CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
CHILDREN'S HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
July 13, 2022
Commencing at 2:00 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Mahak Kalra, Chair

Cherie Dimar

Pat Glass (not present)

Donna Grigsby, MD

Michael Flynn (not present)

Kailyn Nalley (not present)

Darlene Oxendine (not present)

Beth Savchick (not present)

Courtney Smith, PhD

Beverly Largent, DMD (not present)

MS. BICKERS: I counted three board members unless I missed someone.

MS. KALRA: Let me just double-check. I know, like I said, Dr. Grigsby is going to join in a couple minutes. That might be correct. We do have a number that's a 502 number as well as -- well, there was another phone number, too.

If you guys don't mind putting your name in the chat box, so that way, we know and can recognize the phone numbers. Everyone else has their names listed, so that's easier to tell who you are and who you represent.

So with that being said, welcome to our July meeting. We'll skip quorum, establishing a quorum, knowing that we're waiting on Dr. Grigsby, and we'll wait on a couple others to join in the meantime.

And, also, we'll skip the approval of minutes, and we can kind of just go into the old business that we have.

As a heads-up, I will be hopping off at 3:00, but Dr. Grigsby, who's the vice chair, is happy to take over. I have a scheduling conflict.

So with that being said, I know the last couple times we've met, we've talked about receiving data and especially when it's data around COVID vaccines as well as the impact of COVID on dental visits and dental care.

So with that being said, we sent a list of really data points that we want by age, race, and region as well as other data markers for you all to share. I know that was a point of concern last time.

My only request is if we could get that -- those presentations prior to the meeting, I think that would be helpful for our TAC members. So that way, we could analyze the data and see what you're presenting ahead of time. So that way, we can come prepared with questions. So that is just my only note so we're using this time efficiently and effectively.

So with that being said, I think we should go ahead and get started. Erin, I don't know if you have a method to the madness of who we want to present first.

MS. BICKERS: I usually just start calling out an MCO. I usually go in

alphabetical order, or I go backwards. But I'm just going to go random today and see how it goes.

So is Passport with us, Passport by Molina? I'm sorry.

MS. BEAL: I would have responded to Passport. I just couldn't get off mute. Yep. I'm here.

MS. BICKERS: If you'd like to go first.

MS. BEAL: Sure. And I assume that you want me to share screen? That was the intent of making me a co-host; is that correct?

MS. BICKERS: Yes, please. Not everyone sends me their presentations ahead of time, so I try to let you guys do your own presenting.

MS. BEAL: No problem. Hold on one second. All right. Before I switch into slideshow, can you guys see that?

MS. KALRA: Yep. You're good.

MS. BEAL: Okay. And then I'll switch to the slideshow, and I'll ask for confirmation one more time. Can you still

see that?

MS. KALRA: Yep. You're good.

MS. BEAL: Thanks, Mahak.

All right. So we also have already sent this in, so I know Erin has already got a copy of our presentation. And she, I assume, will be posting that on the website and sharing with the group. But let me go ahead and get started.

I know that you guys wanted information just in general about the COVID-19 vaccination and where we're at with our EPSDT members, some information on oral health, and then current status of well-child exam rates. So I will give you those.

Again, we tend to think in terms of pediatrics and always break our eighteen to twenty years old out because they still are part of our EPSDT population. So I like to include those in my datasets at all times.

This is where we stand currently as of actually July 5th data on our EPSDT member level of vaccination rates. And, of course, it is fairly predictable right now. Those that are the oldest have the highest rate.

Those that are our brand-new vaccination-eligible members, our six-month to four-year-olds, have the lowest rates. And as a health plan as a whole, we're at around 46 percent, so we still need to catch up some of our younger members to that 46-percent range.

Any questions about the data, Mahak?

MS. KALRA: I was just going to mention -- I know we asked by race and region.

MS. BEAL: I have that coming up.

MS. KALRA: Okay. Sounds good. Thanks.

MS. BEAL: It was going to get really busy if I tried to cram everything into every slide, so there you go. So here's our trends by region, by race, and by gender. And this is comparing the population as a whole within each of those to itself so that we could really get -- we really like to kind of zone in on where we may have some disparities within the population, specifically not across the population as a whole if that makes sense.

And the data, of course, is always interesting when we do it that way, and we know that some of these numbers that you're going to look at, on the right in particular, where we have really high rates of vaccination with specific race and ethnicities is probably due to the fact that we have incredibly low numbers for that population as a whole. So grabbing a handful means we've grabbed most of those members and gotten them vaccinated, or they've chosen to get vaccinated themselves.

Any questions about this data map?

MS. KALRA: Can you remind us the region breakdown? Is there a map that we could see? So that way, we could say, oh, that is northern Kentucky area, or whatever the location is.

MS. BEAL: I will confess I don't have a map handy at this exact moment that I could flash on the screen, and I apologize for that. And next time we report out, I will report it out on a map. Does that help?

MS. KALRA: I think that would be helpful. I don't know if the other TAC

members agree. But Dr. Smith or Cherie, if you think that makes sense to have it on a map.

DR. SMITH: Sure. Sounds cool.

MS. DIMAR: It does. I don't know what the regions are, where they are.

MS. BEAL: That's okay. I'll make sure that we do that. And if it would help, I can update the slide and re-send it to Erin. Would that be of value to you guys as you start noodling through the data in the lingering weeks of the month?

MS. KALRA: Definitely.

MS. BEAL: Okay.

MS. PARKER: I have a map that I can share. This is Angie with Medicaid.

MS. KALRA: Oh, great. Do you have one that you could just link in the chat?

MS. PARKER: Maybe. I will see what I can find and see if I can put it in the chat. If not, I'll have Erin send it to everyone.

MS. KALRA: Okay.

MS. PARKER: But I can tell you that Region 1 and 2 is western Kentucky.

Region 3 is Louisville area. Region 4 is northern Kentucky. Region 5 is Fayette County and surrounding central Kentucky. I can't -- well, maybe 6 is northern Kentucky. So I -- 7 and 8 is eastern Kentucky.

DR. THERIOT: Yeah. Because eight is Prestonsburg area. I know that one.

MS. PARKER: Thanks, Dr. Theriot.

DR. THERIOT: I don't know why I know it.

MS. KALRA: All right. Jessica, do you want to continue?

MS. BEAL: I will happily continue for you. Everybody knows that Passport is dominant in Region 3, so you can see that our percentage is higher there. But that's also a good thing because we have the bulk of our EPSDT members in that region.

So we would want to be higher because that means that a larger actual number of our members are vaccinated when we are higher in Region 3 as a whole. But you can see that some of them were rural areas, as is the case with the adult population lagged behind as well.

You asked a little bit about maternity members. And the easiest, best way for us to pull that was looking at currently pregnant members. So you can see that our vaccination rate for currently expecting mothers within the health plan is around 38 percent.

We do work to try to drive this number up through our -- we have two care management programs dedicated to maternity members. And, of course, they're always stressing the importance of COVID-19 vaccinations for ensuring healthy mom and baby outcomes.

And we keep our -- we have over the last -- oh, gosh. We're over a year now; right? For the last over a year, we keep our staff up to date on all the latest recommendations so that they're constantly changing and matching their messaging to CDC, FDA, and ACOG regarding safety and efficacy for the pregnant population as part of their motivational interviewing datasets.

Any questions?

(No response.)

MS. BEAL: Okay. You asked for a little bit of information on efforts and

challenges. Of course, like all the other MCOs, we have incentives that we offer, and I apologize for not sharing a slide on what those are at the moment.

But we are in the process of updating them to add in our six-month-old to four-year-old population, and we don't actually have those DMS-approved published yet. They will be next week. But we are, of course, adding incentives to include those newest members.

In 2021, when the vaccines first dropped, we did a really rigorous call campaign to all eligible members ages twelve and up. And, of course, all of our member-facing staff were provided in 2021 the same type of information that we gave our high-risk OB and our Supporting Healthy Moms and Babies program, CM staff around vaccine hesitancy with ongoing updates to data information as it was made available so that they could do their best to help persuade members to make healthy choices for themselves.

We did targeted mailings. We continue

to do targeted mailings to members, pulling down data around who still needs vaccinations. Of course, social media messaging, and we always tailor that to the latest information around boosters or the latest update to populations that can get vaccinated. And then, of course, the care management team as a whole is always addressing COVID-19 vaccination care gaps with engaged members.

I -- this is the most PC way that I could think to explain the challenges in the commonwealth, is just to say it's an uphill climb in Kentucky as a whole. I think we all acknowledge that Kentucky is well behind the curve when it comes to the comfort level that our citizens have with getting vaccinated or their desire to get vaccinated.

And, of course, that trickles down to the Medicaid population which is always behind as well. So that further impedes the population as a whole. We do know that parental vaccine hesitancy has been, of course, an issue for our five to seventeen-year-olds and is, again, going to

be an issue for our six-month to four-year-olds.

And so we tailor messaging to try to address that as best we can with keeping our finger on the same pulse that everyone else does, knowing that the prognosticators are saying that, you know, about 15-percent uptake is what we're looking at initially, and it'll kind of titrate down from there.

So we are very well aware of the challenge for any parent making a very hard decision about things that they don't always understand well, and so we try to give them as much information in the simplest way possible to help improve their desire to pursue more information, directing them predominantly back to their child's providers because we know they are the most trusted source of information for caregivers and parents.

