have accurate
10 and updated addresses for them so that we can
11 reach out to them.
12 Also want to make sure that our provider
13 community knows that if you have someone in
14 your office and you notice that they have a
15 change of address, if they're a Medicaid
16 member, instruct them to contact the Cabinet,
17 if they have not, to update their address.
18 Again, as we go forward, we'll have a
19 60-day notice from -- prior to the Public
20 Health Emergency ending from CMS. So the
21 current one extends into October of 2022, so
22 we will again provide information as that
23 becomes available.
24 And then we are also going -- right now,
25 we're going through a lot of the

1 flexibilities that we have been afforded
2 under the Public Health Emergency and
3 implementing some of those as we can. So
4 that when the Public Health Emergency ends,
5 there will not be a huge disconnect or
6 interruption of services, particularly around
7 telehealth.
8 We have updated our telehealth
9 regulation. The only thing that we're
10 waiting on as far as telehealth is concerned
11 is guidance from the federal level regarding
12 HIPAA-compliant platforms. As you know,
13 during the Public Health Emergency, providers
14 have been allowed to use Zoom and FaceTime
15 and those sorts of things, so we're waiting
16 to see if we'll be allowed to continue those
17 platforms in telehealth but, again, waiting
18 on information from the Federal Government.
19 And, again, our goals are to comply with
20 all requirements, all state and federal
21 requirements. We want to prevent any
22 unnecessary terminations in the Medicaid
23 program. Again, that's why it's really
24 important for us to have accurate, updated
25 addresses.

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1 We are working with our Managed Care
2 Organizations to kind of stagger mailings
3 based on individuals who need to be
4 redetermined when the Public Health Emergency
5 ends. So as you are aware, right now, the
6 Department cannot terminate anyone except for
7 presumptive eligibility members, individuals
8 who pass away, individuals who request to be
9 removed from Medicaid, or individuals who
10 move out of the state.
11 So right now, we do have individuals who
12 have never done a redetermination or who may
13 have forgotten that they need to do a
14 redetermination when the Public Health
15 Emergency ends. So, again, definitely
16 focusing on our member population and keeping
17 everyone enrolled that qualifies in the
18 program. And we want to have some sort of
19 smooth transition for those individuals who
20 may lose coverage but qualify for a Qualified
21 Health Plan.
22 And as the senior deputy commissioner
23 reported, we now have Kynect and the
24 Qualified Health Plans, the state-based
25 exchange, in our department which will make

1 some of those transitions and communications
2 a lot easier. So, again, just focusing on
3 our members.
4 And I think that I will turn it over to
5 the senior deputy commissioner for anything
6 I've missed and to talk about our
7 communications strategy.
8 MS. CECIL: Thank you. As the
9 Commissioner mentioned, we are working on a
10 communications strategy, and that is for very
11 different reasons. One is for member,
12 obviously ensuring that the member
13 understands what action he or she might need
14 to take to maintain eligibility.
15 The other is for the provider. We want
16 to make sure providers understand what's
17 happening. You know, there were some
18 flexibilities that we implemented related to
19 providers so making sure that all the
20 providers understand how the unwinding
21 affects them. But, also, it's important for
22 providers to understand what's happening to
23 the member.
24 And we want to make sure our advocacy
25 organizations that we know we're going to

1 need to utilize to help get the message
2 out -- and we do want a common message. We
3 want to make sure everybody is telling
4 everyone the same thing to try to reduce any
5 confusion.
6 So we will have a very comprehensive
7 communication plan, and what we don't want to
8 do is roll it out too early because we don't
9 want to create chaos or fear or anxiety
10 unnecessarily. And so we -- you know, that's
11 why we just continue to monitor the status of
12 the Public Health Emergency.
13 The 60-day notice will be what will
14 trigger our moving forward with the
15 communications. And until then, as the
16 Commissioner mentioned, we really just
17 want -- we're asking members and we're asking
18 kind of everyone just to encourage members to
19 make sure their information is updated in our
20 system so we have contact information.
21 We do plan to leverage the Managed Care
22 Organizations. CMS has allowed states to
23 utilize them kind of a little differently
24 than normal, including being able to update
25 contact information and us be able to rely on

1 that without a secondary verification.
2 We're going to work with our MCO
3 partners on reaching out to their members
4 specifically affected. And so I think
5 that'll maximize the resources on who -- you
6 know, how can we keep these members covered.
7 And we're going to be using lots of
8 different ways of communication which is what
9 this slide speaks to. Just really quickly,
10 so that you all understand the way we process
11 renewals, there's an automatic processing
12 that goes on behind the scenes once we
13 turn -- flip the switch to restart
14 everything. So that'll happen behind the
15 scenes.
16 What that does is a lot of people can be
17 what's called passively renewed. We have all
18 the information. We can verify all that
19 information. There's no additional action
20 needed from the member. And so those folks
21 go down the passive renewal lane, and they'll
22 get a notice of renewal, no additional steps.
23 It's the ones that have to do something
24 actively, so they have to respond to a
25 request for information because we couldn't

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1 verify something. So it's the active
2 renewals that we're going to focus on.
3 Right now, we estimate around about
4 180,000 people may be subject to an active
5 renewal. That changes every month.
6 Sometimes the system is able to verify
7 somebody. Because this is all kind of going
8 in the background anyway. Even though we're
9 not doing any terminations, it's happening.
10 And that's why we can kind of identify how
11 many people may be subject to an active
12 renewal.
13 So we'll send out that active renewal
14 packet. I mean -- yes, that renewal packet.
15 They'll get it. It'll tell them exactly what
16 it is that we need. They upload the
17 information. They can do that various ways.
18 Then it'll be reviewed, and either a notice
19 of renewal will be issued or the notice of
20 denial. Of course, we always -- the member
21 has the opportunity to request a review or to
22 appeal any denials.
23 And then we're going to send this out to
24 everybody. I know it's probably a little
25 hard to see, but this just goes through a

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1 scenario, a timeline if, for example, the PHE
2 does end on October 13th.
3 I think what's important for everybody
4 to realize is that, again, we start the
5 process pretty early. And we give at least
6 40 days' notice to the member that they, you
7 know, may potentially be deemed ineligible.
8 So this sort of walks through kind of what
9 that looks like.
10 So if the PHE ends in October, November
11 would be the first month that we could
12 terminate people. So, again, it kind of goes
13 back two months. We'll start the renewal
14 process the next month, the month before a
15 termination, a potential termination.
16 They'll receive notices. They'll be able to
17 work on those notices.
18 We'll be working closely with the MCOs,
19 making them aware of which members are
20 potentially subject to a termination.
21 They'll be doing outreach. We're going to
22 work very closely with our connectors and
23 other organizations to make sure there's a
24 ton of support out there for people so that
25 we don't let anybody slip through the cracks.

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1 And then so, again, November -- the end
2 of November would be the first time since the
3 pandemic and the Public Health Emergency that
4 we might have to terminate somebody. So
5 we'll get this out.
6 One other thing to note is that the home
7 and community-based programs, the 1915 (c)
8 waivers, we have what's called an Appendix K
9 that has created the flexibilities for those
10 programs. It expires six months after the
11 PHE ends. So we'll be continuing to monitor
12 those, so they'll have a different timeline
13 and different communications but just wanted
14 to note that.
15 CHAIRMAN PARTIN: Okay. Thank you.
16 So that was a very thorough explanation about
17 what's going to happen with the unwinding.
18 So at our next meeting, what I guess we'll
19 need to know is an update on the Basic Health
20 Plan and then where we expect we are in that
21 process of unwinding.
22 MS. CECIL: Right. We'll know by
23 the next meeting whether it's been extended
24 again, the Public Health Emergency, be
25 extended again. So, you know, again, until

1 that 60-day notice, things are just status
2 quo. We're not doing any terminations. The
3 flexibilities stay in place. It's just when
4 we get that 60-day notice, we'll start doing
5 major communication.
6 CHAIRMAN PARTIN: Thank you. And
7 then you're going to send us all of the
8 slides; right?
9 MS. CECIL: Sure will. And we'll
10 also post it to our website.
11 CHAIRMAN PARTIN: Okay. Perfect.
12 Okay. So we have a little under an hour and
13 a half left for our meeting. And so I would
14 like to ask the TACs to keep their reports
15 short so that we can get through all of those
16 and have time for any questions that were
17 left over for Aetna and Anthem and then the
18 reports from Humana and Molina/Passport.
19 So let's go ahead and, again, please
20 just keep your report short. Tell us any
21 pertinent information that we need to know
22 and then your recommendations so that we can
23 get through all the TAC reports quickly.
24 First up is behavioral health.
25 DR. SCHUSTER: Good afternoon. We

1 met on July 14th, and we had a quorum,
2 approved our minutes. We continue to have an
3 issue around payment for members who have
4 dual coverage. We've solved it, I think, for
5 Medicaid and Medicare but not for Medicaid
6 and commercial insurance. So Angie Parker
7 from DMS was very helpful in giving us some
8 follow-up information.
9 We also had a discussion about the
10 no-show data portal, and we will be asking
11 for more detailed information about who the
12 providers are who are making reports.
13 We had a very important discussion, I
14 thought, about provider credentialing. And
15 at our next meeting, we will have someone
16 there from Kentucky Hospital Association.
17 They have worked with Aperture to create a
18 credentialing alliance, and three of the MCOs
19 belong to that. So we're trying to get a
20 handle on how that works and how it will help
21 providers speed along the credentialing
22 process.
23 We also looked at telehealth, and we
24 were very happy to have Jonathan Scott, the
25 reg guru from CHFS, talk to us about

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1 907 KAR 3:170. I advise you all to look at
2 that. That's the recently-adopted reg from
3 Medicaid about changes in telehealth. So
4 that was very helpful, and we had lots of
5 questions answered as well.
6 We also are following the work of the
7 interim task force in the legislature on
8 emergency medical services. I've spoken to
9 you all before about the problem of
10 transport, particularly for people with
11 behavorial health issues, where the ambulance
12 drivers and EMS are taking the position that
13 they don't have to transport, quote, those
14 crazy people, end quote. So we're -- we
15 worked on House Bill 777, and we're
16 continuing to monitor that task force.
17 We did have one recommendation. The
18 behavorial health TAC recommends that DMS
19 issue a Frequently Asked Questions document
20 to members and providers on telehealth
21 services based on their most
22 recently-approved regulation. So that is our
23 only recommendation.
24 We will meet again September 8th, and I
25 think that's record time for me to talk about

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1 behavioral health. Thank you.
2 CHAIRMAN PARTIN: Thank you,
3 Sheila. Could you give me the citation again
4 for that regulation?
5 DR. SCHUSTER: Yes. It's
6 907 KAR 3:170.
7 CHAIRMAN PARTIN: Thank you.
8 DR. SCHUSTER: Yeah. Well worth
9 looking at. And if the department can do an
10 FAQ, I think it would be super helpful to
11 providers as well as to consumers for that
12 matter, and that was our recommendation.
13 CHAIRMAN PARTIN: Okay. Thank you.
14 Next up, children's health.
15 (No response.)
16 CHAIRMAN PARTIN: Okay. Consumers
17 rights and client needs.
18 MS. BEAUREGARD: Good morning,
19 everyone. I'm Emily Beauregard with Kentucky
20 Voices For Health, and I'm the chair of the
21 consumer TAC.
22 We met on June 21st, and we met remotely
23 using Zoom. We had a quorum present. We did
24 discuss at that time wanting to go to some
25 sort of hybrid meeting option and have one

1 meeting a year where we're in person
2 together, similar to what the MAC has
3 discussed. And I think everyone was in
4 agreement with that decision. But with the
5 rising COVID rates, I think that we'll be
6 putting that off for a little while yet.
7 We were very pleased to learn at our
8 last meeting that Kentucky has received
9 approval from CMS to lift the five-year
10 waiting period for legally-residing pregnant
11 immigrants who are otherwise eligible for
12 Medicaid. This is something that our TAC has
13 recommended in the past, and we think that,
14 you know, this is a great way to improve
15 maternal health, a good step in that
16 direction. I know that's been a priority of
17 the MACs recently.
18 And we were also happy to hear that the
19 governor has approved all appointees for the
20 new Health Equity TAC. We hope those
21 meetings will begin soon, and, again, another
22 great opportunity to work on reducing
23 disparities in maternal health.
24 We discussed network adequacy again at
25 this meeting. We recognize that most

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1 Medicaid members are really unaware of
2 network adequacy rules and how to request an
3 out-of-network provider when a particular
4 MCO's network isn't sufficient.
5 And we really appreciate that Angie
6 Parker put together a draft memo in response
7 to a request that we had made for information
8 that could be shared with consumers that
9 explains the rules, their rights, and how to
10 change MCOs if the network won't meet their
11 needs. We're going to review this draft and
12 discuss it again at our next meeting and may
13 have some recommendations that come out of
14 that.
15 We also revisited the State's spending
16 plan to invest in home and community-based
17 services with ARPA funding, and we understand
18 that, you know, that's on hold right now due
19 to a directive from the legislature to
20 increase provider rates. But we also
21 understand that CMS requires, you know, our
22 rate study to be conducted to justify any
23 rate increases.
24 And all that said, it seems that this
25 has perhaps delayed any -- some plans in

1 paying for on-boarding costs of PDS employees
2 that are hired by waiver participants. And,
3 you know, the waiver participants are
4 unfortunately having to shoulder the burden
5 of these costs for on-boarding their
6 employees while they're on incredibly limited
7 and fixed incomes. And so that is a concern.
8 And it may be that I'm not completely
9 understanding this issue, but it continues to
10 come up. And it's an issue that's being
11 raised by one of our TAC members who is a
12 participant in a home and community-based
13 services waiver.
14 So we have submitted to -- well, to you,
15 Dr. Partin, and to Erin our report along with
16 a statement from Arthur Campbell, who is one
17 of our TAC members, about this issue. So
18 please share that with MAC members if you
19 can. I'll be sure to -- I believe it was
20 Dawna who was staffing today. I'll be sure
21 to share it with you as well.
22 And I think that covers, you know, most
23 of what we discussed at our last meeting. We
24 didn't have any recommendations this time,
25 which is unusual for us. But I do expect to

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1 have a few at our next meeting.
2 And I just wanted to touch on a couple
3 of things that were discussed earlier. You
4 know, transportation is a huge barrier to
5 people getting to their appointments. When
6 you were talking about the no-show rates, we
7 know that transportation is always cited as
8 the primary barrier that people face.
9 And so thinking about how nonemergency
10 medical transportation can help to address
11 some of that no-show rate and what we can do
12 to improve access through the NEMT program, I
13 think, is a good goal for us and perhaps for
14 the MAC to start exploring. And then, you
15 know, community health workers, I think,
16 could also be part of the solution there.
17 And, you know, thinking about the
18 unwinding and what we need to be doing in
19 order to make sure that people are aware and
20 responding to those renewal notices, I hope
21 that providers will be part of the solution.
22 You know, when people are coming in to
23 see their provider, asking if their, you
24 know, address is up to date and making sure
25 that they are updating it in Kynect or that

1 the provider is filling out a form to update
2 that address, I think, could be really
3 beneficial. There is a form that exists that
4 most providers aren't aware of, but we know
5 that people often don't find out that they've
6 been disenrolled until they seek care either
7 at a provider's office or go to the pharmacy.
8 And so that's just something else that I
9 would suggest keeping in mind. And I think
10 that's it for us.
11 CHAIRMAN PARTIN: Okay. Thank you,
12 Emily. Next up is dental.
13 DR. BOBROWSKI: Yes. This is
14 Dr. Garth Bobrowski, and we don't have any
15 specific recommendations from the TAC at this
16 time. But we did want to express our
17 disappointment in the -- our request from
18 last time about a fee increase. We want to
19 thank the primary care TAC for bringing up
20 and bringing it to the forefront of the lack
21 of dentists and access to care from eastern
22 Kentucky.
23 But the -- and I'll be brief here. But
24 even the KDA and the executive committee of
25 the KDA and the executive board of the KDA

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1 had reached out. The -- part of the DMS
2 response was based off of an ADA report that
3 is not a hundred percent accurate. And they
4 were showing that the -- I've got part of it
5 here, that Kentucky ranked the highest in the
6 nation in terms of reimbursements at 104.8
7 percent. And, folks, that's just not so.
8 But as was reported earlier, I know with
9 one of the research things on Hepatitis C,
10 she said, well, some information came in as
11 one percent. Some of it came in as 11
12 percent. And sometimes -- as you all know
13 that have done research or been involved with
14 that, sometimes your research design and
15 methodology can affect your outcomes of your
16 research or sway your thoughts on your
17 research.
18 But the -- this is kind of why a lot of
19 dentists have quit seeing a lot of the
20 adults. The No. 1 thing was the low
21 reimbursements. No. 2 was the failed
22 appointments. No. 3 was the administrative
23 burden that they're put under.
24 But I did want to thank Dr. Caudill and
25 Avesis for their increase in some of the fees

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1 to the participating dental providers, and I
2 did want to thank them for that.
3 The -- and I'll just leave it at that
4 for today. Thank you.
5 CHAIRMAN PARTIN: Thank you,
6 Dr. Bobrowski. Next up is nursing home care.
7 (No response.)
8 CHAIRMAN PARTIN: Home health care.
9 MR. REINHARDT: Good morning,
10 everyone. Evan Reinhardt with the home
11 health TAC. The TAC met on June 21st and had
12 some robust discussion on reimbursement rates
13 which continue to be a concern in our space
14 as well as some other ongoing old business
15 topics. And we did not have any
16 recommendations at this time.
17 CHAIRMAN PARTIN: Okay. Thank you.
18 MR. REINHARDT: Thank you.
19 CHAIRMAN PARTIN: Hospital.
20 MR. RANALLO: This is Russ Ranallo
21 from the hospital TAC. We met on -- we met
22 on June 14th, and we had a quorum. We had no
23 recommendations. DMS provided us a metric
24 report on the IPRO and denials, and we are
25 reviewing that.

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1 We also had discussion on incarceration
2 data, and adjustments and fixes with that
3 continue to be ongoing and a few others that
4 are in my report. But for sake of time,
5 that's all.
6 CHAIRMAN PARTIN: Okay. Thank you.
7 Intellectual and developmental disabilities.
8 MR. CHRISTMAN: This is Rick
9 Christman. The IDD TAC met on July 19th.
10 Main order of business was that we learned
11 that the State is still waiting on approval
12 from the Federal Government, CMS, for
13 approval of the rate increases that are
14 contained in the state budget. Beyond that,
15 we had no recommendations. Thank you.
16 CHAIRMAN PARTIN: Thank you.
17 Nursing TAC.
18 (No response.)
19 CHAIRMAN PARTIN: I believe the
20 nursing TAC put in the chat that they had to
21 leave early, so I don't think they had any
22 recommendations. And they can submit a
23 written report.
24 Optometry?
25 MR. COMPTON: Steve Compton. We

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1 met on May the 5th. We had a quorum. We had
2 some great discussions. We meet again next
3 week, but we have no recommendations.
4 CHAIRMAN PARTIN: Okay. Thank you.
5 Persons returning to society from
6 incarceration.
7 MR. SHANNON: Yes. This is Steve
8 Shannon. We met on July 14th. We had a
9 quorum. We have no recommendations, but we
10 continue to get updates on the 1115 waiver
11 amendment for folks returning from
12 incarceration. I think our real work will
13 start then.
14 We did hear updates about other state
15 initiatives that will impact folks returning.
16 One is AppalReD, encourages people being
17 hired. I think employment is a big part of
18 that and the recovery-ready communities.
19 There will be a Senate Bill 90
20 implementation council that will look at
21 diversion as people get arrested, so they
22 don't go into incarceration. They go to
23 treatment.
24 And the Opioid Abatement Advisory
25 Commission, we got an update about that

1 commission as well in the attorney general's
2 office. Thank you.
3 CHAIRMAN PARTIN: Thank you.
4 Pharmacy.
5 DR. POOLE: Yes. This is Ron Poole
6 with the pharmacy TAC. We met on July 20th,
7 had a quorum. I'm cutting this in half even
8 though it's going to seem lengthy because we
9 had a couple of, kind of, hot topics for
10 sure.
11 In trying to cut it down, in
12 negotiations with legislators for
13 House Bill 48 in 2021 -- it passed in March
14 of '21, and it went into effect July of '21.
15 The Kentucky Department of Medicaid Service
16 was excluded from this law due to the
17 discrepancy in the Centers For Medicare
18 Services not recognizing pharmacists as
19 healthcare providers. And I want to
20 reiterate that point just then.
21 I'm sure it's -- you can imagine how
22 embarrassing it is for pharmacists who fill
23 for 48 million Part D recipients nationwide
24 that we're not still recognized as healthcare
25 providers. But the Kentucky Department of

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1 Medicaid Services would have to have filed
2 for a waiver, which they can, in order to
3 comply with this law.
4 The Kentucky Department of Medicaid
5 Services have received 827 million dollars
6 from drug rebates from Senate Bill 50 that we
7 got passed in 2021. It didn't go into effect
8 until July of 2021. So looking at potential
9 ample funds to develop and create clinical
10 pharmacist services, taxonomy codes, billing
11 codes. To date, all we have is a HCPCS code
12 in order to develop just for consulting with
13 immunizations.
14 Clinical pharmacy services, just
15 brushing over, we did this -- I was on the
16 board of pharmacy when we developed a lot of
17 these clinical services for pharmacists that
18 we worked in correlation with Kentucky
19 Medical Association and also the Kentucky
20 Academy For Family Practitioners where we do
21 acute uncomplicated UTI testing -- all this
22 is point-of-care testing -- Group A strep
23 testing, flu prophylaxis, and antiviral
24 testing, colorectal cancer screening, TB
25 testing, pharmacogenetic testing,

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1 anticoagulation clinics and models.
2 To also being able to dispense under
3 protocol for tobacco cessation and alcohol
4 use disorders, travel health prophylaxis,
5 allergic rhinitis, emergency contraception,
6 anaphylaxis treatment, where people can just
7 come in and get an EPI pen in an emergency
8 situation and it be legal.
9 Same thing with naloxone. They can come
10 in and get a prescription without having to
11 worry about getting a doctor because it's by
12 a medical doctor's protocol.
13 Expanded immunization protocols, which
14 has been around the longest of all of these.
15 Oral contraceptive evaluation. Opioid use
16 disorders, working with monitoring and
17 potential interaction and intervention with
18 those, the long-acting injectable, education
19 and administration for antipsychotics.
20 All of your adherence education and
21 packaging that's been going on for some time,
22 and then all of your just educational
23 programs on self-care conditions, self-care
24 with diabetes, OTC probiotics, interview and
25 recommendations, and things that somebody --

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1 a lot of people know about is transitions of
2 care, chronic care management, and remote
3 patient monitoring.
4 The motion was, you know, due to the
5 charge of the CMS memo on 5/12 of '22, which
6 states that state Medicaid programs are
7 expected to give all provider types
8 authorized to administer COVID-19 and
9 childhood vaccinations under the HHS COVID-19
10 PREP Act.
11 Declaration, opportunity to enroll as
12 Medicaid providers and receive Medicaid
13 payment, not only for actually delivering or
14 injecting vaccines, but also for stand-alone
15 vaccine counseling about these types of
16 vaccines provided to beneficiaries for
17 eligible -- for EPSTD.
18 And due to the passage of House Bill 48,
19 an insurer, or a third-party administrator
20 for such insurer, shall provide reimbursement
21 to a pharmacist for a service or procedure at
22 a rate not less than provided to other
23 nonphysician practitioners if the services --
24 if the service or procedure is within the
25 scope of practice of pharmacy, would

1 otherwise be covered under the policy plan or
2 contract to the service or procedure, or
3 provided by a physician, advanced nurse
4 practitioner, and physician assistant. In
5 addition --
6 (Brief interruption.)
7 DR. POOLE: In addition to all
8 other compensation that may be reimbursed to
9 a pharmacist under this chapter, the
10 employer, insurance, or payment obligor shall
11 be liable for reimbursement of a pharmacist
12 for a service or procedure at a rate not less
13 than that provided to other nonphysician
14 practitioners for the service or procedure.
15 The PTAC asks for the MAC to ask and
16 encourage the Kentucky Department of Medicaid
17 Services to enroll individual pharmacists as
18 Kentucky Medicaid providers. In addition to,
19 PTAC asks the Kentucky DMS to create taxonomy
20 codes, billing codes specific to pharmacists
21 performing vital clinical services, and
22 create equitable and unbiased pharmacist
23 reimbursement models for providing these
24 clinical services which can greatly improve
25 the quality of life and the status of one's

1 health care for all of our Medicaid
2 recipients.
3 The second discussion was on NADAC
4 pricing, which is what our reimbursement is
5 based on for our prescription drug claims.
6 We have heard plenty of reports from all over
7 the state of some reimbursement not being up
8 to date on NADAC.
9 Adrienne McCormick with MedImpact
10 educated us, the PTAC, on how NADAC prices
11 are updated, from manufacturers' increasing
12 prices to then updating First Databank to
13 NADAC being updated by Myers & Stauffer to
14 MedImpact and Magellan databases picking up
15 these price increases from NADAC database.
16 The process may take two to three weeks.
17 In addition, the website and report
18 generated by the National -- or the NADAC
19 comparison data is rather lengthy. This last
20 one dated July 20th that was just issued --
21 so what Medicaid does is they go back -- or
22 excuse me. What Magellan and certainly
23 MedImpact do is they go back and they
24 backdate some of the price increases because
25 of the process taking two to three weeks,

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1 which is nice.
2 But to be able to go back and query over
3 21,000 different NDC numbers is rather
4 time-consuming. And me personally, I'm
5 decently tech savvy, so I was able to create
6 a little piece of software that allowed me to
7 look at the 21,825 different NDCs and compare
8 them for the date ranges that were backdated
9 to see which drugs I could re-bill -- or
10 reverse and re-bill. Not everybody has that
11 ability to do that.
12 So the TAC -- the motion was the PTAC
13 requests that all pharmacy Medicaid providers
14 be informed of the website and report that
15 can be accessed which informs each provider
16 of drugs that have had their price increases
17 backdated are eligible for reversed and
18 re-billing for increased reimbursement.
19 In lieu of the difficulty of pinpointing
20 with such a lengthy report to go through, we
21 ask that MedImpact work with us on
22 creating -- with the pharmacy providers,
23 working with us on creating and sending an
24 electronic report to every pharmacy enrolled
25 with Medicaid MedImpact and each of the

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1 pharmacy claims that were reported by the
2 NADAC as a price updated for each pharmacy's
3 system. That's -- that's a request and a
4 motion for consideration.
5 I have spoken to Adrienne McCormick in
6 person, and she was nice enough to get on the
7 call with us the other day. But that is our
8 request, and that is the end of my report.
9 Sorry about the length. Thank you. I did
10 cut it down.
11 DR. HANNA: Can I just make just a
12 couple of comments, if possible? Do we have
13 time? Just quickly, I just did want to
14 say -- I want to voice some concerns, too, as
15 far as with the provider -- you know, being
16 able to enroll as providers as pharmacists.
17 Because I just wanted to say that, you
18 know, during the pandemic, pharmacists have
19 provided -- we've been open continually
20 during the pandemic and provided over 70
21 percent of the vaccinations across this
22 commonwealth. And CMS has recognized
23 pharmacists as being an important healthcare
24 provider, not only in the delivery of
25 vaccination services but also in

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1 consultation.
2 In light of that, they clearly stated
3 this in their expectation and memo that they
4 did send to Medicaid providers, and it's hard
5 for me to understand how this can be ignored
6 as a directive.
7 Also, I wanted to, you know, just say
8 that now as we're faced with this challenge
9 in distributing Paxlovid in many areas of our
10 state who have limited access, pharmacists
11 can help in this endeavor. But because we
12 are not -- don't have a provider number, it's
13 very challenging because there's no
14 reimbursement for this. And those who are
15 providing this understand what that takes.
16 You know, there's a lot of time involved
17 in looking for drug interactions and making
18 sure you have lab levels and that type of
19 thing. Without that ability, it makes it
20 hard. And so many of our -- you know, our
21 patients may, you know, be challenged with
22 having access to Paxlovid. So that's another
23 area where I find this challenging.
24 And during the PAC meeting, there was a
25 comment made that part of the reason for not

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1 recognizing pharmacists was due to fiscal
2 considerations. There were some other points
3 made, but that was one of them. And that is
4 somewhat challenging for me to understand.
5 You know, as Dr. Poole has submitted in his
6 report, the services that pharmacists do
7 provide focus on public health. And I do ask
8 the Cabinet if the charge of DMS is to focus,
9 you know, primarily on fiscal savings -- you
10 know, that comment was made which kind of
11 bothered me -- or on providing access to
12 care.
13 As, you know, Dr. Poole said, we found
14 the savings from Senate Bill 50 were 800
15 million. And in the rebates alone, it seems
16 that some of these savings could be
17 reallocated to help provide these valuable
18 health -- public health services to the, you
19 know, beneficiaries that we serve.
20 And that's why I think this is a very
21 valuable thing. I think that the Department
22 of Medicaid Services should follow the
23 directive of, you know, CMS and look to
24 providing, you know, pharmacists with an
25 ability to go through these services and be

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1 listed as a Medicaid provider. Thank you.
2 CHAIRMAN PARTIN: Thank you. Any
3 other comments?
4 (No response.)
5 CHAIRMAN PARTIN: Okay. Then we'll
6 move on to physician services.
7 DR. GUPTA: This is Ashima Gupta.
8 We did not meet.
9 CHAIRMAN PARTIN: Thank you.
10 Primary care.
11 MR. MARTIN: Yes. This is Barry
12 Martin. Our chair, Mike Caudill, could not
13 make it today, so I'm giving the report. We
14 met on July 7th, and we had a quorum. And we
15 continue to work well with DMS and the MCOs
16 on various aspects and appreciate
17 Dr. Bobrowski's comments about us tag-teaming
18 with the dental TAC on trying to help the
19 dental shortage and the dental disparity
20 throughout the state which leads us to the
21 two recommendations from the primary care
22 TAC. They both relate to dental.
23 One is for a state policy review of the
24 current dental workforce shortages in
25 Kentucky including the use of dental

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1 auxiliaries to expand healthcare workforce
2 capacity. That recommendation is supported
3 by DMS.
4 The other recommendation we had was
5 related to dental, of course, and it's for a
6 policy review relating to current dental
7 enrollment levels and state-funded dental
8 colleges, in-state and out-of-state dental
9 graduate retention levels and dental
10 scholarships, dental loan and loan
11 forgiveness options for Kentucky dental
12 graduates.
13 Review the equity of current dental fee
14 reimbursements provided by the state Medicaid
15 program and its MCO contractors, and review
16 the policies and programs that support local
17 coordination, care coordination and the
18 integration of dental prevention and
19 treatment services into hospitals, public
20 health departments, school health clinics,
21 FQs, and RHCs, of which DMS supports that
22 recommendation as well. So those are our two
23 recommendations.
24 CHAIRMAN PARTIN: Okay. Thank you.
25 Next up is therapy services.

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1 (No response.)
2 CHAIRMAN PARTIN: Okay. It looks
3 like we don't have a report from therapy
4 services. So I'd like to have somebody make
5 a motion to accept the recommendations from
6 the TACs. Could somebody please make a
7 motion?
8 MR. MARTIN: This is Barry. I'll
9 make a motion.
10 CHAIRMAN PARTIN: Second?
11 MS. ALDRIDGE: I'll second it.
12 CHAIRMAN PARTIN: Who is that?
13 MS. ALDRIDGE: Teresa Aldridge.
14 CHAIRMAN PARTIN: Thank you,
15 Teresa. Is there any discussion?
16 (No response.)
17 CHAIRMAN PARTIN: Okay. All in
18 favor, say aye.
19 (Aye.)
20 CHAIRMAN PARTIN: Any opposed?
21 (No response.)
22 CHAIRMAN PARTIN: Okay. The
23 reports are accepted. Next --
24 DR. SCHUSTER: Madam Chair, this is
25 Sheila Schuster. I actually thought, as a

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1 member of the MAC, that I would receive the
2 written reports from the TACs. Did I miss
3 that, or have they never been circulated to
4 the MAC members? This is only my second
5 meeting.
6 CHAIRMAN PARTIN: They should be.
7 We should receive the reports from the TACs.
8 DR. SCHUSTER: And I assume that
9 they would be circulated prior to the meeting
10 so we could look through them beforehand?
11 MS. CECIL: They're not always
12 presented to DMS prior to the meeting. It's
13 after the meeting, after the report has been
14 given and the recommendations have been
15 approved, that then we send them out. But I
16 will double-check to make sure the reports
17 are going out along with other
18 communications.
19 DR. SCHUSTER: Yeah. I don't
20 remember getting them after the last meeting.
21 That was my first meeting on the MAC.
22 CHAIRMAN PARTIN: And, also, the
23 response back to the TACs. The MAC has not
24 been receiving the response from DMS for all
25 the TACs. We used to, and we haven't been.

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1 So I would like to request that.
2 MS. CECIL: Okay.
3 CHAIRMAN PARTIN: That all the MAC
4 members receive the response to the
5 recommendations from the TACs.
6 MS. CECIL: Okay. I'll
7 double-check with Erin, but I'm pretty
8 certain she sent those out about two weeks
9 ago. But we'll follow up.
10 CHAIRMAN PARTIN: Okay. Thank you.
11 DR. SCHUSTER: Thank you.
12 MR. MARTIN: Deputy Commissioner,
13 will these reports be the actual transcribed
14 minutes, or will these be condensed into
15 summaries?
16 MS. CECIL: No. So whatever report
17 is submitted by each TAC is what will be sent
18 to the MAC members. I know there's been a
19 question from several of the TACs about the
20 transcripts versus meeting minutes.
21 Prior -- we had a previous court
22 reporter who was willing to provide minutes
23 that was not necessarily contracted work from
24 the department, but she -- for some TACs,
25 they requested minutes, and so she prepared

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1 those.
2 Unfortunately, our contracted court
3 reporters that we use now do not provide
4 minutes. So the transcript for most of the
5 TACs have been what has constituted the
6 minutes of the meeting. And so, you know,
7 they should be reviewed. And if there are
8 any necessary changes, that should be noted
9 in the next TAC meeting.
10 We have had some problems, and we're
11 working through those, on the timeliness of
12 receiving those transcripts. But we are
13 committed to providing those to each meeting
14 30 -- to the members of each meeting 30 days
15 after. So you at least have, at a minimum,
16 30 days to review those and note any
17 necessary changes.
18 If -- you know, TACs certainly -- and,
19 again, it's kind of all over the board. Some
20 chairs do their own minutes, but the
21 transcript -- so at a minimum, the transcript
22 will serve as the minutes. But, certainly,
23 TACs are very different in how they utilize
24 that information and turn them into minutes.
25 MR. MARTIN: I just wanted to

1 forewarn Sheila that she will be getting a
2 whole lot of information.
3 MS. CECIL: I appreciate that.
4 Thank you.
5 DR. SCHUSTER: Well, I might be
6 really interested in reading it all. Thank
7 you. I just think it's -- I think it's very
8 helpful to know what different areas of
9 providers and consumer representations are
10 looking at and discussing even if you don't
11 have a recommendation. Because I think it
12 gives you a sense of: What are the issues
13 that are bubbling up out there, and are they
14 being heard from from other parts of the DMS
15 world?
16 MR. MARTIN: Yeah. You'll have a
17 lot of bedtime reading, Sheila, when you get
18 the transcripts.
19 DR. SCHUSTER: Okay. Thank you for
20 the warning. No, I don't want the
21 transcripts.
22 MS. CECIL: Right. So to clarify,
23 Barry, what generally -- when there's a
24 report made from a TAC, there is something
25 typed up, one page or two pages typed up that

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1 the Chair sends as the actual report.
2 MR. MARTIN: Okay.
3 DR. SCHUSTER: Yeah. I was not
4 volunteering to read the transcripts. I
5 barely skim through the ones for behavioral
6 health, and so thank you.
7 MR. MARTIN: You're welcome.
8 CHAIRMAN PARTIN: Right. So just
9 to summarize, in the past, we did receive the
10 reports that the TACs submitted. We have not
11 received those in a while. So if the TACs do
12 submit a report, then, that will be
13 disseminated, then, to all the MAC members.
14 And then the recommendations -- the response
15 to the recommendations from DMS should also
16 be sent to all of the (audio glitch).
17 Okay. Next up is questions from the MAC
18 for Aetna or Anthem on their previous
19 presentation from May. Any questions?
20 (No response.)
21 CHAIRMAN PARTIN: Okay. Then we'll
22 move on to the reports from the MCOs. And we
23 probably need to limit those reports to no
24 more than about -- a little over 15 minutes
25 so that we can get through the rest of our

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1 meeting. First up is Humana.
2 MR. DUKE: Good morning. My name
3 is Jeb Duke. I'm the health plan leader for
4 Humana Healthy Horizons. I think if you give
5 us control of the screen maybe, we can bring
6 up our presentation.
7 MS. CLARK: Okay. I've just made
8 you a co-host. You should be able to share.
9 MR. DUKE: Awesome. I think
10 Rebecca Moran will be sharing her screen, and
11 if she can't, I will figure out the
12 technology and bring it up. Well, let me go
13 ahead and try it.
14 MS. MORAN: I think I might have to
15 be made co-host. Oh, there we go. I just
16 got access to do it.
17 MR. DUKE: Perfect. Thank you
18 again for the opportunity to speak. I think
19 we had planned to keep our comments to around
20 15 minutes. There's a lot of data that the
21 MAC requested, and what we've done -- I think
22 there's 33 slides. We've put all the core of
23 the data requests into the appendix. So
24 we'll be available to answer questions after
25 our comments or, during the next MAC meeting,

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1 to come back with any specific requests.
2 Humana was founded in Kentucky. We
3 remain a Kentucky organization. As we think
4 about Medicaid, we've been in the Medicaid
5 program in Kentucky since 2013. But this is
6 actually our third year of being a
7 fully-integrated health plan with all Humana
8 resources.
9 What that means is every -- every part
10 of our organization from a process
11 perspective, from an organizational
12 perspective, is made up of Kentuckians. If
13 you call us, our provider call centers, our
14 member call centers, our claims adjudicators,
15 our clinical intake teams, our physicians,
16 and our nurses are all Kentuckians. And
17 we're here to support Kentuckians with a high
18 level of focus on doing the right thing.
19 From our perspective, our membership is
20 split 50/50 between urban and rural. But
21 since we joined during the expansion of
22 Medicaid, what we have found is that,
23 primarily compared to the other
24 organizations, we serve more members through
25 expansion. And through that, we have a much

1 higher prevalence of members with substance
2 abuse and opioid disorder use.
3 And you'll find that in a lot of our
4 programming. It's really focused on clinical
5 care for adults and people with high acuity
6 and chronic needs.
7 If we want to go to the next slide.
8 We're going to spend a little bit of time
9 talking about benefits and what value-added
10 services or expanded services are.
11 Rebecca, next slide. Well, I'll keep
12 going. Expanded benefits are benefits that
13 go beyond fee-for-service Medicaid, so
14 they're things that address social
15 determinants. They're things that address
16 access to care, and really things that are
17 geared towards training, interventions to
18 ensure members have access to preventative
19 care.
20 One of the things we do is a workforce
21 program. So in our workforce program, we do
22 things like employment coaching. We provide
23 reimbursement for our members who need
24 daycare during an interview. We provide
25 transportations to interviews. We provide

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1 reimbursements for GED testing, and we
2 provide reimbursement for our criminal
3 expungement. So the goal is to find people
4 who want to get back to work and wrap
5 resources around them in order to get them
6 back into the workforce in Kentucky.
7 In addition to that, Humana has recently
8 announced we're going to be hiring 200 new
9 associates in rural Kentucky really geared
10 towards those communities that were impacted
11 in western Kentucky through the tornados.
12 If we think about our basic needs
13 programs, again, expanded benefits, we offer
14 additional access to cell phones. That means
15 you're going to get more data. You're going
16 to get more talk time, and you're going to
17 get more texts so that there's no reason a
18 Medicaid member enrolled with Humana is not
19 willing to either pick up their phone and
20 speak with us or to one of our case managers,
21 or they're not willing to use their data to
22 use one of our digital apps to access key
23 information for their health care.
24 We also do things like sports physicals.
25 And one thing that I'm really excited about,

1 and it's -- from a timing perspective, it's
2 pertinent. We're now offering free
3 back-to-school haircuts. So any of our
4 members enrolled in Humana can go get to the
5 barbershop or to the beauty shop before we go
6 back to school, and they can show up ready to
7 learn on day one.
8 We also offer significant expansion for
9 wellness programs. So things like diabetes,
10 tobacco cessation, weight loss programs, our
11 24/7 access to a physician. All of these
12 programs can have interactive, video-enabled
13 digital access for our members for clinical
14 programming.
15 In addition to that, we do programs for
16 pregnant women to include our rewards
17 program, support with breastfeeding. And one
18 thing that's somewhat unique is that we're
19 now offering access to doula services. So if
20 a member wants those supports during their
21 pregnancy, they can come to Humana, and we
22 will reimburse providers for access for those
23 services.
24 Rebecca, next slide. Part of our
25 rewards program, if we think about expanded

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1 benefits as well, is our access to rewards
2 programs. So at Humana today, a member can
3 feasibly get $540 of rewards, gift cards, for
4 doing things like preventative services,
5 vaccinations, or participating in our
6 programs for pregnancy. I'm excited about
7 what this opportunity provides when we think
8 about incentivizing members to do
9 preventative care and improve outcomes.
10 What I'll tell you is we're going to do
11 more. So we're looking at our benefits for
12 next year. We're going to increase it.
13 We've seen the impact it has on our quality
14 programs and our HEDIS. And we're going to
15 double-down on it. We want our members
16 engaged in their care, and we want tools that
17 are available to encourage them to do that.
18 Next slide. So from an operational
19 perspective -- and I think we provided this
20 in a MOAC. So a lot of attendees, I think,
21 attend the same meetings. But network is
22 important to Humana. So the No. 1 job that
23 we have as a health plan is ensuring that our
24 members have access to physicians and access
25 to care.

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1 From Humana's perspective, there's --
2 across a slew of provider taxonomies, we
3 offer every single provider that has a
4 Medicaid ID in the state. That includes all
5 acute-care hospitals. It includes all CMHCs,
6 long-term care hospitals, inpatient
7 psychiatric, critical access hospitals,
8 FQHCs, psychiatric residential centers.
9 In addition to that, we have over 6,000
10 PCPs, over 700 OB/GYNs. And when you compare
11 Humana's network from a specialty
12 perspective, we believe we offer one of the
13 broadest networks of specialty care. So when
14 members needs -- have high needs, they can
15 come to Humana, and they can have access
16 throughout our network.
17 Across our next slide, how do we
18 maintain that network? So you can build a
19 network, but it truly does have to be
20 maintained. I know we talk about -- a lot in
21 the MAC about: Are we meeting our time and
22 distance requirements that are within our
23 contracts with DMS?
24 At Humana, yes, we are. We plot our
25 members on a monthly basis ensuring that time

1 and distance to all contractually-required
2 physicians are meeting those standards. But
3 we're also serving our providers and members
4 to get feedback and recommendations for
5 improvements.
6 We're also using tools that would
7 suggest to us on a monthly basis what
8 providers are in our other networks. So our
9 commercial or our Medicare providers that may
10 be good targets to bring into our Medicaid
11 program and also providers that exist on the
12 master list from Medicaid that don't exist in
13 our network today, so we can reach out to
14 them to contract.
15 And lastly, we actually -- we look at
16 utilization. So we talked about the Non-Par
17 process a little bit earlier today. So we
18 look at our members' utilization and request
19 from providers to have a single-case
20 agreement. And what we do is we can convert
21 those single-case agreements and make them
22 participating providers within our network.
23 Next slide. So we're going to talk a
24 little bit about population health in our
25 clinical programs. Kristan Mowder, I'll do a

1 handoff to you.

2 MS. MOWDER: Hi. This is Kristan.

3 So I'm going to talk with you about

4 population health and the focus we have on

5 that. The core of what we do as a health

6 plan is to use our data sources to create

7 various risk stratification methodologies.

8 Those could be like identifying chronic

9 conditions, our prediction of what we might

10 want to see, and severity models to generate

11 those risk levels. These risk levels then

12 inform our outreach for case management and

13 SDoH supports.

14 Through this identification, we attempt

15 to help members focus on making better

16 decisions, encouraging them to work with

17 their healthcare providers, promote

18 prevention activities, address SDoH needs,

19 and reward for their healthy behaviors

20 through their Go365 programs which Jeb just

21 talked about.

22 So along with what you just saw on the

23 other slides, we reward for those

24 preventative and quality visits such as the

25 prenatal visits, postnatal visits, child

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1 visits, diabetic screenings, and then offer
2 those SDoH activities like our workforce
3 development program and housing assistance.
4 Next slide, please. So this is what
5 we're going to talk about, incentives aimed
6 towards improving our health. And so Jeb
7 talked a little bit about our Pacify and our
8 Vida programs. And so our Pacify program is
9 for, you know, prenatal and newborn support.
10 What we've seen in that program as far
11 as outcomes is that we've seen a 12-percent
12 increase in our prenatal visits and a
13 15-percent increase in our postnatal visits.
14 And we use this program in conjunction with
15 our moms first case management program.
16 With Vida, you know, that program is
17 geared towards our prediabetics and our
18 Type II diabetes. And so some of the
19 outcomes we've seen with that is our
20 medication adherence increased by 50 percent
21 and PCP visits up to 29 percent. And so that
22 can be a self-serve application, or it can --
23 we can also refer from our case management
24 chronic condition program.
25 Some of the other things that we have

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1 going on in population health is our VOA
2 partnership where we're using community
3 health workers along with the community
4 health workers that we have, and they are in
5 the targeted six zip codes within Louisville
6 that they're focusing on for us.
7 We also have some programs around ER
8 diversion, and so we have MDLIVE access,
9 which is a telehealth access. And that's to
10 help promote diversion from ER or urgent
11 treatment when those are levels of care that
12 really aren't, you know, needed for what's
13 really going on with the member.
14 Our Where to Get Care program is
15 multifaceted. So that program is where a
16 member goes into the ER, and they get a
17 letter or, like, a flyer that talks about,
18 you know, reasons to go to the ER, when to go
19 to your PCP, when -- you know, maybe the
20 telehealth might be important, you know, all
21 of those things. And then it also gives
22 information about how to outreach to our case
23 management if they need additional support.
24 Then with our HIE expanded integration,
25 we also look at that data around ER visits as

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1 well and then we give those that were
2 identified 24 hours after that visit and turn
3 those over to our case management team for
4 them to be able to outreach and help them
5 with whatever needs they may have.
6 From a quality perspective, we've
7 enhanced our SDoH assessment. So we have
8 questions in our different assessments when
9 we do outreach around SDoH and then we also
10 implemented what's called the Prepare which
11 is very SDoH specific. And then we also
12 educate our providers on that Prepare as
13 well.
14 Here recently, we've began additional
15 work on colon cancer screening. That's
16 really good to the PIP that we have going on,
17 which is a project improvement plan. And
18 we're working on being able to send out
19 in-home test kits around colon cancer
20 screening.
21 And then as Jeb mentioned, you know, we
22 have the Go365 rewards to reward for those
23 healthcare pieces and then also, you know,
24 SDoH. And they can get up to, you know, $500
25 in incentives around that.

1 Let's go to the next slide, please. So
2 here we're going to talk about addressing
3 care gaps, and so that's gaps in care related
4 to, like, our HEDIS and quality. And as you
5 can see, you know, we've had some
6 year-over-year success in working with our
7 membership on improving those. So we've just
8 put on here some of our basic healthcare
9 pieces that you look at.
10 So, like, our comprehensive diabetes
11 care, we've seen great increases in that.
12 Our prenatal and postnatal visits, we see
13 increases in that. Our child visits, you
14 know, we've seen increases in two out of the
15 three. And we're doing interventions to help
16 focus on that 15 months to 30 months, to be
17 able to help increase that, and then we've
18 also seen increases in our weight assessment
19 and counseling.
20 And so through that data integration
21 that I talked about before that identifies
22 members for outreach, we have processes in
23 place. When they do get ahold of them, they
24 do a preventative screening that addresses
25 all of these gaps in care.

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1 We're also looking at our data
2 integration to make sure that we're picking
3 up all of the claims data and HIE data to
4 give credit for those to help close those
5 gaps. And then, you know, like I said,
6 putting that information in our assessments
7 to make sure that we're really identifying
8 and working with the members when we are able
9 to work one on one with them.
10 So I will go to the next slide, please,
11 and I will turn it over to Brent. Thank you.
12 MR. WILKERSON: Thanks, Kristan.
13 And we just have a few more slides as we wrap
14 up the content we had prepared today. What I
15 would add is, you know, like Jeb mentioned,
16 we've got a pretty heavy appendix with a lot
17 of content that specifically answers a number
18 of questions or requests in the original list
19 of items. So that will all be in the broader
20 presentation slide deck.
21 You know, just as we close out, we did
22 want to touch on a couple of quality
23 recognition programs. We engage with our
24 primary care provider network with two
25 programs, the model practice and the quality

1 recognition program. These are both -- both
2 incentive-based. And they require our
3 primary care physician groups to -- and their
4 member panels to meet certain quality
5 measures.
6 These quality measures, the targets
7 themselves are developed annually. And
8 depending on whether you're eligible for the
9 quality recognition program or the model
10 practice, you're eligible for incentives
11 calculated on a per-member, per-month basis.
12 And that could be payable on a quarterly and
13 annual basis.
14 I think the important thing, as we think
15 about the value of these programs, you know,
16 they do create an opportunity for increased
17 engagement between us and the provider
18 community. They definitely increase the
19 amount of reporting and data sharing between
20 us and the primary care providers and,
21 ultimately, just greater alignment between
22 all of the health care stakeholders on the
23 quality-focused initiatives that we're all
24 focused on.
25 The last thing I would say here, when we

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1 talk about the scope and the reach of these
2 programs, 90 percent of our members are
3 aligned to PCPs that are eligible to
4 participate in at least one of these programs
5 today.
6 And so we can go to the next slide. And
7 so the last slide in our prepared content, we
8 did want to acknowledge COVID vaccination
9 rates and our process to both, you know,
10 quantify and maintain a status for all of our
11 members and how we've used that data and
12 other incentives.
13 You know, the first thing I would say
14 is, you know, for 18 plus months, we've been
15 integrating a broad array of datasets; right,
16 to get that single source of truth across the
17 members we serve and understand their
18 vaccination status to continually refresh
19 that data and understand at an aggregate
20 level what the vaccination rates are across
21 the members we serve, across the number of
22 demographic segments.
23 A lot of the trends we see are the same
24 trends that, I think, the other MCOs would
25 see as we look at the broader Medicaid

1 population as a whole. You know, we see
2 higher vaccination rates among higher age
3 bands. We see higher vaccination rates among
4 certain regions, specifically Region 3 and
5 Region 5.
6 You know, this tracking and trending has
7 been important over the last year and a half
8 in the aggregate. But I think a lot of the
9 value has also come from the way in which we
10 track and trend this at a member level and
11 how we allow this information and this
12 analytical process to drive downstream
13 outreach, education to our members, inquiring
14 are there barriers that an individual has to
15 becoming vaccinated that we can help remove.
16 And so we pair a lot of care management
17 outreach and engagement with our members, and
18 we've paired that with -- and all MCOs have
19 offered incentives, to some extent, for
20 becoming vaccinated, and we have, too. So
21 those have been in place.
22 The last thing I would say, we still
23 see, you know, a material proportion of our
24 members that we don't report being
25 vaccinated, and we see that across the

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1 program as a whole. But one thing we did in
2 Q3 and Q4 of last year was to actually
3 develop a study and engage with our members
4 that were unvaccinated, so a study
5 specifically on the members we serve,
6 inquiring from them, you know, their thoughts
7 on the vaccination. And if they are truly
8 hesitant, you know, what are those reasons.
9 So we wanted to understand from their
10 perspective how we might be able to tweak our
11 approach through incentives or outreach and
12 better understand barriers.
13 We do see among those that indicated
14 they're still not vaccinated and they're
15 hesitant to become vaccinated a lot of the
16 themes that we see nationally throughout a
17 lot of studies. You know, a lack of trust in
18 the vaccine, concern for the side effects,
19 and then just the way in which, you know, the
20 rapid development of the vaccine occurred,
21 you know, some were kind of still on the
22 fence trying to understand maybe later but
23 not yet. We want to see as more data comes
24 in. So just another way in which we wanted
25 to engage with our members and understand

1 from their perspective any hesitancy.
2 So I'll pause there. That is all the
3 content we had prepared for the -- for the
4 main presentation. As I mentioned, we've got
5 a lot of content in the appendix to answer a
6 number of other questions.
7 CHAIRMAN PARTIN: Thank you.
8 Anybody have questions?
9 DR. BOBROWSKI: This is
10 Dr. Bobrowski. I've got just a couple. I'm
11 a Humana dental provider, but I notice you
12 mention on one of your slides that there was
13 some expanded dental benefits. And you don't
14 have to take time right now, but if I could
15 get some information on that.
16 And then the other question I had is:
17 Do you have quality measures for dental on,
18 like, receiving these quality bonuses? I
19 know you've got them set up in other health
20 areas, but I haven't seen anything for
21 dental. And you can email me or -- I know
22 we're short on time today.
23 MR. DUKE: I appreciate the
24 question, and maybe we can follow up with
25 some more detail. So one thing I would make

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1 sure that we're being transparent on is
2 there's a Humana dental network that supports
3 our commercial and Medicare members.
4 And in the Medicaid space currently
5 today, we do partner with Avesis. So the
6 Avesis contracted rates and the Avesis
7 network are different than the Humana dental
8 network. And that's something, you know,
9 we're looking at long-term.
10 But in regards to enhanced payment, we
11 don't currently have an enhanced payment
12 program for dentists, but we do reimburse to
13 primary care physicians mostly, and are
14 moving into behavorial health. I think as
15 managed care continues in the state, we'll
16 look at other specialty provider types and
17 figure out where we can move the number on
18 quality. And I'll get some more detail on
19 those responses.
20 DR. BOBROWSKI: Thank you.
21 MR. DUKE: Thank you, sir.
22 CHAIRMAN PARTIN: I have a question
23 about the meals program. How are meals
24 provided in rural areas to participants?
25 MR. DUKE: Great question. So our

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1 meals program is for members who are
2 discharging from the hospital. Those meals
3 are sent to the members frozen. If they
4 request it, we do have shelf stables. But
5 when it's issues with refrigeration, we can
6 provide alternatives.
7 And, also, during COVID, we opened that
8 up. And, also, during the response for
9 western Kentucky, we opened that up to all
10 members. So in times of emergency, we
11 provide extra access to food. In others,
12 it's to improve and reduce readmission rates.
13 But primarily, the mechanism is via mail,
14 UPS, FedEx.
15 CHAIRMAN PARTIN: Okay. Okay.
16 Thank you. And then the other thing is: Can
17 we make all these slides available, sent to
18 the MAC members, and then also available on
19 our website so other stakeholders can --
20 MR. DUKE: Absolutely.
21 CHAIRMAN PARTIN: Okay. Thank you.
22 Any other questions?
23 (No response.)
24 CHAIRMAN PARTIN: Okay. Thank you
25 very much.

1 And we will move on to Molina and
2 Passport. Do we have --
3 MR. SADLER: Hey, guys, that's my
4 cue. This is Ryan. I am popping online,
5 just dialing a couple of folks here this
6 morning to check on them from the flooding.
7 I see Dr. James on. Meredith, are you
8 on to share our presentation? Thanks.
9 MS. NORRIS: I think I just need to
10 be made a co-host as well, Ryan.
11 MR. SADLER: Okay.
12 MS. CLARK: I just added you as a
13 co-host.
14 MS. NORRIS: Okay.
15 MR. SADLER: This is not a halo. I
16 just have a glowing effect on the top of my
17 head. So, anyway, apologize for the screen
18 there.
19 MS. NORRIS: I think it's starting
20 to share maybe.
21 MR. SADLER: Dr. Hanna, I see you
22 there.
23 MS. NORRIS: Okay. Can you see my
24 screen?
25 DR. JAMES: Not yet.

1 MR. SADLER: Not quite yet.
2 MS. NORRIS: It's thinking about
3 it. Okay.
4 DR. JAMES: There you go.
5 MR. SADLER: Good. Okay. Well, by
6 way of formal introduction, my name is Ryan
7 Sadler. I'm the plan president and CEO of
8 Passport Health Plan by Molina Healthcare. I
9 think all of you guys know the parent company
10 of Passport is Molina. Molina is a large
11 Medicaid organization actually based out of
12 California, but we operate health plans -- I
13 think it's 19-some-odd states across the
14 country and so, of course, here, too, in
15 Kentucky.
16 I'm in Louisville and as are most of our
17 staff, although we do have staff scattered
18 throughout the commonwealth. We've got
19 around 700 today, and we're hiring. We're
20 looking for another 400 or so staff to join
21 us, so you may see or hear that out in the
22 community.
23 And we can go ahead and advance to the
24 next slide, please. I'm going to tee this up
25 in terms of some introductory comments and

1 then the real subject matter experts on the
2 team will chip in and provide some detail but
3 happy to answer any questions along the way
4 as well.
5 So, look, you know, Passport has been
6 around, and Molina has been around for quite
7 a while. On the Molina side, we started as a
8 provider-oriented organization. We were
9 started and founded by Dr. Molina
10 specifically operating clinics for low-income
11 individuals. And that's been the basis upon
12 which we built Molina and that we've expanded
13 in that way.
14 So our -- our sole focus really is
15 government-sponsored health care
16 predominantly for the underserved and
17 underprivileged. It's the lens through which
18 we think about our entire business.
19 We do operate a small plan on the
20 Marketplace in Exchange. We also operate a
21 small Medicare line as well, but it's really
22 intended to be supplemental to our members
23 that might need access to care as they move
24 through the continuum, not necessarily to be
25 our primary focus. So in Kentucky, it's

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1 probably 99 percent Medicaid-focused and then
2 we have a home for folks to land if they need
3 access to our services beyond Medicaid.
4 But, look, central to our model is
5 intended to be a provider-focused
6 orientation. You know, our company ceases to
7 exist without our provider partnerships. And
8 if we're doing business well for you, then
9 you'll be able to do business well, you know,
10 for our patients and our members. And so we
11 try to be mindful of that as we're working in
12 the community.
13 And, you know, hopefully you're finding
14 that working with us, there is some ease at
15 which to do that. If there's not, then
16 that's on us to address and constantly want
17 that feedback. To the extent that we need to
18 make some changes, we want to be open to
19 that.
20 Next slide. These are just some of the
21 commitments that we've made to the
22 commonwealth and we continue to deliver on.
23 I mentioned our 1,100 jobs and our staff
24 locally. You know, one of the beautiful
25 things that we've got going on right now as a

1 result of the pandemic is that, you know, as
2 people are backfilled -- not terminated. But
3 let's just say they resigned for one reason
4 or another wherever they may be in the
5 country, I can backfill those people here in
6 Kentucky, oftentimes, in a
7 financially-advantageous way but also, you
8 know, selfishly because I want to, you know,
9 build a bigger and better presence here in
10 Kentucky.
11 And so as we're doing that, we're
12 saying, you know, we don't need all 1,100
13 jobs for our health plan, so to speak, but
14 we've got plenty of room to hire them for the
15 enterprise at large. So we've got sort of
16 this regional operating model which is
17 supplementary to our health plan and
18 operation as well. So that's how we're able
19 to staff as many people as we do.
20 You see our membership number. It's
21 about 330,000 members. And just -- if you
22 could go back real quick. And, of course,
23 our network, no surprise. Like most of the
24 Medicaid MCOs, we've got a significant number
25 of providers and systems.

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1 We are really an any willing-provider
2 operation. So if folks want to participate
3 in the Medicaid program, we want you to
4 network. We've tried to be as open a network
5 as we can.
6 And then just finally, our -- you know,
7 our multimillion dollar investment and
8 contribution strategy through our community
9 organizations. That's something we promised
10 to do when we came here, and we're delivering
11 on that every day as we support our folks
12 that need help.
13 So let's -- yeah. Let's advance to the
14 next slide. This is really just a small
15 victory lap. I'm pretty excited about this.
16 We were nominated through Louisville
17 Business -- Louisville's Best Places to Work
18 through Louisville Business First. And so,
19 anyway, there's 50 organizations on the list.
20 And I say this, and I raise this, just
21 because in this world of remote setting,
22 trying to create some sort of culture where
23 people want to be here, they want to
24 contribute, they want to focus on member
25 services and taking care of our patients.

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1 It's, you know, it's harder and harder every
2 day. And so drilling down into how we create
3 a culture of folks that are excited to be
4 here and choose to be here every day is a big
5 priority. And, in turn, that, I believe,
6 generates better outcomes for our patients
7 and our members.
8 Next slide. Go ahead. I think we can
9 go back one. Just a quick note. We do try
10 to incorporate these Remember the Member
11 slides and stories into our presentations, a
12 lot of this internally. But I just -- it's
13 important for us on the insurance side, on
14 the payor side, to step back and remember
15 what all you guys see every day on the front
16 lines as providers just how we are impacting
17 the lives of the members that we serve.
18 And for some of us, you know, we can
19 actually have that personal interaction with
20 the members. But for most of us on the payor
21 side, you know, we're back office. And so
22 trying to remember the mission that we're all
23 here to serve, which is patient care, has got
24 to be top of mind.
25 And so this is just a way, an example,

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1 of how we're trying to connect our people to
2 that member interaction. So this will be in
3 the slides, and I don't want to read it to
4 you. But please feel free to review it, and
5 you'll get a sense of, kind of, how we
6 interact. And in particular, this story is
7 about our tornado relief which is all the
8 more pertinent today in and around the
9 flooding relief efforts that we have going on
10 as we speak.
11 So just at a high level, we're reaching
12 out to every staff member who lives in the
13 impacted communities over in eastern Kentucky
14 right now. We're texting and calling all of
15 our members that are impacted in these
16 counties that live there. We're
17 cross-referencing those members with anybody
18 that's been in active case management. We're
19 making direct outreach to those folks to make
20 sure that they're doing okay.
21 We're cross-referencing that with any
22 member that has received a prescription in
23 the last 30 days under the premise that maybe
24 their prescription that they need is now gone
25 because of the flooding, and how do we make

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1 sure they have access to an emergency fill
2 and the like. So there's a lot of outreach
3 happening as we speak to make sure we're
4 connecting the dots where we can.
5 And in some cases, we can't help. And
6 in some cases, we are able to connect those
7 dots for folks that are -- you know, lost
8 power and in the coming days may still have
9 lost power and just need access to food that
10 can stay, you know, nonperishable.
11 So, anyway, lots of work going on. This
12 is a good example of that from the tornado
13 relief perspective, but it's really the
14 playbook we're following again today in
15 eastern Kentucky. So I just -- if I don't
16 make it clear, our thoughts and prayers are
17 with our folks that are out there now because
18 some of them are going through some tough
19 times.
20 Okay. So next up is our membership
21 slide. This gives you a breakdown of where
22 our members are, age ranges and the like
23 based on region. Clearly, the majority of
24 our membership is in the Louisville area, but
25 you get a sense they're -- of the breakdown

1 as we look at our footprint across the
2 commonwealth.
3 Look, I'll just tell you just briefly,
4 you know, particularly for our provider
5 partners, I have a real sense of commitment
6 to making sure that our services are
7 available just as much in the east and west
8 part of the states -- part of the state as
9 they are in Louisville.
10 I think it's really important that, you
11 know, if I believe that our services we're
12 providing are great, maybe even exceptional,
13 I want to make sure that those same services
14 are available to our members, you know, in
15 the rural parts of the commonwealth as well.
16 And so I think I have an obligation to make
17 sure that I'm doing as much there as we are
18 here. And so you'll see that kind of come
19 through in the slides and, hopefully, over
20 time as we continue to grow.
21 All right. I'm going to turn it over to
22 our quality folks, so we'll make sure we've
23 got our quality team on.
24 MS. ANDERSON: Hi. Good afternoon.
25 This is Leslie Anderson. I'm with the

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1 quality interventions team.
2 We can move to the next slide.
3 All right. So we completed our preliminary
4 2021 HEDIS data and compared that to our
5 performance from last year, and we're seeing
6 an improvement in over 60 percent of our
7 measures across the board. So we're very
8 excited about that.
9 Some of the areas that we've seen the
10 greatest improvement in are the diabetes A1C
11 control, and that's really a reflection of
12 the work that we're doing for the diabetes
13 management Performance Improvement Plan.
14 And, also, we had a big push this year
15 to try and get folks back in to see their
16 PCPs, you know, especially since a lot of
17 people sat out in 2020 because of the
18 pandemic. And we're seeing that the efforts
19 that we put in are really working when it
20 comes to our well-care visits for our kiddos.
21 So across the board, from birth through
22 adolescents, we saw improvement.
23 Prenatal/postpartum is also a focus
24 measure for us, and we have a maternity care
25 program as well as some value-added benefits,

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1 and we're seeing that pay off in improvements
2 for our timeliness of prenatal care.
3 And then also our follow-up after
4 hospitalization for mental illness. This,
5 again, is kind of related to the work that
6 we're doing for the Performance Improvement
7 Plans, this one for the social determinants
8 of health. We have an enhanced discharge
9 planning process for those folks that have
10 been hospitalized for behavorial health, and
11 we're seeing great improvements there.
12 We've also identified some areas that we
13 are focusing on for this year. For the
14 cancer screening, we have started a
15 partnership with the American Cancer Society,
16 and we are identifying barriers for folks and
17 strategizing ways to get people to get those
18 cancer screenings completed. And then we are
19 also focusing on the entire behavorial health
20 domain of care as a focused opportunity for
21 us this year and moving forward.
22 Next slide, please. And this is just a
23 year-over-year snapshot of our HEDIS
24 performance. Again, you know, 2019 and 2020
25 were before the Molina acquisition. But as

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1 you can see, we have made improvements across
2 the board.
3 For that last one there on the chart,
4 the well-child visits, the HEDIS measures
5 changed moving into 2020, which is why we
6 omitted 2019, since it wasn't an
7 apples-to-apples comparison. But, again,
8 improvements in all of those domains of care.
9 We're also very excited that we have
10 launched our value-based contract on January
11 1st of this year. We are currently -- it's a
12 targeted rollout for certain providers, and
13 51 percent of our membership is actually
14 already covered by the value-based contract
15 with the provider groups that have signed
16 already this year.
17 It is PCP-focused, and it is
18 quality-driven, so it is a lot of HEDIS
19 performance. We're looking at NCQA and plan
20 performance and then, of course, it's patient
21 centered. So all of the reports that we're
22 giving our providers can be drilled down to
23 the member level, so they can see exactly
24 what each member is in need of as far as
25 screenings and services.

1 And we also have an SDoH Z coding
2 component as part of our value-based
3 contract. That allows us to kind of get the
4 more holistic picture of the member outside
5 of just physical health.
6 Next slide. And then this is a snapshot
7 of our value-added benefits program. We have
8 a very robust program of extra benefits and
9 incentives that we offer our members. So,
10 like I had mentioned previously,
11 prenatal/postpartum is a focus for us, so we
12 do offer our members an infant carrier or a
13 car seat if they have a prenatal visit in
14 their first trimester. There's also lots of
15 opportunities for earning gift cards for
16 well-child visits.
17 And then on the bottom there, it says
18 diabetic A1C screening, but we actually offer
19 a number of diabetic benefits. So we have
20 A1C screening. We also have a gift card for
21 eye exams. And then new, as of January 1st
22 of this year, we're offering a 25-dollar gift
23 card for our members that complete diabetes
24 self-management and support classes just to
25 help support that effort to drive -- drive

1 our diabetic members to the resources that
2 are available to them.
3 Next slide. And then, again, these are
4 just some additional benefits. The health
5 risk assessment, the 25-dollar gift card
6 there was also a new addition that was added
7 at the beginning of this year that helped
8 support the efforts, again, for the SDoH
9 Performance Improvement Plan, and it also
10 helps us to get a more complete picture of
11 all of our members.
12 And then there are a number of gift card
13 incentives for cancer screenings. And it's
14 not listed here, but we do have a value-added
15 benefit of a free FIT kit for at-home colon
16 cancer screening for all of our eligible
17 members.
18 And I will sign it over to Stephanie.
19 MS. STONE: Hello. I'm Stephanie
20 Stone. I'm our AVP of healthcare services
21 here at Passport, and I'm going to move
22 quickly through my slides because I know we
23 are very short on time. But I am happy to
24 answer any questions today or following today
25 that any of you may have.

1 This slide just shows that our -- that
2 we are leading the charge. We are the first
3 health plan as far as the percent of our
4 vaccine-eligible members who have received a
5 COVID vaccine. And, of course, we slice this
6 and look at it many ways. We have multiple
7 interventions to try to increase vaccination
8 rates, and it is always a focus, to -- and
9 especially now that the six-month and older
10 crowd are now eligible for the vaccines as
11 well.
12 You can go to the next slide. Our care
13 management services are, of course,
14 individualized to the needs of every member
15 that we serve. We have different acuity
16 levels that basically increase the intensity
17 and frequency of the work with our members
18 based on the needs of those members with
19 level one being lowest acuity, focused more
20 on health education, and level four being the
21 most intensive services that we provide. And
22 all of our services and care management are
23 focused on helping to improve our members'
24 health and quality of life.
25 Next slide. This slide just illustrates

1 that we have a large, multidisciplinary care
2 management team. It includes licensed
3 clinical professionals as well as certified
4 community health workers and certified peer
5 specialists working within our team.
6 Next slide. So related to -- one of the
7 aspects related to social determinants of
8 health, every health risk assessment that is
9 sent to our members initially and annually
10 include questions related to social
11 determinants of health. Those questions can
12 trigger further interventions such as
13 depression screening and additional care
14 management services.
15 All of our members that are in care
16 management effective January of 2021 complete
17 the Prepare SDoH screening. I know Kristan
18 mentioned that earlier from Humana. We have
19 been doing that since January of last year as
20 well to help us further identify barriers to
21 our members accessing health care.
22 Next slide. Our community engagement
23 team works with a wide array of advocates in
24 the community to identify barriers at that
25 community level. This slide is just

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1 illustrating some of the factors that are
2 being influenced by these collaborative
3 efforts.
4 Next slide, Meredith. We have, as I
5 mentioned before, certified community health
6 workers. We call them community connectors.
7 We also have housing specialists who do
8 exactly what you might think. They're
9 working to address any and all barriers and
10 needs that our members have related to
11 housing. We also have certified peer
12 supports that Dr. Hanna is going to talk a
13 little bit more about in a minute.
14 But these roles, I kind of look at them
15 as helping to provide families and members
16 with that first meal of fish so that, then,
17 we can go on to teach those individuals to
18 fish once they have the full belly.
19 So we have a collaborative related to
20 social determinants of health with UofL's
21 Peace hospital. We've been working to
22 facilitate enhanced discharge planning to
23 include social determinants of health-related
24 information.
25 I won't go into a lot of detail due to

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1 the time, but I will say this has been a
2 successful project. And because of the
3 success, we're expanding this to include
4 another treatment facility in the next month
5 or so.
6 You can go to the next slide. So I do
7 want to spend a little bit of time here.
8 This is our Emergency Housing Voucher Program
9 that we're very proud of. The Louisville
10 Metro Housing Authority and the Coalition For
11 the Homeless came to us last year with an
12 identified need. They had a grant to provide
13 emergency housing vouchers, but one of the
14 stipulations of that grant was that they
15 needed to have housing navigators to be able
16 to walk individuals through the process and
17 ensure their success after -- before and
18 after receiving the emergency housing
19 voucher.
20 There was a staffing need. There
21 weren't enough housing navigators to be able
22 to accept all of the vouchers and give them
23 to individuals in our community.
24 So we, at Passport, agreed to allow our
25 housing specialists and community connectors

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1 to act as housing navigators for any of our
2 members who happened to be eligible or
3 receive one of those vouchers. This took the
4 burden off of our community partners and
5 allowed them to focus their housing
6 navigation efforts on our non -- individuals
7 that weren't Passport members. And we took
8 on the -- on carrying the load for our
9 members who were receiving these vouchers.
10 You can go to the next slide. So as a
11 result of this, there were 200 emergency
12 housing vouchers that were awarded within the
13 Louisville community. 103 of those went to
14 Passport members. We currently have 26
15 members that are in active housing navigation
16 and 45 members that have been housed.
17 Note that that number is only our
18 members, not their children or partners that
19 may have been housed with them. So the
20 actual number of individuals housed is much
21 higher than that that were impacted by our
22 team being able to step in and provide these
23 services.
24 Next slide, Meredith. So what we gained
25 from this besides helping individuals, of

1 course, was strengthened partnerships with
2 our community agencies that serve those
3 experiencing homelessness or those at risk of
4 losing their housing. We gained invaluable
5 knowledge about navigating those systems
6 within at least this part of our state.
7 And due to the success of the
8 collaboration that we had on those emergency
9 housing vouchers, we've been asked to partner
10 on a new project serving individuals who are
11 experiencing homelessness and living in
12 homeless encampments.
13 So great success overall, and we're
14 excited to see where it goes next. And I'll
15 turn it over to Dr. Hanna.
16 DR. HANNA: And I see we're at
17 time. Can I just check and see if we're to
18 continue on here or what the -- I just wanted
19 to -- well, I'm going to keep going. So --
20 CHAIRMAN PARTIN: If you can keep
21 it real short. Because right now, we're at
22 time for our whole meeting, and we've still
23 got a couple of other points to make. So if
24 you can make your points real quick and then
25 just share your slides after.

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1 DR. HANNA: Okay. That sounds
2 good. I'm going to tell you two things about
3 peer support specialists. First of all,
4 Passport is innovative in the fact that we
5 use people with lived experience; that is,
6 people who have actually experienced a
7 substance use disorder or mental illness as
8 staff to do outreach.
9 And we have -- our staff are in
10 recovery. But for those conditions, being in
11 recovery doesn't mean that the condition is
12 in the past. Chad Corgill, one of our peer
13 support specialists that lives over in Rush,
14 he says to me, "Dave, I've been sober for 13
15 years. But every single day, it's a
16 decision."
17 But what's important about that is when
18 they reach out to people, they become a
19 living embodiment of hope for our members who
20 are struggling with use of substances or
21 mental illness, that change in their life is
22 possible.
23 And our goal of our peer support
24 specialists is that they will engage with
25 people and help them get connected with the

1 services they need. We're not trying to
2 replace or duplicate services in the
3 community. And their outreach is explained
4 in the slides that's here.
5 And we are really focused on reaching
6 the people that can't be reached. I'm just
7 going to tell you this. Tammy Hedge is
8 another one of our peer support specialists
9 who lives in Louisville, and we were talking
10 about going into the community as COVID began
11 to ease last year. And, you know, some of
12 the places that our peer support specialists
13 have to go aren't the most attractive places.
14 And she said to me. She says, "Dave, I'll go
15 anywhere." She says, "I know what it was
16 like not to be able to get myself the help."
17 And so that's what we're trying to do
18 with our peer support specialists. They've
19 worked with members with opiate use disorders
20 and our high emergency department
21 utilization, really trying to connect with
22 people to help them get the help they need.
23 And, Meredith, I think you can move on.
24 MR. SADLER: Hey, I think we'll
25 probably just wrap --

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1 PARTICIPANT: Hanna, eastern
2 Kentucky is wide open.
3 MR. SADLER: Yeah. From the
4 Passport side, I think we'll just wrap, and
5 we'll submit our slides to you guys. And if
6 you have any questions, happy to answer them
7 or reconvene next time.
8 CHAIRMAN PARTIN: Okay. Thank you
9 very much. So, again, if the slides can be
10 shared with all of the MAC members and also
11 put on the website for stakeholders to see
12 those. And then if we have questions at our
13 next meeting, we can bring those up.
14 Does anybody have any questions now that
15 they would like to ask?
16 (No response.)
17 CHAIRMAN PARTIN: Okay. Then
18 moving along, next item is election, and we
19 have three people for each slot who have
20 submitted their names; myself as chair,
21 Dr. Bobrowski for co-chair. And, Teresa, did
22 you submit for secretary again?
23 MS. ALDRIDGE: Yes, I did.
24 CHAIRMAN PARTIN: Okay. Did
25 anybody else want to submit their name for

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1 nomination?

2 MS. CECIL: We didn't receive any

3 other nominations, Dr. Partin.

4 CHAIRMAN PARTIN: Okay. Thank you.

5 Then we'll just do a voice vote in favor of

6 these three candidates.

7 MR. MARTIN: Do you need a motion

8 to accept the slate, Dr. Partin?

9 CHAIRMAN PARTIN: Yes, please.

10 MR. MARTIN: I'll make a motion to

11 accept the slate as submitted.

12 MR. GILBERT: And this is Kent

13 Gilbert. I'll second it.

14 CHAIRMAN PARTIN: Okay. All in

15 favor, say aye.

16 (Aye.)

17 CHAIRMAN PARTIN: Anybody opposed?

18 (No response.)

19 CHAIRMAN PARTIN: Okay. So our

20 chair, co-chair, and secretary will remain

21 the same for the coming year.

22 We have one item of new business, and

23 Dr. Gupta has some points and questions that

24 she would like to raise.

25 DR. GUPTA: Thank you, Dr. Partin.

1 My question for DMS and the MCOs is: How do
2 the organizations plan to handle the fallout
3 from the abortion ban in Kentucky?
4 Specifically, there's an estimated general
5 overall increase expected for maternal death
6 that's an overall increase of about 21
7 percent with an increased increase in
8 non-Hispanic black women of about 33 percent.
9 So this means that year over year, up to 33
10 percent of non-Hispanic black women are
11 expected to die in some regard to pregnancy.
12 Also, how are the organizations planning
13 to take care of the increased foster care
14 demand financially which will also increase
15 the poverty rate which equals increased
16 violence which also increases the death rate?
17 There will be less women working, increased
18 mental health illness, decreased access to
19 health care by -- from OB/GYNs. Already in
20 the state, there's not -- I think 50 percent
21 of the counties do not have one OB/GYN.
22 And then lastly, what -- how is DMS and
23 the MCOs planning to help women who are
24 Medicaid recipients to obtain abortions
25 across state lines? Will they help with

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1 transportation? Will they help finance
2 paying for the abortion?
3 So those are just some things I've been
4 thinking about, and I'm pretty sure you all
5 have been thinking about it, too. And you
6 don't have to answer it now. This is for
7 maybe some future meetings.
8 CHAIRMAN PARTIN: Thank you,
9 Dr. Gupta. So if DMS could -- that would be
10 a recommendation or a request from the MAC
11 for DMS to respond to at our next meeting.
12 Does anybody else have any other
13 business that they would like -- oh, somebody
14 just made a comment.
15 MR. MARTIN: This is Barry. I just
16 want to give kudos to DMS. They've been
17 doing a lot of really good things, especially
18 over the last year or two years. And I think
19 sometimes we get lost in the things that we
20 need and want, and I think they've done a
21 really good job. And I'd like to tip my hat
22 to them. I mean, can we do better? Of
23 course. But we can all do better.
24 CHAIRMAN PARTIN: Thank you, Barry,
25 and I agree. It's been a pleasure to work

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1 with Commissioner Lee and Deputy Commissioner
2 Cecil. They have been very responsive to our
3 concerns and our questions and any
4 recommendations from the TACs and also
5 engaging in discussions about future issues.
6 So yeah, I would like to echo your comments.
7 DR. SCHUSTER: Madam Chair, this is
8 Sheila Schuster. I would like to thank
9 Dr. Gupta for so comprehensively outlining
10 many of the issues and concerns that we --
11 many of us have had, and I appreciate her
12 bringing that forward to put on our agenda
13 for the next meeting and also want to
14 re-enforce what Barry just said.
15 You know, the Medicaid staff has been, I
16 think, immensely responsive in so many ways.
17 Some of us are working on separate issues
18 like the SMI waiver and the SUD waiver and so
19 forth and just have found the staff to be
20 ready and willing to meet with us and explain
21 what's going on and keep us in the loop. So
22 I appreciate that.
23 DR. THERIOT: In response to
24 Dr. Gupta's question, we have been discussing
25 this, the issue internally and with some of

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1 our MCO partners. We don't really have an
2 answer for you right now, but we are -- we
3 welcome the chance to talk about this at the
4 next meeting.
5 CHAIRMAN PARTIN: Thank you. Okay.
6 So I will put that back on the agenda for the
7 next meeting, and hopefully by then, we'll
8 have some feedback.
9 Okay. So this has been a busy meeting.
10 Does anybody else have any other issues that
11 they would like to bring forward?
12 (No response.)
13 CHAIRMAN PARTIN: Okay, then. Can
14 we have a motion to adjourn?
15 MS. ROARK: I make a motion to
16 adjourn.
17 MS. ALDRIDGE: I second it. This
18 is Teresa.
19 CHAIRMAN PARTIN: Thank you,
20 Teresa. Any discussion?
21 DR. HANNA: Bye, everybody.
22 DR. SCHUSTER: Thank you.
23 CHAIRMAN PARTIN: All right.
24 Meeting adjourned. Thank you.
25 (Meeting adjourned at 12:36 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 9th day of August, 2022.

16

17

18 *\/s/ Shana W. Spencer*

19 Shana Spencer, RPR, CRR

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