CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

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Via Videoconference
July 27, 2023
Commencing at 10:04 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter
APPEARANCES

ADVISORY COUNCIL MEMBERS:

Elizabeth Partin - Chair
Nina Eisner
Susan Stewart (not present)
Dr. Jerry Roberts
Dr. Garth Bobrowski - Co-chair
Dr. Steve Compton
Heather Smith
Dr. John Muller
Dr. Ashima Gupta (not present)
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert (not present)
Mackenzie Wallace (not present)
Annissa Franklin (not present)
Sheila Schuster
Bryan Proctor (not present)
Peggy Roark
Eric Wright
PROCEEDINGS

CHAIR PARTIN: I'll call the meeting to order, and I'm going to take the roll call.

MS. BICKERS: Did you need me to do that today, or is Heather on?

CHAIR PARTIN: I don't know if we have the secretary or not.

MS. BICKERS: Okay. I have got the list ready so -- Beth?

CHAIR PARTIN: Here.

MS. BICKERS: Nina?

MS. EISNER: Here.

MS. BICKERS: Susan won't be here today. She sent us an email.

Dr. Roberts?

(No response.)

MS. BICKERS: Heather Smith?

MS. SMITH: Here.

MS. BICKERS: Dr. Bobrowski?

(No response.)

MS. BICKERS: I thought I saw him logged in. Maybe we lost him.

Dr. Compton?

DR. COMPTON: Here.
MS. BICKERS: Dr. Muller?
DR. MULLER: Here.
MS. BICKERS: Dr. Gupta is not going to be with us today.
John Dadds?
(No response.)
MS. BICKERS: Dr. Hanna?
(No response.)
MS. BICKERS: Barry Martin?
MR. MARTIN: Here.
MS. BICKERS: Kent Gilbert?
(No response.)
MS. BICKERS: Mackenzie Wallace?
(No response.)
MS. BICKERS: Annissa Franklin?
(No response.)
MS. BICKERS: Dr. Schuster?
DR. SCHUSTER: Here.
MS. BICKERS: Bryan Proctor?
(No response.)
MS. BICKERS: Peggy Roark?
MS. ROARK: Here.
MS. BICKERS: Eric Wright?
DR. WRIGHT: I'm here. Thank you.
DR. BOBROWSKI: And I'm here,
Bobrowski.

MS. BICKERS: Sorry. I lost count. Give me one second. I'm sorry. I counted ten, so we should have a quorum. You're good to go.

CHAIR PARTIN: Okay. Great. Thank you.

Next up is approval of the minutes. Would somebody like to make a motion?

DR. SCHUSTER: I'll move for their approval. This is Sheila Schuster.


CHAIR PARTIN: Thank you.

Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Any opposed?

(No response.)

CHAIR PARTIN: Okay. Thank you. Minutes are approved.

Old business. What is the status of Anthem MCO? And I guess this goes to the commissioner.
COMMISSIONER LEE: Good morning.

Still in litigation. No new updates on this topic.

CHAIR PARTIN: Thank you. I'll put that up for next meeting.

Has the letter to the governor on the workforce study, has that been sent?

COMMISSIONER LEE: No. We did discuss this with the secretary's office, and we thought and believe that since we were in the midst of a workforce study already, that the letter should not be -- did not need to go to the governor. So the secretary did make that decision -- secretary's office did make that decision.

So we do have -- and I can jump into C because it's related to B. We do have a preliminary workforce study report. I have reviewed the report. I think it's got some very good information in there.

We will be finalizing that next week and will send that out to the MAC and the TACs for review. And we can discuss it at the next MAC if you all would like a presentation on the report. We can definitely present on
the report after you review and answer any
questions that you may have and talk about
some of the things that we're going to do
going forward.

For example, we do have a state
university partnership that is also going to
be looking at some access and some workforce
that we may be able to fold into this after
you look at the report and have your
questions.

CHAIR PARTIN: Okay. Thank you,
Commissioner. And that would be related
to C; right, the UK analytics study?

COMMISSIONER LEE: Yes. Yes.

CHAIR PARTIN: Okay. So let's put
that on the agenda for the next meeting.

COMMISSIONER LEE: Yes. We can --
we can definitely have a report out, a
presentation on the findings of the workforce
study.

CHAIR PARTIN: Okay. Sorry. I'm
making notes.

Okay. And then the next item is just a
reminder about the update on canceled
appointments, and that will be put for the
September meeting.

And then the PDS legislative rate increase and, Eric, if you would like to speak to that.

DR. WRIGHT: Yeah. First, I want to just thank Commissioner Lee and Pam Smith for meeting with me on Wednesday, June the 21st. We had about an hour meeting to discuss the PDS rate increase and some of the communication that is being sent out to the agencies that oversee PDS services for individuals with intellectual and developmental disabilities, primarily through our 1915C waivers.

Commissioner Lee and Pam agreed that we are working towards a goal of communicating with consistency -- whether it be case managers, support brokers, or however agency described -- the individuals who help families navigate PDS services with those waivers.

I felt very positive about the meeting and, obviously, there was a need to have this discussion as it continues to be a little bit of confusion within the community and social
media related to how these rate increases are being communicated to representatives across the commonwealth.

In that, though, I do suggest that we get a little bit of an update from Commissioner Lee on any developments -- or Pam -- if she would take a few minutes to reflect upon the meeting and some of the results of those discussions.

COMMISSIONER LEE: Thank you, Dr. Wright. I think that the meeting went well, too. I think always, you know, working on our communications is a good strategy.

And, Pam -- is Pam on the call today? And if she would like to provide any additional comments or updates related to the conversation we had with Dr. Wright.

MS. SMITH: I am. Thank you, Commissioner. So we are working on a communication that has -- in addition to, Eric, some of the things that we talked about as far as the timing and that families -- you know, so the families weren't told you have to wait till you re-cert, some direction around that.
That, you know, when a family reaches
out to you and they need to modify the plan
of care, then part of the responsibility of
the case manager/support broker/PDS
coordinator -- that's one of the things also
we're changing, to give everybody one name so
that we don't have, you know, 15 different
names for different programs -- that that
needs to be handled like any other plan of
care change in that it needs to be scheduled
timely.

So we are working on that communication
as well as the communication about the second
rate increase that just went in. It was
effective July 1st. It will actually go into
the system tomorrow night. We are going to
go back and mass adjust claims from July 1
until that goes in tomorrow night. But that
communication is going out hopefully this
afternoon. If not, it will be out tomorrow.

But we are working with -- with our
partners with the ADS and the CMHCs. And,
also, another exciting thing that we're doing
with, in particular, participant-directed
services is we have expanded the availability
of that so that it is similar to SCL and that any certified case manager can perform those functions.

So we're beginning to see some of our other case managers start picking up individuals for PDS that maybe were not in a waiver they served before, or they may -- it may be in the same waiver, but they did not do participant direction before. So that is growing and is expanding.

DR. WRIGHT: Thank you, Pam. Pam, can you speak to a conversation that you and Commissioner Lee and I had related to -- with the rate increases, there was a discussion about a request to CMS about -- and I guess it was related to budget increases related to the waivers as well and how that might be addressed. I believe there's a plan that you all have in place with CMS; is that correct?

MS. SMITH: So right now in particular -- and I'm sorry. My dog has decided he is going to talk right now, so I apologize.

DR. WRIGHT: No. That's okay.

MS. SMITH: I apologize for the
noise in the background.

Right now, there are -- in Michelle P in particular, there -- in the regulation, there is a budget amount. There's a limit of 40,000 if a plan is only participant-directed services and 63,000 if the plan has both traditional and participant-directed services.

So through Appendix K, we have waived -- there are a lot of actually -- we waived several limitations, but one of them was that budgetary limitation. Because, one, it does not make sense that we're going to increase the rates but then we're going to leave an old budgetary cap in there, which would, you know, result in individuals either not being able to give their employees a pay increase; or, B, them not getting the amount of services that they needed.

So we -- as part of the initiatives right now, with us modifying the waivers and rewriting the regs to reflect the rate increases, we are looking at that -- at all limitations. And so that would be limitations on the amount of service hours a
week as well as limitations -- those budgetary limitations. But we are not enforcing that 40,000 and 63,000-dollar amount right now. So it allows the individuals to have access to be able to pay their employees a fair rate based on the rate increases.

DR. WRIGHT: Thank you.

MS. SMITH: You're very welcome.

CHAIR PARTIN: Okay. Thank you all.

Next up, we have a report from DMS about community health workers and how they function.

COMMISSIONER LEE: Yes. I think Justin Dearinger is on the -- in the meeting, and he will be providing an update on this. Justin?

MR. DEARINGER: Hello. Thank you, Commissioner.

Yes. We started July 1st providing reimbursement for community health workers for several provider types, and we'll go through a little presentation now to talk just a little bit about that.
So some of the qualifications for being a community health worker, you have to be a legal United States resident. You have to be employed as a community health worker in the state of Kentucky, to be at least 18 years old, and meet and maintain the certification or recertification requirements.

Those certification and recertification requirements are put in administrative regulation through the Department For Public Health, and they are maintained there. Some of the services that a CHW can provide: The preventative services, health promotion and education, facilitate provider communication, patient education, and other approved DMS services.

A couple of things that we as -- in the Department For Medicaid Services, in meeting with providers and provider groups, were able to see is something that you had brought up earlier, was no-show lists. One of the things that continue -- that we continue to strive and fight against are: What are the causes of individuals that are Medicare (sic) recipients not showing up or not cancelling
appointments? And part of that process is finding out exactly why they're not showing up so that we can attack those different areas.

Some of those things can be found out by using community health worker services. Community health workers provide services that -- again, you'll see one of these says facilitate provider communication. They reach out to individuals to see if they've changed phone numbers, changed email addresses to make sure that they're getting their notifications for their appointments, to make sure they understand that they have to cancel appointments and give notifications.

In addition, we talk about other approved services and patient education. Those things are part of how to access services such as transportation services, nonemergency medical transportation, other forms of assistance that they may need in order to get to their appointments as well as being able to find out -- reach out and find out reasons why they may have missed an
appointment, which the biggest percentage of -- when that report comes out of no-shows, the biggest percentage of no-shows is just -- there is no reason given. And so community health workers can also help with that, to be able to pinpoint reasons why individuals weren't able to show up.

All right. Next slide. The health navigation and resource coordination is vital for community health workers to provide. It helps them to find Medicaid providers to receive covered services. A lot of times, Medicaid recipients and individuals don't know exactly which provider may provide the best service to them. And then a lot of times, they'll end up going to an emergency room or to an improper provider for certain services they need.

It helps them make appointments for Medicaid-covered services. This also encompasses helping them to cancel appointments, change appointments for other needed items, arrange appointments that are together, arrange transportation to medical appointments, attend an appointment with the
recipient for a covered service if they are in need of understanding what's going on or understanding certain -- having certain communication barriers. Help a recipient find other relevant community resources such as support groups and other areas of support for the recipient.

Health education and training.
Education and training for health issues such as immunizations, managing blood pressure, managing STDs, diabetes, accident prevention, occupational safety, and control of toxic agents or poison control all assist us with promoting better health for individuals in the long run and, at the same time, keeping costs down to the medical community.

Health promotion and coaching.
Cessation of tobacco use, reductions in the misuse of alcohol or drugs, improvement in nutrition, improvement of physical fitness, family planning, control of stress, pregnancy and infant care, including prevention of fetal alcohol syndrome.

I spoke with a physician yesterday over the phone that talked about the multiple
times he -- and the amount of time that he
spends with multiple individuals going over
cessation of tobacco use or improvement in
nutrition in his clients, when he discusses
nutrition and themselves and in the -- in
some of the younger patients that he sees.
These things can be done by a community
health worker who are trained in these
different things, and it allows clinicians
more time to see more patients and to be more
successful.

So providers -- what type of provider
can bill for community health workers? Right
now, we have alcohol and other drug treatment
entities, behavioral health service
organizations, community health mental --
community mental health centers, FQHCs, or
Federally Qualified Health Centers.

A health system consisting of a hospital
or at least a group of physicians or more
than one group of physicians, a hospital, a
local health department, primary care clinic,
a rural health clinic. And then there are
some other Medicaid providing --
participating providers such as dentists and
midwives that are also able to bill for
community health workers.

Some other requirements for community
health workers. They cannot enroll as
independent Medicaid-participating providers.
They have to be employed by one of the
current Medicaid-enrolled provider types.
They must be related -- the services they
provide must be related to medical
intervention outlined in the individual's
care plan.

There's no reimbursement for CHWs that
are already paid by federal funds through
grants or other means. If reimbursement is
already included in a per diem or cost
settlement type they're not reimbursed for or
for CHWs that are employed by Managed Care
Organizations, or MCOs. And CHWs are not
eligible for WRAP payments.

Those are some of our billing codes
currently, most up-to-date billing codes that
we use for CHWs. As you can see, there are
CPT98960 through 98962. And, basically,
they're the same CPT code that just deals
with how many individuals a CHW is working
with at that moment. And they're in 30-minute increments.

So MCOs hire their own CHWs, and they reimburse -- fee-for-service Medicaid reimburses for CHWs for all different providers.

So the other thing is that there are set limits for some of the community health workers that they can't exceed, but those are broken down by provider type groups so that the limits aren't strictly per individual.

So if an individual goes to a physician today and sees a community health worker; and then on Wednesday, they go to see their dentist and a community health worker assists them there; and then on Friday, they go to see their therapist and a community health worker sees them there, they're able to do all those things within the same week. And those limits don't reflect on each other because they are different provider-type groupings.

So that's all I had for that. I appreciate you taking the time to listen to me. Anybody have any questions or --
CHAIR PARTIN: Justin, I have a question.

MR. DEARINGER: Sure.

CHAIR PARTIN: So community health workers are not something that DMS provides. These are people who are hired by providers to provide services to different practices?

MR. DEARINGER: Yes, ma'am. Absolutely. So all of our -- a lot of our different provider types hire community health workers to assist them in many different avenues of what they do, and community health workers are varied. Currently, there are many types of grants that are used to hire and provide community health workers, and each grant is very specific on what they may do.

Currently, managed -- some of the Managed Care Organizations we have in our state hire -- or have on staff community health workers, and they do more of the varied duties that our providers can use these community health workers for.

So whether it's, you know, taking the time that a physician would sit down and go
over nutritional needs or values with a
patient and freeing up the clinician that way
or if it's assisting an individual with
scheduling and learning transportation
services to make sure that the no-show --
their no-show rate goes down, all those
things can happen through the providers that
are hiring these community health workers.

CHAIR PARTIN: So I receive letters
from various MCOs saying that the participant
has been contacted, and they talk about their
blood pressure. They talk about smoking.
They -- you know, it goes through a whole
list of different things.

Are those community health workers that
are doing that?

MR. DEARINGER: It depends on the
Managed Care Organizations. But I would say
in a lot of cases, that -- or in some cases,
it definitely is a community health worker
that does that.

CHAIR PARTIN: Okay. Thank you.

Anybody --

MS. BICKERS: Dr. Bobrowski has his
hand raised. Oh, I'm sorry, Beth.
CHAIR PARTIN: I was just going to say: Did anybody have any questions?

DR. BOBROWSKI: I've got one question. Justin, can local health departments hire -- I didn't see that. I may have missed it on your list of different provider types -- that could get community health workers? So I didn't know if health -- just local health departments qualify to hire somebody there.

MR. DEARINGER: Yes, sir. Absolutely. If -- as a matter of fact, on the front page of our Kentucky Medicaid website, if you will look on the right-hand side, we have a -- two different links for community health worker information.

One of them is the presentation that I just went over, but the other one is a very extensive fact sheet and FAQ sheet that details exactly what provider types are eligible to bill, the limitations, the CPT codes, and many, many other questions that providers have asked us. And we've added to that list to help individuals understand, you know, all the different ins and outs. It's a
brand-new service, so there are a lot of things that we're still working on as well.

DR. BOBROWSKI: Thank you.

DR. ROBERTS: Can we -- I'm sorry, Eric. Can we get a copy of this presentation emailed to us, or is it on the website?

MS. BICKERS: It'll be --

MR. DEARINGER: It's currently on the website, yes.

DR. ROBERTS: Okay. Thank you.

MR. DEARINGER: But Erin can send it out, too. And I believe that Deputy Commissioner Veronica Cecil has already put the FAQ link in the chat as well.

MS. BICKERS: All presentations are emailed out to the MAC afterwards and then uploaded to the website.

MS. RITTENHOUSE: This is Susan Rittenhouse at Seven Counties. I have two questions, please. The first one is: In regards to the certification, with some provider types, an individual can be hired and has a certain amount of time that they can work, say up to six months, while they're getting that certification. Is there a time
frame for that with community health workers?

MR. DEARINGER: So that's governed by the Department For Public Health Services. And at this time, I don't think that there's that grace period. I'd have to go back and look at the administrative regulation. I don't remember if there is -- if you're allowed to bill for a community health worker's services before they get that training. I don't think so. I'd have to go back and look to be a hundred percent sure, but I can go back and look at that.

I know for sure in their administrative regulation, that before you get your certification, you have to complete a small amount of training from them. But that training, to my understanding, is always available, so they can do that online at any time. And it's not a large amount of training so -- but I would have to go -- I don't believe that right now it's reimbursable, like you said, pre -- pre-certification.

But it's something that we're -- that's one of the issues -- like I said, we've
started this July 1st, so it's a new service. And there are a list of topics that we have that we're meeting on currently or that we have meetings set up to discuss, to come up with some solutions and recommendations that we've gotten feedback from providers.

And what you just mentioned is having community health workers set up kind of like peer support service workers. When they start, they have a certain amount of time to get their certification, and they're still able to reimburse as long as they're under supervision.

MS. RITTENHOUSE: Correct.

MR. DEARINGER: That's something that we've discussed as well. So a lot of different things that we've looked at. We're trying to make the process for payment for dental providers smoother and easier. We're looking at limitations, all those things that we're talking about and discussing so -- but thank you for bringing that up. And I'll try to find out exactly, but I'm pretty sure that that's not correct.

COMMISSIONER LEE: Hi, Justin.
This is Commissioner Lee. Yes. You are correct, Justin, that the CHW, the community health worker, does have to be certified in order for the provider to bill for their services. Now, providers can hire individuals that they think -- or that are working towards their certification and have them in the office getting them familiar with the services array and their members that they serve, but they cannot bill for that community health worker until the community health worker receives their certification.

MS. RITTENHOUSE: Okay. Thank you.

My second question is a little more complex, and you may not have an answer but would like to at least put it on the radar.

I know that community mental health centers are eligible for this provider type. Four of the community mental health centers in Kentucky currently are also CCBHCs, and I understand that this code is not eligible for WRAP payments.

My question is that the CMHCs have received correspondence that we cannot bill for outpatient CMHC services and for a CCBHC
on the same day as a CCBHC service. Is this
code going to be exempt from that requirement
so that we could provide this service as a
CMHC on the same day that there's a CCBHC
service being provided?

MR. DEARINGER: That's a good
question, and it is an in-depth question. So
let me take that back and get an answer back
to you, so I'll give you an answer a hundred
percent.

MS. RITTENHOUSE: Thank you very
much.

MR. DEARINGER: Yep.

DR. WRIGHT: Hi. This is Eric. I
had a question, too. Two quick questions.
First off, when you look at this, Justin,
give me an example of about how much time and
training goes into this, you know. And as
you see people unfolding kind of this and,
you know, launching this into their agencies,
are they advertising these positions with,
you know, a certain salary range? And if so,
can you kind of give an average of what these
people are being paid?

MR. DEARINGER: So right now, the
average amount of training time just depends
on, you know, again, if they're certified.
If they're already certified, it's very
minimal, being able to describe exactly what
you are looking for for this CMH -- or the
community health worker.

Each provider type will -- and each
individual provider will have different needs
for that CHW's services. Some may need
individuals to strictly focus on no-shows and
reducing that no-show rate. Others will want
them working on nutritional education or
whatever their priority is for those
individuals.

I know I spoke with one provider last
week, and they have a lot of their office
staff that are constantly working on
assisting individuals with -- helping them
kind of go through different -- the paperwork
and the processes of just the visit itself.
And so they were getting backed up in their
office where a CHW would be able to assist an
individual with that type thing. So every
provider kind of will be different.

And as far as pay range, we don't have
that information yet. We have some
preliminary information from the MCOs, but
I'm not sure that that really correlates. So
I would hesitate to give any of that
information because we just started the
services July 1st.

I think toward the end of the year,
we'll have a better understanding of how much
these individuals are being paid and some of
their specific roles that providers have
hired them for. And we can -- we can kind of
give out some reports and look at some
assessments based on those things.

I don't know if you had any more,
Commissioner Lee, but...

DR. WRIGHT: One real quick
follow-up is: And can an individual start
this certification process without being --
like, you could say, hey, here's an
opportunity for someone to start this
certification process and become certified
without having an agreement to be hired?

MR. DEARINGER: Absolutely. So
someone can become a certified community
health worker. They just can't be reimbursed
through Medicaid until they're employed by an enrolled provider type.

CHAIR PARTIN: So is there an educational program for these people to attend? Is it a formal educational program?

MR. DEARINGER: There is. There are a set standard of education that they have to obtain from the Department For Public Health.

CHAIR PARTIN: Okay. So that's through the --

MR. DEARINGER: The Department of Public Health has a program that they go through, and they have educational requirements that they -- that they approve that has to be met in order for them to get their certification through the Department For Public Health.

CHAIR PARTIN: Okay. Okay. Thank you.

Anything else?

DR. COMPTON: Madam Chairman, this is Steve Compton. I do have a question. Why are optometrists not listed on those that can hire community health workers?
MR. DEARINGER: So optometrists are listed as -- are in -- in that services -- and I believe that they're lumped into the -- maybe the -- one of those groups. I can't remember.

DR. COMPTON: CMS defines us as the physicians. It could go under that.

MR. DEARINGER: That's where it's at. I'm trying to --

DR. COMPTON: Okay.

MR. DEARINGER: I apologize. I'm trying to pull up my FAQs, but I think they're grouped into the physician group.

DR. COMPTON: I've got it in front of me, so I just --

MR. DEARINGER: Okay. There you go.

DR. COMPTON: Thanks for clearing that up. Thank you.

MR. DEARINGER: Sure.

DR. COMPTON: Bye-bye.

CHAIR PARTIN: Okay. Any other questions?

(No response.)

CHAIR PARTIN: Okay. Thank you,
Justin.

MR. DEARINGER: Thank you.

CHAIR PARTIN: Next up, we have an update on maternal and child health.

DR. THERIOT: Hi. This is Dr. Theriot. I'm not sure what screen you guys are seeing. I hope you're seeing slides.

CHAIR PARTIN: We are.

DR. THERIOT: Oh, good. All right. I just wanted to give a little update on maternal health. And this should not take too long, but I wanted to talk first a little bit about the dashboard that we've been talking about. Just -- it's not ready yet. It's still in production, but I wanted to give you just a snippet about what we're planning.

Whoops. I cannot advance. Hmm. Why can I not advance? Well, anybody have any ideas? It worked. Okay.

So the maternal health data -- (audio glitch) contain maternal data but will have some child data as well. Child data is going to include, like, ER visits, well-child
visits, immunizations. And the maternal data will have types of deliveries, like, C-sections versus vaginal deliveries, if the baby was term, preterm, late term. And then different categories of -- if mom received certain screenings, if there was a doula involved, the smoking status, NICU admissions, things like that.

And so when you go into the dashboard, you'll have a drop-down list, and you can sort the data by year. And this is -- in this example, it's sorted to 2020. You can sort by Managed Care Organization. So you can just look at data from all of the MCOs, or you can look at specific MCO, or you can look at fee for service. It's also broken down by race and ethnicity. So that's the main toggle that you can see.

And so these are just little examples. So this is the example of the type of delivery, and I picked one year and picked all deliveries for that year. And so you can see we had -- what? -- 16,000 or so vaginal deliveries during that year and 9,286 C-sections.
Then we broke the C-sections down a little bit more. Was it a primary C-section, meaning it's the mom's first C-section, versus a repeat C-section? And you can see how that breaks down.

Now, you can take this graph, and you can break that down by race. You can manipulate the graph a little bit.

This is an example when I just changed it from all MCOs to one MCO, and so you can see the difference there. Like, in this one MCO, the primary C-sections were 25 percent of the births versus -- what was it? -- 21 percent for everybody together.

And then again, you can do it for race or whatever you happen to be looking at. I -- so I broke it down by race. And on the left, you see it's all MCOs for a year of births for the black race. And you can see the primary C-section rate was 20.64.

And then on the right side -- and let me move this out of the way. The primary C-section rate for the white women was 21.08, so fairly close. But, again, you can just break it down how you really want to look at
things.

This is an example -- again, this is one year. And I keep moving our little pictures around. This is one year of data, and you can click on -- let's see -- November of 2020. And if I was in the interactive -- (audio glitch) this. Well, actually, this red one. You can click on this, and I can see that 25 percent of the moms that gave birth during that month of that year smoked cigarettes. And, again, you can break it down by different -- the different things as well.

Just a glance at the child data. You can, you know, click on an age group and a month and a year, and you can see how many children had a well-child visit during that time or a vaccination or an evening visit. We're trying to add in the COVID vaccinations as well. And then you can sort, just like we talked about, the same categories of sorting.

Do you guys have any -- go ahead.

(Brief interruption.)

DR. THERIOT: I'm sorry? Does anybody have any questions about the
dashboard?

DR. SCHUSTER: Dr. Theriot, this is Sheila Schuster. I guess I'm curious about -- were you all curious about where people were giving birth?

DR. THERIOT: Yes. What I didn't show you --

DR. SCHUSTER: So home, hospital, and if we ever get birthing centers and if they're in Kentucky or elsewhere?

DR. THERIOT: Yes. We can do that. We also have it broken down by county. And then what I didn't show was also a list of top ten diagnoses for women that were admitted to the hospital postpartum and top ten diagnoses for women that had an ER visit postpartum.

And I couldn't show all of this. I really would have liked to do it interactive. No. 1, I was really worried that the Internet wouldn't cooperate if I did that. But because it's still in production, I really couldn't show a lot of the detailed information yet.

DR. SCHUSTER: Yeah.
DR. THERIOT: And I think all of those things are very important to look at. Because, again, it'll show us a snapshot. It'll show us trends. So if -- if we make a big intervention, for example, the extending care to 12 months' postpartum, we know the day that went into effect and then we can follow it out to see outcomes, you know, if it had anything to do with our outcomes.

Or if an MCO makes a big change in -- you know, with doula care or something like that, we know when that started. We can see how that's helping our population. So I'm really excited about it, and it should be -- it should be done soon.

DR. SCHUSTER: This is Sheila again. It would also be helpful to have -- I'm so glad you're going to have the top ten diagnoses for admission postpartum. Because with Senate Bill 135 passing and our emphasis on more education and maybe getting more treatment providers out there for perinatal mental health issues, it'll be interesting to follow that data as well. Thank you.

DR. THERIOT: Yes. Thank you.
And I didn't point it out. But in that squiggly line graph, you can also look at if mom was screened for substance use, if she was screened for SDoH, if she was screened for postpartum depression. So that will all show up in that graph as well that you can break down.

DR. SCHUSTER: Super. Thank you very much.

DR. THERIOT: Thanks.

CHAIR PARTIN: And that will be on the DMS website?

DR. THERIOT: Yes. That's our plan.

CHAIR PARTIN: Great.

DR. THERIOT: And then I wanted to -- real quick, the 2022 maternal mortality review report came out this month. It's always a little bit behind. And I wanted to give you a few highlights from that report.

Our maternal deaths actually stayed about the same as they were last year. We had 63 maternal deaths in 2020. And, again, we -- this report is produced from the work of the Maternal Mortality Review Committee.
And that committee takes a look at every single maternal death or a death of a mom, either while pregnant or within 365 days of being pregnant, and really drills down and looks at every single -- (audio glitch) happened. Was it preventable? What were risk factors leading up to the death, if any, and then what can we do to change it?

And so it takes a lot of time to go through these reviews, which is why, you know, this is so kind of behind -- couple of years behind. And I can tell you we had a meeting earlier this week, and they're usually six-hour meetings. (Audio glitch.) Only got through ten cases for going into -- with each one of the cases.

So you can look in 2019, we had 61 deaths. And then 2020, we had 63 deaths. Kind of holding steady. 2018 was a bad year with the 76. When we look at the pregnancy-related deaths -- and those are the deaths that happen because of the pregnancy. You know, it wouldn't have happened if the mom hadn't been pregnant. Those are holding steady as well. And our 2019 rate is 16.9.
The 2019 United States rate -- national rate was 20.1.

And so these are the ones I think of as -- you know, it's a hemorrhage. It's a heart problem. It could be eclampsia. You know, these are the medical deaths that happened. Now, not to say that they should have happened or -- you know, because a lot of them are preventable. But these are a little bit different -- (audio glitch) that big number of 61 that encompassed every death that, obviously, most of them had nothing to do with being pregnant.

They -- you know, it could have been an overdose. It could have been a car accident or natural that we looked at. And a good number are accidental deaths and then you have homicides and suicides.

A lot of those accidental deaths I can tell you are overdose deaths. And when we dive down and look at all the records, at least the committee has questions that maybe some of these ones that are deemed accidental are actually suicide. But without an actual note or something like that showing intent to
commit suicide, you can't deem it suicide legally.

So even though it's such a high number of accidental deaths, if -- I really think some of those really should move over to that suicide category, and we need to do something about that.

Speaking of drug overdose deaths, we have about 50 percent of our moms in that accidental maternal death category that die because of overdoses. And that is a huge number. That is why our maternal death rate is so high in Kentucky, is overdose deaths, and it's higher than the rest of the nation.

In case you're wondering about racial disparities, we still have a huge racial disparity. About half or twice as many maternal deaths occur for black women compared to white women, and we still have to work on that.

And so really what we gleaned from that 2019 cohort is about 20 percent of the deaths were pregnancy-related deaths at 16.9 deaths per 100,000. Overall, deaths from all causes, we were at 115.1 per 100,000. 54
percent of the mortality cases had substance use linked to their death, and almost 90 percent are preventable. And when you look at the national deaths -- (audio glitch).

COMMISSIONER LEE: Dr. Theriot --

DR. THERIOT: In Kentucky, 89 percent are prevent --

COMMISSIONER LEE: -- you keep kind of going --

DR. THERIOT: Oh, I'm sorry. Did I --

COMMISSIONER LEE: -- in and out a little bit, Dr. Theriot, yeah.

DR. THERIOT: Oh, okay. Should I just repeat this slide?

I -- all I was saying was that the -- about half of our cases, 54 percent of our mortality cases have substance use linked to their death, and 89 percent of our cases are deemed preventable of all of the cases.

And, nationally, the CDC says 60 percent of the deaths are preventable. And our number is so high because of substance use. And so, really, if we wanted to make a difference, we really need to focus on the
substance use and opioid epidemic.

And I think that's it. You guys have any questions?

DR. SCHUSTER: Dr. Theriot, this is Sheila Schuster. With the racial disparity between the black moms and the white moms, I'm a little surprised that that's not listed as a key finding.

DR. THERIOT: Well, I guess it is -- it's not different from the other years, unfortunately. And it is a key finding, like you said, that we didn't mention.

The other interesting thing is when I look at those deaths, those -- I mean, a few of them might be overdose deaths, but those deaths are not related to substance use. Usually, those deaths are related to a medical reason, you know, like a hemorrhage or a cardiovascular reason, not a pregnancy-related death.

DR. SCHUSTER: I think that is key to point out because I think people that are just going on whim or prejudice or whatever would associate perhaps black deaths with
substance use disorder, and --

DR. THERIOT: You're right.

DR. SCHUSTER: -- I really think
that that's important to point out when we
discuss this data. I mean, I think we need
to keep focusing on the racial disparity.

And I will tell you, from presenting in
the legislature, that legislators are having
a hard time hearing that, that there is a
racial disparity. So the more that we can
delve into that and point out the things that
it's not related to, I think, is really,
really important. So I ask you to consider
that.

DR. THERIOT: Thank you. I will.
That's a very good point.

DR. SCHUSTER: Thank you very much.

CHAIR PARTIN: Any questions? Any
other questions?

(No response.)

CHAIR PARTIN: Okay. So our next
update on maternal/child will be in six
months. And, Dr. Theriot, would you -- when
you do that report, could you point out
that -- or pull out that data about the
reason for the mortality, increased mortality with the black women versus the white women?

And maybe we need to look at Hispanic women as well and see if there's a difference there and look at the causes of the deaths, not just say that it's not related to substance abuse. But maybe we need to start looking at some of the other reasons so that we can zero in on what we can do to help prevent that.

I'm not sure if Dr. Theriot heard that.

DR. THERIOT: I did. I'm sorry. I didn't realize I was on mute. But I said that was a great idea. I've written it down. Thank you.

CHAIR PARTIN: Okay. We'll look forward to hearing that in six months.

Okay. Any other questions?

(No response.)

CHAIR PARTIN: Thank you very much. As always, your presentations are very informative and helpful, and I appreciate it. Okay. Commissioner, you're up next.

COMMISSIONER LEE: Good morning. A couple of updates. I know that many of you
may have seen the press release that went out related to our Mobile Crisis State Plan Amendment being approved. We have an implementation time of September 1 of 2023. Leslie Hoffmann and her behavioral health team have worked very hard on the behavioral health Mobile Crisis State Plan Amendment.

And I know that we have an aggressive agenda for the next MAC to include the -- the workforce development report. But I think, you know, it definitely would be beneficial to have Leslie or her team on the meeting next time to just give you an update on the mobile crisis and go over some of the provisions that are outlined in the state plan.

Earlier this week, we also submitted -- or last week, July 14th, as part of an Emergency Medical Transportation Task Force, we submitted two state plan -- or a State Plan Amendment that contains provisions in there for ambulances or EMS -- EMTs, EMT providers to treat in place.

Currently, our transportation -- our ambulance transportation reg only allows an
emergency ambulance to transport to a
hospital. So we're following along the lines
of other states who have submitted State Plan
Amendments to allow those EMT providers to
come and treat an individual in place without
transport.

Again, currently, those providers do not
receive -- do not receive reimbursement if
they don't transport. So we believe that may
help get some of those services that
individuals need and prevent -- get the
services they need in that location rather
than transporting them unnecessarily to a
hospital.

We are also looking at CMS to help us
with -- we have created a state plan for
treat, triage, and transport of individuals.
So this means that an EMT could go to -- or
an ambulance could go to a site of a 911
call, for example, assess the situation,
treat the individual in place, triage them,
and transport them to a location other than a
hospital.

Those locations could include actually a
physician's office. It could include an
urgent treatment center, for example, so that that individual can get the most appropriate care.

Now, this would not be a replacement for a nonemergency medical transportation benefit that we have in place already. And this -- these transportation State Plan Amendments are designed to work in conjunction with our Mobile Crisis State Plan Amendment because the crisis -- Mobile Crisis State Plan Amendment does have a provision in there that allows two providers to go to a site and then one of those individuals has to be a behavioral health specialist.

So we are -- we believe that this will -- these SPAs in combination will definitely allow a greater flexibility with transportation needs for our members. Again, we have just submitted those to -- that state plan to allow treat in place and treat, triage, and transport.

We are -- definitely have some priorities in the department, as you heard with Dr. Wright's conversation that he had with Pam and I related to PDS and certain
things in the HCBS waivers. We still have a
large focus on our HCBS waivers.

As some of you may know, we do currently
have a waiting list in our HCB waiver
program, which we have never had before. The
good news is that waiver renewal year starts
on August 1st, so we do believe that we have
enough slots to clear up that waiting list
from the HCB waiver. However, we do
anticipate that we may have another waiting
list as we move forward. So, again, a lot of
focus on our HCBS programs.

The other main focus that -- a lot of
our work has been related to unwinding from
the Public Health Emergency. And we have
Veronica -- I think Deputy Commissioner
Veronica Cecil is on the call, and she can
give you an update about where we are with
unwinding.

Veronica?

DEPUTY COMMISSIONER CECIL: Thank
you, Commissioner. Good morning, everyone.
I am going to share my screen, and we will
provide these slides after the meeting to all
the MAC and TAC members and then it will also
be uploaded to the MAC website for anyone else that would like to see them.

To really just -- I'm really going to try to do my best to be quick through all this but just a snapshot of what the enrollment is looking like. We were originally doing a graph that showed pre-pandemic, but it's getting too big and too weedy.

So we -- this is looking at from January of 2022. You will see that there is a dip. Medicaid renewals that were subject to redetermination started in May, and so that's why you are seeing a bit of decline.

Our current enrollment as of the date of July 3rd, which is the data metric that was used for this, was 1,642,210. So that is below the -- you know, we were over -- a little over 1.7 million prior to the start of redeterminations.

We have four cohorts going on right now so four months of redeterminations that are somewhere in the pipeline. So our May redeterminations, even though we started those in -- initiated those in early April,
they're continuing. We're continuing to show data on them. And the reason for that is because we do have -- you know, members do have the capability to request reinstatement within 90 days of their termination. So for May, that would have been May 31st.

So if somebody just missed a notice and then discovers walking into a provider's office that they no longer have coverage, they can still provide information to us, and we will retro that coverage back as if no gap.

So keep in mind, providers, you know, we are asking for you all to help us connect those members to support and resources to complete that application or that redetermination.

So the numbers you will see will change. In May, the numbers have, you know, increased for approvals and/or terminations as a result of people coming back in and completing those redeterminations if they've received a notice.

We did extend a group of individuals. You'll see there on the left side, 6,669 were
extended. We did that. CMS is allowing
states to extend members for -- to conduct
additional outreach if they've not responded
to a notice. We're doing this specifically
for our long-term care and waiver providers,
you know, our really vulnerable individuals
of our program, to make sure that they do
have the opportunity to complete that
redetermination and not be procedurally
terminated as a result of not responding.

So we have asked CMS and have received
approval for Kentucky to be able to do an
additional 60 days, if needed, to provide
that additional outreach. So of those that
we extended for May, 4,100 have been
processed, so they might fall under approval
or the termination bucket depending on how
the redetermination was completed.

We did extend -- so the original
extension for these members were to June, and
we did extend another 2,500 through July.
The difficulty here, and certainly a priority
for us, is to make sure that all those folks
have responded to that notice because we
cannot extend them beyond the end of July.
So we are prioritizing those individuals. We're working with facilities and case managers to make sure that that individual understands that they need to take action and submits that notice.

The pending bucket is really those folks who had a task when May 31st came, that there was a task pending. And so those are also prioritized, so we can make sure we can complete that redetermination. We still have 85 left over from May.

But we're tracking -- I mentioned the reinstatements, and the good news is that we have been able to reinstate. So in the approval bucket is around 3,500 -- a little over 3,500 individuals. So it just shows that people are coming back in, and that's a good thing.

Here is June. Similar -- I'm not going to go through all of the specific data points because you all can have this. But, you know, starting to, again, see -- we extended -- just wanted to point out we did extend additional folks that had a June 30th end date so that we could continue to
outreach to them and work with them to get that redetermination response in.

We do have pending 1,396 from the June renewal. Those tasks are being worked as quickly as possible. You know, sometimes those do result in an additional request for information that has to be issued because once the worker starts completing the redetermination, there's information missing. So an RFI might still go back out, but those are still being worked.

And, again, from the June renewals, we've got a little over 1,400 that have been able to be reinstated because they did -- after their termination date did come back in and provide the information that we needed.

So July and August, these look a little different because they're still in process. July 31st is approaching and so July renewals. You know, we are working. We had a larger amount of passive cases, and about 60 percent of those were -- we were able to redetermine automatically, so that member did not have to take any action to get redetermined for Medicaid.
Of the active renewals -- so they did have to respond to a notice. Of those, we've had a little over 3,500 that have turned in their information, and we've determined 2,600 of those is eligible and 646 as ineligible. That's an actual determination of an eligibility. We are tracking the number of individuals who are also eligible for a Qualified Health Plan and that advanced premium tax credit, which, as you all may remember, allows that Qualified Health Plan premium to be really affordable; in some cases, at zero cost. We're tracking that because we want to make sure that there's no gap in an individual's coverage. If they're ending Medicaid, we want them to immediately be able to access coverage through the Qualified Health Plan. So we're tracking these individuals to ensure that they are making that connection and they're signing up. For August, again, you will see a large number of cases that qualified -- or a larger percentage of cases that qualified for
passive. That's always great. And in that, we almost had 90 -- excuse me, 70 percent that were automatically reetermined. So that number is coming up, which is always great, because that means people don't have to take action.

We've got 367 active renewals that have been completed for August. 241 determined eligible, 89 determined ineligible. So continue to work on those cases as well.

Just a reminder. This is the rest of the unwinding period. So we've already sent out -- I'm sorry. We're about to -- in the beginning of August, we'll be sending out notices for September renewals, but here is the distribution for the rest of the unwinding.

Keep in mind -- and I mentioned this in May -- that we did push a lot of cases that have children to later in the unwinding period because we are implementing continuous coverage for children. And that system -- automated system change, it doesn't go into effect until September.

So we wanted to make sure that if a
child is determined eligible, they're granted that 12 months' continuous coverage. For any child that comes in, though, between April and when the system goes into effect does still get that continuous coverage. It's just more of a manual process.

Wanted to show -- because a Qualified Health Plan coverage is also very important as we go through unwinding, but this is a snapshot of what that enrollment looks like. We're, you know, always happy to see it tick up because that means people are moving off of Medicaid who have been determined ineligible and accessing that coverage.

Just also wanted to remind you that -- we've talked about this before. But the Office of Civil Rights, when it comes to telehealth, is requiring providers to return to HIPAA-compliant platforms. That due date is coming up August 9th, so this is just a reminder to make sure that if you're doing telehealth, you have to be in compliance with a HIPAA-compliant platform.

Continue to always advocate to please sign up for one of our social media accounts,
like us or follow us, because it is the best way to stay up to date on the most current information on unwinding, get information out when we hear scams or trends. We do have the monthly stakeholder meeting. All of those meetings are recorded and posted including the presentations on our unwinding website.

We just had a -- this month a specific stakeholder meeting for the 1915C waiver members and providers. That information is out there. So if you did not -- you were able not able to join that, I encourage waiver providers to go out and access that and watch it and look at the presentation on your -- at your convenience. It provides a lot of really good information.

And then, you know, we're striving to keep providers in the loop. The KLOCS report, the Kentucky Level of Care Report, that's accessible by our long-term care waiver providers. It allows them to identify the members that are subject to a redetermination.

And then in KYHealth-Net -- don't forget, providers -- you can see that
redetermination date. So as the member comes into your office, if it's a date that has passed and they've lost coverage, you know, definitely connect them so that we can make sure that loss of coverage, that they were actually ineligible and then connect them to a Qualified Health Plan if that's the case. Or if it's in the month or the next month, just ask them if they've checked to see if they have a notice or have received a notice from Medicaid.

Well, I -- that's the end. Happy to take any questions that someone might have about unwinding. And, Dr. Schuster, I see you trying to raise your finger.

DR. SCHUSTER: I have never figured out how to raise my hand on these Zoom things.

DEPUTY COMMISSIONER CECIL: It's okay. You can see fingers.

DR. SCHUSTER: Thank you very much, Veronica. It's always good information. I'm curious under your terminated, there was a category that was actually the largest percentage, and it said procedural reasons.
DEPUTY COMMISSIONER CECIL: Yes.

DR. SCHUSTER: So they are not ineligible. So what's a procedural reason? Can you give us an idea?

DEPUTY COMMISSIONER CECIL: Yeah.

Honestly, the biggest portion of that is they did not respond to a notice.

DR. SCHUSTER: Okay.

DEPUTY COMMISSIONER CECIL: And that's been challenging not just for Kentucky but across the United States, for state Medicaid agencies to get folks to actually respond to the notice, so a determination can be made based on the information that relates to that case.

So, you know, we've been doing tons of outreach. So by the time that somebody's renewal end date comes up, they've heard from -- (audio glitch) both when the notice goes out, then a couple of weeks later. And then on the 15th of the month --

I'm going to turn off my video because I'm having trouble.

Then on the 15th of the month of their renewal, if we've not received anything from
them, they get another call. And then the
Managed Care Organizations separately are
also outreaching to their members.

So we really have tried to exhaust all
outreach efforts. But we're still learning,
and I think we have new opportunities to do
that. And, you know, for instance, with back
to school, we've got some plans on how to get
information to families through
back-to-school efforts.

So the biggest challenge really has been
just encouraging someone to return the
notice. Even if they're -- even if they
think they're no longer eligible, we'd still
like to be able to make that dual
redetermination.

But, you know, I think most folks, when
they get it, may think they're not eligible
because they do -- I mean, some do know their
income is above the Medicaid federal poverty
level, so they're not even responding.

DR. SCHUSTER: Okay. Thank you. I
wondered if that's what it was because that's
been the biggest bugaboo, I think --

DEPUTY COMMISSIONER CECIL: It has.
DR. SCHUSTER: -- because everybody is trying to figure out, with multiple contacts, why people are not responding. So thank you very much, Veronica.

DEPUTY COMMISSIONER CECIL: You're welcome.

Nina, I think I saw your hand next.

MS. EISNER: Yes. I just want to make sure that I'm clear on what non-HIPAA-compliant platforms are excluded. So, obviously, FaceTime. But what else? Anything else?

DEPUTY COMMISSIONER CECIL: So I do want to -- (audio glitch) disclose that I am not the expert on HIPAA-compliant platforms. But I would say -- so yes, FaceTime, our understanding. Gosh. I apologize. I'm blanking on -- there is one other that I know.

CHAIR PARTIN: Facebook Messenger.

DEPUTY COMMISSIONER CECIL: Thank you. Thank you, Dr. -- yeah, Dr. Partin. Facebook Messenger is another one.

MS. EISNER: Okay.

DEPUTY COMMISSIONER CECIL: Now, I
highly recommend -- because there's been
acknowledgment by a lot of the
non-HIPAA-compliant platforms of the issue,
and I think they're trying to find ways to
become HIPAA-compliant. So definitely check
in with those platforms directly to see if
they've got, you know, things in place to
make them HIPAA-compliant.

MS. EISNER: Thank you.
CHAIR PARTIN: Doxy.me is compliant
and free. So I'm not advertising or
anything, but that's one option.

MS. EISNER: What is it?
CHAIR PARTIN: Doxy.me.

MS. EISNER: Doxy.me?
CHAIR PARTIN: It's d-o-x-y dot me, m-e.

MS. EISNER: Okay. Thank you.
MS. BICKERS: Dr. Bobrowski has his
hand raised.

DEPUTY COMMISSIONER CECIL: Yes.

DR. BOBROWSKI: Yeah. Question on
the -- and I don't know if this is an
unforeseen problem or not. But just with the
unwinding, some of our procedures in the
expansion codes are multi-appointment procedures, like making a denture, doing a root canal on an infected tooth. Of course, dentists don't get paid until the procedure is complete.

But we're getting some calls on folks that are -- have been unwound and no longer -- they got the procedure started, but now they are no longer eligible for Medicaid, leaving the dentist stuck with, well, what do we do.

Can -- are they supposed to go back now and charge the patient or -- because they already have paid the expenses, you know, from lab supplies, office supplies, time paying for staff. And the critical thing is that, technically, we're not supposed to bill it until it's finished.

So I don't know. Have you all talked about that or looked at that?

DEPUTY COMMISSIONER CECIL: We have, Dr. Bobrowski, and thank you for bringing that up. We, in fact, have a meeting this afternoon with the Managed Care Organization leadership, and this is an
agenda item. We -- we do want to provide
guidance to providers.

I think it is certainly our intent not
to disrupt a service that's been initiated
and -- especially, you know, dentures. And
we know there's a whole host of services that
require that multi-appointment modality. So
we are discussing it and do plan to issue
guidance so that you all have that available
to you to rely on. You're welcome.

DR. BOBROWSKI: Thank you.

DEPUTY COMMISSIONER CECIL: Any
other questions?

(No response.)

DEPUTY COMMISSIONER CECIL: Okay.

Thank you.

CHAIR PARTIN: Thank you, Veronica.

Commissioner, would you send me an email
with the -- for the agenda item for the
mobile crisis health plan? I was trying to
take notes on what that was, but I couldn't
write fast enough. And if you could just
send me --

COMMISSIONER LEE: Yes.

CHAIR PARTIN: -- what that item
will be, I'll put it on the agenda for the next meeting.

COMMISSIONER LEE: Yes. We will send that to you, Dr. Partin.

CHAIR PARTIN: Thank you.

Okay. Next up are the reports from the MCOs, and I would like to say that we are now -- we've got about -- well, we're going to run short on time, I think. So I'm just kind of letting everybody know that we'll do the best we can to end up on time, but we might run over just a little bit because I want to make sure that everybody gets the information that they need and is able to ask questions.

Okay. So next up is the reports from the MCO, and Aetna and WellCare are going to report today. Aetna, why don't you go ahead and go first?

MS. MANKOVICH: Thank you. Can everyone hear us okay and see our screen? Lauren, I think it looks good from my vantage point.

CHAIR PARTIN: Yes.

MS. MANKOVICH: Okay.
DR. SCHUSTER: Looks good.

MS. MANKOVICH: We will jump in.

My name is Paige Mankovich. I'm the market president for Aetna Better Health of Kentucky. I have Dr. Madelyn Meyn here with me today. She is our regional CMO.

We have a very extensive deck. And to your point, Dr. Partin, we do not have time to go through all of it. So we are going to stick to our 10 to 15 minutes, leave a little bit of time for questions. At the end, please feel free to ask us questions.

And we did provide our email addresses here on the screen. So if you don't have an opportunity to get a question in or if you spend some time looking through our deck -- they will be made public. I believe they will be on the MAC's website. You can, you know, take a look through there. And if you have questions, please feel free to send us an email, and we would be happy to engage further based on the information that we have in the deck and what we talk about today.

So moving on into our presentation. We wanted to start by showing what the top areas
of priority were that we set for 2023. So my team met in the fall of 2022, had a very intentional strategic planning session, and really decided that the areas of specific focus based on data that we had and what we know is incredibly important. So I'm going to hit on a couple of these. Dr. Meyn's presentation will take us through the last three.

But I'm going to start by addressing member engagement. So we know that engaging with the Medicaid membership and doing that in a manner that is successful doesn't always look exactly like what you might expect. Traditional methods of outreach sometimes -- mailing, things like that -- is not how we're able to actually reach our members in a meaningful fashion.

So we're utilizing other methods of outreach, text messaging, really focusing on when a member calls in. Or if we're at an event and we see one of our members and talk with them, that we're updating their telephone numbers. We've got email addresses, things like that, because we know
that that's how members engage better with their healthcare company.

We also know that engaging community partners who are neighbors of our members is a really important way to make sure that we are locating our members. We are engaging with them. We know how to get in touch with them. We know that's especially important -- and the deputy commissioner hit on that -- during this unwinding period.

You know, it's incredibly important that we know how to get information in front of our members to ensure that they maintain their eligibility and then also that they're able to access services that they need to be able to access.

As you can see from this slide, our membership is pretty evenly distributed across the regions, also fairly evenly distributed by gender and by age group as far as adults and children. We have approximately 250,000 members, 30,000 of which are with our SKY program, which we'll flip to the next slide, if you will, Lauren, and we'll hit on SKY just briefly.
We spoke last year to this group at length about SKY. And so I'm going to over it pretty quickly, but I don't want that to imply that it's not an incredibly important part of our health plan. It absolutely is. For those who may be unfamiliar, SKY is our sole-source contract where we provide Medicaid coverage for all children in Kentucky who are system involved. So if they're in foster care, if they are in juvenile justice custody, if they have been adopted from foster care, or if they've aged out of the foster care system but are still under the age of 26.

SKY is a high-touch care management model with other ancillary services such as a training collaborative, a lot of, you know, behavioral health services, a lot of interaction with the State. Dr. Meyn is going to get into some of the outcomes that we've had with SKY that we are incredibly proud of.

And then Dr. Meyn will also get into more specifics with actual health outcomes but that health outcomes are a huge part of
our priority area and will continue obviously
to be as we set our strategy for 2024. We
are particularly focused on members with SUD,
maternal and child health care, getting
kiddos caught up on vaccinations and
well-adult exams, and identifying and
resolving social need barriers.

But we also know that in order to have
good health outcomes, members have to have
appropriate and adequate access to care. And
I know that we have an adequate network but,
oftentimes, what appears on paper or on
reports may not tell the reality of the
situation. So because of that, we are very
engaged with our network of all provider
types, making sure that we have appropriate
coverage of providers in all areas, all
specialties, PCPs and beyond, statewide.

One area of focus that we have that I
know is of great importance to this TAC and
great -- or to this MAC, excuse me -- great
importance to us as a health plan is making
sure that we are engaged meaningfully with
our dental network and that we are growing
our dental network and that we're addressing
the needs and concerns of providers there so
that our members have timely and appropriate
access to dental care.

So with that, I'm going to turn it over
to Dr. Meyn.

DR. MEYN: Thanks, Paige.

Good morning, everyone. I'm going to
get into now, you know, a lot of our
programming around physical and social
determinants of health and kind of how we
think about what we're doing and how it
affects our membership and what we're looking
for for outcomes.

So along with, you know, our standard
suite of services that includes case -- care
management and behavioral health services, we
really do try to look at, you know, health
equity and social determinants of health,
women's health, behavioral health, kind of
make them into separate populations that can
mix together but that we have programs and
strategies to identify the needs for these
populations.

Next slide, please. So when we talk
about social determinants of health, what
we're really talking about is getting resources and solutions to members that have issues with food, transportation, security that may take precedent over them seeking medical care. And so resolving social determinants of health resolution issues really do, then, help to reduce kind of low-value care around admissions and emergency room.

So when we talk about what we do, we -- you know, we have gift cards. We have meals delivered. And those solutions then, therefore, take people back into their homes. They take them back to their outpatient services and away from the unnecessary utilization.

Next slide. Here's a long laundry list of all the things that we do around social determinants of health and where we are. The things I wanted to call out were our community investments around housing, our GED certification, our over-the-counter medication benefit, which all our members get along with additional benefit for period necessities to help with that health equity
issue.

And then we do work with a vendor around loneliness and isolation, to identify members who may not come up on a claim but have other issues that we can help resolve but just finding them and knowing what their issues are to get there first.

Next slide, please. Focusing on women's health, the main issue here that we really look at for our members is to drive them into high-value care in their primary care offices to get those screenings for cancer care screenings as well as obstetrical care.

And, you know, our goal is to not just get them into the office but to have that continuum of care even after delivery for a pregnant person. You can see that 182 perinatal and postpartum assessments were completed by care management for quarter one 2023. And those engaged in care management have a higher percentage of delivering after 37 weeks than those that are not.

Additionally, our focus with text reminders has increased our mammogram and our Pap smear rates, which continues to be on a
positive trend.

Next slide. So lots of data. Just trying to hit the highlights here because I know that we're running short on time.

I know, you know, across the country, behavioral health has really been a focus, especially coming out of the pandemic and the rise in anxiety and depression that we've seen, and certainly that's not an isolated incident for Kentucky. So we have a lot focused on behavioral health including behavior -- our change education, our behavioral health crisis line.

And then we also have a focus on SUD prevention and access to MAT therapy. So you can see that over 8,000 members have been outreached to educate around opioid prevention that has also increased our usage of MAT.

Next slide. A focus on chronic condition management is certainly always one of our focuses. You know, it's never changed. These are our HEDIS metrics. These are how we care for our members in making sure that once a member has been diagnosed
with a chronic disease, that they're maintaining the standard of care that is acceptable for those conditions.

And you can see that through additional programming around screening reminders, free blood pressure cuffs, and remote patient monitoring, we've been able to increase all of these metrics related to chronic conditions including blood pressure control rates, hemoglobin A1C testing, as well as diabetes testing rates.

Next slide. Population health and prevention wellness is also kind of the other end of our spectrum where we have chronic disease and then the prevention. And, typically, you know, we do a very good job about prevention and focus on children and getting them into well checks but, you know, recognizing that adults need these preventative measures as well to prevent those chronic diseases.

Through our HRAs and our digital campaigns and our additional text messages as well as our community outreach programs and our member advisory committees, we do have an
increase in annual well visits for both children and adults.

Next slide. So what does this all mean? I mean, we have lots of programs, good results. Everything is trending up. But does it make a difference? And you can see here that 92 percent of our members are satisfied with our PHM programs as well as 82 percent, which I think is an astounding number, have made changes in how member cares for themselves since starting and being involved in one of our programs.

The next two slides are very busy, and I'm not going to bemoan the great work that we've done. But you can see just from a visual that all of our outcomes are trending positive. So coming out of the pandemic, recognizing that we need to have extra effort, extra programs, extra ways that -- you know, that people are engaging in their health care through their phones, through remote patient monitoring, through texting.

You can see that we have positive trends for our HEDIS MY 2022 both in our health plan and then the next slide will show you the
positive trends that we have for our SKY program.

All of this in all says that, you know, we are a three-and-a-half star rated program, and we look forward to our future years to continuing those upwards trends. This is all very -- I think that a lot of the next slides are kind of standardized. Some of the other presenters will probably have similar slides, and so I won't, you know, kind of go into a lot of that data that's to come.

But I did want to focus on this slide to say, you know, in the last few years, we've seen an increase in the amount of authorizations that have been requested, but our denial rate has stayed somewhat stable. So that just means that we are getting more authorizations and approving more services for the members in Kentucky.

A list of, you know, why prior authorizations may be denied. I know this is always a contentious issue. And, you know, things do get denied. That is part of the managed care process. And, really, the main reason for denials are lack of medical
necessity.

We decide as an organization how to -- you know, what needs an authorization. We look at low-value care. We look at expensive care. We look at care that has a lot of potential risks involved to assure that those members that are needing the services are the ones that are actually getting the services and that they are being performed by providers that are credentialed and have quality outcomes related to those services.

So, you know, a denial is not always an easy thing to receive, but there is, you know, evidence supporting that. And we do follow our criteria in order to make those determinations.

A lot of these denials, too, when there's lack of information or -- you know, there's an opportunity to have a discussion with peer-to-peer. They can be turned over, whether on a peer-to-peer or in appeal. So there's always that opportunity.

Next slide. So the next four slides really are just the diagnosis and trends around behavioral health, physical health,
ED, and inpatient utilization. And we can kind of just flip through these slides quite quickly because of time knowing that, you know, what we're really seeing -- and I just want to stop here, is this behavioral health inpatient trend. You know, we're really monitoring this.

This, again, is a trend across the country, recognizing that people are having a lot of behavioral health -- there is an increase in the predominance and prevalence of the behavioral health issues. But I think also the pandemic has allowed us to have greater access; right?

So we're accessing -- members are accessing care that they normally wouldn't with, you know -- like I said, with digital, with phones, with our behavioral health crisis lines, with the mobile crisis implementation that's, you know, going to be occurring in the fall.

So while this trend may be going up, I think that it's a trend that we just are -- is new to us because of all the increased services and opportunities to engage with
those services.

This is just the physical health inpatient. And I'll stop here real quick, the readmissions. We can see the readmission trends are pretty stable throughout the years, both for behavioral health and physical health. And, you know, that is something that we're always working on.

With all these programs, with the increase in network that Paige referred to, with our case management, with, you know, outreaching members for SDoH resolutions. So this is something that's always, you know, in the back of our mind.

And the last slide that I'll comment on is our primary expenditure for -- primary drivers of expenditure. And, you know, again, it's the mental health non-inpatient, so that's all those outpatient services.

You know, having people receive those services when they are medically necessary is a good thing. So seeing that volume, again, I think it's just a testament that we're providing more services, and more people are accessing them.
But the real story around cost is retail Rx, so the number of scrips has increased as well as the cost.

And that's the end of our presentation. Very quick, I know, trying to be cognizant of the time. So we'll take any questions. I'm happy to have this opportunity to present. Thank you so much.

MS. MANKOVICH: Nina, I see your hand there.

MS. EISNER: Yes. Thank you. Thank you so much for your presentation. Under the prior authorization issue, I was pleased to see that the number of denials was staying flat relatively.

But I did note that the slide showed that the total requirements for prior authorizations are on a real upward trend, and it's concerning at a time that it requires additional burden of providers when there's such a workforce shortage. So just a comment.

MS. MANKOVICH: So -- sure. And I appreciate that, and I thought that might come up. And I can actually explain, I
think, that a little bit more specifically.

So in 2020 and 2021, we had a relaxation of prior authorizations, so I think what you're seeing in that uptick is as things were able to be turned back on for prior authorization, there was a natural increase.

We also had an increase in membership because of the Public Health Emergency and members not going through a redetermination. So you've just got -- we've got a bigger pool of members that were subject to or receiving treatment that might require a prior authorization.

But to your point, you know, we do have a UM steering committee that pays attention to the number of services that -- we're, you know, having very high approval rates on prior authorization, to say: Do we really need to have a prior authorization on that? And we will remove prior authorizations.

So that work is ongoing on a regular basis. It's not an annual review. It's a quarterly review, I believe. So I think -- I think there's several factors that are playing into that increase, but your point is
well-taken.

DR. MEYN: In fact -- and we work with providers around prior authorization and removing prior authorizations. In fact, right now, we're working on -- you know, with a provider that didn't see the necessity for a 90-day but would -- I mean, for a 60-day but needed -- wanted 90-day.

So we looked at: What are the denial rates for the provider? What are the denial rates for the procedure? And, you know, changed that requirement to make it the 90 days instead of the 60 days.

So it is a collaboration. But, again, you know, just to stress the point of, you know, making sure that our members are getting evidenced care and that -- not wanting people to undergo services -- procedures when they aren't evidence-based is kind of -- you know, and making sure that quality outcomes are happening are our primary focus.

MS. EISNER: Thank you for your ongoing attention to this matter.

MS. MANKOVICH: Sure.
DR. ROBERTS: Yeah. Your point about PAs being retracted -- requirement being retracted and then re-implemented is noted. You know, a more detailed PA breakdown may be beyond the scope of this presentation. The -- looking at how many -- how many of your codes require PAs over -- you know, over a period of years is something that, Beth, we may look at -- when we set forth the criteria for the MCO presentations, that may be something to look at next year, is, you know, the number of -- number of codes that require PA over time.

You know, your denial rate stays, you know, pretty consistent, but it is concerning with the -- you know, at the comment that was made. You know, if you're denying the same amount but you're requiring a significantly increased number of PAs -- you know, and, again, these numbers are a bit skewed because of coming out of COVID.

But that's -- I can tell you that is one of the greatest obstacles that my colleagues have with seeing Medicaid patients, either enrolling in Medicaid to begin with or in
capping the number of Medicaid patients that
they see is -- you know, the reimbursement
rates are what they are. We all have, you
know, a program that we're working within.

But when it requires a significantly
increased administrative burden or profound
amounts of bundling within, you know, groups
of procedures performed, you know, the same
day or PAs for things that -- you know, that
are just not -- you know, they historically
haven't required PAs.

I do appreciate the fact that you're
looking at evidence-based care. That's
great. The, you know, transparency on why an
item or service was -- now requires a PA
would probably help it, you know, go over
better, a little bit better with physicians.
But that would also provide an opportunity to
say, okay, look, well, here is the evidence.
Let's remove the PA if we can find an
evidence-based consensus but the -- yeah.
That's my comment.

MS. MANKOVICH: Thank you.

CHAIR PARTIN: Any other questions?

(No response.)
CHAIR PARTIN: Okay. I had a -- I had a couple questions. One, where you listed the primary care providers at the very beginning, you listed physician. You did not list nurse practitioners or certified nurse midwives.

Are they included in that physician count, or did you just leave them out?

MS. MANKOVICH: We have a lot of additional information in the appendix. I'm looking at it right now. So participating providers by region, we do have physicians and nurse practitioners listed on page 34 of our deck. So it's in the appendix.

I do not see that we have nurse midwives on here. I may be speaking out of turn. So I apologize, and I will go correct myself if I am. I'm not sure if that's -- I apologize. I don't know if that's a Medicaid-covered service at this very moment, but I will take that back and double-check.

CHAIR PARTIN: It is.

MS. MANKOVICH: Okay.

CHAIR PARTIN: Nurse midwives are -- services are covered. Okay. So --
MS. MANKOVICH: So we can -- we can supplement with that.

CHAIR PARTIN: Okay. And then my next question is related to the -- sorry about my dog -- related to the gift cards. Do the recipients -- or the participants automatically receive the gift card? For instance, if they had a hemoglobin A1C, you know that because of the lab billing. So do they just automatically receive the gift card, or do we --

MS. MANKOVICH: We have -- we have a member of our HEDIS team or a group within our HEDIS team that does outreach the member to confirm where they live, what phone number, what mailing address to send it to. Because, often, the mailing address that we have on file is not where they live anymore. So we do have to validate that with the member.

We would love to get to a point where it could be instantaneous, but these often are -- whether they're electronic or hard copy gift cards, we want to make sure that they're actually making it to the hands of
the member.

CHAIR PARTIN: Okay. But you automatically do that --

MS. MANKOVICH: Yes.

CHAIR PARTIN: -- based on the billing codes and that sort of thing?

MS. MANKOVICH: Yes.

CHAIR PARTIN: Okay. I just wanted to make sure that the provider didn't have to do something.

MS. MANKOVICH: No.

CHAIR PARTIN: Okay. That's the only questions I had. Thank you.


CHAIR PARTIN: Anything else?

(No response.)

CHAIR PARTIN: Okay. I would just like to add that because there is so much information here, probably members of the MAC will want to look at these presentations. And so I'll add to the agenda for the next meeting that if people have questions after they've looked at them, that they can ask questions to each of the MCOs at the next
meeting. So you may or may not receive questions at the September meeting.

MS. MANKOVICH: We will be prepared.

DR. MEYN: We love them.

MS. MANKOVICH: Yeah.

CHAIR PARTIN: Thank you.

MS. MANKOVICH: Thank you.

CHAIR PARTIN: Okay. Next up is WellCare.

MR. EWING: Okay. Good morning.

I'm Corey Ewing, plan president here at WellCare. Just wanted to say thanks for the opportunity to present to you guys today. I'll be pretty brief in my comments, and we'll toss it over to my team and let them get into the meat of the deck.

But a little bit about WellCare. Most of you know who we are, but we've been here since day one, 2011, when managed care came into the state. We're fortunate to currently hold the largest market share in the Medicaid space with 32 percent of the market share with primarily the majority of our members being in Regions 7 and 8.
We see quite a bit of acuity coming out of that region, and the reason I point that out is you'll get to hear a little bit about the work we're doing around social determinants of health because it's a lot of those things that lead to those higher acuities. But you'll get to hear the team speak to that in great depth here shortly.

With that, I will toss it over to Marc Nyarko. He's our chief operating officer, so I will let Marc go.

MR. NYARKO: Hey. Thanks, Corey.

MR. EWING: Okay. There we go.

MR. NYARKO: All right. Awesome.

So we build a robust provider network to support our membership base, and we've met accessibility standards for all provider categories. Thinking about the accessibility standards, we're supposed to -- and for urban members, one provider within 30 miles; and for rural members, provide one provider within 50 miles. We are 100 percent adequate for 33 of 37 categories, and our lowest rating is 95 percent for endocrinologists.

We continue to assess our network.
adequacy looking for potential gaps. We also have a comprehensive review on a quarterly basis when we're looking at our network. And when we identify potential shortages, we launch a targeted improvement initiative.

An example of that is with applied behavioral analysts. In 2020, we realized we had a gap, and we launched recruitment then. We went from 74 ABAs to 225 and are currently 100 percent adequate with that.

In addition to that, you know, when members are in-network -- when an in-network provider is unavailable and a member needs an out-of-network provider, we're very quick to negotiate with that provider, and we can engage with a single case agreement within 8 to 24 hours.

Next slide. This slide outlines the out-of-network requests that we received in 2022 by quarter. The majority of the out-of-network scenarios, remember, was out of state. And so that's when we would engage with those providers to do a single case agreement.

And, you know, we do take a look at
patterns in our out-of-network claims, the utilization. And we'll reach out to negotiate with a provider with a network agreement if we feel like there's, you know, an opportunity there.

Telehealth is a very important tool that we use to ensure access. We've actually paid claims to over 12,000 distinct provider IDs and 89 unique provider types. Looking at the graph on the left, you'll see our spending from 2020 to current has been very robust.

Now, I'd like to turn it over to Paula McFall who -- our senior director of behavioral services. Paula?

MS. MCFALL: I'm on mute. I'm sorry.

I'm here to talk about our primary drivers for spend, and much of it is behavioral health. So just giving you some information on that. Of course, the trend began during the pandemic, and it continues.

Overall, behavioral health's per member per month spend rose 12.8 percent in calendar year 2022 compared to 2021. Lower level, including non-BH services, are key drivers
here. Data shows that there are some members that only receive BH services that are peer support or community support rather than clinically-based treatment by a licensed provider.

So here's two examples of peer support.

PMPM --

(Brief audio interruption.)

MS. MCFALL: I'm sorry. PMPM rose 135 percent from 2019 to first quarter of 2023. And the units per thousand also surged to 198 percent. Prior to that, in 2020, peer support was our 11th PMPM ranking, and now it's 4th.

Community support services rose 114 percent in the same time period and also jumped per K -- units per K 115 percent over time. And community support was 16th in 2020 for PMPM ranking, and now they're 6th.

Next slide. A couple more examples.

Therapeutic behavioral health, the PMPM jumped 213 percent during that same time frame as did the units per thousand. And psychoeducation units per thousand jumped 222 percent from 2019.
Next slide, please. This is a slide that compares a couple other states that Centene have a Medicaid business, Ohio and Indiana. And it looks at community-based services, which includes your peer support, comprehensive community support, and then your outpatient services, which is provided by a licensed clinician or physician, nurse practitioner.

So Kentucky has 37 percent fewer members per thousand of community-based services than Ohio, but they are 125 percent higher in units per utilizing member. Similarly, the units per thousand for members in Kentucky are 43 percent higher than Ohio for the community-based services despite 37 percent fewer members per thousand.

And as you can see from these slides, the -- in contrast, we are much lower for outpatient clinical services than Ohio and a little bit lower than Indiana there.

On the table to the right, for 2021 to 2022, we had a 24 percent increase in PMPM for community-based services. Units per thousand were 11.6 increase. Units per
utilizing member were 26.6 percent increase
and then units per K were a 41.3 percent
increase, so just showing trends.

This is the last slide. We just wanted
to show a couple more examples of the trend
going up. For partial hospitalization, our
PMPM has gone up, from '21 to '22, 42
point -- 42 percent. Users per K, 21.5
percent; units per utilizing member, 30
percent; and units per thousand, 58 percent.

Also, applied behavioral analysis, which
we expected to increase since we did increase
our provider -- providers across the state.
So this is actually a trend we wanted to see.
The PMPM is 56.5 percent increase. Users per
K, 59.2 percent increase. The utilizing
members decreased very small, 1.2 percent,
and then units per K increased 57.3 percent.

And I will now have Dr. Patel talk to
you about denials and approvals.

DR. PATEL: Thank you, Paula.

MS. MCFALL: Yep.

DR. PATEL: So our goal for
selecting services for prior authorization is
to ensure that the members get access to the
most appropriate clinical care, and so we want to have member-centric care.

And, for example, pre-pandemic, before PA was suspended, BH providers would often submit authorization requests for pediatric members but then subsequently call our medical affairs team, which we do have some child psychiatrists on board, for the best advice of what the next best clinical service should be. Should it be psychotherapy? Should it be ABA, or should it, you know, be short duration of stimulant?

And so what I'd like to say to that is there's a broad spectrum of inputs when a PA is determined chiefly driven by clinicians who are regularly viewing the published evidence-based literature and guidelines along with support from data analytics, certified coders, and with a broad review for fraud, waste, and abuse.

Next slide, please. And so as you can see here, our service categories for top ten authorizations by volume for '22, most of our things are fully approved greater than 90 percent with the lowest being radiology and
consultation and treatment.

The top denial reason, similar to the previous MCO, is medical necessity. And then a distant second is denied for no prior authorization. And so, typically, the most common reason is there's not enough information in the prior authorization.

And we understand it's a delicate balance of reducing the burden on the provider and encouraging expeditious care in an evidence-based fashion for our members. It's a dance.

Next slide, please. And so what we will say about ER utilization with physical health and behavioral health is -- top ten diagnosis, upper respiratory infection is No. 1 along with cardiac chest pain and other chest pain. COVID-19 has fallen down, but it's still on the list and then you will see some things that are not surprising to you.

But you will see distinct BH ER claims is increasing year over year from 332,000 back in 2020 up to 359,000 and change in 2022, and physical medicine ER claims from 344,000 to 370,000 as well.
And we also acknowledge, as the pandemic has subsided and utilization is increasing as people are looking to get the care that may have been avoided in that time, some of this is expected. But I do think some of it is unexpected.

Next slide, please. With that ER utilization in mind, what we do know is when we are able to have members who have not churned out or members who are not suffering redetermination, members who we can continuously have enrolled in our plan for at least six years, which is 156,000 and change members, you will see that our ER visits for that cohort has extensively fallen from 2017 to 2022. I'd like to highlight that number, from 128,000 and change to 90,000.

But the number that I would like to highlight the most is our ratio of PCP visits to ER visits increasing. So for that cohort, we are able to connect those members all the way to their primary care physician at a larger range. And that's because we have care managers who establish relationships. We have an analytics team who has an immense
amount of ability to do prioritization and quality work.

We do understand that there's a balance between using technology and using a warm handoff and warm touch. As Corey had mentioned, our members out in eastern Kentucky, they are not always adept to using high-tech applications. And so we do use a balance of both, and I think it's necessary to have multiple tools in our toolkit.

Next slide, please. And we also let data drive our care management initiatives that we do. We don't have any pet projects. And what we do talk about is food. Food insecurity is a big issue. We believe that food insecurity -- without having consistent food, the correct food, and food for your family can result in other SDoHs being exacerbated, augmented, and decrease in the management of chronic conditions.

And so we have a program with Good Measures that is quite vast and deep, and you will see the tremendous amount of results here. Inpatient visits per 1,000, less than 21 percent, decreased by 21 percent. Non-ER
inpatient by 7 percent, and total medical per
member per month spend by 6 percent.

How do we drive this outcome? We
continually assess the initiative. Our data
analytics team has developed a Kentucky
market tool for Kentucky members alone. We
don't use a corporate tool. We don't use a
United States tool. We use a
Kentucky-created and Kentucky-based tool
because we're serving Kentucky members.

Next slide, please. And, you know,
something that's near and dear to our heart
is substance use disorder and how we can
combat that. We have an opioid task force
that was started back in 2021. As I've
alluded to, we use data to drive our
decision-making along with our care
management team, which is out in the field,
along with the experts of our pharmacy team.

What we have seen is 68 percent of our
members taking an opioid disorder medication
have received therapy in conjunction with
that medication. And what I'd like to say
about that is we encourage and emphasize
higher-level therapy, clinically appropriate
therapy, evidence-based therapy, and appropriate duration of therapy. Because all those things matter in terms of decreasing recidivism in substance use disorder.

We have a member-facing and a provider-facing report. Percent of members compliant with pharmacotherapy, percentage of members receiving counseling, and prescribed Narcan. Our providers know this for their panel, and we're able to use our care management and our quality teams to help providers reach the appropriate goals to impact our members.

Next slide, please. I'd like to pass the deck over to our senior director of member experience, Darren Levitz.

MR. LEVITZ: Thank you, Dr. Patel. To carry on what you said, at WellCare, we rely on data rather than hunches to drive our community involvement. While any social determinant program has its merits, it's essential to ask if it's the most relevant to the needs of the community.

WellCare's process incorporates multiple publicly-available data resources as well as
our own proprietary data to calculate with precision the most consequential needs of each of Kentucky's 120 counties.

For example, we include data from the Social Vulnerability Index to help identify each community's susceptibility to adverse impacts of natural hazards including disproportionate death, injury, or loss of livelihood. We look at other resources such as the rural health hub to assess where food deserts are, or are there maybe limits on provider types such as dentists.

Another source of data is a compilation of requests we receive from our Community Connections Help Line, a free resource available to all Kentuckians. Using the CCHL's data, we're able to identify thousands of requests we receive and target them to specific cities, counties, and even zip codes.

It's through these data sources and more that we create tools such as the map that you see. These maps are provided to WellCare's community engagement team members that live across the state and serve in the communities
they each live in.

Taking a look at this example, Fulton and Muhlenberg are two counties at the highest risk for this region. Digging in deeper, the data shows us that the three biggest barriers to care are housing, crime, and environmental conditions.

The community engagement coordinator is then given contact info for hyper local, community-based organizations that address those needs. While nobody would turn down a food insecurity program in these counties, based on the data that we see, the best use of resources is to invest in programs like rent assistance, reentry initiatives, and improving water quality. These analyses are conducted for each of the eight Medicaid regions in all 120 counties through the state of Kentucky.

As mentioned previously, our Community Connections Help Line is a heavily leveraged resource by our members. In a given year, we receive thousands of calls from people in need. We listen to their concerns and dig deeper to find where they may be struggling.
Let's face it. When someone is food insecure, they are also likely dealing with other issues like housing instability, or they are in need of utility assistance. In fact, on average, we assess 2.4 needs for each person that calls the CCHL.

WellCare does not rely on purchasing data for the CCHL. We found, especially after COVID, that the CBO info on external resources is out of date, and several CBOs aren't even listed as operating anymore. Instead, the community engagement team is responsible for gathering all federal, state, and local resources. These must be entered and/or reverified throughout the year.

Because of the stringent process, we address literally 99 percent of the caller's needs on the spot. For the 1 percent that we don't, we take on average just four hours, only half a day, to find a viable resource.

As a quick aside, our best practice used to be two days. But we realized that when people call the CCHL, they aren't calling for rent that's due in three weeks or refrigerators that may be empty next month.
Their world is on fire, and getting back to them as quickly as possible is critical.

There always used to be a supposition that there's an ROI on SDoH programs, but the results have always been tough to quantify, but not now. We not only use our data to help guide our grants but to demonstrate the value they bring.

On this slide, I'll give three brief examples. In Bowling Green, we've partnered with HOTEL INC where we provided a grant to help their clients provide safe and stable homes. Based on the data, comparing six months prior to the program and six months after, we saw a dramatic 67 percent reduction in inpatient visits, a 100 percent reduction in readmissions, and a 23 percent reduction in ER visits.

With Welcome House in northern Kentucky, we help people as they transition from housing uncertainty to housing stability. Again, comparing six months' data prior to the program and six months after, we saw with these members a 43 percent reduction in inpatient visits and a 33 percent reduction
in ER visits.

And lastly, our example of Water Into Wine, where we dealt with food insecurity.

After our grant, we saw a 50 percent reduction in inpatient visits and an incredible 61 percent reduction in ER visits.

Being sensitive on time at this point, I'm going to turn this back over to Corey Ewing, our plan president, to WRAP up.

MR. EWING: The majority of the slides -- our deck is, as you can see, we're only about halfway through it, so it'll be available for you guys. I know we're short on time, so we wanted to stop here and see if there are any questions for any one of our presenters today. And, again, we appreciate the opportunity to present for you all today.

CHAIR PARTIN: I have a question and a comment. On one slide on substance use disorder treatment, I was curious because -- there was 68 percent of those patients receiving treatment, and I'm assuming that's with buprenorphine. Correct me if I'm wrong on that. Are we talking about buprenorphine?

DR. PATEL: That is correct.
CHAIR PARTIN: Okay. So both of
the -- the Kentucky Board of Nursing and the
Kentucky Board of Medical Licensure require
counseling as part of treatment with
buprenorphine. So I just found it kind of
interesting that 68 percent of members
received therapy in conjunction with the
medicine. So that's just a comment.

And then my question is that -- or
comment is that -- not related to your slides
but that, recently, Kentucky legislation was
passed to allow APRNs to prescribe controlled
substances and, in the past, noncontrolled
substances independently after having a
collaborative agreement for four years. And
so there are now many nurse practitioners who
do not have a collaborative agreement.

And I just got word that a psych mental
health practice was hiring a nurse
practitioner and wanted to credential with
WellCare, and they were not able to
credential because they didn't have a
collaborative agreement.

So I'm wondering if WellCare is going to
change their policy on that since there are
going to be many nurse practitioners who no
longer have prescribing agreements.

    MR. EWING: I would -- I would love
to get the specifics on that one because I
would love to see what happened with that.

    CHAIR PARTIN: Specifics on the
denial?

    MR. EWING: Of who actually the
case -- who it was, the provider was, because
that does not sound -- I want to make sure
that that was -- that doesn't sound like it
was handled correctly.

    CHAIR PARTIN: Okay. So you do
know that there are --

    MR. EWING: Absolutely.

    CHAIR PARTIN: Okay. And that you
will credential --

    MR. EWING: Uh-huh.

    CHAIR PARTIN: Okay. I will -- I
will get that information to you. Can you
send me your email so that I can get that
information to you?

    MR. EWING: Absolutely.

    MR. OWEN: Dr. Partin, I just
put -- Stuart Owen. I just put my email in
the chat as well.

CHAIR PARTIN: Okay. So should I email you?

MR. OWEN: Yes. Yes, please.

CHAIR PARTIN: Okay.

MR. OWEN: Thank you.

CHAIR PARTIN: Thank you.

MS. BICKERS: Dr. Bobrowski has his hand raised.

DR. BOBROWSKI: I got a quick question, and this might just be a typo. But I think it was slide 16. It was in the list there. It listed out rental. Was that supposed to be dental?

MR. OWEN: Dr. Bobrowski, I think that's DME, durable medical equipment rental items.

DR. BOBROWSKI: Okay. Thank you.

MR. OWEN: Certainly.

CHAIR PARTIN: I don't see the email in the chat.

MS. BICKERS: Beth, I can get you Stuart's email.

CHAIR PARTIN: Okay. Great. Thank you.
Any other questions for WellCare?

(No response.)

CHAIR PARTIN: Okay. Thank you, guys, very much, and I'm sorry that we didn't have time to go through all the slides because I know there's a lot of valuable information there. So we will be looking at that and maybe have questions at the next meeting.

MR. EWING: Okay. Thank you.

CHAIR PARTIN: So at the September meeting, Anthem and United will be presenting.

So next up, we have reports and recommendations from the TACs, and first up is Behavioral Health.

DR. SCHUSTER: I'll go lickety-split. Thank you. Sheila Schuster reporting for the TAC. We met on July 13th and had a quorum.

We got a report from Ann Hollen about the unwinding. And I will tell you, and I want Veronica to know that we made a big pitch with not only our providers but also with the peer-run, consumer-run centers to
get the word out there for people to respond
to those inquiries from Medicaid.

We did have an issue involving pharmacy
that I wanted to bring to everyone's
attention because it's troubling. I had
gotten an email from someone who used to work
at an SUD treatment clinic, and they had
gotten a letter from about seven or eight
pharmacies in western Kentucky that they were
no longer going to fill prescriptions for
psychostimulants for any of their clients.

A neighboring clinic that does
full-service behavioral and physical health
got the same letter, and it took some time
for me to get that information to Medicaid.
And I was glad at the BH TAC meeting that
Dr. Prather said that it had been taken care
of, that they had called the pharmacies.

And the pharmacies had complained about
how the prescriptions were coming in, or
something like that, and then just had
decided that they weren't going to fill the
prescriptions. And they apparently are now
filling the prescriptions, although I've not
heard that confirmed back from the provider
organizations.

I guess my concern is, that's an instance where people were absolutely not getting their prescribed medications, and I heard about it really just via the grapevine. So I don't know what kind of system we need, but we really need to not have that kind of thing happen. And I don't know if pharmacies can just decide willy-nilly. Maybe it's something I need to discuss with the pharmacy TAC, or we need to put on their agenda but really concerning.

We got an update on the 1915(i) SMI waiver that will have supported housing from Pam Smith, and we're looking for those town hall meetings to take place hopefully in September.

We have no new recommendations for the MAC.

I want to end on a positive note, and that is to thank all of the MCOs but particularly Herb Ellis from Humana for working together so well to get a bypass list together for dual-eligible Medicaid members who have Medicaid and a commercial insurer.
And Herb reported that it's been in effect since May 1st and is working very well, and there are no problems. So we've had that on our agenda for -- you know, since we've been in existence, which is about 12 years.

Our next meeting is September 14th.

Thank you.

CHAIR PARTIN: Thank you, Sheila.

DR. HANNA: Sheila, I would like to -- this is Cathy, pharmacy up here. I would like to, you know, maybe talk to you offline to find out what in particular was going on there. I mean, you know, you always want to make sure you know what the situation is.

And, also, just -- you know, pharmacists do -- with their professional judgment can, you know, not fill it. But, typically, it's unusual to see a policy. You know, if it was a policy, that's a little bit different so...

But we can talk about that, and I'll be happy to, you know, help in any way I can.

DR. SCHUSTER: Thank you very much, Cathy. I'll reach out to you for sure.
CHAIR PARTIN: Okay. Next up, Children's Health.

MS. WHATLEY: Hi. Alicia Whatley here from the Children's Health TAC. We did meet earlier this month on July the 12th, but we do not have any formal recommendations at this time. And we have our next meeting scheduled on September 13th.

CHAIR PARTIN: Thank you.

Consumer Rights and Client Needs.

MS. BEAUREGARD: Hey, everyone. Emily Beauregard with Kentucky Voices For Health, and I'm the chair of the Consumer TAC. We did meet in June, on June 7th. We had a quorum. We met on Zoom.

We revisited a number of topics that we typically discuss and monitor. I'll just highlight a couple because of, you know, the time here today. Earlier, there was a lot of discussion around Medicaid renewals. Of course, that's something that we are monitoring very closely. And we're all, I think, concerned about the low response rate that Deputy Commissioner Veronica Judy-Cecil mentioned, you know, with so many people
receiving notices and not responding to them.

And, you know, just historically, I think this MAC has probably discussed for years, you know, response rates and also bad addresses or people who, you know, don't have an updated address. The mail gets returned to Medicaid.

And we know that before the pandemic, that returned mail rate was, like, between 30 and 40 percent on any given month. That was pretty standard. The returned mail rate now is so low, it is, one, I think partly a good thing, a testament to the work that DMS and the MCOs have done to collect better addresses and more up-to-date addresses.

But we do wonder if there are some of these notices being mailed to addresses where people no longer live and just -- and being, you know, actually left there, delivered, not returned to sender. Because during the pandemic, we understand that the postal service did have some flexibilities as well and didn't have to verify whether someone was necessarily currently living in a particular -- at a particular address.
So we're wondering if that is partly
to -- you know, at least would partly explain
the low response rate, that mail is being
delivered but not being delivered to, you
know, the actual person that was -- it was
addressed to because, you know, they no
longer live at a particular address.

That's something that I think we need to
keep really digging into to try to understand
more. And regardless of whether that's the
case or not, if we continue to see such a low
response rate, I think we really need to look
at what kind of community response we need to
kind of collectively be working on.

And providers, I think, play a huge role
in that. You know, if people are getting
notices and not understanding them or not
opening them because they're getting too many
notices and they just assume that maybe it's
junk, they don't understand that it's
important -- whatever the case may be.

The more providers we have who are
looking in KYHealth-Net, who are identifying
that renewal date, making sure that their
patient is aware of it and, you know,
providing them with assistance or at least connecting them with a connector, I think that could go a long way in preventing people from, you know, losing their coverage simply for not responding.

You know, we understand this process. There will be some people who are no longer eligible. That's always the case. But I just can't wrap my head around that being about half of people currently enrolled in Medicaid. And I know that's going to be incredibly disruptive to providers as well, not just to the individuals who, you know, are seeking care and finding out that they're uninsured suddenly. So that part about KYHealth-Net, I think, is just something I hope providers are aware of and are doing.

And something else that we've noticed is that, you know, presumptive eligibility enrollment has been really low for many months now, partly due to the fact that not as many people need it. But, also, House Bill 7 passed in 2022 which prohibited the State from doing the determination of presumptive eligibility.
But hospitals and Federally Qualified Health Centers can still use presumptive eligibility. And I'm just wondering how many are, you know, doing that when someone is coming and finding out that they're uninsured.

Because right now, going through reconsideration or an appeals process or a new application, that all takes time. There's going to be a backlog because so many people -- there's so much, you know, paper being processed right now or so many new applications and renewals being processed, that I really feel like we need to revisit presumptive eligibility and make sure that people have that option if they suddenly find out that they're uninsured. And it's because, you know, they just didn't respond to a notice in time. So I think that's something that we all need to be keeping in mind and reminding, you know, providers, that that is an option.

And then, finally, I'm going to skip over a few of the things that I put in the report that you all should have. But we did
discuss the new dental, vision, and hearing
services that are now covered by Medicaid and
have been, you know, for this calendar year.

And, you know, having talked with a
number of providers now, a lot of community
health workers, Medicaid beneficiaries, it's
becoming pretty clear to us that most people
don't think that these services are still
covered. Maybe weren't aware of them to
begin with because it's been a short period
of time.

But even those who were aware, whenever
the services started in January, assume that
because of Senate Bill 65 that was passed in
March and then the most recent administrative
reg review committee meeting in May where the
emergency regs were found deficient, I think
there's a lot of confusion. And the
assumption being that, you know, because of
that bill, because of the deficiency, that
the regs aren't in place and, you know,
active.

And I think we're really missing such an
important opportunity to get people access to
these services. So just want to really raise
awareness of the fact that a lot of Medicaid beneficiaries and probably even providers aren't aware that these are still covered services, should be covered for the remainder of this year, and we hope will be permanently covered, which is something we need to work on with our legislators. But that's something that has been concerning to us.

Now, we know that there are thousands of Kentuckians getting access, especially to glasses. You know, there are many thousands also getting access to some sort of dental care or hearing aids for the first time. But I think many more would if they knew that this was available to them.

And I understand that there's also network adequacy issues there and providers, you know, being a little reluctant to participate because they don't know what's going to happen with these services. But the services are just so valuable and so life-changing for people and to, you know, health outcomes generally speaking, that I think we really need to find ways to make them work better for Kentuckians and work
better for providers.

And then just to that end, we did make one recommendation at our last meeting, and that was that DMS provide communication to providers and connectors about the status of Medicaid dental, vision, and hearing services so that more people are aware and have that information.

And then our next meeting will be on August 15th at 1:30 p.m. Thanks.

CHAIR PARTIN: Thank you, Emily.

Any questions?

(No response.)

CHAIR PARTIN: Okay. Next up is Dental.

DR. BOBROWSKI: Yes. This is Dr. Bobrowski, and we had -- our last TAC meeting was on May the 12th, and we did have a quorum.

And I'm going to tie this in with -- a short report here with some of the phone calls that the Kentucky dental office -- Kentucky Dental Association office is receiving.

And one of them is that several dentists
that -- even though we have pushed for and are in favor of the expansion codes, several dentists are calling and saying, well, they feel like that the DMS has just ignored the provider. Said we're small businesses out here, and we can't keep providing services at below cost when others -- grocery stores, whatever, they get 100 percent of their costs paid for. Dental gets about a third of our costs paid. The dentists say we've got lab bills, time invested. It's just below what some of those expansion codes are paying for.

Nothing's being done to help stop these failed appointments. For example, Monday morning, I had three failed at 8:00. Tuesday, I had two. Wednesday, I had two. This morning, I had three that didn't show up at 8:00. It's just hard to keep doing this.

But the other thing is that we just got a call from a lady dentist over towards the Richmond, middle of the state area, that they're doing the dentures and the root canals and stuff. But her comment was, is that -- excuse my French and her French. But she said she's breaking her back and losing
her ass, you know, to provide these services.

Now, the next thing is, is that hopefully on a brighter, more positive note, at the Kentucky Dental Association meeting in August, we are going to have a Medicaid forum. The title of it is: Kentucky Oral Health, 49th. A Road Map to Change. I'll be the moderator for a panel discussion with MCOs and interested parties, and Commissioner Lee has agreed to be there.

But that will conclude my report. Thank you.

CHAIR PARTIN: Thank you, Dr. Bobrowski.

Any questions?

(No response.)

CHAIR PARTIN: Okay.

EMS?

MS. BICKERS: Keith is unable to be on today. He got stranded in Maryland trying to get a new ambulance.

CHAIR PARTIN: Oh, dear. Okay.

MS. BICKERS: But they did have a meeting. They have no current recommendations.
CHAIR PARTIN: Okay. Thank you.

Health Disparities?

DR. BURKE: Hey, this is Jordan Burke. We were able to meet on July 5th, earlier this month. We did have a quorum.

We had a great presentation of our transportation services, looking at value-added benefits. And all the different MCOs, you know, are providing those and which ones may be attracting people to actually use those services more and get them involved with it.

We also had some discussion looking at interpreter services and, you know, how truly accessible and feasible using those are right now and what ways we can maybe make that a little bit easier, specifically for urgent care appointments, so you don't have to call 48 to 72 hours beforehand and how that can be streamlined when those patients come in.

But no recommendations at this time.

CHAIR PARTIN: Thank you.

Home Health Care?

(No response.)

CHAIR PARTIN: Hospital Care?
MR. RANALLO: This is Russ Ranallo, the chair of the Hospital TAC. The Hospital TAC met on June 23rd, and we had a quorum. We had several -- we reviewed several items, but we do have one recommendation.

Kind of a caveat. We have not had a recommendation in a long time. We've had a very collaborative relationship with the Cabinet over the last few years, but we don't see eye to eye on this one item.

In the middle of June, we got a letter from DMS, a hospital provider letter that told the hospitals that the Sepsis 3 criteria would be adopted for sepsis coding and replacing Sepsis 2.

I sent a report in to DMS -- or the MAC for this. I'll go through some of the highlights. Sepsis 2 is the currently accepted and adopted coding, and it's a disease process that -- it's an inflammatory response to a known or suspected infection.

In 2016, the Critical Care Congress adopted a new definition of sepsis, the third international consensus definition for sepsis and septic shock, so that's commonly called
now Sepsis 3. And it narrowed the sepsis
definition and only described sepsis as a
life-threatening organ dysfunction.

And if you go forward, in 2018, WellCare
began to apply the Sepsis 3 definition in
their inpatient coding reviews and started to
adjust DRG assignment and change payments.
We brought the issue through the Hospital TAC
to DMS, and there was a series of meetings
that were held between the hospitals, DMS,
MCOs. And the outcome of those meetings was
there was a memo and -- at the end of 2019
from Dr. Theriot that instructed the MCOs
that DMS would follow Sepsis 2, the current
CMS and ICD-10 definition of sepsis until CMS
adopted Sepsis 3.

Fast forward to June 13th of '23 when
the hospitals got a provider letter informing
them that Sepsis 3 would be used replacing
Sepsis 2. I put those letters in my packet
to the MAC. The Hospital TAC was not
included in any of the meetings or discussion
of the change.

The current coding guidelines and coding
clinics -- so the current coding methodology
is -- they're all written by four parties, CMS, AHA, AHIMA, and NCHS. That's the National Center For Health Stats in the CDC. They currently -- the current coding guidelines for ICD-10 and CMS coding are Sepsis 2, not Sepsis 3.

And from a coding standpoint, in Sepsis 3, there's no sepsis without organ dysfunction. There's only severe sepsis. So you would never see an account in Sepsis 3 coded to sepsis. You would either see severe sepsis or no sepsis at all. And that's not, again, consistent with current coding guidelines, coding clinics, coding indexing. So it -- CMS has not endorsed Sepsis 3 yet.

And so after the hospitals reviewed it, there's numerous concerns moving to Sepsis 3. Administrative costs and burdens. We will need to code Medicaid cases differently than Medicare. And with our EMRs -- I know particularly with my EMR, our coders code cases. They don't code by payer.

So myself and others will have to reconfigure and adjust our EMR to separate the groupings of patients due to the
different coding requirements, which will
cost us money and will make our coders less
efficient. It also will have an
inconsistency, again, with what CMS currently
does and recognizes as sepsis coding, which
is Sepsis 2.

We have concerns about crossover claims
where Medicaid is secondary and Medicare is
primary if Medicaid uses a different coding
requirement than Medicare and how those
claims will be adjudicated, denied, have to
be appealed, and that whole process.

We don't believe that the change is
consistent with the current regs. The
current regs for acute inpatient hospital
reimbursement define diagnosis codes as codes
maintained by CMS. CMS, again, uses
Sepsis 2, not Sepsis 3. The regulation also
assigns a DRG grouping to match with the CMS
Medicare groupings, which would not be able
to be done using just Sepsis 3.

Quality and mortality. There's some --
a blurb there. But, essentially, when you
change the coding, you will have different
DRG assignments for those with Sepsis 3 than
are in Sepsis 2. And depending on how you compare outcomes between patient groups across states between payers, you could see -- I know when WellCare denied those back in '18, we saw sepsis being regrouped to UTI. So you have the potential to see mortality in DRGs like UTI and then suggesting that the hospitals are providing poor care to not very sick patients.

There's payment impact. Lots of organizations are pushing -- even DMS, through the HRIP quality goals that we're currently under, are pushing for recognition, diagnosis, and early management of sepsis. So one of our HRIP quality goals is sepsis screening in the ED and the use of sepsis bundles early in care. DRG payments are supposed to match the payments for the cost of care. And when you eliminate that code for sepsis and only allow the coding for severe sepsis, it's going to change the DRG assignment and reduce payment. When we ran into this in 2018, the sepsis denial showed an average case impact of more than $4,000 per case.
The hospital association also has voiced numerous concerns, and I've attached that letter in my packet to the MAC. The recommendation is the Hospital TAC recommends that the MAC advise DMS to repeal hospital provider letter A263 dated June 13th, 2023, and that letter changed hospital utilization management and coding to Sepsis 3 criteria.

CHAIR PARTIN: Okay. Is that --

MR. RANALLO: That's the report.

Any questions I can answer?

CHAIR PARTIN: Any questions?

MS. EISNER: I have my hand raised.

CHAIR PARTIN: Go ahead, Nina.

MS. EISNER: Yeah. And not a question but just to reinforce the very significant importance of the Cabinet responding to this request very quickly. The guidance in that June 13th letter that Russ talked about gave instruction to basically do something that CMS and ICD code -- or ICD-10 coding is not consistent with, and so it's very critical that this matter be addressed quickly.

CHAIR PARTIN: Thank you.
MS. EISNER: Thank you.

CHAIR PARTIN: Next, Intellectual and Developmental Disabilities.

(No response.)

CHAIR PARTIN: Nursing Home?

MR. SKAGGS: This is Terry Skaggs. I am chair of the Nursing Home TAC. We met on June 14th. We heard details regarding our July 1, 2023, rate setting. We heard a report on the Medicaid unwinding and did ask for a specific breakdown specific to long-term care. And we should be able to see that at our next meeting.

We discussed the transition of our assessment methodology. The current system sunsets September the 30th, and we're working with Medicaid to assure that the transition of the methodology, which actually sets our rates, is case mix neutral.

We discussed scheduling of a rebasing that is due July of '24, both in our price and capital components of our rates. We're working with Medicaid right now to assure that there's adequate funding in the -- in the budget for the next biennium to pay for
the rebasing. We're also working with them
to determine the timing of the capital
appraisals that'll be used in that rebasing.

And I actually have a call tomorrow with
Medicaid to discuss the methodology for that
rebasing. Medicaid rates have not been
rebased since 2008, so it's very important to
our provider group that this rebasing is done
correctly.

And unless there are questions, that's
the Medicaid TAC.

CHAIR PARTIN: Any questions?

(No response.)

CHAIR PARTIN: Okay. Thank you.

MS. BICKERS: Beth, Rick with the
IDD TAC just logged in if you wanted to go
back for a report.

CHAIR PARTIN: Okay. We'll go back
to Intellectual and Developmental --

MR. CHRISTMAN: Thank you. Thank
you for that. I've been dealing with a lot
of issues here.

Yes. We had a meeting, and there was a
quorum. I think probably the one thing of
note is we noted that there's another waiver
being worked on, a children's waiver.

Basically, it's a feasibility study right now that would serve children who have mental illness, autism, or another developmental disability.

And that concludes my report.

CHAIR PARTIN: Okay. Thank you.

Nursing Services?

(No response.)

CHAIR PARTIN: Optometry?

DR. COMPTON: Steve Compton, a member of the Optometric TAC. We have not met since the last MAC, so we have no recommendations. We do meet next Thursday.

That's the end of my report.

CHAIR PARTIN: Thank you. Persons Returning to Society From Incarceration?

MR. SHANNON: Yeah. This is Steve Shannon, chair of the TAC giving the report.

We had a quorum. We received update from Medicaid and our MCO partners, and we have no recommendations. And we meet September 14th.

Thank you.

CHAIR PARTIN: Thank you.

Pharmacy?
DR. HANNA: The Pharmacy TAC did not meet since the last meeting. Their next meeting will be on August 9th. Thank you.

CHAIR PARTIN: Thank you.

Physician's Services?

(No response.)

CHAIR PARTIN: Primary Care?

MR. MARTIN: Yeah. This is Barry Martin. Thank you, Chair. We met on July 11th at 11:00 a.m. via teleconference. And I sat in as chair for Patrick Merritt in his absence. And we met, and we got an update from DMS and the MCOs.

And one of the -- we did come out with a recommendation. We've been working with DMS and the MCOs about standardizing some quality care measures. And the MCOs and DMS come back with some. And we just wanted to make a recommendation to the MAC that we have a little more collaboration and input with those standards of care, coming up with those standards of care and having some mutually acceptable standards. That's our recommendation.

CHAIR PARTIN: Okay. Were you not
satisfied with the standards?

MR. MARTIN: No. We -- we were kind of given the standards. We just want to have a little more input, and we would like to have been involved in the discussion before being given them. We'd like to have some input on responding to them and -- is all we're asking for.

CHAIR PARTIN: Okay. Thank you.

MS. BICKERS: Barry, this is Erin. Do you mind to follow that recommendation up to me in an email, please?

MR. MARTIN: I can.

MS. BICKERS: Thank you so much.

MR. MARTIN: Thank you.

CHAIR PARTIN: Any questions?

(No response.)

CHAIR PARTIN: Okay. Therapy Services?

(No response.)

CHAIR PARTIN: Okay. That concludes the reports and recommendations from the TACs. Would somebody like to make a recommendation to accept the reports and the recommendations from the TACs?
MS. EISNER: Beth, it's Nina Eisner. Can I go back to the Hospital TAC, the urgency of my recommendation of supporting that? I would like to make a motion that the MAC accept the TAC recommendations.

CHAIR PARTIN: Okay. What we're doing right now is accepting them in total.

MS. EISNER: Okay. So we don't need -- we don't need to specifically state why it's so critical to accept the TAC recommendation for hospitals?

CHAIR PARTIN: Let's -- I think that we need to note that. But, typically, we just accept the recommendations in total for --

MS. EISNER: All right.

CHAIR PARTIN: For the TACs.

MS. EISNER: Okay.

CHAIR PARTIN: Let's put a special notation there about the urgency for a response to the Hospital TAC.

MS. EISNER: Yes.

CHAIR PARTIN: Okay. Would somebody like to make a second?
MR. MARTIN: Yeah. I'll second.

CHAIR PARTIN: Thank you, Barry.

MR. MARTIN: This is Barry.

CHAIR PARTIN: Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Anybody opposed?

(No response.)

CHAIR PARTIN: Okay.

Recommendations are accepted.

Okay. And moving along here. The next item is actually something to include on the September meeting, and this has to do with the MCO's report of 98 to 99 percent adequacy and compliance for services by Kentucky's third-party quality contractor. IPRO, our secret shopper reports, show only a 30 to 40 percent compliance. So there's a concern about adequacy of compliance that does not address actual accessibility of services.

So the MAC requests a report from DMS at the September meeting addressing the discrepancy between the MCO reports of
compliance versus the IPRO report.

And then next up is Item 9. Physician locum tenens may bill under absent physician provider number using a modifier. The locum tenens position is not required to be credentialed with Medicaid to do this.

Many nurse practitioners, nurse midwives are establishing practices and require coverage for their practices when they are on vacation or absent due to illness. So we're requesting that Medicaid regulations should be amended to afford APRNs the same opportunity as physician practice owners.

And that would be -- that would be a recommendation coming from the MAC, so I would ask if somebody would make a motion to accept that recommendation and a second.

DR. SCHUSTER: I'll move that, Beth. This is Sheila Schuster.

CHAIR PARTIN: Thanks, Sheila.

A second?

MR. MARTIN: This is Barry. I'll second it.

CHAIR PARTIN: Thank you, Barry.

Any discussion?
MS. BICKERS: Beth, do you mind to follow that up with me in an email, please?
This is Erin. Sorry.

CHAIR PARTIN: Yeah. Sure.

MS. BICKERS: Thank you.

CHAIR PARTIN: You want me just to repeat this in an email?

MS. BICKERS: Yes, ma'am. I do my best to capture everything while I'm taking notes. But when it comes to recommendations, I like to make sure I have them in writing, so I know exactly the ask and I don't miss any information.

CHAIR PARTIN: So the ask is exactly what's written on the agenda.

MS. BICKERS: I'll -- then I'll copy it from the agenda. Thank you.

CHAIR PARTIN: Okay. Thank you.

Any discussion?

(No response.)

CHAIR PARTIN: All in favor, say aye.

(Aye.)

CHAIR PARTIN: Anybody opposed?

(No response.)
CHAIR PARTIN: Thank you. And next up, Item No. 10, and let me find the explanation. The -- are members who are dually eligible for services, Medicaid and Medicare or Medicaid and a commercial insurance, going to be moved from MCO to FFS, or fee-for-service status?

And the background on that is after years of effort and urging by the behavioral health community, we now have a solution that is working to make sure that providers are able to bill and get reimbursed by the MCOs for services rendered to dual-eligible individuals.

DMS worked to provide a bypass list for those who had Medicaid and Medicare, but the commercial insurers presented a much bigger problem because they vary in which services they provide coverage for and reimburse. The MCOs worked well together to come up with a separate bypass list for commercial insurers. And while it has only been in effect for about two months, it is working very well.

We thought the problem was solved, but now we are hearing that DMS is thinking about
moving all of the individuals who are dually eligible from MCO coverage to fee for service. And we would like to know the rationale for this, and it is strongly being considered.

So, again, this would be a recommendation coming from the MAC, and so we need a motion and a second.

DR. SCHUSTER: Beth, this is Sheila. It's a question first.

CHAIR PARTIN: Okay.

DR. SCHUSTER: I mean, I want to know if it's being considered and then we need to be able to make a response to it, I guess, is my thinking about it, about putting it on. And I don't know if anybody is on in Medicaid and can respond to it or if it needs to roll over to the September agenda.

CHAIR PARTIN: Is Commissioner --

COMMISSIONER LEE: Yes. Hi. This is Lisa. Can you hear me?

CHAIR PARTIN: Yes.

COMMISSIONER LEE: Okay. Great.

Thank you. Yeah. We had been looking at moving some eligibility who had third-party
liability over to the fee for service, but
that has been put on hold. We are not
looking at that right now. So no, it's not
being considered at this moment.

CHAIR PARTIN: Okay. So we don't
need to do anything about this right now?

COMMISSIONER LEE: No. Not right
now, no.

CHAIR PARTIN: Okay.

DR. SCHUSTER: Let me request,
then, Commissioner, that if it's being
considered again, that those of us who have
worked so hard on this issue, both from the
MCO perspective and the provider and the
consumer perspective, be included in those
discussions?

COMMISSIONER LEE: Yes. If that is
brought up again, if we are thinking about
moving those individuals with third-party
liability to fee for service, we will bring
that up before the MAC when the
discussions -- when and if the discussions
begin.

DR. SCHUSTER: Thank you. And I
would like for the BH TAC to particularly be
involved. Thank you.

CHAIR PARTIN: Okay. Thank you.

Any other business?

(No response.)

CHAIR PARTIN: Okay. The last thing on our agenda are nominations for the MAC chair, vice-chair, and secretary. My -- my term on the MAC has expired, and I will continue to serve until I have a replacement. But in all fairness to the MAC, I felt like I should not run for chair.

So the positions -- we're taking nominations for the MAC chair, vice-chair, and secretary today and then we will vote at our September meeting.

DR. SCHUSTER: I would like to put my name in nomination to serve as the MAC chair. This is Dr. Sheila Schuster.

CHAIR PARTIN: Okay.

Anybody else?

(No response.)

CHAIR PARTIN: Okay. Vice-chair?

DR. BOBROWSKI: This is Garth Bobrowski. I'll put my name back in the hat for vice-chair.
CHAIR PARTIN: Okay. Thank you.

Anybody else?

(No response.)

CHAIR PARTIN: Okay. And then

secretary? I think Mackenzie is not on the
call today, but she is our current secretary.

MR. MARTIN: I'll recommend her to

sustain in that.

MS. EISNER: I agree.

MR. MARTIN: That'll be her

punishment for missing today. This is Barry.

CHAIR PARTIN: Thank you, Barry.

Erin, would you let Mackenzie know?

MS. BICKERS: Yes, ma'am.

CHAIR PARTIN: Thank you.

MR. MARTIN: Madam Chair, I think

we ought to cease nominations now and approve

as submitted.

CHAIR PARTIN: Okay. Thank you.

Okay. So somebody want to make a motion
to adjourn? We're about 15 minutes overtime,

and I appreciate everybody staying on.

MR. MARTIN: Did we have --

MS. EISNER: Before our motion to

adjourn, I'd like to thank you for your
service as chair of the MAC. Really appreciate it and your leadership, so thank you. And now I'll make a motion to adjourn.

MR. MARTIN: Chair Partin, do we need to vote on the nominations or --

CHAIR PARTIN: We'll just vote at the next meeting.

MR. MARTIN: Okay.

CHAIR PARTIN: Thank you, Nina. I appreciate that. As we all know, when our terms expire on the MAC, we're just gone, and we don't get a chance to say anything after we leave. So I appreciate that. Thank you very much.

MR. MARTIN: I'm sure our paths will cross again, Chair Partin.

CHAIR PARTIN: Probably so.

DR. SCHUSTER: I think there is unanimous appreciation, Beth, for the many, many years that you've served as chair and really moved the MAC into being, I think, a much better functioning and more important part of the policy determination for Medicaid.

We have excellent communication with
DMS, and I intend to build on everything that you've done. You've left me difficult shoes to fill, but we all appreciate everything you've done for the MAC and for the people that the MAC serves and for all the providers of services.

CHAIR PARTIN: Thank you, everybody.

So we have a motion to adjourn. Second?

DR. SCHUSTER: Second.

DR. BOBROWSKI: Second.

CHAIR PARTIN: Okay. No problems with that one, huh?

All in favor?

(Aye.)

CHAIR PARTIN: Thank you, everybody. See you in September.

(Meeting concluded at 12:52 p.m.)
CERTIFICATE

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

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

Dated this 11th day of August, 2023.

/s/ Shana W. Spencer
Shana Spencer, RPR, CRR