And then the other thing we started noodling through is the possible need for more education on vaccination after a COVID-19 infection because the rates have been so high in the commonwealth. They were

high last fall. They were high again in the winter. They are high again now.

And we are starting to wonder if possibly there's just kind of that more lackadaisical attitude around, well, my kids probably already had it, or my family already had it. So we're not going to bother with vaccination now.

So we're just now starting to try to think through how we might be able to map that data a little bit and start tailoring some other outreach around reminders about getting vaccinated even after you have tested positive or you suspect you've had COVID.

You asked for information about oral health data pre- and post-pandemic. Unfortunately, even though you guys know me from Passport Legacy days, we are technically a new health plan, and our datasets pre-COVID are a little challenging to pull.

So we got creative, and we looked at our CMS-416 datasets which we roll up their federal fiscal year dataset on our EPSDT population that we send to the state every single year. And we were able to look back

at that data to give you just a small sense of where, kind of, our dental service rates were before the pandemic and after.

And 2019 is a really good capture of before for us because, again, it represents a federal fiscal year. And you can see that, obviously, there was a decline as 2020 progressed and into 2021 when things were at their, you know, worst in 2021 with lockdowns, et cetera, and people still trying to figure out where they were at and where they were headed.

We do know that oral health services for pediatric members tend to be a challenge in the commonwealth as a whole regardless of pandemics or otherwise. So, again, I apologize. We can't give you more drilled-down, specific data, but we hope that this gives you a small sense of what we have -- what we are able to see in terms of trends pre and post -- or pre, during, and eventually moving into post.

Any questions about that?

DR. GRIGSBY: This is very helpful and very disturbing all at the same time.

MS. BEAL: I know. That's why we're all here together; right? To try to problem-solve some of this.

DR. GRIGSBY: Yes. I feel like this sort of -- and I apologize. This is Donna. I was a little late to the meeting. This, I think, lends itself for us to understand why early childhood, you know, carries are such an issue in our patient population, in our children.

MS. BEAL: Absolutely. And so I'm giving you my EPSDT dashboard I built specifically to capture fluoride varnish because I think that that's really important. And we know that the guidance was updated and pushed pretty hard out to PCPs in December of this past year, and so we're starting to track that and try to improve those rates, both for getting our kiddos in with oral health providers but also PCP supplying fluoride varnish.

And I thought you guys might want to see -- again, we don't have this data tracking and trending prior to COVID, but this is where we are year-to-date for

fluoride varnish. You can see, of course, this kind of having been applied to the age ranges that we would most expect according to USPSTF guidelines; right? So looking at our five and under, we're seeing a decent volume for the first half of the year, but we would love to see that be a little bit higher.

Interestingly enough, in spite of USPSTF guidelines being up through age five; right, we still see our six to nine-year-olds and our ten and fourteen-year-olds getting some of that additional layering of prevention with fluoride varnish, tapering off as they turn into what most people consider adults but I still think of as kids at eighteen, nineteen, and twenty.

Any questions? This is something that we're working on with some campaigning and education pretty hard this year for our members, both directed towards our members and directed towards providers.

(No response.)

Okay. And then here is year-to-date for preventive physical health visits for our EPSDT members. I will just note that, again,

this kind of matches HEDIS and follows our datasets that we turn in for CMS-416s. But -- so this doesn't break down my W30 kiddos; right, in terms of how many have had one, two, three, four, five, six, seven, et cetera.

But you can see that, of course, the -- as is always the case, the majority of our children under the age of one have had at least one visit because they should have had multiples in that year, and the same goes for our one to two-year-olds. Because, again, there's multiples.

And it starts to taper off, like it always does, as we move into adolescents and the teen years with a nice, steady hit in that ten to fourteen range because those ten and eleven-year-old well-child checks to get into middle school, always bumps us up.

Any questions about year-to-date for preventive physical health exams for our EPSDT members or any additional information you would like to see next time around if we are asked to present again?

DR. THERIOT: Do you know what

percent are hitting that zero to fifteen months and getting all of their recommended visits in that time?

MS. BEAL: I can -- when I stop sharing the screen, Dr. Theriot, I will pull up our dashboard and see if I can pull that information down and pop it into the chat for you. If I can't, I will ask our quality team to pull the data and get it back to you.

DR. THERIOT: Thank you. Because this is just worrisome to me that they have one visit -- 84 percent have one visit, and there's -- or more. But it should be 100 percent have -- at least have one visit, and so that's -- you know, it's just a little worrisome.

MS. BEAL: Right. Especially since we tend to count that in-hospital first visit as a visit. I know. I know. And we have some lovely dashboarding that helps us drill down on our providers and start to give them some feedback around their membership and our concerns for their membership so...

DR. THERIOT: Thank you.

MS. BEAL: You're welcome. And I

think that's my last slide other than -- so that you all have my contact information if you ever need to reach me.

MS. KALRA: Any questions for Jessica?

(No response.)

MS. KALRA: I don't see any, but, Jessica, this was really helpful and exactly what we wanted and needed so thank you for delivering. I know we had a long conversation with all the MCOs last time we met on what we're looking for.

Again, I would just stress, hopefully, we can get this data sooner before -- prior to our meeting. So that way, we have enough time to analyze and start having that conversation.

MS. BEAL: Now, how far in advance would it be helpful for your team? And the reason I ask is I know that we were told that the agenda would be, for sure, posted at least ten days prior to the meeting. That still doesn't give us a ton of time to do the dive and pull the information together.

But what would be the most helpful for

the TAC so that we're thinking that through on our end? It does take us a while to pull data and vet it, of course, but...

MS. KALRA: Certainly. And I know that when we met last time, we spoke about immediately having a draft of the agenda already prepared by the end of the call. So that way, us, as a TAC team, kind of gets together, walks through exactly what we want for the next meeting. So that way, you all have at least a quarter to be ready and presenting. So I would say a week in advance would be plenty of time.

MS. BEAL: Awesome. Okay.

MS. KALRA: But it would be ideal to have that. And our goal is to hopefully have the agenda squared away, like I said, by the end of today. So that way, you guys have plenty of time.

And that's what we did this last time, this last meeting. We actually drafted the agenda and shared that with Erin immediately after the call. So that way, that could be shared out. I don't know, like, DMS' process to communicate --

MS. BEAL: No, no. That's --

MS. KALRA: -- with you, but I know on our end, we tried to at least communicate.

MS. BEAL: That's helpful. We will look for it posted, then, sooner than the ten days prior, which is what we had been informed. So we didn't -- admittedly, we didn't look, and I was afraid to take my own notes as gospel for what you wanted. Thanks.

MS. KALRA: You're totally fine. And that obviously is not directed just to Passport but to all the MCOs. So with that being said and it doesn't sound like any other questions, I think we could go on to our next MCO. Erin, do you want to call out the next one?

MS. BICKERS: How about Anthem?

MR. COX: Sure thing. This is Stuart Cox with Anthem, and let me make sure my sharing is working. Please confirm when my screen is shared, please.

MS. KALRA: We can see it, Stuart.

MR. COX: Okay. Very good. So my name is Stuart Cox. I am the director of Clinical Quality Programs with the Anthem

Medicaid program here for Kentucky. And I have also with me Amanda Stamper, our director leading our Anthem elevate population health vaccination domain team.

So I'm going to have her speak first and cover off on our COVID vaccination data and then I'll cover the other two components. Amanda.

MS. STAMPER: Thanks, Stuart. And thank you to the TAC for allowing us to present today. This is the COVID dashboard that Anthem puts together, and this is our overall population. We wanted to share this information with you all before we dive down into the younger age groups.

But you can see here that Anthem is sitting at about 35.8 percent of our overall membership vaccinated. And quickly looking at this, you can see the vaccination by age group all the way up from, you know, adolescents to adults.

The regions and the counties there, the vaccination rate by county, the top ten counties that are -- that have the highest vaccination rate and the bottom ten counties

that have the lowest vaccination rate and then the actual vaccination that each of the members received, and then the race is also listed there and the gender. But like I said, this is for our overall Medicaid population.

And, Stuart, if we could go to the next slide. So talking about members ages five to seventeen -- and this information is accurate as of June 27th of this year -- we're sitting at about 13.41 percent of our eligible members who have been vaccinated in that age range. And you can see there's clearly a significant decline in the vaccination rate as our members -- as they go down in age.

You know, we have done some research on this, and we'll talk about that a little bit on the next slide on some of the things that we have learned and some of the things that we have done to help combat that. And then you can also see here to the right the regions and the vaccination rates by regions.

Any questions on this slide before we move to the next one?

DR. GRIGSBY: I apologize if you've

said this, but does that include the flu vaccine as part of that data so that --

MS. STAMPER: No. These are strictly COVID vaccinations, yes.

DR. GRIGSBY: Oh, I'm sorry. You're right.

MS. STAMPER: Thank you for that question.

So here, you can see it's about the same, female to male, in the vaccination rate. And by race, it does vary significantly among some races versus others.

So what we have, as well as Passport, we have a member incentive. We have 100-dollar member incentive for anybody who receives at least one dose of the vaccine. We've done significant outreach to our members via text, via email, via phone calls.

We also have a provider incentive that -- we actually had two different provider incentives, one that we ran last year to help increase the vaccination rate that we paid providers based on the number of members they had originally vaccinated and if they were able to increase that rate by the

end of the year. We paid out a pretty significant -- up to $250 per person vaccinated.

This year, we're continuing to run a provider incentive program that each member that gets back that they vaccinate throughout the entire year, they'll receive $50 per member vaccinated.

So we're running that campaign in conjunction with our member campaign and promotion so that members are receiving information from their provider at the same time that they're receiving information from us on their -- the healthy reward that they can receive. Because we know that having that provider input and recommendation is really a big driver in individuals receiving the vaccination.

We have worked with Foundation For a Healthy Kentucky to do focus groups specifically with parents and their children to figure out, you know, what are the barriers that these parents are facing in getting their children vaccinated. And, overwhelmingly, in the four different focus

groups that we held, the No. 1 thing that we heard was parents want that direct recommendation from their pediatrician about their specific child.

So they don't want to go through the drive-thru vaccination events. They don't want to go to the pharmacy. They really want that one-on-one conversation with their pediatrician.

Some of the other things that we heard were they want the shots also given in the office because they want to ensure that medical record accuracy, that they're worried that if they go to CVS or to Walgreens, or wherever it is, that they're worried that that information will not get back to their pediatrician's office. And so they want to make sure that that vaccination record sits within their pediatrician's office.

Some of the other things that we heard was that during the school year, parents were really hesitant to do the vaccination because a lot of these kids play sports, or they're involved in extracurricular activities. And they were worried that the side effects of

the vaccine would prevent them from being able to participate because they thought they might be sick for a couple of days or that they would have to miss school.

And then what we were hearing from the parents who were a little more hesitant was they believed that it's safer for their child to practice good social distancing and handwashing versus getting the vaccine, that they would rather focus their efforts on preventing through the hygiene versus the vaccination.

We also partnered with the foundation to hold focus groups in partnership with the Health Plan Association to do focus groups along with pregnant women or women who had recently delivered. And similar to what we heard through the focus groups with children was the pregnant women wanted that direct recommendation from their OB. They wanted the OB to look at them and say, look, this is why I think you should get the vaccine and why it's important for you to get it.

But we also found that there's a lack of access to the vaccine inside of OB offices.

So they're usually, like, in the PCP offices, but most OB offices don't have access to the COVID-19 vaccine. So that is definitely a barrier. But that a lot of the women said that if their OB had said yes, I recommend you to get the vaccine and if it had been available that day, they would have gone ahead and gotten the vaccination.

We also learned that it's more than just the mother's decision when they're pregnant, that a lot of times, they rely heavily on their partner, their spouses' feedback as well, too. And so even if the mother was willing to get it, if the husband was reluctant, they would not get the vaccination. So it's a two-party convincing system.

There was also a lot of misinformation on the effects of the vaccine on the placenta and the baby, that most women didn't realize that the vaccination did not actually pass through the placenta, that the baby just got the antibodies from the vaccine.

So when we developed the marketing campaign that went around these focus groups,

we did a lot of education on the myths, busting the myths around the vaccine and pregnancy.

And then some of the other things that we heard were there's just not enough research on pregnant women and the vaccine. So, you know, I'm just not comfortable doing that.

And then they, too, as well, said that they were able -- they felt safer social distancing, really staying at home and not exposing themselves to public places and practicing good hygiene, and they felt like that was a safer choice for them instead of getting the vaccination.

So those are some of the things that we have learned through focus groups that we have done with both parents and pregnant women and women who have recently delivered.

MS. KALRA: Amanda, can I ask a few questions?

MS. STAMPER: Absolutely.

MS. KALRA: So for these focus groups, where did the foundation -- like, who did they reach out to? How did they get

connected to these two different sets of groups and then also what time frame was that? Because I know, obviously, public opinion has shifted --

MS. STAMPER: Yes.

MS. KALRA: -- you know, over time. So just, you know, if you could give me a better understanding of that, that would be helpful.

MS. STAMPER: Yeah. Absolutely. So the focus groups that we did with children, we did that probably late last fall. It was more last fall. School was getting ready to go out. And what we did was we actually launched the marketing campaign that went along with that. We held the focus groups -- I believe it was, like, September or October, and we launched the marketing campaign in December.

Because our goal was -- based on what we had learned, that parents were hesitant because of all these extracurricular activities and missing school, we saw a window of opportunity during that winter break. Because kids were not going to be in

school, and there wasn't going to be extracurricular activity. So we saw that as an opportunity to launch that marketing campaign.

But we worked with -- they identified women -- or I'm sorry, families from all over the state, and we held them virtually. So we had people from eastern Kentucky. We had people from western Kentucky, northern Kentucky, central Kentucky.

And we brought them all together, and we had four different focus groups. And we had both hesitant and parents who had vaccinated their children as part of those focus groups. So they were intermingled. And like I said, the parents were from all over the state with all different views on the vaccination.

For the pregnant women, they actually utilized a marketing company up in northern Kentucky who identified women who were either pregnant or had recently delivered, focusing on women in a certain income bracket.

So we didn't know if they were necessarily on Medicaid or not, but we knew that the income bracket that they fell in,

that they probably were Medicaid recipients. And they also came from all parts of the state as well, too.

They used -- I'm not sure how they identified them. They're a company that they specialize in putting focus groups together. So if we wanted to get more information about that, I'm sure that I could reach out to the foundation, and they could help us with that. But those were also held virtually as well.

MS. KALRA: So if I'm thinking of, like, timeline and thinking of latest timeline from last fall, that was right when or even before the announcement of five to eleven-year-olds?

MS. STAMPER: So -- no. It was -- we rolled that out -- I'm trying to remember. When did five to eleven come out? It was, like, October; right? Five to eleven was in October. So that campaign ran after five to eleven was announced.

And then the -- and I'm sorry I didn't answer this question on the pregnant women. That one actually rolled out in May of this year.

MS. KALRA: Okay.

MS. STAMPER: Yeah. So the five to eleven had rolled out when the campaign for the children had rolled out.

MS. KALRA: Okay. Any other questions?

(No response.)

MS. STAMPER: And one other thing I do want to point out as well is we -- during our text campaign, we have the ability to receive text messages back from individuals who we text, our members specifically.

About 50 percent of the feedback that we have received from members who have not received the vaccination has been pretty volatile, some words that we probably don't want to get into on this call. But there is definitely abrasion amongst individuals who do not plan on getting the vaccination who we continue to outreach to.

And then there's also a handful of parents who aren't necessarily hesitant about getting their child vaccinated, but they're still very hesitant about taking their children into a doctor's office still at this

point. And -- because they're afraid that they're going to expose their child to the -- to COVID specifically.

MR. COX: Amanda, if I could also add, we just had some late-breaking information come in on our member incentives, and we've been steady. It's still in the hundreds of redemptions against those COVID vaccination incentives. And matter of fact, in June, we doubled the number that we had the previous month or so. So we're still seeing members vaccinating and utilizing the member reward.

MS. STAMPER: Great. Thank you, Stuart. And I think, Stuart, that may have been my last slide, so I'm going to pass it back to you. Thank you.

MR. COX: Okay. Thank you. Okay. For our child dental utilization from 2019 to 2021, we're encouraged in that in the first six months of '22, we're showing a good recovery here. Our numbers are on track to exceed, of course, where we've been.

You can see for the dental visits, the fluoride applications and sealants, that we

have been -- there was definitely lower rates '19 and '20, and we've exceeded -- well exceeded those in '21 here.

We do have the ability to get this stratified data, and we can -- we'll provide that to you. We'll go back with our dental leadership team and do that.

But the point is on our -- to where we're tracking so far and in looking with our ADV, our child dental rates as well, that's the same thing. We're seeing encouraging numbers with those appointments starting to come back.

And dental was a big focus for us in both of the last two years. As a matter of fact, as part of our Elevate Population Health Model, we do have a dental domain. We have eight domains that we've -- we're combining our efforts between our HEDIS work groups, these population health teams, and, of course, our PIP workgroups as well. So we have this three-way focus of energy in looking at the area -- the biggest areas of opportunity.

And dental days that we're actually

looking at focusing on how -- bringing our members in for actual remote dental events. We've established those within critical GEO areas in the state, and we're starting to do more of those.

But we're looking at those members who are noncompliant with their dental visits. They're conducted through mobile units that are set within the community church or businesses on Saturday.

We have event texts for dental days that go out. They're sent to the members within those access ranges that we identified. The outreach serves a purpose twofold, a communication for the event and a reminder that the member has not had their annual dental visit at this point.

And for participation in that, the member is provided a 25-dollar gift card, and a Sonic electric toothbrush is given as a value-added benefit as a part of the visit. And, of course, they're also eligible, then, for our healthy rewards dental reward as part of that.

Our Anthem Medicaid has expanded our

codes to the provider reimbursement schedules as well to include oral cancer screening and tobacco education for children and adults as part of that.

Any questions on the dental?

MS. KALRA: Can you talk about your strategies to getting folks back in the chair? I mean, I know you mentioned a couple, like, with your dental days and such. But, I mean, what I'm hearing is you guys feel pretty confident in what the plan is right now.

MR. COX: Yeah. The outbound messaging, really, that's a critical piece to create the awareness as well. And if we can even -- you know, as we work with our provider team, the teams that work with our providers on looking at gaps in care, also mentioning the importance of this piece about tobacco education and dental education in addition to wellness visits. You know, can providers help remind members, hey, you know, dental health is important, too, in addition to your overall WellCare visit health.

In addition, we've actually -- we've

implemented an adult member incentive award in addition to our award for the ADV. So we're hoping to stimulate some further interest and activity there with gift cards that will be -- you know, again, that's not -- ADV is a HEDIS measure, of course, but the adult dental range is not. But we've seen that it's important enough to do that, so we're adding that member incentive as well. Does that help or any other --

MS. KALRA: Yeah. Definitely helps me. I don't know if others have any questions.

MR. COX: I think -- I think as we -- we have an opportunity for continuous improvement as we're doing the messaging. Again, I think all the MCOs will have the same concern about the amount of messaging we do and the possible abrasion and how we structure those.

We're looking carefully at our scripting and how we might optimize that for the future as well as just, again, that messaging to providers overall but how we can make contact through these clinic day events. We think we

can look for specific gaps at opportunity areas and help there.

For our well-child visits, we've actually broken out our HEDIS measures here, our W30, zero to fourteen months; W30 children, fifteen to thirty months; and our well-child visits for those age three to twenty-one.

And this one is a little challenging when we get into the data because we've had retired measures here, our original W15, W34, and then the adolescent well-child visit, WellCare visit. So we're looking at '20 and '21 here.

And we have already started to see some increases in '21, and we're optimistic with these rates we're seeing for '22, that we will -- at least for the W30, I think we're on the right track there. It is a little bit low for our child -- the well child at three to twenty-one. We plan to dig into that more and monitor carefully there.

We do know that -- Amanda mentioned, as we did messaging throughout the last year, that -- regarding the COVID vaccination, that

we did have verbatim replies back to messages from members, sometimes significant numbers, to where there was still concern about taking a well child in for a well visit with the risk of COVID.

So I guess we're in hopes that with the -- if the current COVID rates can continue to fall, that there's more confidence going into the fall. Obviously, the next few -- the next month or so here is critical as children get ready to go back to school. So we're hoping that'll also start to drive that WCV number significantly with preparing for school.

So barriers to well-child visits. Not all providers give vaccinations. Some are small or do not have many Medicaid members, so there may be a financial impact to them for that.

Medicaid fee schedules have not been updated in a long time, creating a possible financial issue for pediatricians providing vaccinations. Some parents have expressed concern about their child getting the vaccination and reluctance to get over those

scheduled appointments.

And the solutions we're working on, working to determine if sports physicals can count as well as a well-child visit, partnering with high-volume providers to consider pilots for increasing well-child visits and vaccination rates. And then we're actually working with our analytics teams on robust gap-in-care reporting, particularly around vaccinations, child vaccinations and the adolescent.

We know that flu and the HPV vaccination are two critical components to -- first, the child vaccination. But for the adolescent, the HPV is critical. And we know that there are concerns with the members in the larger population about that one, and so we're working on messaging. Particularly with providers, can we provide them with tools or messaging support so they can help to explain better the importance of the -- with the IMA (Combo 2) and the HPV vaccination.

Any questions?

DR. THERIOT: Hi. This is Dr. Theriot. I'd just like to throw out that

a well-child visit can be also a sports physical, but the reverse is not true. There's a lot of, like, depression screenings, things like that, that happens at the well-child visit that does not get done at a sports physical. And so they're not equal to each other.

So it is true that, especially, the adolescents will go to a little clinic or go somewhere to get a sports physical, but that is definitely not the same thing as going to your pediatrician to get your well-child visit.

MR. COX: Got it. Thank you for that clarification. Makes sense.

DR. GRIGSBY: Dr. Theriot, though, don't you think that kids who go to their pediatricians for their sports physicals get the same level of care for a sports physical that they do for -- I mean, many -- I don't know. You may have an insight into that -- that go to their PCPs, they're going to get that same level of screening that they would --

DR. THERIOT: I agree. I do. Yes.

You're going to do it all when they come in.

DR. GRIGSBY: Sure.

DR. THERIOT: Whether they think they're getting a sports physical or think they're getting a well-child visit, they're going to end up getting both. But that is not true if they go someplace else. Thank you.

MS. KALRA: So that -- Dr. Theriot, that's only the case if they go to a pediatrician, is what you're --

DR. THERIOT: Correct. To their, you know, their primary doctor that they usually see.

MS. KALRA: Okay. Because I know Eva just put a comment in there that the KHSAA has added the depression screening to the sports physical as well to make it that, like, overarching, encompassing kind of physical.

MR. COX: I think it's important -- we recognize it's important to tie in with these well-child visits, also, as we've talked with our DMS partners about the quality strategy for the next few years, the

WCC measure, the weight, BMI assessment, and counseling for nutrition and physical activity are critical components of that.

So going forward, you know, we see that as an important area to stress and include in consideration with these visits. So that's something -- we're going to be looking at our messaging as well and support for providers on how to make sure that's being executed.

Anything else?

MS. KALRA: Doesn't look like it, Stuart. Thank you so much. Again, this was helpful to have, so I appreciate you all delivering.

MS. BICKERS: Anybody from United on?

MR. RICH: Yes. This is Dr. Adam Rich. I've got a little dental information I can share with you. I regret to say that Dr. Cantor had to be out today, and she has our COVID stuff so -- and well-child information. So we'll have to get that to you at a later date. I apologize. And it kind of came up unexpectedly to me.

So -- but I do have a little information

to share about dental. If I can -- I'll attempt to share my screen. I'm not -- this will be a first, so I could easily do it wrong.

But what I've got -- I mean, obviously, we weren't in the -- UnitedHealthcare hasn't been here long enough to share pre- and post-pandemic data, and I apologize that the format is probably not really what you were looking for. But I just tried to give a little comparison of what last year looked like, January to June, to what this year looked like for our members and -- as far as dental visits go.

And as you can see, we've seen a significant increase in utilization as compared -- for the first six months of last year versus the first six months of this year, and so I'm very encouraged by that.

The other thing that I'd like to point out -- and I apologize. I don't have it in a percentage format, and I'll get that worked back to you at this slide.

But what I'd like to point out is our membership is at 40 -- or about 50 percent of

what it was at last year, too. So we're having a better impact on our members, not just seeing more members, but as our percentage of members would also have increased based on that as well. Because we have less members currently than we did last year as a part of the presumptive eligible population that dropped off last July.

So can I answer any questions in regard to dental? In that regard, does anybody have any --

MS. KALRA: Dr. Rich, do you mind sharing -- since you have seen an increase in visits, you know, are there specific tactics that you all are using as an MCO that would be beneficial for us as TAC members to hear?

DR. RICH: We're just trying to engage our members at every turn. So, you know, whether it's -- whether it's -- I participate in all our member and our medical health rounds. We do maternity rounds. We do behavioral health, our complex care cases, and review. And we try to make dental health right there and oral health comparatively important to overall health and bring that

in.

So every member, we're trying to impact and say: Hey, when was your last dental visit? Do you have any dental issues that you're aware of? Can we get you scheduled to see a provider?

And, also, I think we're constantly -- we continue with mailings. We've got Honest Source that we're trying -- that we're using to send information out to our members. So we're doing emails. We're doing letters. We're doing telephone calls, telephonic (inaudible), and texts to our parents and our members as well. So just trying to engage them.

And also with the -- we're giving -- for those members that we have established with PCPs, we're identifying those members to the PCP to say -- we just started this last month, so I can't say that this impacted this data. But we're trying to get, you know, our PCPs to also encourage or make that connection for the -- to close the gaps for our members and get them in -- get them scheduled with a dentist as well.

MS. KALRA: That's helpful, Dr. Rich. Any other questions?

(No response.)

MS. KALRA: It doesn't sound like it, Dr. Rich, so I think you're off the hook for the moment.

DR. RICH: Awesome. Now, how do I stop this? Oh, and I also meant to turn this on, so you can see I dressed like Stuart today. So we have the same outfit on.

MS. KALRA: You guys called each other before, I'm sure.

DR. RICH: And our hair is the same way and everything.

MS. BICKERS: Do we have anybody from Aetna?

MS. PULLEN: Hey, there. This is Kelly. Let me go ahead and get my screen share going. Can you all see that?

MS. KALRA: We can.

MS. PULLEN: All right. Perfect. I'm going to have Susan Vickers, our director of quality, kick us off.

MS. VICKERS: Good afternoon. Can you hear me okay? Everybody good?

MS. KALRA: We can, Susan.

MS. VICKERS: Great. I'm Susan Vickers, and I'm going to share some of our data with you today. We're grateful to have both our SKY line of business as well as our general line of business. And so we've kind of divided out and conquered some of the data. Therefore, Kelly and I are going to both share with you all, kind of, how we've decided to splice this.

So we, as requested, looked at our COVID vaccinations for our children and adolescents as well as pregnant women. We wanted to look at our dental care and the impact we've seen on those years of COVID-19 over the past three years, and then also sharing some HEDIS rates on well-child visits with you.

So the next slide, Kelly. You can keep on flipping. We'll look at our pregnant members and impacts of COVID-19 first. So overall, we have a total of 3,156 of our members vaccinated who are also pregnant, and we did want to just call out -- I know we're talking about children's health here, and I think it's important to also recognize our

youngest members who are pregnant.

So within the SKY population, we've seen a very, very small percentage of our SKY members age zero -- of course, zero but our younger SKY members under the age of eighteen who are vaccinated, so almost one percent.

And then in the general line of business, those members under eighteen who are pregnant, about four percent of those vaccinated. So I think that's important to call out.

We also wanted to just look at the both positive and negative impacts of COVID that we've seen in our population, and I think it's important to call out the new expansion of coverage for our postpartum members who can now, kind of, preserve that continuity of care 12 months after birth.

We did, I think, as a nation see that that continuous enrollment due to the health -- public health emergency did kind of fill that gap in coverage for postpartum members and then we're grateful that that's been expanded for these members which we hope will yield better health outcomes across the

board.

We have seen a significant impact on maternal mental health. And when we did some drill-downs into disparities among our population, specifically in the prenatal period, we found African-American women in those Regions 3 and 6. We saw a disproportionality of prenatal members with substance use disorder and housing issues that we are working to address with some interventions that you'll see in a second.

And then in that postpartum period, we have identified disproportionate members in Regions 5 and 8. We're seeing that serious mental illness, substance abuse, housing, and then social connectivity and isolation as drivers among those disparities that we've identified.

We did want to call out some of the interventions, as others have. We do a campaign to promote behavior change on self-advocacy for our members. That campaign is multimodal, and it goes to racially -- a racially diverse cohort.

We ensure that our members are receiving

that message. The text appointment scheduling for prenatal visits as well as member incentive for those visits, we hope, will impact as well as our community health workers and our HEDIS outreach coordinators.

We have both remote patient monitoring targeting toward our prenatal and postpartum members as well as a Pyx Health system, which is a platform that addresses isolation, loneliness, promotes mental health screening. And we're doing some targeted outreach to connect our pregnant and postpartum members with that platform for round-the-clock connectivity with people who can support them.

We do our trimester screening and post-delivery outreach among our care managers, and then using a social risk stratification method to really look at engagement and deployment of interventions for pregnant and postpartum members based on those disparities that we mentioned, you know, housing, social connectivity, house literacy, and others.

I'll move on, Kelly, so that you can --

next, we are going to look at our COVID vaccination rates for our general population, ages eighteen and under. About seven percent of our total population has been vaccinated, or 17,250 members age eighteen and under. We looked at our total -- our percent of total vaccination by race, not as others have, each race with a percent vaccinated.

So, again, you know, the majority or percentage of vaccinated are those white, non-Hispanic, followed by black, and then Hispanic. And, again, we all are struggling with data especially in that not provided, unknown, no ethnicity, not applicable data points that we are working to resolve in the files and the data that receive.

Much like others have shared, you know, our membership in population, you know, is concentrated in certain areas of the state, so that has to be accounted for. But looking at vaccination totals by region, in the general population, our most -- our highest percentage of vaccinated are in Region 5 followed by Region 4 and Region 6, I believe, are the second and third highest.

And then you can see the age breakdown among our total vaccinated in our general population. And we really just did twenty-five and under to look at children's health here. But that age twelve to fifteen and twenty-one to twenty-five are those with the highest percentage of totals for age breakdown.

Kelly is now going to do our SKY population real quick.

MS. PULLEN: Thanks, Susan. So Susan already kind of reported out how we pulled that total percentage again. So seeing here, based on how we pulled that data, obviously, our highest percent vaccinated are those that are white, non-Hispanic. In terms of that region breakdown, we're seeing Regions 3, 5, and 4 as those with the highest vaccine rates.

And then down below, you can see that age breakdown. Our highest are going to be those that are ages six to fifteen for the vaccination followed by that sixteen to twenty group.

In this next slide -- and I'll start,

and Susan can certainly jump in to give any context. But before we jump into general, kind of, barriers and trends for children and adolescents, I did want to just call out some specifics for the SKY population. And that really is a barrier that's related to that legal consent process.

We've got a large portion of our SKY population that are committed to out-of-home care. And if rights are not terminated, DCBS has a formal process to obtain parental consent for the COVID-19 vaccination.

It is not as simple as DCBS as the legal guardian just providing that consent for the vaccination. They, and Aetna, too, are really trying to pull in that child's legal parent at the time that they do want to, you know, be vaccinated and obtain their consent.

So that has created a little bit of a barrier because we know with kids in out-of-home care, there may be challenges in reaching those parents and obtaining that consent. So we tend to see with the SKY population in general a lower percentage of our members that are vaccinated in comparison

to our general population.

You can see on the screen here none of this is novel, as our other colleagues have really reported, you know, similar barriers that we're experiencing for our population. But during COVID, obviously, that apprehension with going in to the office to visit a pediatrician has definitely been a barrier as well as those that are experiencing homelessness or those that may live in rural areas, having trouble getting into the office.

We also have seen in our population a higher vaccine hesitancy among our non-Hispanic black parents and those parents that have lower income and parents of children who have that public health insurance.

Just as other folks have said, there's a lot of myths and misinformation out in the community, and that has certainly contributed to that hesitancy as well. But we've noticed that especially in parents that -- who have, you know, access issues, maybe as it pertains to Internet or, you know, looking up some of

those healthcare providers or just have that limited ability to be able to pull and dispel some of those myths; right, and seek out those sources of truth. So that was another trend that we noticed.

We also have noticed some social determinant of health and inequities that really have kind of exacerbated those vaccination disparities, again, looking at children maybe with special healthcare needs such as those that have lung, heart, or kidney disease; those with immune system problems, malignancy, diabetes, blood diseases. Just, again, difficulty; right, getting into the office to be vaccinated or getting into one of those vaccination clinics.

So next, we wanted to try to talk about really specifically the impact of COVID on our dental visits. And Susan and I always try to present our information in a visual format that's easy for folks to read and understand. So Susan put together this graphic so you can look at the charts and see the year-over-year data.

And you can see from that oral evaluation between 2019 and 2021, we've actually had a 12.11-percent increase in those oral evaluations. We've had a 51.2-percent increase in the topical fluoride and varnish therapeutic application. And then we've had a 4.31-percent increase in that limited oral evaluation.

We did see a negative impact on the other indicators here that you see on the screen, a 1.24-percent decrease in oral evaluation for patients three years and under, an 8.86-percent decrease in that comprehensive oral evaluation for a new or established patient, and then a .86-percent decrease for sealant per tooth. And then the largest decrease that we saw or a negative impact was in that emergency treatment of dental pain. That was a 51.16-percent decrease here.

I will -- at the end, when we come to the conclusion slide -- talk a little bit about specific strategies that we have in place, not only to address the dental impacts that we've seen but also try to drive up

COVID vaccinations and then also what we're about to show for our well-child checks as well.

MS. VICKERS: So we just wanted to share some of our recent rates related to well-child visits. And as someone else mentioned, of course, W30 was introduced as a measure in measurement year 2020, so we don't have that previous year, 2019, rates to compare.

But in that zero through fifteen months category, we did see a bit of an increase in percentage year over year among our population who received that well-child visit. And then fifteen to thirty months, we did see an increase -- a decrease, excuse me, of well-child visits in that first thirty months of life, specifically 15 through 30 months.

The next slide, Kelly, if you want to go ahead and switch, we were -- and, again, this is our whole population. Kelly is going to break down our SKY population within this here in a second.

Our child and adolescent well-care

visits, we did see an increase year over year from 2020 to '21, or measurement year 2020 to measurement year 2021, in all three age categories as well as the total. So we did see a jump in that three to eleven, twelve to seventeen, less of a jump but still a positive increase between eighteen and twenty-one years, and then our total did increase by almost seven percentage points, and I forgot that percentage right there.

Kelly, your turn.

MS. PULLEN: So we wanted to break out SKY in particular, and we'll talk about it when I talk about interventions and strategies. We've got a really intensive care management model in SKY. And when Susan presented our most recent data from HEDIS, we were really delighted in the results.

One of our primary goals in that program is to ensure that everyone that's enrolled is getting their well-child, their dental, and their vision appointments. And so we have a really robust care management strategy put into place to make that happen. And so we're really pleased to report this data.

What we're seeing here is that well-child visits in the first 30 months of life -- and you're seeing our measurement period for 2021 in comparison to that quality compass national average. And our SKY program is trending and tracking above that national average, which is something that we're really proud of.

So for well-child visits in the first fifteen months, we're sitting at 59.38 percent. And for well-child visits for members that are 15 to 30 months, we're sitting at 74.60 percent.

Oh, I went too fast. I apologize. For the next dataset here, this is for ages three to twenty-one. Again, the trend that you're going to see here is that the SKY program is sitting above that national average, again, with the exception of those members that are eighteen to twenty-one.

So for those kiddos that are three to eleven, we're sitting at 61.16 percent; for twelve to seventeen, 56.72 percent. Eighteen to twenty-one, we're at 25.94 percent, under that national average. And in terms of our

total, we're sitting at 53.30 percent in comparison to that 46.12 average, which is really exciting.

So in terms of, you know, strategies and interventions, one thing that we are really looking at is the success that we've seen as it pertains to the well-child, the dental, and our vision appointments in SKY and how we can apply some of that same resource to our traditional or general population, as we like to call it.

We've got care managers in SKY that receive a daily report to tell us whether or not a member has received that care and then they're able to outreach and really drive and coordinate with the enrollee and with particular providers to ensure that members get into those services.

We do have the ability to expedite requests and expedite that scheduling with certain priority providers that we have. We're really looking at how we can apply this intensive care management model to our traditional population to help drive up that participation.

In addition to that, in SKY, we've got member incentives for those physicals, those dental appointments, and that vision appointment. So we're giving $25 per exam, so a member can receive up to $75 for going to those appointments. That's another thing that we're tracking and trending, to see how we can apply that to our traditional population to incentivize folks in going to those very necessary appointments.

We also, in SKY, are partnering through Avesis with one of our dental providers to offer some local dental clinics and, particularly, are going to be starting out providing those at different residential treatment facilities throughout the state. We're really trying to help those providers in being able to meet the needs for the members.

In particular for SKY, we've got kids that are in residential agencies that have staffing ratios that might be very difficult to maintain, given the staffing challenges that we see. And so we're trying to bring this service right directly to their door so

that the child doesn't necessarily lose access to the services that we need. And we are looking into the ability to also expand that and host some community mobile dental clinics in the state.

We also have been putting together an action plan, based upon our HEDIS results, to really target some of our outbound messaging, education, and some of those other member incentive campaigns, so really looking to provide some specific action, again, to drive these numbers up for the entire population at Aetna.

For COVID-19 in particular, we do have member incentives, and we are going to be continuing to offer those to try to help drive up that vaccination rate.

And I'll pause and see, Susan, if you've got anything else you want to add by way of strategy or intervention.

MS. VICKERS: Yeah, I did. I heard some other of our colleagues mention clinic days, and I think that's important, that partnership between specifically our value-based providers and Aetna to promote --

you know, we can engage our members and our providers and really come to engage those members from both sides to get people to, you know, an arranged appointment at a clinic day that's close to them and really make this as easy and convenient as possible.

So that's something that we are also really working hard to establish. We have one in eastern Kentucky coming up and hope to really route members to that clinic so that we can increase and engage in their wellness and in vaccinations.

And I think that's all we have.

DR. GRIGSBY: Thank you.

MS. PULLEN: Any questions for us?

DR. GRIGSBY: Mahak had to step out to another meeting, but does anyone have any questions?

(No response.)

DR. GRIGSBY: That's encouraging, to see that increase. Thank you all for sharing that, and I appreciate any sort of insight that you have into how you all sort of accomplished those gains just like your other colleagues.

MS. BICKERS: WellCare.

MR. OWEN: Good afternoon. Can y'all hear me? Okay. This is Stuart Owen with WellCare, the other Stuart.

Can y'all see the screen?

(No response.)

MR. OWEN: I'm not hearing anything.

MS. CECIL: No, Stuart. It's not showing, not yet.

DR. GRIGSBY: We see you.

MR. OWEN: Oh. Can you see the screen now, the presentation?

MS. CECIL: There we go.

DR. GRIGSBY: Yes. Thank you.

MR. OWEN: And I apologize. I did not think to send this in advance. I apologize for that. We will definitely do that in the future.

So the first thing is kind of broad. We do stratify the data by age and ethnicity and region. But the first is kind of an overview of under eighteen, over eighteen. We're looking at fully vaccinated and then at least one dose.

And so you can see under eighteen here, it's just under ten percent, so not good. Compared to over eighteen, it's about 38 percent. And then at least one dose, under eighteen is, you know, eleven percent. It's a little bit higher. And at least one dose, it's about 48 percent for the adults.

But what's interesting and which is actually, you know, arguably disturbing, here's a graph timeline. This is just under eighteen. It tells you their vaccinations per month, and you can see last spring is when it was approved, FDA, for the age group.

And so, you know, it took off. You get up to about 3,800 a month. Late summer, then it starts to fall. And, of course, we get the -- you know, in the fall, you get flu vaccines, and people are getting vaccinated more. And it picks back up.

But then this year, I mean, it has just dropped off, and it -- you know, essentially, it's like people have made up their minds, it seems like. And I believe it was Dr. Beal talking earlier about Kentucky, you know, the population being challenged. And I think --

you know, to summarize it, we're kind of better than southern states, but we fair very poorly nationwide.

So -- and then the next one, we get into more of -- we've got the age groups. Five to eleven, twelve to fifteen, sixteen to seventeen, by ethnicity. And, you know, there's not a great deal of variance.

You know, Asian/Pacific Islander is really high, as you can see. You know, I think it's a small number actually. But you can see they tend to be -- there's not a great deal of variance there among ethnicity.

And then with region, you know, no shock. Region 3, which is, you know, the Louisville area. Region 5, they're the best, you know, Lexington area. But, you know, even so, you know, the lowest is Region 4, which is a little bit surprising. That's south central Kentucky at around 24 percent for 12 -- excuse me, about 20 percent. And then the highest is, you know, almost 32 percent for the Louisville area.

So that was a little bit surprising that eastern Kentucky -- you know, I guess I kind

of assumed that would be the lowest. But, you know, but, I mean, there is some variance, but still, there's not a great deal of variance.

And then we look at pregnant members who have been -- of course, all COVID vaccine data. It's been very low. It's been extremely challenging. There's a lot of fear, you know, uncertainty. I don't know. I don't trust it. I don't trust it. I don't trust it. We've talked about before, you know, the myths about COVID.

And, you know, it was recently -- I think a week ago, I saw an article. There's a new -- one or two new COVID vaccines, I guess, that have been developed under the -- kind of the traditional, orthodox way that was just released. And, you know, I'm not a clinician, so I don't know the exact details.

But seventy-seven percent -- there was a survey of people who have not been vaccinated. Seventy-seven percent said not interested in the new one, that's, you know, the same way the flu vaccines have been developed in the past. Not interested. You

know, even -- you know, even though, they still -- they're not interested in it.

So, I mean, a lot of people just made up their minds about it, you know, for different reasons. You know, it's been mentioned. You know, they say, well, you know, I've got -- a lot of people. And we all know somebody that's had COVID. Probably, you know, quite a few of us on this call have had COVID, and it's like, well, you know, we survived. Yes, it was rough.

So it's just -- it's definitely more challenging motivating people. And so we have -- here's the look of our incentives, and all the MCOs have incentives. You know, we added a provider incentive, $40 for the first dose. All of these are effective through September, and we're going to extend them. But they're effective through September. We've got the other ones that we've done, you know, the 100-dollar gift cards.

But what we have learned -- I talked to our marketing slash community engagement director. And he said, this has been his

biggest challenge in his career for marketing, is getting people -- finding out what the trick is to get people to get vaccinated for COVID.

And what we have learned -- you know, we all have these incentives. What we've learned is it has to be immediate. If you say get your -- you know, get your shot today. In two weeks, you'll get a gift card. They're not going to do it.

We had -- all of us, all the MCOs through our trade association, Kentucky Association Health Plans, last year offered multiple Disney World trips, you know. It's like a sweepstakes and very disappointing turnout for that.

You know, WellCare, we did a pilot project for a while last summer in certain areas, certain counties, where we said we will send a nurse to your house, to your house to get vaccinated, and we had very disappointing results from that.

But what we've learned, it has to be immediate. And so kind of our couple -- our biggest and most successful events is last

year at the state fair in August -- again, all the MCOs, our association, we had a booth where you get vaccinated right there. You got a 25-dollar gift card to Walmart. You got free admission to the rides at the fair, and we had -- it was approaching 1,000 people that got vaccinated. And that was our most successful event.

And then, just recently, last month in June, at both the state baseball tournament and state softball tournament, we also had the booth there. We had nurses on site giving vaccines and offering a 25-dollar gift card. And we had about 700 people that got vaccinated at that.

And we've definitely learned it's got to be something right away. It's got to be immediate reward. That's the only thing that worked. But even so, it's still, you know, a huge challenge.

The next slide, we've got our well-child visit, and so you can see the three-year, pre-COVID 2019 and then 2020 COVID, 2021 COVID. And something that's noteworthy, unfortunately in a bad way -- I'm going to

try to highlight -- is you can see our well-child visits went up from 2020, which is no surprise, to 2021. You know, 2020 was kind of, you know, the worst of COVID. Our well-child visits went up in 2021 in those categories.

Our childhood immunization combo and adolescents went down. This is -- this is routine immunizations. This is not COVID. And so, you know, again, it just seems like there's that fear or stigma that has kind of spilled over from COVID that there are more people now distrustful of vaccines in general.

You know, it's not a huge amount. But, nevertheless, that doesn't make sense that, you know, more kids were getting their well-child visits, but we have a drop-off in their regular, routine immunizations.

So the next slide is our dental visits by these key procedures, you know, the annual evaluations and the sealants, the urgent care. And so we've got the volume, you know, year over year. And then this column here, 2020, percent of 2019.

So 2020 -- in other words, you know, during COVID compared to pre-COVID. And so that tells you, like, right there, 81.72 percent. The volume was 81.72 in COVID than it was pre-COVID for the periodic oral eval and, you know, it's all red. All of it, obviously, no surprise at all. But that just tells you the percent in the heat of COVID compared to pre-COVID.

And then I did the same thing for 2021, going again comparing to pre-COVID and, you know, it's still all red, still not back to pre-COVID levels even though the numbers went up.

And that's what that far right column -- it looks at, okay, 2020, the heat of COVID, to 2021. So everything green, it improved. It improved, but you can still see in the 2021 column, that it's still less than the pre-pandemic level. It's still lower. And then, you know, just overall in 2020, 73 percent of the volume of all these codes compared to pre-COVID, and then 2021, 87 percent.

Now, you know, I mean, one thing, with

2021, this is as of July 1, and providers have 12 months to submit claims. So the 2021 data is probably going to improve. You know, I don't know exactly how many providers -- you know, I would imagine most are probably pretty quick about billing, but there -- you know, there could be some that there's definitely a lag. So they may improve some.

And so then this next slide is our quality team, is what's so critical in addressing all this. And so these are just some of the things that we do. Of course, the vital thing that others have mentioned on the call as well is the care gap reports.

You know, we've got staff that generate regularly these care gap reports and share them with the PCPs, the member PCPs, and identify the areas where they're lagging, their members are lagging, and talk to them about addressing that.

And we also have incentive payments for providers to incentivize a lot of procedures and screenings and stuff like that that we share as well. You know, we have the EPSDT status reports that we share.

We have text message campaigns, and I want to point out -- I think it was -- I think it was Amanda and Stuart of Anthem. They were talking about text message -- and maybe someone else as well -- abrasion. And we absolutely see that, members not quite so warmly receiving some of our text messages. So we -- I will just say, you know, just echoing this, we absolutely see that as well.

We have member incentives which I'm going to get to on another slide. But, you know, some other things. You know, we -- that quality team, they identify noncompliant providers, you know, where they're lagging on their childhood immunizations.

They help them. They go to the office and help them how to motivate parents and members basically and identifies, you know, any kind of billing problems or something. Are they doing it, but they're just not billing it? They don't understand how to bill it.

Same thing. You know, we target those who are turning two and who haven't had their immunizations and also the same thing with

the same providers. We target turning thirteen and haven't had their immunizations.

And so then I mentioned the value-added benefits, you know, just to address the social determinants of health big picture. And some of the stuff that we do, especially targeting children, is, of course, during -- you know, especially in 2020, there was a lot of remote schooling and into 2021 as well.

And so that's one of the things -- one of our value-added benefits that we rolled out this year is an Internet hotspot for ages eight to eighteen. We also give twelve one-hour tutoring sessions for ages eight to eighteen. And all of these, all you have to do is just apply for it.

We have as far as -- and this is what we had before as well, something to point out. They are for pregnant women who complete their prenatal visits. They have the choice of a baby stroller, a playpen, a car seat, or a six-pack of diapers.

And, of course, we have some other stuff, you know, for children, the -- you know, the sports physicals and the -- where

we pay for that and then we have college scholarships, GED. We have pharmacy, over-the-counter benefits as well, you know, which benefits the whole family.

And then -- and I mentioned this before as well. These are some of the specific screenings, services, procedures that we incentivize in our payments this year for -- you know, we -- bonus payments that we give to providers to incentivize.

So you've got the metabolic screening for children and adolescents on antipsychotic meds, the childhood immunization combo. You know, like we talked about before, the body mass index, and then tobacco cessation as well for pregnant women.

And that is it. Anybody have any questions?

DR. GRIGSBY: Yeah. This is Donna. Just clarifying, so you will pay for a well-child check and a sports physical for the same patient?

MR. OWEN: Yeah. As a value-added benefit, we'll pay it. If, you know, somebody wants it, yeah, we'll pay for it.

And that was very interesting. I believe it was Eva Stone talking about the sports physical expanding to include the depression screening. That was -- to me, that was breaking news. That was very interesting.

DR. GRIGSBY: Yeah. Okay. Thank you. That's --

MR. OWEN: Sure. Yeah.

DR. GRIGSBY: Thank you. Yeah. Any other questions?

MR. OWEN: And I'll send this to Erin.

DR. GRIGSBY: Okay.

MS. BICKERS: And last, but not least, Humana.

MS. TSAI: So sorry. I was on mute. So my name is Sanggil Tsai. I am associate director for Kentucky Medicaid at Humana.

So what I'm going to do is I'm going to share some of our data and actions taken to improve the vaccination rate as well as well-child visit in 2021 and 2022.

So the first slide you are looking at

right now is our children's vaccination rates. So when we look at our whole population, we noted that 40 percent of our members have received COVID vaccination. And when we look at the children, it's only 20 percent. So that's what I noted here.

And we broke down those rates by age, race, and region. And when you look at the age group, we've noted that fifteen to twenty years old got the highest vaccination rate with 34 percent.

And race, just like the nation is trending, Asian or the Pacific Islander is highest with 45 percent, and Caucasians are 19 percent. That's what I noted here. And I just state that here so you can see that's the numbers. So when we analyze the data by region, this is what we see.

So Region 1, right there, and Region 4, right down there, got the lowest vaccination rate with 13 percent. And Region 3 is 27. It's the Louisville area. And then Jefferson County area is 24 percent. That's what we noted with our vaccination rate.

And in 2021, we completed a vaccination

hesitancy study to better understand why some members are not taking or not willing to take the vaccination, and we received about 2,000 responses from our members. And when we analyzed the data, this is what we found.

More than half of those that were unvaccinated at the time firmly believe but very hesitant to take the vaccine -- vaccination. And we look at the why, and this is what we found. Twenty-five percent said I don't trust the vaccine. Waiting -- twenty-three said waiting for more data, and seventeen said concerned about side effects. That's what we noted.

And next slide is about our pregnant members. So as we know, the pregnancy is one of the risk factors for severe COVID. And we know all the implications or complications that goes with it. And I'm going to jump down to the barriers.

We noted in this population that distrust of the vaccine impact on the child was one of the big barriers. And, also, they noted they want some support from provider or direction, guidance.

And some members didn't see the urgency to get vaccination because they don't have any complications with their pregnancy. And another interesting point that we found is that the access or transportation to vaccination sites have not been reported as barriers by this population. That's something unique.

So actions we took to improve our vaccinations are as follows. The members engaged in case management or any other programs at Humana were assessed for COVID-19 vaccination history, barriers, and hesitation. And our team has outreach programs, patient outreach programs to assist our pregnant and pediatric members with chronic medical conditions because they are at high risk. So that's an ongoing intervention. And we're also trying to incentivize our members to get their vaccine, so that's $40 there.

And one of the lessons learned, per se, is that the hesitant members report they trust in their providers, and that's more likely -- they more likely depend on the

providers as the deciding factor when making their decision to take or not to take.

So when the -- ensuring the conversation with -- between providers and patients at every touch point, we believe, could improve the uptake. It's the one takeaway from all the product we've done.

And another thing is the motivational interviewing techniques to address those hesitation and misinformation may be more impactful when we're trying to increase our vaccination rate. So that's what we learned from this population.

Next slide is our well-child visits. So what I did is we put the three measures here, the age, from the first to fifteen months, fifteen to thirty months, and then three to twenty-one. And the first one is that we expect them to have at least six or more visits. And the second group is two or more, and the three to twenty-one years group has to have at least one annual visit.

So first, the light green is our rate in 2020. The dark green is the 2021. The last one is the national average. So you can see

this improvement in the first to fifteen months group. The fifteen to thirty, we drop little bit but about one percentage point. But it's really below than the national average. So we have some interventions we are working on to make sure this can be addressed this year.

And then the -- this is good news. The annual visit for this age group, three to twenty-one, we improved dramatically, about eight percentage point; so significant but, still, it's lower than national average.

So we have those actions in place and working on all those measures. What we noted year-to-date this year is we are trending better than last year, so that's very good news. So that's what we are doing.

And then barriers, I'm not going to go through it because I think already all the other health plans mentioned. But one thing that I think not mentioned is that appointments being booked out far in advance.

So what it does is -- like, for instance, the first age group, first to fifteen months, we want them to have six or

more visit. But when the one appointment push back, that delay the next appointment, next appointment. So getting that six within time frame or timely, it's a little bit hard. So we're trying to make sure that we get -- our members get the first and second one timely, so everything else follow. So that's one of the interventions we're trying to put in place.

And actions taken in 2022. Like other health plans, we have provider-targeted and the member-targeted interventions. Provider-targeted, we have incentives and provider engagement and support and education and resources available to our members -- our providers. Sorry.

And then we have a member incentive and then we have a member vaccine team working with our members, CM/Mom's First, and EPSDT coordinators. And we want to make sure that we refer our members to CM or SDOH coordinators so that their needs can be addressed. So that's what we have.

Last one is dental. Humana became the sole administrator of the contract in 2020,

so I just put the 2020 data here. But I can definitely go back and then get more data and see what we can provide after the meeting.

I think that's all I have.

DR. GRIGSBY: Thank you. Any questions?

(No response.)

DR. GRIGSBY: Thank you all so much. This was so helpful, to see all of this data. Thank you. I'm sure there was a lot of work that went into getting all of this information together, so thank you guys so much for going to the lengths that you did to give us that much data about that many aspects. Thank you.

Any questions about anything we just reviewed?

(No response.)

DR. GRIGSBY: Okay. Are we ready to move on to new business? Although I don't think we have a quorum, so I don't think we can vote on anything today.

MS. BICKERS: You do not have a quorum.

DR. GRIGSBY: Okay. So we've been

through all the old business. New business is talking about the plan to return to in-person meetings.

MS. BICKERS: I will take that one. So far, we have been looking into some of the different options. For example, with some of our larger committees, like the MAC, for example, we try to utilize the LRC building. And they're not allowing their audio equipment to be used outside of their staff, so that would cause an issue there.

So we've been trying to look at some different avenues where we can still -- if anyone would like to return in person, that they can work on doing that while we're trying to -- you know, to vote on that. And we're trying to find some spaces that will accommodate and still allow for the hybrid.

I can tell you that a lot of the TACs so far have preferred the virtual option for the fact that they are having more participation and more people on. I think we have -- we had 45 on at our max number before some people had to drop.

And so -- the commissioner's conference

room, of course, would accommodate some of the smaller TAC committees. However, with it being an open meeting, we have to have a space large enough that whoever would like to come in person can come.

And so far, we've kind of just been leaving that up with the TACs. Most of them so far have opted to continue virtually as long as they can. Maybe having an option of meeting in person once a year just to kind of meet and greet, see faces, be together.

So that's kind of what some of the other TAC members are doing so far. Some of them are just leaving it on the agenda to see how it goes per month with the spaces, with the rates, with people -- I'm not sure about your TAC in particular. But I know there are some TACs, they travel far. I don't know if you guys are local to Frankfort.

And so that's just kind of what we've been, you know, letting some of the other TACs and MACs know, that we can still -- as far as I know now, we can still offer the Zoom. If somebody -- say, Donna, just for you, for example, you're going to be in

Frankfort and might miss the meeting unless you're going to be there, if you let me know a couple days ahead of time, you can always join me in the conference room. And I can be in the office.

And so that is possible, you know, if you find yourself, you're going to be in Frankfort and you would like to be in office, we can also offer a hybrid. I have -- as long as you give me enough time to let the security desk know so I don't get fussed at, that is always an option.

But so far, most of the TACs have opted to stay virtual because they're having more participation. And it's easier to fit into their day, particularly if they have to travel more than 30 minutes or so. So we're kind of just leaving that in each TAC's hand.

So if you want to leave it on your agenda maybe until you have more members present to discuss it. Because I know one of you had to drop, so I think there's only three of you on currently. But we're open to discussions. It is on the agenda, so if you guys want to discuss it today.

Unfortunately, without a quorum, you can't vote. But I don't think you necessarily have to vote on that, but I could be wrong. I think that's just more of a -- as time goes, you know, a lot of them are just trying to figure out what their best option is.

DR. GRIGSBY: From my standpoint, I feel like -- this meeting is a little bit of an exception, but I feel like we've had increased participation by being able to maintain the virtual option. I know -- I mean, I'm in Lexington. I think Mahak is in Louisville. I'm not sure where everyone -- I know we're in a variety of places. I don't know that any of us are actually in -- any of the TAC members -- are any of us in Frankfort?

DR. SMITH: I'm in Louisville, yeah.

MS. DIMAR: I'm in Louisville, too.

DR. GRIGSBY: Okay. So I feel like that, for the most part -- and I think that's true in the past. I feel like our participation has been better on -- with

virtual meetings than it has with in-person meetings.

DR. SMITH: I've only been on the TAC since the pandemic, so I don't have very good -- I don't have any history other than that. I mean, it works better for me virtually, but I would definitely make whatever works -- whatever the consensus is, I would make it work.

DR. GRIGSBY: Okay. Thank you. I feel like we're down some members at this point as well, and I don't know if there are members that retired from their jobs that are no longer representing their organizations.

Erin, do you know that?

MS. BICKERS: So as far as whether they have retired -- I'm going to apologize. My dog is starting to bark. I think my husband just came home. Okay. Sorry about that. I just didn't want a big bark in the background.

As far as I know, I know since I have taken over, you guys have not had a quorum. Now, whether or not some of those people are retired, no longer with that organization, no

one has reached out to notify me that those positions are vacant.

But I know that's something that the chair and I just discussed privately in a chat before she dropped off that I'm going to -- I've got a note to follow up about inactive members. And if you have them, if there's a process of getting active members. So I'm not 100 percent sure.

In the past, when someone has left their position or would no longer be serving, I usually get an email from them or the association, or they'll let me know in a meeting. But you guys have some members that I don't think I've ever met or am able to get some emails through.

So that's on my notes to follow up on my side because I have noticed, and that was something I have -- I think your last meeting, I brought up to my supervisor that you guys have -- you're down over half of your members since I have been taking over.

And so I don't -- I'm not 100 percent sure what that process is, as I'm still learning everything that Sharley did. But

that is on my follow-up, to see what we can do as far as about reaching out to these associations and making sure that you guys have active members so that you are able to have quorums and you are able to approve your minutes and have an active committee moving forward.

And so there's two people on you all's committee that I can't even get emails to go through. They always bounce back. And so I verified those emails with you guys, and you can't get through to them either. So -- and I know things happen, and maybe they were gone before I took over.

So I just -- I don't know right now, Donna. So I do apologize, but that is on my follow-up list to try to figure out what I can do on my end.

DR. GRIGSBY: Thank you. And I feel like Michael Flynn was a pretty active member, and I know he's someone that mentioned that he may be retiring at some point. So I don't know if being able to reach out to him -- because I know he was someone that did attend the meetings in the

past.

MS. BICKERS: And so that has been on my radar, you know. And so, of course, being new, you know, I kind of wanted to get a few meetings under my belt with you guys. Because I know people go on vacation. They get sick kiddos. They get sick themselves. And so -- but as of this meeting, that is on my follow-up notes today.

DR. GRIGSBY: Okay. Thank you.

MS. BICKERS: You're welcome.

DR. GRIGSBY: So perhaps just keeping the discussion about whether we're having virtual or in-person meetings can go to the next -- can be forwarded to the next meeting. And then I don't think we can make any recommendations since we don't have a quorum.

MS. BICKERS: No, ma'am.

DR. GRIGSBY: And then the MAC meeting representation. I'm not sure if that was something we brought up at the last meeting because no one could attend the MAC last time. Is that correct, Erin?

MS. BICKERS: The representation --

so I had sent out a template to the chairs, and that was something that I had it added on there. So that way, when the MAC is going through their list, if I know that no one is going to be there, I can let the chair know that nobody is there, to move on a little faster.

And so that next meeting is July 28th. So if somebody -- if you guys find out that no one is going to be there to give a report or an update, just let me know. And I can let the chair know, and then she'll just skip over.

DR. GRIGSBY: Okay. Perhaps you can send that, Erin, to Mahak and the rest of the members to see -- I think usually the chair is the representative, but I don't know what her schedule looks like so...

MS. BICKERS: Absolutely. And I do know that the MAC bylaw -- excuse me. I got tongue-tied. The MAC made a recommendation and voted and approved that any TAC member may give the recommendations and reports to the MAC, not just the chair. So that was something that has been voted on and moving

forward, so if she cannot be there and one of you guys can be there to present.

I know last meeting, you guys raised the question on whether or not I could present for you, and that's a hard no. I did ask, and I am not allowed to present or report, you know, anything with the MAC for -- on behalf of the TACs other than to say they don't have a representative today.

DR. GRIGSBY: Okay. All right. Thank you. And what time is that meeting on the 28th?

MS. BICKERS: It is -- let me check. I always want to say 10:30, but it's 10:00 to 12:00.

DR. GRIGSBY: Okay. And that's a Thursday; correct?

MS. BICKERS: Yes, ma'am. Oh, 10:00 to 12:30. My apologies. That one is a two-and-a-half-hour long meeting.

DR. GRIGSBY: Okay. All right. Any other comments about that?

(No response.)

DR. GRIGSBY: And the date of our next meeting is September --

MS. BICKERS: 14th.

DR. GRIGSBY: 14th. From 2:00 to 4:00; correct?

MS. BICKERS: Yes, ma'am.

DR. GRIGSBY: Anything else anyone wants to bring up before we go?

(No response.)

DR. GRIGSBY: Thank you all again to the MCOs for all of that wonderful information that you provided and all your hard work at getting that to us. And if you -- just a reminder, if you could get those presentations to Erin.

MS. BICKERS: And Eva Stone was kind enough to email me all of the links that she was dropping in the chat. So I will also send all of that information as well. Because I know sometimes things get lost in the chat box. And so she was kind enough to go ahead and email those to me as well, so I will add that to the email with the presentations.

DR. GRIGSBY: Great. Thank you, Eva.

DR. SMITH: Dr. Grigsby, are we

going to stay on to talk about an agenda or -- it would just be the three of us, I guess, or -- for next time.

DR. GRIGSBY: I -- yes. Yeah. Let's do that and then we can -- I can follow up with Mahak. Erin, if you want to stay on as well.

MS. BICKERS: I can do that.

DR. GRIGSBY: Okay. I feel like (inaudible) I can't see anybody, but I think that's my issue. All right. Those of us that are TAC members, please stay on. Thank you all so much to everyone else who's with us, and we appreciate all of your good information today. Thank you all.

MR. OWEN: Thank you. Have a good rest of the day. Thank you, everyone.

(Meeting adjourned at 3:53 p.m.)

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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 26th day of July, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR