

CABINET FOR HEALTH AND FAMILY SERVICES  
ADVISORY COUNCIL FOR MEDICAID ASSISTANCE

\*\*\*\*\*

Via Videoconference  
September 22, 2022  
Commencing at 10:03 a.m.

Shana W. Spencer, RPR, CRR  
Court Reporter

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

APPEARANCES

ADVISORY COUNCIL MEMBERS:

Elizabeth Partin - Chair  
Nina Eisner (not present)  
Susan Stewart  
Dr. Jerry Roberts (not present)  
Heather Smith  
Dr. Garth Bobrowski - Co-chair  
Dr. Steve Compton  
Dr. John Muller (not present)  
Dr. Ashima Gupta  
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 (not present)  
Eric Wright (not present)

Commissioner Lisa Lee  
Senior Deputy Commissioner Veronica Cecil

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

CHAIRMAN PARTIN: Good morning, everybody. We'll go ahead and call the meeting to order. And first up, I have an announcement. We have new members of the MAC. Susan Stewart is not new. She's been reappointed, and Heather Smith has been appointed to replace Teresa Aldridge who was serving as the MAC secretary.

So as you may have noted it, later on in the agenda, we have an election for secretary. And as far as I know, we only have one nominee.

Erin, have you heard from anybody else?

MS. BICKERS: No, ma'am.

CHAIRMAN PARTIN: Okay. Okay. So we'll do that at the end of the meeting.

So next up, Erin, would you mind calling the roll call?

MS. BICKERS: Not at all. Beth Partin. Oh, hold on. I've got people logging in. One second. Sorry. We've got people in the waiting room now.

CHAIRMAN PARTIN: Okay.

MS. BICKERS: Nina Eisner.

(No response.)

1 MS. BICKERS: Susan Stewart.  
2 MS. STEWART: I'm here.  
3 MS. BICKERS: Dr. Roberts.  
4 (No response.)  
5 MS. BICKERS: Heather Smith.  
6 MS. SMITH: Here.  
7 CHAIRMAN PARTIN: Dr. Bobrowski.  
8 DR. BOBROWSKI: Here.  
9 CHAIRMAN PARTIN: Dr. Compton.  
10 DR. COMPTON: Here.  
11 MS. BICKERS: Dr. Muller.  
12 (No response.)  
13 MS. BICKERS: Dr. Gupta.  
14 (No response.)  
15 MS. BICKERS: John Dadds.  
16 (No response.)  
17 MS. BICKERS: Dr. Hanna.  
18 (No response.)  
19 MS. BICKERS: Barry Martin.  
20 MR. MARTIN: Here.  
21 MS. BICKERS: Kent Gilbert.  
22 (No response.)  
23 MS. BICKERS: Mackenzie Wallace.  
24 (No response.)  
25 MS. BICKERS: Annissa Franklin.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

(No response.)

MS. BICKERS: Sheila Schuster.

MS. SCHUSTER: Here.

MS. BICKERS: Bryan Proctor.

(No response.)

MS. BICKERS: Peggy Roark.

(No response.)

MS. BICKERS: Eric Wright.

(No response.)

MS. BICKERS: I counted seven,  
Beth.

CHAIRMAN PARTIN: Okay. So we do  
not have a quorum. Hopefully, some other  
people will be joining us later on in the  
meeting so that we can vote on business.

MS. BICKERS: I'll keep an eye out  
for anyone joining in the waiting room and  
will let you know.

CHAIRMAN PARTIN: Okay. Thank you.  
So moving right along, let's go into old  
business. And first up is my standard  
question. When will Medicaid update  
regulations to reimburse Certified  
Professional Midwives?

COMMISSIONER LEE: This is Lisa

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Lee, Commissioner for the Department For Medicaid Services. We are still evaluating and have no timeline as of yet.

CHAIRMAN PARTIN: Okay. We'll just keep that on the agenda. Thank you, Commissioner.

Update on missed and canceled appointments. How is the reporting going? Is there a common thread as to why patients are not showing up for appointments?

COMMISSIONER LEE: Again, this is Lisa Lee. I did go out, and I have looked at the 2021 stats. And I can put this into a format and send it out to all the MAC members if you -- if you would like.

But based on my initial analysis, I noticed that 308 providers in 2021 reported 1,556 no-show appointments for 569 members. We did identify one member with 73 missed appointments.

That member was in an HCBS waiver program, and our division of long-term care was -- community alternatives. I forget -- we went through a reorg, and I forget the exact name right now. But they

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

are researching that member specifically.

And somebody has asked me to put this in the chat. I will do that.

CHAIRMAN PARTIN: That's -- that's a lot.

COMMISSIONER LEE: Yes. So those are just a few numbers that we've looked at. And, again, this information is only as accurate as the providers will insert information.

But we had another member with 35 no-shows which was also a waiver participant. And then the next two members with 26 and 19 no-shows were in long-term care facilities. So we've noticed that the members -- or the members with the most no-shows are in waiver or long-term care facilities.

One provider reported 108 no-shows. And this, again, is for the full year of 2021. The provider entering the most no-shows, the one with 108, was a multi-therapy agency. So it appears that, you know, some of our waiver members and our members in long-term care facilities are not getting to their therapy appointments.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

The second-most provider who reported the most no-shows was a transportation provider. 56 -- of the 308 providers reporting, 56 of those only reported one no-show throughout the year.

The reasons listed for no-show, the No. 1 was just "other," so we don't have any information for that. 447 were for no-show, no reason provided. And then there were 550 for unknowns.

So, you know, a couple of things. If we can identify ways to get those "unknowns" and those "no reason provided," maybe we could hone in on this a little bit more.

But I think the bigger -- or the one thing that we can look at is, of those providers reporting, we definitely have the information on the member, so we can find out what's going on with those members.

Why are they not being transported? Why are they missing their appointments, and what type of appointments are they missing? We did only have 13 for transportation issues. 28 people we showed actually rescheduled their appointment.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

So those are some stats from the 2021,  
and I did put some of those in the chat.

CHAIRMAN PARTIN: And then you'll  
send that to the MAC members?

COMMISSIONER LEE: Yes, we will.  
We'll start formalizing the report. And  
that's for 2021, and we can continue to pull  
these stats for -- as we go forward, either  
on a quarterly basis, so that you all can see  
what's going on. But, again, only as  
accurate as the providers who use the  
KyHealth Net to log those.

CHAIRMAN PARTIN: Okay. Thank you.  
And I would like to urge all of our members  
on the MAC and the TACs who are providers to  
make sure that your facilities are reporting  
these.

Because I think this is important  
information for us to track and be able to  
figure out. It's a big issue, I think. I  
know it's a big issue in primary care, and I  
know Dr. Bobrowski has talked about it being  
a problem for the dentists.

So you're right, Commissioner. It's  
only as good as the people who report. So if

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

we would do that and urge our colleagues to also do that, I think that would be helpful.

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

CHAIRMAN PARTIN: Okay.  
Dr. Bobrowski, go ahead.

DR. BOBROWSKI: Sorry. I'll be brief but just -- I got a text from a dentist at lunch Tuesday. He says -- I'll just read it. He said, "We're getting close to cutting Medicaid off." He said their office is down to blocking off a four-hour period per week for Medicaid patients.

And the last one that he had, he had seven no-shows for that four-hour period of Medicaid patients. And he does not report, you know, these folks, but his comment, it said it's inevitable. It's -- this is the end game.

So, you know, we're losing providers because, you know, they block off time, and they just don't show up. So -- and I appreciate that -- I know the commissioner is kind of working to see what kind of behavioral issues are keeping people from

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

their appointments.

But it's just like the same thing. Tuesday morning, I had five Medicaid people not show up. And it just knocks out time where other people could get in, and they don't have a reason for not showing up. They might show up a year later or six months later, and everybody has forgot about it by then.

But I just wanted to kind of give you an update on some recent dental things. Thank you.

CHAIRMAN PARTIN: Thank you. So I would again ask, Dr. Bobrowski, to have your colleagues report this so that we have the data, and the Department of Medicaid can help us work on this.

Okay. Next up, update on reimbursement for multiple visits on the same day.

COMMISSIONER LEE: And we're still evaluating, and we do not have a timeline for completion at this time.

CHAIRMAN PARTIN: Okay. But we're looking towards -- towards that?

COMMISSIONER LEE: There will be an

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

update provided later on, yes.

CHAIRMAN PARTIN: Okay. So next meeting.

COMMISSIONER LEE: Yeah. We're still evaluating, so we may be able to have a little bit more information at the next meeting.

CHAIRMAN PARTIN: Okay. Should I keep the update on canceled appointments?

COMMISSIONER LEE: I think going forward, particularly with the -- maybe we can just give an update when we give the department update, or the MCOs can give updates during their presentations.

CHAIRMAN PARTIN: Okay. So how about if I just move that -- I'll forget about it if we just do it once a year. Every six months?

COMMISSIONER LEE: Sure. That will be great.

CHAIRMAN PARTIN: Okay. Next up, Hepatitis C prenatal screening, number of cases and number treated.

COMMISSIONER LEE: I think Dr. Theriot is on the call, and she can give

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

an update on that.

DR. THERIOT: Hello. This is Judy Theriot with Medicaid. I wish I had more news, but we have tried to get numbers for the amount of Hepatitis C in prenatal screenings that we have. And, honestly, the number we got was 14 percent, and I don't believe that.

When I talked to the OB/GYNs and to the pediatricians that take care of the babies in the nursery, they all say they have, you know, that test result for -- on the moms.

And so I'm doing something wrong with the way I'm pulling this data, and I'm trying to do it a different way. So I'm waiting for those results, and I can report back hopefully next month.

Now, the number -- and the number treated, also, I'm waiting. Because we're waiting on not only the total number treated for the state but, of that, how many were treated in the postpartum period. So we're trying to get those numbers as well.

CHAIRMAN PARTIN: Okay. Okay. Great. Well, that'll fit in with our

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

November update, maternal/child health. So we'll just move that to next meeting.

MR. MARTIN: This is Barry. I just wanted to update. I had went back and checked our numbers as well with our OB patients. And all of our OB providers are screening pregnant mothers for Hep C, so those numbers definitely don't reflect what's really going on.

DR. THERIOT: Right. I agree.

CHAIRMAN PARTIN: Okay. So maybe we can get a better idea by November. Okay. Next up is an update on Basic Health Plan and the unwinding.

COMMISSIONER LEE: So we are restarting our Basic Health Plan internal planning meetings. We are also meeting with some potential carriers. So activities have begun on the Basic Health Plan, just some preliminary planning.

Again, an anticipated start date would be January 1st of 2024. So a few internal meetings and more to come on that as we go forward.

With unwinding, we have engaged some

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

outside sources, a contract to assist with our unwinding activities to make sure that we do not miss any opportunity to improve our program as we go forward as we unwind.

We still think that the Public Health Emergency end date may be in January of 2023. That would be after open enrollment and -- after open enrollment for Medicaid and after open enrollment for Qualified Health Plans is over. So we are anticipating a January date right now of the Public Health Emergency end.

CHAIRMAN PARTIN: Okay. That was my next question because that's what I've been reading. It sounds like it'll be -- end in January. So will the enrollment period be open again in January to allow people to sign up?

COMMISSIONER LEE: Well, we'll just have to wait and see what sort of activities the Federal Government comes out with related to unwinding and the actual effective date.

For example, we know that they did have a special enrollment period for Medicare enrollees last year. So they may come up with some special ones.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

But we'll just have to wait and see what the Federal Government allows us to do after -- when the Public Health Emergency ends.

CHAIRMAN PARTIN: Okay. And did you say starting January 2024?

COMMISSIONER LEE: '23, I mean. I'm sorry.

CHAIRMAN PARTIN: You may have said '23, and I wrote -- okay. So I'm going to keep this on agenda, but we won't talk about it again until January. I'm just going to keep it on there as a reminder to talk about it in January.

COMMISSIONER LEE: You know, one of the most important things about unwinding is we want to make sure that keep individuals enrolled that qualify. So as individuals come into your -- into your offices, if they do an address update in your office, if you tell them that they also need to report that to the State so that they can get important information, that would be great.

CHAIRMAN PARTIN: Okay.

COMMISSIONER LEE: From the State



1 as we begin to -- because some of the  
2 individuals -- of course, our concern is some  
3 individuals are enrolled in Medicaid for the  
4 first time, and they've never gone through  
5 that recertification process. So they may  
6 not know what that looks like or the  
7 information that they need to look for in the  
8 mail. And some individuals who may have to  
9 supply information back to us, if we don't  
10 have an updated address, they may not get it  
11 in time.

12 So we just want to make sure that we  
13 don't want anybody to fall off the rolls  
14 unnecessarily. So that address update is one  
15 of the most important things that we can do  
16 for our members as we go forward.

17 CHAIRMAN PARTIN: Okay. Thank you.  
18 And then the next item is the new FAQ for  
19 telehealth. And I just wanted to say that  
20 that was very helpful and thank you. I know  
21 it was helpful for me. Well, anyways.

22 Okay. And, Commissioners, you're still  
23 up. The next item is updates from you.

24 COMMISSIONER LEE: So update on  
25 enrollment. We currently have 1,661,499

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

individuals enrolled in the Department For Medicaid Services in Kentucky. Of those, 625,000 are children. And as some of you may know the stats, we have just a little over a million children under the age of 18 in Kentucky. And right now, more than half of those children are enrolled in Medicaid or CHIP.

And speaking of enrollment, last week, the Kentucky Department For Medicaid Services won a national award from the Robert Wood Johnson Foundation at a national conference that was held in Seattle, Washington, and it was for innovation in enrollment during the pandemic.

So we are getting a lot of national attention on our efforts to find and enroll individuals in the program. So we're very proud of that award.

I was unable to attend the conference due to a family emergency. But Secretary Friedlander did go and accept that award on behalf of the Kentucky Department For Medicaid Services. So, again, we're very proud of that award.

1                   We also have a new Health Disparity and  
2                   Equity Technical Advisory Committee. And  
3                   that committee, I don't think, is formalized  
4                   in statute yet, but it is -- so even though  
5                   it's not an official Medicaid TAC, you know,  
6                   perhaps the MAC would like to provide regular  
7                   updates from that Disparity and Equity TAC.  
8                   They could provide regular reports. The  
9                   first meeting, I think, was held on September  
10                  7th. So if we add them to the agenda, they  
11                  may be able to give an update.

12                  Earlier this week, the chief financial  
13                  officer and myself met with the Emergency  
14                  Medical Services Subcommittee or adviso- --  
15                  is it -- commission or committee. I forget.  
16                  But, anyway, we met with the Emergency  
17                  Medical Services Subcommittee.

18                  And they had requested that we research  
19                  and pay for ambulance services for treatment  
20                  on site rather than transportation. Because,  
21                  currently, ambulance transportation is only  
22                  reimbursed when that ambulance provides  
23                  transportation from a site to an emergency  
24                  room at a hospital.

25                  So there may be times when those EMTs

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that are associated with the ambulance can treat that patient or that person right there on site rather than transporting them to a hospital. In the event that they do that, there's currently no reimbursement for that service.

So they had requested that we research for looking into that treatment on site rather than transporting because it may save funds for them to -- instead of transporting unnecessarily to an emergency room, those individuals could be treated on site. So we are researching that based on that request earlier this week.

We also met yesterday with the Budget Subcommittee For Health and Human Services. And part of the conversation that we had yesterday focused on employment for Medicaid members and, you know, trying to discuss and find ways to help Medicaid members transition off of Medicaid to employer insurance.

So there was some talk about how we could -- and when I say "we," I think it means the committee and the department and I think this committee that we're -- right now

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that we're talking to, is, you know, what kind of ideas. What can we come up with to help individuals transition to employment?

But that's a really broad, big question and hard to answer because I think, first of all, we need to know what sort of jobs are out in the communities. We need to know a lot more information about how we could help individuals transition.

So, again, that was a big topic of conversation at the budget subcommittee yesterday. And I wanted to inform this committee that that's a topic that continues to be out in the communities, is: How do we assist individuals that maybe are not working, transition out of Medicaid and into some other form of insurance?

So I think those are all the topics that I have today for an update. But I do think that if you have time, the committee members have time, that it would be maybe valuable to go out and listen to some of the conversation on the budget subcommittee that was held yesterday.

We can get a link to that presentation

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

so you all can see, No. 1, we presented on the Medicaid budget. We talked about a lot of different things in that committee yesterday. But that focus on community engagement or employment of Medicaid members was a big topic. Again, we'll send out a link.

And it may be beneficial at the next meeting, if you want us to, to present on the Medicaid budget, the closeout of state fiscal year 2022 and where all the expenditures went. If you would like an update on that, just let us know. We'd be more than happy to provide that during the Commissioner's update next -- at the next meeting.

CHAIRMAN PARTIN: Yes. I would like that, Commissioner. And then also, could you update us on what's happening with the committee work on people being employed as they go off of Medicaid?

COMMISSIONER LEE: Yes. So House Bill 7 does have a provision that we work with workforce development. So we are trying to -- well, we're discussing file transfers on individuals who may opt in to have us send

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

their name to workforce development so that they could work with them in order to obtain employment or search for jobs. We still have a little bit more work to do on perfecting that. But we could try to have an update in the Commissioner's report next -- at the next meeting.

CHAIRMAN PARTIN: Okay. Okay. And then one more thing. Could you speak to what's going to happen now with the Court's decision on Anthem?

COMMISSIONER LEE: So there are still options for appeal. So right now, we are sort of in a holding pattern because we have to wait to see if there are additional court proceedings before taking any action.

CHAIRMAN PARTIN: So if the courts decide that Anthem will be excluded, what will happen to those participants who have signed up with Anthem?

COMMISSIONER LEE: Well, we'll have to wait until all of the appeal decisions -- all of the appeal options are off the table and then we will formalize a plan and communicate that.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

CHAIRMAN PARTIN: Okay. I'm going to put that on the agenda for next meeting, if there's any update, so we don't forget about it.

Does anybody have any questions for the Commissioner?

(No response.)

CHAIRMAN PARTIN: Okay. Well, thank you very much.

COMMISSIONER LEE: And I don't know, Beth, if you saw in my note in the chat that I do have an in-person meeting across town. I'll have to leave the office a little bit later, but I'm going to stay on as long as I can. I'll definitely be here for at least another 30, 45 minutes.

CHAIRMAN PARTIN: Okay.

COMMISSIONER LEE: But if you have questions for Medicaid, we do have Medicaid staff on here that can answer, and we do have Senior Deputy Commissioner Veronica Judy-Cecil who will be able to fill in.

CHAIRMAN PARTIN: Okay. Oh, I'll just note it on the agenda. At the last meeting, there was a question about the



1 ramifications of the abortion bill as far as  
2 Medicaid is concerned. Do we have any update  
3 on that?

4 COMMISSIONER LEE: We do not have  
5 an update on that.

6 CHAIRMAN PARTIN: Okay. Then I  
7 guess we'll just keep that for next time.  
8 Okay. Thank you, Commissioner.

9 Okay. Well, we are moving right along.  
10 Next up is reports from the TACs, and today  
11 we will start with Therapy Services.

12 (No response.)

13 CHAIRMAN PARTIN: Okay. Nobody  
14 from Therapy Services?

15 MS. BICKERS: I'm sorry. I  
16 couldn't get myself off mute, Beth. They  
17 cancelled their last meeting.

18 CHAIRMAN PARTIN: Okay. Okay.  
19 Thank you. Primary Care.

20 MR. CAUDILL: This is Mike Caudill  
21 with Primary Care. Good morning, everyone.  
22 We had a meeting back on September the 1st  
23 and several different issues. One of them  
24 was dealing with the dental workforce  
25 recommendations.

1                   As the MAC will remember, we talked  
2                   about that last time. And Deputy  
3                   Commissioner Veronica Cecil had told us that  
4                   DMS has appointed a -- or that their dental  
5                   director, Julie McKee, will be doing a  
6                   presentation at our next meeting because  
7                   she's done a survey and has information  
8                   related to the workforce. Also, there will  
9                   be presented at our next meeting the current  
10                  state of Medicaid on this, a discussion with  
11                  the Primary Care TAC members as to what we'd  
12                  like to see as the next step.

13                  And it was also noted Commissioner Lee  
14                  had presented to the Kentucky Dental  
15                  Association conference on August 27th their  
16                  findings in this line. And, finally, just to  
17                  follow up on this, there will be a  
18                  stakeholders' meeting seeking involvement and  
19                  input across the board including KPCA, the  
20                  dental schools, and the stakeholders involved  
21                  in that.

22                  Another subject we talked about was the  
23                  DMS-covered SUD benefits. We were seeking a  
24                  crosswalk to know what benefits that each  
25                  SUD -- that was available for SUD patients by

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

each MCOs, much like they had done for us before on COVID benefits, so that we could compare them and easily produce document and help customize it to our SUD patients. That is being looked at.

And while we were talking, Veronica Cecil emailed the MCOs to see if they had any additional things beyond the department requirements that might be put on a list showing value-added products so that providers would have that one document and be able to better serve their patients.

And I think one other thing worthy of bringing up here, standardization of quality measures across all MCOs for value-based contracting. We have a problem in that each MCO sets their own value measures and -- quality measures, and it's sometimes confusing and extra work.

And so the Department agreed to help coordinate that, to a certain extent, understanding that MCOs are still free to add their individual thing but to develop a core group of quality measures that would be consistent across the different MCOs.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

And we talked about emergency credentialing. On July the 28th, I woke up to being blocked off from my -- getting into my office two miles one way, one way or the other. And within two hours, it was up over my driveway.

And we had providers that literally were saving other people's lives with boats and jet skis and kayaks. And then we had other employees who were being saved by people with kayaks and boats and jet skis.

And we had providers that could not get to work. We had no place to work. We had almost two, two-and-a-half feet here in central office. And we got to wait to watch, those that did make it to work, a raging torrent going down what used to be called Main Street.

We had great response from our other QHCs across the state. Many of them sent in supplies and people and providers to help fill in the gaps. But we had to send them back because there is no provision for providers, like the other FQHCs, even though they were deemed -- were credentialed and

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

everything else. But there's no provision that, in a declared emergency, they can go and work at another facility through any type of expedited process.

Part of that, of course, is Medicaid and being credentialed with Medicaid. And Veronica Cecil was seeking to help expedite that, and she's going to be coming back to us on that with the idea of being something along the lines -- and I'm not speaking for Medicaid but something along the lines that an abbreviated form can be sent in and the actual documentation that's needed be followed up within 30 days or some time limit to be set.

And, Madam Chairman, that's my report from Primary Care TAC.

CHAIRMAN PARTIN: Thank you. I have one question. With these FQHCs, would that also include the rural health clinics?

MR. CAUDILL: Yes, ma'am. That was part of the discussion. They would be included.

CHAIRMAN PARTIN: Thank you. Okay. Physician Services.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

DR. GUPTA: Hi. This is Dr. Gupta. We met in person on September 16th. We had a quorum. We do not have any recommendations. It was really nice to have Commissioner Lee in our meeting in person. And we tried to address -- tried to solve all the health problems in Kentucky, which is not possible. But we had a great conversation. Thank you.

CHAIRMAN PARTIN: Thank you. Pharmacy.

MS. BICKERS: Beth, I believe they also cancelled their last meeting.

CHAIRMAN PARTIN: Okay. Persons Returning to Society From Incarceration.

MR. SHANNON: Yeah. This is Steve Shannon giving the report. We did meet last Thursday. We have no recommendations. We had a good discussion about and we keep being excited about the potential Medicaid waiver for folks leaving incarceration, and we're going to move our focus on folks currently in jail as well. We haven't really focused on that population. Thank you.

CHAIRMAN PARTIN: Thank you. Optometry.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

DR. COMPTON: This is Steve Compton from the Optometry TAC. We met on August the 4th. We had a quorum. We had some great discussion, but we have no recommendations at this time.

CHAIRMAN PARTIN: Okay. Thank you. Nursing Services.

(No response.)

CHAIRMAN PARTIN: Okay. Intellectual and Developmental Disabilities.

MS. DEMPSEY: Hello. Can you hear me?

CHAIRMAN PARTIN: Yes.

MS. DEMPSEY: Yeah. This is Patty Dempsey with the Arc of Kentucky. We just wanted to report from the Intellectual and Developmental Disabilities TAC. We met this week on Tuesday, the 20th. Had a good meeting but have no recommendations at this time. Thank you.

CHAIRMAN PARTIN: Thank you. Hospital.

MR. RANALLO: This is Russ Ranallo, the chair of the Hospital TAC. We did not have a meeting, and our next meeting is

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

scheduled in October.

CHAIRMAN PARTIN: Thank you. Home Health.

MR. REINHARDT: Good morning. This is Evan Reinhardt from the Kentucky Home Care Association. The Home Health TAC met on August 30th. We do not have any recommendations but did continue our discussions on home health reimbursement rates and supply issues, both in terms of access and MCO publication of those supplies limits. So that's all we have for today.

CHAIRMAN PARTIN: Okay. Thank you. Nursing Home.

MS. BICKERS: Nursing Home Care has cancelled their meetings for the rest of the year and will pick up in March.

CHAIRMAN PARTIN: Okay. Dental.

DR. BOBROWSKI: Yes. This is Dr. Garth Bobrowski. The TAC met on August the 12th. We did have a quorum. We did not have any recommendations at this time, but, of course, a lot of our discussions do focus around access to care.

We did have one question. Mike with



1 Primary Care, y'all had mentioned, I guess,  
2 at the last MAC meeting about the use of  
3 dental auxiliaries or the dental workforce.  
4 Can you give us any clarification on that, or  
5 what's your all's thoughts or...

6 MR. CAUDILL: We actually had to  
7 turn down help of dentists being sent in, and  
8 part of that is because that's the FQHC  
9 where -- deemed as a Federal Qualified Health  
10 Center for purposes of the FTCA. And we're  
11 working on this on multiple fronts.

12 As far as the flood, we have a dental  
13 department at our main clinic, and we're  
14 still seeing patients out of a mobile van  
15 that was loaned to us while we're going  
16 through renovations on the clinic.  
17 Everything had to be stripped out, a lot of  
18 the equipment replaced or at least  
19 refurbished with new parts and stuff.

20 DR. BOBROWSKI: Yeah. Thank you.  
21 Boy, we're -- I've got family that live in  
22 eastern Kentucky, and I used to live there  
23 with them. But it's just awful, what folks  
24 are having to go through, but thank you.  
25 That's my report.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MR. CAUDILL: Thank you, sir. And I've been corrected. We, this week, managed to get back in our dental clinic and no longer using the van now.

CHAIRMAN PARTIN: Okay. Thank you. Consumer Rights and Client Needs.

MS. BICKERS: I don't believe Emily is on, but she sent an email that they did not have any recommendations at this time.

CHAIRMAN PARTIN: Thank you. Children's Health.

MS. BICKERS: They did have their last meeting a few weeks ago and did not have a quorum and no recommendations.

CHAIRMAN PARTIN: Okay. And Behavioral Health.

MS. SCHUSTER: Well, I've got a report. The BH TAC met on September 8, and we did have a quorum. We had representation from Medicaid and also the Department For Behavioral Health, Developmental and Intellectual Disabilities. And all of the MCOs were represented.

We had an excellent presentation by folks from the Kentucky Hospital Association

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

and Verisys about the credentialing alliance in which -- to which three of the MCOs belong, Aetna, Molina, and WellCare.

We had discussed this at our July meeting, and these folks were very kind to give an excellent presentation about how the credentialing alliance will work. They're hoping to have other MCOs join.

And I understand that the process will go live at the end of September or early in October, and so they will let us know. But we were very appreciative of the information. I think it will help providers both in initial credentialing and also re-credentialing.

The TAC continues to be very interested in the no-show data portal, and we had asked for a report specifically about what kinds of providers are reporting. Because we want to really urge our behavioral health providers to use the portal.

And Justin Dearing with DMS was looking into that and has forwarded information to us after the TAC. So we'll talk about that at our next meeting.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

We also had an excellent presentation from Dr. Katie Marks from the Behavioral Health Department on a pilot program being conducted by the -- what they call KORE, K-O-R-E, Kentucky Opioid Response Effort. And it's about prescription digital therapeutics.

This is a topic that we have talked about in our previous TAC meetings. They had a piece of legislation passed that urged CMS to make these reimbursable, and they're hoping that Kentucky Medicaid will also add them to the reimbursement system. The data was very supportive of including these in the treatment armamentarium, if you will, to treat people with opioid use disorders.

We continue to have -- and I can't believe that behavioral health is the only group that's having this problem -- to get reimbursement for people with dual coverage, Medicaid plus Medicare or Medicaid plus commercial insurance.

And the Medicaid/Medicare has been fairly well worked out with the assistance of DMS staff. But as you can imagine, with all

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

the different commercial insurers out there, it's very difficult to figure out what they cover and what they don't cover.

The problem is that they will not typically issue an EOB saying that they won't cover that service, and the MCOs want to be sure that they have been billed first.

So we had discussion about the TPL form, the third-party liability form. We also had an offer of help from DMS staff, and we are following up trying to get specific information.

So, again, we're going to keep this on. Our biggest concern is that most of these members that have commercial insurance and Medicaid are children, and we're really concerned that those providers will simply quit serving those kids because they can't get reimbursed for their services. And, obviously, we don't want that to happen. Medicaid doesn't want that to happen.

Yes. Steve Shannon says we've been debating this with the MCOs since November of 2011. I mean, this goes back years and years and years, and it just is -- and I'd be

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

interested in hearing from the behavioral health -- I mean, the physical health providers, physicians and FQHCs and so forth, whether you run into the same problems.

We also talked about the inordinately high frequency of MCO audits. There was one provider who, in 2020, had between 250 to 300 audit requests; and, in 2022, has had 2,800 audit requests just in this year. Medicaid staff was helpful in talking about many of these are related to a service called targeted case management.

Because there is no prior authorization for that, the MCOs certainly are within their rights to audit the providers, but it is a real problem. So we are continuing to look at that.

We also got an update on the 1115 waiver authority. And as Steve Shannon mentioned, that specific waiver on SUD, which would be -- would start treatment for people while they are incarcerated, which is obviously a huge departure for Medicaid to approve that, and then make sure that they have a continuation of care when they are discharged

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

from the jail.

We had brought the recommendation to the MAC in July to have an FAQ about telehealth, and so we take some of the credit for bringing that to Medicaid's attention. And the FAQ and the one-page, kind of, graphic design information piece were just excellent. So I want to add my thanks to those of others.

We also had some new business around the lack of inpatient services or beds for children with complex needs, comorbidities of physical and mental health issues or mental health and developmental, intellectual issues.

We have no recommendations at this time, and we will meet again in November. Thank you very much.

CHAIRMAN PARTIN: Okay. Thank you, Sheila. One comment. Yes, the physical health does have that same problem with the reimbursement, with the dual eligible patients. So yeah, it's a problem.

MS. SCHUSTER: Well, we've been working with the MCOs. Some of the MCOs have

1           what they call a bypass list which allows you  
2           to know which codes are covered by which of  
3           the commercial insurers, and it expedites the  
4           process then. But not all of the MCOs either  
5           have a bypass list or make it available, so  
6           we're continuing to work on that.

7                     But I'll keep you posted. I mean, if  
8           you want to send me any information, Beth,  
9           I'm happy to throw that in the next time.  
10          This has been a perennial issue. As Steve  
11          pointed out, we've been talking about this  
12          for what, 11 years now.

13                    CHAIRMAN PARTIN: Most of the  
14          information that I have is just when I'm  
15          looking at the EOBs that we get. I see that,  
16          you know, they're not reimbursing, and  
17          they're saying the other one has to do it  
18          first. I don't have any -- I don't have it  
19          quantified or --

20                    MS. SCHUSTER: Yeah.

21                    CHAIRMAN PARTIN: But I know it's a  
22          problem.

23                    MS. SCHUSTER: Well, and the MCOs  
24          pointed out -- and I appreciated their  
25          reminding us -- that they have an obligation.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Medicaid has to be the payor of last resort, so they need to know that all other payment options have been exhausted. And so that's why they've been, you know, requiring that there be some paper trail to show.

And the problem is that we can't get the commercial insurers -- you know, if you don't cover a service, they don't want to say that it's denied. And so you get into this, kind of, catch 22.

But I will certainly keep you posted and report back here to the MAC. Because I suspect there are other physical health providers who have the same issue. Thank you.

CHAIRMAN PARTIN: And then there's a question in the chat about where the telehealth FAQ can be found. Erin, is that posted on the website? I know I just got it as part of a -- in an email. So I'm not sure where it's visible to the public.

MS. BICKERS: It was presented in the Behavioral Health TAC, so it is posted on their website.

CHAIRMAN PARTIN: On the DMS

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

website?

MS. BICKERS: Yes.

CHAIRMAN PARTIN: Okay.

MS. BICKERS: I can post it on the MAC website if you would like as well.

MS. SCHUSTER: I think it would be helpful to have it on the MAC website also because people might not know to go to the BH TAC.

CHAIRMAN PARTIN: Yeah.

MS. BICKERS: Beth Fisher is on here. She can tell you if it's posted anywhere else.

MS. SCHUSTER: Thank you.

CHAIRMAN PARTIN: Okay. And then the other thing, Erin. Would you add the new TAC for the Disparity and Equity that the Commissioner talked about to the list of TACs?

MS. BICKERS: Yes, ma'am.

CHAIRMAN PARTIN: For next time. Okay. So moving along to next on the agenda. Does anybody have any questions for the MAC regarding the Humana or Molina/Passport presentations from last time?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

(No response.)

CHAIRMAN PARTIN: Okay. Well, I have a question for Molina/Passport, and I guess I would direct this to UnitedHealthcare as well when they speak.

Just recently, Passport has started to give their reimbursement via credit card payment, and that is costing us money in order to get paid. In order to get paid, we have to submit the credit card and, for each one, it's costing us 3.5 percent.

And so we're being penalized with our reimbursement, so to speak. And I would -- I would assume that other health care providers are also experiencing this who are credentialed with Passport. And so I would like Passport people to speak to this, if you would.

MS. BASHAM: This is Nicole Basham, vice president for Network and Operations. There is an opt-out option for the EFT credit card that you have. And, certainly, if you want to send your information, I can get more information to you on it.

We did move to that process 30 days ago

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

or so. I'm not sure of the time frame, so I apologize if I'm out of that time frame. But we did move to that process as Molina as a whole, so Kentucky was included in that.

There were some communications that went out on it on the ability to set up another avenue. So, Ms. Partin, I'm happy to talk with you offline about how we work through that, and we can get some information back to you.

CHAIRMAN PARTIN: Okay. That would be great. I would like to add, yes, with the letter, there was a phone number to call. But when you call that number, you're put on hold forever, and I don't have time to sit on hold waiting for somebody to talk to me about it.

And then the other thing is that what my billing company told me was that we had to submit first through the credit card before we could update to the EFT. And so, again, this is -- this has cost us money. Where we should have been receiving that reimbursement, we're losing 3.5 percent on every payment.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

So it's not -- it's not so easy to fix, and it's not so easy to get answers when you call the phone number.

MS. BASHAM: I've put my email in there. If you wanted to connect with me, then I can connect you. We can go around the phone number. How's that?

CHAIRMAN PARTIN: Okay. Let me --

MS. BICKERS: Dr. Bobrowski has his hand raised, and I can also pull the information from the chat and email it to the group after the meeting.

CHAIRMAN PARTIN: Would you do that? Yeah. That would be easier than me trying to writing it down.

MS. BICKERS: Yes, ma'am.

CHAIRMAN PARTIN: Thank you.  
Dr. Bobrowski.

DR. BOBROWSKI: I had to get un-muted. Sorry. Dentistry had got a bill passed last year, House Bill 370, that is trying to eliminate those EFTs. We call them virtual credit cards. And it passed the House and passed the Senate and was signed by the governor this -- back in July.

1                   And we found out, too, that -- I can't  
2                   say that all, but some of the insurance  
3                   companies -- you know, we were doing the same  
4                   thing, losing anywhere from 3.5 to 5 percent  
5                   with those virtual credit cards. And we  
6                   found out that some of the insurance  
7                   companies -- I'm just going to use this as an  
8                   example because it's easy math. If the  
9                   charge was five percent, some of the  
10                  insurance companies kept 2.5 percent, and the  
11                  other went to the other company, you know, or  
12                  to the bank. Half went to the bank; half  
13                  went to the insurance company.

14                  So they're making the money while we're  
15                  suffering. So we had to get a bill passed,  
16                  you know, to eliminate that but -- and you're  
17                  exactly right. I think it's an intentional  
18                  move by insurance companies to be put on hold  
19                  for, you know, sometimes 45 minutes, an hour.  
20                  And I think that's an intentional move.  
21                  That's just my opinion, and I'll stick by  
22                  that.

23                  MS. BASHAM: So we certainly  
24                  appreciate your feedback. We will say that  
25                  it's certainly never our intention to put

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

somebody on hold that long. And, you know, when I get those complaints, I certainly pass those on. We have commitments that we have to meet regarding time frame. No one should ever be put on hold for an hour.

So my information is in the chat. If you experience that or any other concern, you certainly are welcome to reach out to me. As I said, I'm the COO for Molina and -- Molina/Passport and also, you know, over Network and Operations. So you're certainly welcome to pass on concerns that you may encounter to my email address that's there.

CHAIRMAN PARTIN: Okay. And I had one more point to make on that. I have right now two credit card payments for reimbursement that have been denied. And I tried calling the number and was put on hold forever, and I had to hang up.

But, I mean, it's just adding insult to injury where I'm being penalized by having to pay to get paid and then the credit card isn't approved when we submit it. So that's another problem.

MS. BASHAM: I know. There's a

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

couple of problems there that I'd like to make sure we get addressed, so I would love your examples. If you would please just connect with me after this, let's get these addressed.

CHAIRMAN PARTIN: Okay. Thank you.

MS. BICKERS: Beth, Barry Martin also has his hand raised.

CHAIRMAN PARTIN: Go ahead, Barry.

MR. MARTIN: Yes. This is Barry as well on Passport. We are having an issue where we offer the infusion, COVID infusion therapy, and Passport is requiring a prior authorization on this treatment.

Can we get clarification on that? Because it's kind of hard to test and treat on the same day if you have to get a PA.

MS. BASHAM: I can certainly do that. If you will -- with my email, if you'll shoot me your contact information, we will -- I can connect, and we'll connect with the clinical team to see why that would be.

MR. MARTIN: And we're also kind of having an issue with the other MCOs, all of the MCOs, getting the -- I call it BEB, B-E-B



1 for short, the BEB treatment on the fee  
2 schedule. So if you guys could kind of look  
3 at that and help expedite, get that on the  
4 fee schedule so we can bill for it, that's  
5 holding up our -- getting these treatments  
6 out to our patients.

7 CHAIRMAN PARTIN: Does anybody else  
8 have any questions for either Humana or  
9 Passport?

10 (No response.)

11 CHAIRMAN PARTIN: Okay. Then we  
12 will move into the two reports from the MCOs.  
13 First up is UnitedHealthcare.

14 MS. HENSEL: Good morning. This is  
15 Krista Hensel. I'm the CEO of the  
16 UnitedHealthcare community plan of Kentucky,  
17 and I believe that Greg Irby, our COO, will  
18 be pulling up the slides. As he's doing so,  
19 I just want to say thank you guys for sharing  
20 your specific examples of things you're  
21 experiencing.

22 I like to call that -- early in my  
23 career, I worked for a gentleman who came up  
24 from behind me as I was heads-down in a  
25 spreadsheet. He happened to be a physician.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

And he said in a large booming voice,  
"Krista, a desk is a dangerous place from  
which to view the world." And he had me  
follow him down the hallway and sit and  
listen to our nurses on the phone.

So that sticks with me, and that's  
exactly the kind of experience you guys are  
providing in this forum, is the reality  
testing we need oftentimes to see things  
beyond the spreadsheet or the PowerPoint  
presentation and let us know what you're  
actually experiencing. So thank you for  
those great examples, and I think Greg will  
be able to speak to some of those as we move  
through the presentation.

CHAIRMAN PARTIN: Okay. Krista,  
before we start, UnitedHealthcare is also  
causing us a problem with the credit card  
reimbursements so...

MS. HENSEL: Yeah. That's totally  
new news to me. In fact, my COO and I were  
IM'ing back and forth during that dialogue,  
saying, huh. First time hearing of this.  
That's not what we are -- that's not what we  
were hearing from our operations. So we want

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

to definitely lean into that and take that offline and see what's going on between your reality and what we're seeing on our side.

CHAIRMAN PARTIN: Okay. Thank you.

MS. HENSEL: Yeah. But thank you so much for having us today. I know your time is really, really valuable, and this meeting does seem to always have an overpacked agenda so appreciate the invitation to speak.

I'll first just introduce myself, Krista Hensel. I joined the UnitedHealthcare Community Plan of Kentucky team back at the beginning of the year, but I've been with UnitedHealth Group overall since 2005 and was really, really excited for this opportunity.

I spent a lot of my childhood growing up around the Louisville metro area, and my parents are originally from here. They retired back five years ago. And when I got to call my mom and tell her that I was moving me and my family, including her grandchildren, about ten minutes from her house, it was very, very happy tears.

So great, great to be able to combine my

1 passion around health care and helping people  
2 live healthier lives with really a fondness  
3 and grounding that Kentucky is home. So glad  
4 to be here and glad to be back in the market.

5 So I just want to share really quickly,  
6 so you can help us hold -- help me hold  
7 myself and my team accountable for some  
8 guiding principles we've put there.  
9 Obviously, our mission is to help people live  
10 happier lives, but how we do that is really  
11 important to me.

12 So I just want to share with you, really  
13 quickly, what I've laid out for my team is  
14 execution, differentiation, and  
15 relationships.

16 From an execution perspective, we need  
17 to, you know, execute on the basics, make  
18 sure we're paying claims on time, making sure  
19 we're answering the phones, all the things  
20 that we have committed to both in our  
21 proposal and our contract.

22 Differentiation, that we really do have  
23 an opportunity. We are the newest MCO in  
24 Kentucky, and we have the opportunity to pull  
25 in some best practices from across our

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

enterprise and bring that to life in  
Kentucky.

But the way we do that is important, and  
that's relationships. So it's venues like  
this, us getting out into the community,  
making sure our providers, physicians,  
nurses, dentists, our community partners, our  
members, that we are building relationships  
across the board. Because it does take a  
village.

So put that out there. I will put my  
email address out there in the chat here  
momentarily as well. If that's not your  
experience, I want to hear about it.

In the spirit of relationships, I want  
to take a minute to just introduce my team.  
Some of them may be folks you recognize.  
Some of them may be new to you. So I have  
already introduced myself.

Dr. Divya Cantor is our chief medical  
officer. She's been with us since the plan  
launched in '21. OB/GYN by training, and you  
will see her speak here in just a little bit.

Greg Irby is our chief operating  
officer. He is new to that role but has also

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

been with the UHC Community Plan of Kentucky since 2021. You'll also hear him speak today.

Michael Lines is our chief financial officer. You can see him there in the eye glasses appropriately for digging into spreadsheets that he spends his days looking at. He won't be on the call with us today, but he is a part of my leadership team.

And then Ashley Hobbs, who is the director of enrollee services, recently promoted into that role. She had been our market growth lead.

So here's some of our key leaders across Kentucky. I wanted you to be able to know who these folks are and put a face with the name and, like I said, hopefully build relationships.

I want to just take a minute to talk about where we've been so far in '22 and where I think we're headed. Many of you are likely aware that we've been the newest MCO, the smallest since entering due to a number of market dynamics, some of which were already spoken to earlier in this call.

1                   But just to give you a sense of the  
2                   growth we have been experiencing, we started  
3                   the year under 65,000 lives. The latest  
4                   report -- this is a little dated as we're  
5                   pushing about 90,000 lives that we have  
6                   accountability for. You can see how that  
7                   splits across region. Obviously, Region 3  
8                   with Louisville and Region 5 with Lexington  
9                   making up a good share of those members.

10                   But, really, the punch line here is  
11                   maybe you haven't seen as many  
12                   UnitedHealthcare Medicaid members through  
13                   your offices yet, but I suspect you'll  
14                   continue to see more and more. And we're  
15                   really excited about that.

16                   We, like I said, take it very seriously,  
17                   the accountability of helping to care for  
18                   these members. We know you're a huge  
19                   component of that. And we're excited, as we  
20                   continue to grow, being able to be even more  
21                   impactful across the health counts of the  
22                   state.

23                   I will take a pause and transition it  
24                   over to Greg who is going to go a little bit  
25                   deeper into our operations.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MR. IRBY: Thanks, Krista. I appreciate it. We're happy to talk about our program. Our theme is helping people live healthier lives, so I appreciate everybody giving us this opportunity.

MS. HENSEL: Greg.

MR. IRBY: Yes.

MS. HENSEL: Going to intervene just a little bit. For some reason, you're coming across, at least on my speakers, as a little bit muffled.

MR. IRBY: Let me check where my audio is coming from.

MS. HENSEL: Great. Thank you so much. Sorry. I just -- virtual technology fun.

MR. IRBY: Exactly. Does that sound a little bit better?

MS. HENSEL: So much better, Greg. Thank you.

MR. IRBY: Perfect. No. Thanks for letting me know. No. So I was just saying I do appreciate the opportunity to talk about our program. We see ourselves as a piece of this puzzle, and we love the



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

opportunity to partner with folks like you, our providers who are treating members.

What you'll see from this slide here is that we've got a broad network of providers throughout the commonwealth, many of whom are on this call today. So we want to take a moment just to say a formal thank you for the care that you're providing to members. We don't take that for granted, and we're excited to partner with you on it.

As you can see, we're at 95 percent of our goal for medical network services, meaning that 95 percent of our members are within a reasonable distance to a medical provider. That number looks like 96 percent in our behavioral health network and then 94 percent in our dental network.

The other piece that we look at with network adequacy is making sure that our members are able to schedule appointments in a reasonable time frame. As you likely know, we set appointment-scheduling standards for our providers, and they're listed here. So I won't walk through those.

But we monitor those time frames through

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

quarterly audits, and we've seen really good results. To date, we're sitting at a 99-percent compliance with our primary care routine appointment scheduling and 90 percent of behavioral appointment scheduling. What that practically means is that 99 percent of the audits that have done, we are able to get an appointment scheduled in the required timeline.

So, again, I'm just going to say a thank you -- especially in light of some of the conversation that happened before, thank you for providing the care to members and making the time in your schedule. Because we know that sometimes that doesn't always work out, and sometimes you end up with a missed appointment. So I'll just say thank you for making the time in your schedule so that people can get access.

Outside of the office, we're also seeing consistent utilization of telehealth services. Many of our providers, they're making telehealth options available to our members, and we see that as a real value to them. Telehealth, it eliminates barriers,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

things like transportation, child care, and rigid work schedules.

So this is a really good way to ensure equitable delivery of health care. As you'll see in the chart, we're seeing consistent utilization in all of our regions, and it's creating access in both urban and rural communities.

Well, one of the goals that we've set for our team is to continually improve the experience of the providers we serve. So I'm really happy to hear some of the feedback that we've heard on this call, and I want to just say that we are an open door for feedback like that. As we hear about opportunities like that, we're immediately jumping into action to make sure that we can improve the experience of our providers.

So we've already taken a couple of takeaways today, but I'll just say, in the same way that Krista published her information, I will as well. I look forward to hearing from you and helping to solve problems to be the best partner we can be.

As Krista mentioned, we entered the

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

market in 2021. Since that time, we've worked really hard to stabilize and improve some of our processes. And some of the ways we've looked to measure this is through our provider appeals and our claim adjudication timelines.

And as you can see here on the slide, we're seeing continuous improvements in both of those. Between Quarter 3 of 2021 and Quarter 2 of 2022, we saw a 55-percent reduction in provider appeal volume. Similarly, on average, we're adjudicating claims in less than nine days from the day that we get them in hand, and more than 99 percent of our claims are being finalized in less than 30 days.

So, again, we just want to emphasize that our goal is to be a great partner to the providers that serve our members, and we want to do everything with our processes to make that happen.

In this next section, we're going to talk a little bit about how we support our members outside of the provider office. For some members, their first step into health

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

care comes through our customer service center. So we try to make the most of those conversations.

In our approach, we seek to understand the individual needs for our members and then connect people to community resources and then we hope to partner with those community organizations and expand on the great work that they're already doing to foster health and to promote health equity.

As these images will show, we're seeing high concentrations of both medical and nonmedical needs, especially in Region 8, the eastern part of the state. The most frequent need that we hear about right now is nutrition and access to healthy foods. And to date, more than half of the requests that we've heard about access to healthy foods we've been able to close and actually have successful referrals back.

So I know that providers on this call, they often hear about members' needs even ahead of us. You're directly with the patients face-to-face, and you will observe needs that we may never know about.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

So I want to take this opportunity to let you know that we are open to hearing about those needs. If you observe a need that you cannot meet in your office, please refer the member to us. We are happy to step in and help connect them to one of our many community partners.

In the appendix of this dec, you're going to see a series of community partners that we work with in different areas for different needs. So we're happy to step in and help with those needs.

As you can imagine, our ability to care for members and connect them to resources was really tested during the recent disasters that have been experienced. When we heard news of the flooding, our teams immediately jumped into action to support our members and providers in any way that we could.

Our case managers, they started immediately reaching out to members who are in case management programs, whether that's a complex case management or chronic condition program or a behavioral health case management. We started reaching out to them

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

to make sure that they had access to the services that they need, whether that was medication, community services, social determinant services, or medical services.

We equipped our customer service center to make sure that they were ready to intake those requests, and we published information on our websites and set up our intake systems to automatically direct people to where they needed to go. We eliminated authorization requirements in the impacted counties to make sure there were no administrative barriers to accessing care.

And our team was able to partner with community organizations to bring meals to impacted communities. I was encouraged when I saw pictures back from some of our community representatives out there who were just right alongside with food truck vendors and other providers of services ready to serve members.

So we were able to donate a little over \$200,000 towards relief activities, and we know that that work is still ongoing. I heard somebody else mention that providers

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

were coming up on -- in boats and jet skis and things like that. And we're just in awe of the work that's happened and the way that people rallied to support the community, and we're honored to be part of that.

We provided similar support back in 2021 when western Kentucky was hit with tornados. I won't take the time to read through this full slide, but I'll say again that our team immediately jumped into action to help members who were impacted. We were grateful in being able to give \$500,000 towards relief activities in western Kentucky, and we partnered with one of our vendors to donate 5,000 meals. So we were really happy to partner with our community there.

Our goal in both disasters was to make sure that people knew how to access services and to eliminate any barriers and to bring services right to them when we can. So -- and we're going to continue operating that way.

The last thing that I'll mention about our support outside the doctor's office is that we've made concentrated efforts to



1 engage members with presumptive eligibility.  
2 We're sending communications to members so  
3 that insurance doesn't become a barrier to  
4 them living healthy lives.

5 We've hosted open houses and expanded  
6 our hours of operation for our call center.  
7 We've published updates, all with the goal of  
8 helping members know how to keep their  
9 coverage.

10 So I do want to transition over to  
11 Dr. Cantor, our chief medical officer, and  
12 she'll talk a little bit more about some of  
13 the benefits and services we offer to  
14 members.

15 DR. CANTOR: Thanks, Greg. I  
16 appreciate that. Good morning to everyone,  
17 and I am so appreciative of being able to let  
18 you share -- let us share our work with you.

19 So as Krista and Greg have pointed out  
20 about our memberships, some operations  
21 information, along with the disaster relief  
22 efforts, I'd like to pivot and switch gears  
23 and talk about some of our everyday clinical  
24 work, our bread and butter, which is to help  
25 our members live healthier lives. And we do

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that through various supporting structures and teams that work to accomplish this goal.

You've heard us talk about these first three top line items, the healthy first steps. It's a way to engage with those low-risk and high-risk moms. Home delivered meals, you've heard about that from Greg. And Wellhop is an online group prenatal care platform.

The other three are just as good. The Boys and Girls Club is a sponsored membership for after-school care, giving kids a safe place to be. Sports physicals are free to our members, and providers are reimbursed for this service.

On My Way program is very cool. It's an interactive program that helps our Kentucky youths about real-world situations like how to make a budget, figure out taxes, how to write a resumé, and interviewing skills.

Some more benefits on the next slide, please. Thank you. There are several here. I won't read through all of them, but a couple I'll just speak about. The behavioral health app, Sanvello, it's an on-demand app

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that helps with anxiety and stress, and it's so well-received by those using it.

Given the pandemic and the rise in mental health, I think anywhere where we can provide further support, further tools is so important.

We have Virtual Care with doctor chat, and it gives access to providers on a telehealth platform that's supplemental for our members. In looking at this utilization, we've found that, by using this platform, we avoided close to 75 percent emergency room and urgent care visits.

As Greg mentioned, we're constantly trying to listen to our members, listen to you all. And one of the platforms that we have is through the quality and member access committee. And that's right in the middle of the slide where we're able to give our members a stipend for participation. And that's how we are able to get away from the desk, as Krista said, and learn from each other.

Next slide, please. I'd like to switch gears and talk about COVID vaccination rates.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

To set you all up, this is a graph of all the MCOs' percentage of members vaccinated since May of 2021. UHC is the top line in yellow ending at 48.77 percent compared to the other MCOs as of the most current information available to us.

The red line at the very top is fee for service, and I'd like to point out that that population mix is not the same as the rest of the membership of the MCOs. I'm really proud of this work because we've implemented many facets to improve the vaccination rates and help curb the impact of the pandemic in our community.

And this is how we've done it, through our multiprong approach. We have five tactics. Four are on this slide. So through provider engagement, we have town halls, and it was so well-received. It was in conjunction with Dr. Amy Harrington with DPH. We gave away teenies as part of raffles, so we encouraged members to come to the provider for their shot. And it was a lot of fun to watch people get a teeny.

Member engagement came not only through

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

the cash incentive that continues to the end of this year, but we gave away home-delivered meals. And we've made so many phone calls reminding them of their second dosage needed. We used data to drive targeted outreach, and we worked with our call centers on messaging for this as well.

Next slide, please, is the fifth tactic, our community outreach programs. There are many that you see listed here. I'm only going to talk about two of them. The Kentucky Youth Advocate Focus Group was sponsored by us. And with Mahak Kalra's work, we learned so much from this group as to what was important to this population.

What are their barriers to getting the vaccine? They told us they tend to follow their parents' leads. But if there was a difference in opinion, they wanted more information from trusted sources.

And those trusted sources was not the Government or the CDC or the FDA. But it was more from doctors and influencers and celebrities. So we learned a lot from that, and we used -- we worked with Lynn Bowden,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

and we helped get shots out into people's arms.

We completed a pregnancy focus group survey through KHP, and we interviewed dozens of pregnant women from across the state. We learned, of course, that these moms are super busy. Their time is tight. Their information did not always come from the news but, rather, from their trusted source which was often their family member.

And we learned that if the doctor was more engaged in talking to them about the importance of getting the vaccine and the doctor was able to dispel myths and falsehoods, they're more likely to get the vaccine while pregnant. But if the doctor was more nonchalant about it, then she's less likely to take it as seriously and did not get the vaccine.

All of those conversations helped drive messaging and campaigning geared towards providers which then allowed us to be able to help improve the health of our community.

Next slide. I'd like to briefly give you a success story. Some of you may have

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

heard this before, but I think it's really worth repeating to this larger audience because it represents why we are here and why we do this work.

Very briefly, it's about a young woman who is living with her boyfriend but experiencing domestic violence. She tried to commit suicide by walking in front of traffic. However, luckily, she had limited physical trauma. And our behavioral health advocate was able to learn about her situation. What were her greatest needs, which were employment, housing, transportation, getting to doctors.

Our advocate was able to get all the appointments made. She kept all her appointments, and now is even looking to be a peer support herself. And she has many more tools to help manage her depression and has such a positive outlook for her life.

So that's what we do. We're here to try to help people live healthier lives, and I so appreciate your time with us. Thank you. And I'd like to turn it back to Krista for closing remarks.

1 MS. HENSEL: I appreciate that,  
2 Dr. Cantor. And yeah, we share those success  
3 stories. We call them pretty routinely in  
4 our meetings within the health plan. And,  
5 also, we like to share them in venues like  
6 this because it does fuel each of us  
7 personally. I know I leave the conversations  
8 more uplifted when I'm able to hear how we're  
9 impacting individual members' lives. So I  
10 appreciate you taking a moment there to  
11 share.

12 So I will just wrap this up briefly.  
13 Hopefully, you got the sense that we are --  
14 we try to be very genuine in what we do. We  
15 definitely love the news like this to get to  
16 know all of you, hear your feedback on what's  
17 working and what's not, so we can continually  
18 improve the working relationships, all in the  
19 spirit of helping members throughout  
20 Kentucky.

21 So with that, I think we are wrapped,  
22 and we would open it up for any questions  
23 folks may have.

24 CHAIRMAN PARTIN: Thank you. Does  
25 anybody have any questions?



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

(No response.)

CHAIRMAN PARTIN: I guess not. So thank you for your presentation. And we'll have the slide shared with the MAC, and perhaps people will have questions after they get a better chance to look at the slides.

MS. HENSEL: Absolutely.

CHAIRMAN PARTIN: Okay. Thank you.

MS. HENSEL: Thanks.

CHAIRMAN PARTIN: Next up is WellCare.

MR. EWING: Okay. Good morning. Can everyone hear me?

CHAIRMAN PARTIN: Yes.

MR. EWING: Okay. Thank you. Well, good morning. Appreciate you guys allowing us to come and present today. I'll start with introductions, as Krista did. I'm Corey Ewing, the plan president here at WellCare. I have been with WellCare since February of this year, relatively new to managed care. I've been in this world a couple of years now, this month actually.

I came from the provider world. I was in the hospital business for over 20 years,

1 in hospital administration for 18. And the  
2 last eight of those, I was a hospital CEO, so  
3 very passionate about the provider world and  
4 will always have a special place in my heart  
5 for the providers, love the hospital space.

6 So I come to Kentucky from -- I'm  
7 originally from Alabama, so thus the southern  
8 accent. So my team told me I can't say "roll  
9 tide," so I didn't say it actually. But I'm  
10 glad to be in Kentucky. Definitely feels  
11 like home.

12 And today with me, I have Nate Coiner,  
13 our VP of network; Darren Levitz, our  
14 director of community outreach; and also  
15 Dr. Chirag Patel, our CMO.

16 We're going to give you guys -- really,  
17 we want to be respectful of your time, so  
18 we'll give you a really high-level overview  
19 of what we've got going on here at WellCare.

20 So with that, I'll go ahead and tell you  
21 a little bit about us and then talk about  
22 membership. We've been in the Medicaid  
23 program here since its inception into the  
24 managed care space in 2011. We are currently  
25 the largest managed Medicaid program in the

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

state with right at half a million members, so definitely take care of a lot of Kentuckians in the Medicaid space.

We are also in Medicare across the state this year, fully statewide in Medicare. And then we're new in the marketplace space. Ambetter is our marketplace product. We're in 63 counties this year and will be expanding into 81 next year.

Next slide, please. Go ahead and go to membership. This is kind of how our membership in the Medicaid space is divided up over the state. You can see the majority of our membership is in rural Kentucky. We've got 127,000 members in southeastern Kentucky. Thirty-five percent of our total membership are in the expansion population, and 47 percent of those are in the TANF population.

To kind of show you how the provider network overlaps our membership, I'm going to toss it over to Nate and let him talk to you guys a little bit.

MR. COINER: Thanks, Corey. So we wanted to talk through our provider network

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

and accessibility, and we thought what would be a good depiction is to kind of break up our network by primary care, our specialty groups, our mental health and substance abuse, along with our FQHCs and our HCs and our primary care centers that really show the number in each region of the providers that we have.

One thing that we do kind of want to call out is that the number you see in those regions, that is unique provider. It's unduplicated because we didn't want to double count and overinflate the numbers, so that is a unique number in each one of those regions.

The next slide talks about our primary care and specialty providers compared to our members' location to access. So a lot of good information here, but there's two main things I want to kind of call out. The first thing is that we get to see 95-percent access threshold for all key provider categories as required by DMS. So that's a huge, you know, thing that we focus on.

The other thing is, is that our hospital access, PCP access, and our community mental

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

health center access is all at 100 percent. So we look at this, you know, religiously, making sure that we're, you know, closing any gaps and making sure that the patients and the members get the care -- the right care at the right time.

Finally, the last thing I wanted to kind of touch on is appointment availability. The data that you're seeing right here is actually -- it represents Q1 and Q2 of this year for our access and availability. As you can see, we've maintained a 90-percent threshold or higher with all of the metrics with our lowest score being 93.9 percent, which was for after-hours call returned within 30 minutes.

I just want to call out personally that I know this is taking a lot of administrative work and a lot of work on your staff to make sure that they're answering the phones and making sure they're scheduling timely. I just want to say thank you. I know this takes a lot of energy, a lot of effort on your part. Thank you for that.

I know this is -- it's been challenging

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

with a lot of external forces like the flood and other things. Thank you. It's meant a lot for us, and we want to continue to help partner with you so that we can have a good relationship.

The last thing, I just want to say thank you, you know, for giving us an opportunity to speak today, and I'm really looking forward to continuing to partner with you. I know I've met some of you face-to-face, and some I've met via phone. I plan on getting out there, so thank you.

With that, I'm now going to hand it off to our chief medical officer, Dr. Chirag Patel to discuss quality.

DR. PATEL: Good morning, everyone. I wanted to talk to you guys a little about our quality team and its performance and then talk to you guys about what we're doing around opioid stewardship.

A little bit of background about our quality team. Fifty dedicated staff members identifying care gaps, social determinants of health needs, and other wraparound service needs. We do direct member outreach,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

encourage members to see their PCPs, get the screenings that they need, and appropriately fill their medications.

What I would like to call out, most importantly, is our quality practice advisors reside in the geographic regions they serve. We think that this is imperatively important because it gives us a broad range across Kentucky to serve as a citizen but also deepens our relationships with the providers in that particular region. We're able to meet the members where they're at which we find to be important as well.

We serve members and educate providers around healthcare quality, but we also educate the providers on resources available in the community. Our QPAs are well-versed in what's available, not just from a medical need but from a community-based CHANA need as well.

Each QPA is responsible for two to four HEDIS measures which they've become proficiently experts at and then to design, track, and implement interventions, helping the providers meet those particular HEDIS

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

measures.

In 2022, some initiatives included 11 physical health screenings which we're all pretty familiar with. And then we did have an increased emphasis around behavioral health services, knowing that the pandemic really did uncover a lot of undiagnosed or undertreated behavioral health disease, particularly in the Midwest and Kentucky.

Next slide, please. So really excited to share this information with you guys. As you look across '19, '20, and '21, you will see consistent improvement, particularly in our behavioral health HEDIS measures.

Antidepression medication management, metabolic monitoring for children and adolescents on antipsychotic medication which can be challenging to do, risk of continued opioid abuse. And then subsequently, all the follow-up metrics, particularly follow-up after emergency department visit for alcohol and drug abuse, which is the last one. You'll see consistent improvement.

I credit not just our quality team and our behavioral health team but really the



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

partnership with the Department of Health Services along with the providers in the community who have been leaning into this work even when that's not their subject matter expertise or the easiest work to do. And it's a testament to their effort and emphasis, particularly through the pandemic in '19 and '20.

Next slide, please. You'll see that same sustained improvement on this slide. Follow-up after hospitalization for mental illness also trending up, follow-up after high-intensity care for substance use disorder.

And then, particularly, the one I'd like to call out is the second to last bar graph. Adherence to antipsychotic medications for individuals with schizophrenia also trending up.

What I'd like to call out, in recap of both of these slides, is the providers across the state have really opened up access to manage these patients clinically and pharmaceutically, really ensuring that they had follow-up for face-to-face; ensured that

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

they had appropriate prescriptions filled at 30, 60, and at 90-day; and then also did the appropriate concomitant medical management of their diabetes and metabolic disorders for medications that they're on, which I thought was tremendous show of effort on their part over the last three years.

Next slide, please. What I would like to say is, in this key performance, we did see that the child immunizations did go down through the pandemic, a variety of reasons for that. But the well child visits did go up.

And so, you know, lot of different hypotheses around this, some around vaccine hesitancy, particularly in this age group. But did see a positive response in getting these newborns and these younger members to their primary care physicians. I attribute this to improving healthcare literacy around maternal health which has been a tremendous effort, not just on our part, but many other community partners' part as well.

And so lots to still unpack, journey to go on, particularly along vaccine hesitancy.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

And we continue to look for new partnerships in that realm.

I'll hand it back over to our CEO, Corey, to go to the next slide's part.

MR. EWING: All right. One of the things that, you know, we were really taking a hard look at and were asked to look at is ER utilization. And it's easy to look at the raw numbers and see what's going on in the ERs and with primary care visits.

But we wanted to take a hard look at -- and, you know, have we really been impactful in changing the behavior patterns and keeping folks out of the ER that shouldn't be there. So we actually pulled the data.

Nobody really talks about churn. We know it all happens. We don't talk about member churn within Medicaid. And if you look since 2011, we've had over a million members pass through our hands.

So we decided to take a look back to 2016, so the last six years. And we had 152,000 members that have been with us consistently over that time frame. And what is amazing to see is it's actually, you know,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

what we're here to help do. Decrease unnecessary ER utilization is happening.

So it's going down, and in the corresponding results to that, we're seeing the PCP visits go up as well. So exactly what we hoped would do. We're seeing it happen with those members that we have had for long-term.

So it's going to interesting to see as we continue to monitor that and keep those patients under our purview. Can we continue that trend? I certainly think so.

But it's an interesting -- definitely an interesting trend line to look at. We all saw a little bit of bump with COVID, you know, a little change there. But other than that, the trend line continues to drop.

So with that, I really want to let us focus a fair amount of time on social determinants of health because that's really how we feel we can impact our members and ultimately their health. And I'm going to pass it to Darren to walk through some of the efforts we're doing in that part, so thanks.

MR. LEVITZ: Good afternoon,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

everybody. Thank you for giving me this opportunity to speak on something that we and -- my team are truly passionate about. And that is what happens to the patient outside of the doctor's office and how dramatically that affects their health and well-being.

One thing I hope to impress upon you over these next couple of slides is there's an old marketing saying that if you can't measure it, then it ain't real. And we don't go on hunches. We let the numbers guide our way. And that's something that our team follows every day.

Our members call us through our Community Connections Help Line many times, seven days a week. And when they're calling us, they're not calling us because of something that might happen a month, a week, or even in a couple of days. Their world is usually on fire, and we need to be able to address that.

And we know when they're calling us and they're telling us that, you know, we're not going to make rent, or my utilities are going

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

to be turned off today, that that's likely not the only situation that they're facing. So we take the time to speak with them, give a needs assessment, and find out what other needs that they may be in need of assistance for at that same time.

And you see these numbers here that, in a typical year, we have over 17,000 members that call in through our Community Connections Help Line. And in return, they're receiving nearly 42,000 social service referrals.

That's something else that I'm very proud of this team. We maintain our own database. We do not utilize publicly-available sources. We go out there and have literally hundreds of thousands of federal, state, and community resources that we're continually maintaining and adding to that, to make sure that we address those urgent needs.

As I said, you know, when they're calling us, their world is on fire. Literally, 99 percent of those members are provided with resources on the spot. For

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that remaining small one percent, we used to have a best practice that we would get back to them in 48 hours. We have now narrowed that down to four hours average to respond back to them -- to that one person with a resource that they can use.

So we understand their immediacy. We understand their need. We try to address those as quickly as possible.

Slide. So, you know, it's great that we do these programs, as all of us do. But, you know, what's the outcome? Again, you know, I'm sure I could sit around this room and say: Should we do a food and security program and address food access? And we'd all nod our heads, and I know that's true because I've sat in those meetings. But that might not necessarily be the greatest need. Or what is the outcome if we did that?

Well, we've measured that, and we can quantify those results, making sure that our time, our dollars, and our attention to members are being spent in the most efficient way possible.

Give you a couple of quick key metrics

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

here. People that utilize our social determinant programs, they're five and a half times more likely to do their annual PCP visit. They're 1.4 times more likely to reduce their blood sugar, and they're 1.7 more likely to improve their overall functional status.

And I think we cannot state enough how important it is to go through and quantify those programs and not just say, well, it was nice that we did that. But what is truly the impact that we're doing, and how are we seeing their health and well-being benefited because of these programs.

Another thing that our team does is making sure that we go to meet with community-based organizations throughout the state. I'm not going to read through every one of those line items, but it's suffice it to say that we attend thousands of meetings, meeting tens of thousands of people, and making sure that throughout the state, you know, there's great, disparate needs from eastern to western Kentucky, from rural to metropolitan communities.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

And we want to make sure that we're hearing, what are those needs in those counties, in those neighborhoods, down to that street level, and making sure that we're addressing those needs and maintaining that database so that we can respond to our members in the most efficient way possible.

So a couple of quick examples of some of the benefits that we've derived from attending those community meetings. For example, Fresh Rx for Moms is a program, that we heard that pregnant women and new moms were finding that they didn't have the nutrition that was needed. So we created a program where, every week, we either handed off or shipped to them boxes of fresh produce.

We had another meeting with La Casita center and found out that the Hispanic community was lacking in health screenings, so we set up many events with them where we could provide that service.

We talked to Councilwoman Dorsey and found out that the minority -- minorities in her district were not having access in time

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

to the COVID vaccine. So we made sure that we set up with a faith-based organization in her district to make sure that that health equity was provided to her members, giving them the vaccine access that all of us deserve.

As I said earlier, we really let the numbers drive our approach, and these are two quick maps that you can eyeball and see, you know, where are the greatest health factors within our state. Where are the outcomes that are needed that we need to address the most, and we target our efforts after that.

This is something that has really shifted our approach, and I'm extremely proud of our response to this. As I said, the needs throughout the state -- I've lived here for over 50 years -- are very different. We all know that. Going community to community, we see that.

But what are those needs? You know, earlier when I referenced, if I said let's do a food access program, everybody would probably nod their head. But is that really the greatest need in every county throughout

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

the state?

So what we've done through publicly-available and propriety data is go through and map out all 120 counties throughout the state and find out what the greatest needs are for those individual residents.

For example, in Fulton County, you found out that their greatest need was housing, so we work with our community engagement team to provide them community-based organizations such as Fulton Housing Authority and provide grants to them to make sure that funding is going to their greatest need. And then we track that funding to make sure that our members are improving their health.

Crime and violence is another social determinant that is greatly affecting Fulton County, so we work with the Merryman House there and, again, provide funding for domestic violence assistance. Again, addressing those specific needs that are the greatest for those communities.

And we address those across all 120 counties, making sure that we are providing

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

funding to those greatest needs, measuring the impact, and then continuing where the programs can provide the greatest assistance to the residents throughout the state.

I do have a couple of quick examples of that. We work with Kentucky Homeplace who is a wonderful partner, and they provide a lot of help with people that have chronic conditions. And as you see here, in demonstrative terms, we can articulate that through our SDoH programs with Kentucky Homeplace, we've reduced ER visits 16.4 percent for members with diabetes. We've reduced the reduction in inpatient admissions by almost 29 percent, and over 30-percent reduction in inpatient days.

I won't read through each one of these, but in true quantifiable terms, we're seeing that there's a positive impact through our social determinant program.

Another fantastic partner that we're fortunate to work with is Hotel Inc. And we've worked with them to provide things to student security and job training and job placement. And we're seeing that by

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

providing and working with them, that there's a 10-percent reduction in ER visits and an 18-percent reduction in flu-related visits. So these programs are indeed working.

I do have one more example that I'll show you. Rural Transportation (sic) Enterprises Coordinated. Transportation is a great need, especially in our rural communities. Talk about health equity. You know, simply not being able to get to the resources that they need is so important.

You know, all Medicaid plans throughout the state provide medications at no cost to our members, but they don't do any good sitting on a shelf at the pharmacy if they can't get it. So we are providing 130 members almost 900 trips at no cost to them.

You know, we're seeing a 66-percent reduction in hypertension, 48-percent reduction in asthma, 32-percent reduction in diabetes needs, and a 40-percent reduction in obesity. These are profound numbers that are greatly impacting, you know, in a positive way our members' health and well-being.

Moving on. I want to talk about some of

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

our value-added services. You know, 2021 was an interesting year as we emerged from year one of the pandemic, and we really took that into account as we looked and said, what type of value-added services do we need.

And we talked to our members. We talked to our community-based organizations. We talked to providers and said, you know, let's develop a program that's going to benefit them the most as we were hoping to emerge from the COVID pandemic.

I'll highlight a couple of programs that were geared specifically to that. This year, we offer, not just for members but for their entire families, even if they're not WellCare members, a YMCA membership. That is to get them reengaged in the social component as well as their physical health.

We saw that a number of students throughout the state were falling behind in their education due to the pandemic. We also know that in rural areas, they simply lack access to Internet. Internet is no longer a luxury. It's a utility that we all need.

So we've provided within rural counties

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

throughout the state free Internet hot spots and free Internet throughout the year to help them be able to continue their education the same way that their peers are.

And in addition, to help people catch up with schools, we started a tutoring program this year that gave 12 one-hour either in-person or virtual, tutoring sessions to make sure that these students are on par and where they need to be with their education.

One other program I want to talk about -- I'll share a really quick story. I came to our senior leadership team, and I said, I've got a program that's going to cost us about a quarter million dollars, and we're probably not going to gain a single member. And they all laughed. They're like, yeah, let's do that.

But what this program was was providing a state-based ID card. This is an idea that we had with a community-based organization that we're actually going to be honoring at our upcoming Community Health Champions.

But you think: What does an ID card have to do with your health? Well, without a

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

state-issued ID, you can't rent a home. You can't get a checking account. You can't get a loan. You can't get a job. And this is something that we can very easily provide to our members.

And we are having great success with a lot of the homeless shelters that we're working with in providing these people with an ID that is allowing them to hopefully become more self-sufficient and, you know, eventually no longer be reliant on Medicaid services. It's a simple item, but it's something that is greatly needed.

So we really took into account a lot of different factors as we built our value-added program, something we invested over ten million dollars in this year. But we're seeing really wonderful results, again, measurable results on how they're benefitting our members, our communities at large.

MR. EWING: All right. That's what we had today. The rest of our presentation, it will be -- you know, we will be posting it on the website as well. And with that, if you guys have anything for us. We certainly



1 appreciate the opportunity to present today.

2 CHAIRMAN PARTIN: Thank you. I  
3 have one question. On your presentation and  
4 the previous one was listed free sports  
5 physicals. The participants in WellCare, or  
6 any of the MCOs, don't pay for any of their  
7 visits, that their visits are paid for by the  
8 MCO. So how does that work, or what does  
9 that mean, a free sports physical?

10 MR. LEVITZ: What is required --  
11 for example, like if you want to play high  
12 school sports, they will require that there's  
13 a form that must be filled out. So there's a  
14 well visit to the physician that must be  
15 completed that will allow them to participate  
16 in high school athletics. And that's  
17 usually, like, a 50-dollar visit if it were  
18 out of pocket.

19 And speaking only on behalf of WellCare,  
20 we will cover that cost. So that once a  
21 year, people can go and get that form  
22 completed so that they're allowed to  
23 participate in either school or  
24 extracurricular athletics.

25 CHAIRMAN PARTIN: Okay. I guess I

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

was just a little confused. Because in my practice, we -- when we do the sports physical, we just use that as their annual wellness visit. And so -- and then we fill out the form for the sports physical and then they can use that for anything else that they need.

MR. LEVITZ: Which certainly could be the place. But let's assume the scenario that someone came in in February for their annual checkup. But then in fall, they're getting ready to play soccer or baseball or football, and they need that sports physical completed. But it wasn't done in February because they didn't even know they were going to play in that sport at the time.

You know, I'd hate for someone -- you know, a female member to miss out on field hockey because she's already had her annual visit. This allows her to go and get that sports physical completed but doesn't count against, like, her annual checkup.

CHAIRMAN PARTIN: Okay. That makes sense. So how do we code that, then, if that's the case?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MR. LEVITZ: I'll have to get back with you on that CPT code. That's not on the top of the head. But we can certainly provide that to you.

CHAIRMAN PARTIN: Okay. Thank you. Thanks for the explanation.

MR. LEVITZ: Certainly.

CHAIRMAN PARTIN: Anybody else have any suggestions?

DR. BOBROWSKI: I've got a question. This is Dr. Bobrowski. I notice you have a 300-dollar allowance for health items delivered to their home. What is the usual request on those items?

MR. LEVITZ: That's a wonderful question. So I'll give you a little bit of a history on that. That is, by far and away, our most utilized value-added benefit. Historically, we used to say it was anything that you could find in, like, a Walgreens or a CVS.

Once the State last year moved to the single PBM, they requested that all those items such as, like, an Advil or a Claritin be fulfilled through that. So we adjusted,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

because it's such a popular benefit, to provide what we are now calling health and wellness items. That can include anything from band-aids, sunscreens, adult diapers, you know, baby wipes. Anything that is not medicinal in nature but could still be found at your average drugstore are on there.

It is a very thick booklet. I'm happy to mail you -- we actually just got approved our 2023 health and wellness visit -- our health and wellness catalog. And I'd be happy to send that to you, so you can get a feel of the breath and depth of items that they -- they can even get laundry detergent out of it.

So our members absolutely take great pleasure every month in having those items shipped to their home. And that was especially popular during the pandemic when a lot of people were reticent to go in the stores, to be able to have that shipped. And that shipping cost is not included in the purchase power that we give them each month.

DR. BOBROWSKI: Okay. Thank you.

MR. LEVITZ: You bet.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

CHAIRMAN PARTIN: Thank you. And would you send that information, that list, and also the CPT code for the sports physical to Erin? Then she can send that to us.

MR. EWING: Yes, ma'am.

MR. LEVITZ: Absolutely.

CHAIRMAN PARTIN: Any other questions?

(No response.)

CHAIRMAN PARTIN: Okay. Well, thank you very much.

MR. EWING: Absolutely. Thank you.

CHAIRMAN PARTIN: Okay. Moving on to new business. Erin, have we had any more MAC members join the meeting?

MS. BICKERS: We had two, and that puts us at nine. But we're still short for a quorum.

MS. HANNA: Yeah. I'm here. This is Cathy Hanna. Still short?

CHAIRMAN PARTIN: Are we still short, Erin?

MS. BICKERS: Oh, yes, ma'am. I'm sorry.

CHAIRMAN PARTIN: Okay. Well, then

1 we -- fortunately, we didn't really have any  
2 recommendations from the TACs, so there's  
3 that that we don't have to delay voting on.  
4 But we cannot elect our secretary. We do  
5 have one person who self-nominated.  
6 Mackenzie Wallace. And since she's the only  
7 one, I expect at our next meeting, unless  
8 somebody else self-nominates, we'll have a  
9 quorum, and we'll be able to do that  
10 election.

11 The other bit of news is that we have  
12 the meeting dates -- it's a little bit  
13 earlier than usual for meeting dates for next  
14 year. But I wanted to get those out since  
15 Erin already sent those out to me.

16 So January 26th, March 23rd, May 25th,  
17 July 27th, September 28th, and those are all  
18 typical for what we've done in the past. The  
19 only thing that is varying from the past is  
20 the November meeting is November 30th, which  
21 would be after Thanksgiving instead of before  
22 Thanksgiving.

23 Traditionally, our November meeting is  
24 the week before Thanksgiving, so this will be  
25 after Thanksgiving on November 30th.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Does anybody else have any new business that they would like to bring forward?

(No response.)

CHAIRMAN PARTIN: Okay. Well, we can't vote to adjourn, but we've conducted all of our business. And if nobody has any further questions or comments, we will go ahead and adjourn the meeting.

(Meeting adjourned at 11:55 a.m.)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

\* \* \* \* \*

C E R T I F I C A T E

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 28th day of September, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR