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

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Via Videoconference
July 12, 2023
Commencing at 2 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Donna Grigsby, TAC Chair

Courtney Smith, Vice Chair

Alicia Whatley

Michael Flynn (Not present.)

Cherie Dimar (Not present.)

MS. SHEETS: Good afternoon. This is Kelli Sheets with Medicaid, and I will be your host for today. I don't -- it looks like I'm letting in Courtney Smith right now, and I know we have you on. I don't believe there are any other members unless I've missed someone. So you need one more to have a quorum, so if you want to give it another minute or two, we can certainly wait.

MS. GRIGSBY: Okay. Thank you. We'll wait a couple of minutes, and then we can just skip things that require a quorum and go on to the reports if we don't have an additional member.

MS. SHEETS: I've just admitted Alicia through the waiting room. She's joining now, so that means you do have a quorum at this point.

MS. GRIGSBY: Okay, good. Thank you. And just a reminder to members, we have to keep our cameras on throughout the meeting. I think we usually like for those of us that are joining us as guests to put your name and your title or affiliation in the chat

box, so we can know who all is here.

I have 2:02, so I may wait just another minute before we get started just to make sure we don't have anyone else coming. And obviously, I want to be respectful of everyone's time, so thank you all.

Okay, let's go ahead and get started. We may have some other folks joining us. Okay. We have established a quorum, so I need a move to approve the minutes from the May 10th meeting.

MS. SMITH: I move to approve the minutes from May.

MS. GRIGSBY: Do I have a second?

MS. WHATLEY: I'll second.

MS. GRIGSBY: Thank you. All in favor, aye.

(Aye.)

MS. GRIGSBY: All right, thank you. Our business for today is MCO presentations. As you all remember, last -- in May, we had a presentation on homelessness and food insecurity, and we asked for the MCOs to present their member resources and what kind of programs they had available for members.

So, Erin, I -- no, Erin's not here. Kelli, I don't know if you and Erin received any presentations ahead of time.

MS. SHEETS: We did.

MS. GRIGSBY: Okay.

MS. SHEETS: I believe from all of the MCOs if I counted correctly.

MS. GRIGSBY: Okay. So if someone would like to -- I don't know if we want to go in alphabetical order, or if we want to just let folks speak up, but if someone would be -- if someone would, please start the presentations.

And again, about five to seven minutes, just to let us know what resources you have available for members and how you identify folks that are at risk for homelessness and food insecurity.

MS. JOHNSON: I can go first. This is Megan Johnson with Aetna. I think we would be first alphabetically anyway, so.

MS. GRIGSBY: Okay, thank you.

MS. JOHNSON: Okay, let me share my screen. All right. Can everyone see?

MS. GRIGSBY: Yes.

MS. JOHNSON: Perfect. My name is Megan Johnson; I am the director of quality for the Kentucky SKY program. It is nice to meet everyone. Kelly Pullen's also on the line; I'm presenting for Aetna.

To start, we have our homeless population resources. Aetna's approach to supporting our homeless population is really a cross-departmental collaboration between our CM teams, our care advocate team, our community outreach team, and our SDoH team. Our CM team has a homeless population outreach strategy that includes the recent hire of a CM coordinator that will solely perform homeless outreach.

Our care advocate team identifies gaps in services across both lines of business and addresses those gaps. And specifically, this team is really involved with the Kentucky Homeless Management Information System, Kentucky HMIS, to support our CM team.

The community outreach team cultivates several community partnerships, and they've even set up vending machines for

homeless individuals at Seven Counties.

Our SDoH team has created a comprehensive directory of community resources that helps to address any social determinants of health needs in our population, including housing and food resources. And this directory is available and utilized by all member-facing staff and is updated daily to include any newly identified resources.

So just to talk a little bit more about our strategy, the care management team, as I mentioned, had the recent hire of a care management coordinator for homeless outreach. We have an internal report that identifies our enrollees. And once they're identified for a general line of business, then those are immediately sent for care management. And then, our SOC team and our SDoH team work with our care management team in order to make sure that we're able to establish contact with those members. And if we are able to establish contact, then we perform in-person visits, and then we engage with those stakeholders that are providing

resources to those members to establish a plan of care.

Our care advocate team they are also receiving the same report. We identify our members across both lines of business, and then they use the Kentucky HMIS system to establish connections to see where our members are visiting, what resources they are using, and then they work with care management to make sure that they're aware of where our members are and establish those services and supports. And then they also continue to collaborate with external agencies in addition to our community outreach team.

Our community outreach team has established several partnerships in the community. These are just a couple of those: St. Johns Center, I mentioned the Seven Counties vending machines, TAYLRD, Uniting Partners for Women and Children, Salvation Army, Phoenix Health Center for the Homeless, Hip Hop Cares Homeless Street Outreach, Arbor Youth Services. We have several partnerships.

Just to talk a little bit more about our community resource dashboard that's managed by our SDoH team. This dashboard enables the Aetna CM team to refer members to these participating community-based organizations. This also gives them access to those resources that addresses those needs. And especially because our teams are regionally based, they're able to look by region at what resources are available in that area. Some of those resources include service industries, businesses, individuals, food banks, shelters. But we address all SDoH needs in this dashboard.

For food insecurity, recently our leadership team in Q1 and Q2 of this year did a community listening tour and met with several providers across the state. And during that tour, they actually enjoyed several opportunities to serve at local food pantries on that tour. So, as a result, we, Aetna, has made a donation of $500,000 to God's Food Pantry, and God's Food Pantry works with more than 475 food pantries across central and eastern Kentucky. And

it's estimated that this sponsorship from Aetna will help provide between 3.5 and 4 million meals to central and eastern Kentuckians who are experiencing food insecurity.

In terms of data, we keep an eye on the trends that we're seeing with our population. About 38 percent of our referrals in that community resource dashboard that I mentioned before are for food resources, so it's definitely one of the top needs of our population. Four hundred thirty-four referrals have been made to our community resource partners for food insecurity since January, and that affects 195 unique members.

A few of those partnerships that I mentioned before that we have specifically for food insecurity are Blue Bank Food Distribution, Ella's Outreach Food Pantry, Community Food Bank of Grayson, Soldiers of Jesus Christ, and then, I mentioned before God's Food Pantry. And I won't read to you guys, but you guys can take a look at this.

And that is Aetna's presentation.

Thank you, all. Any questions?

MS. GRIGSBY: Thank you. I'm intrigued by the vending machine concept.

MS. JOHNSON: Yeah, so those vending machines, we restock, and we keep food in there for our homeless population. There was a need that was identified by Seven Counties, and Aetna provided those vending machines. We're hoping to expand those to other places in the future.

MS. GRIGSBY: And do they just -- do they -- how do you -- you just walk up and push a button --

MS. JOHNSON: Yep.

MS. GRIGSBY: -- and food comes out, or?

MS. JOHNSON: Yep, no cost.

MS. GRIGSBY: Okay, cool. That's good. Thank you very much.

MS. JOHNSON: Thank you, all.

MS. GRIGSBY: I believe that Anthem has offered to go second.

MS. FOMBY: Yeah, now, Stuart Cox will be sharing the presentation for me if you don't care to give him access.

MS. SHEETS: Yeah, give me just a second.

MS. FOMBY: Okay.

MS. SHEETS: Okay, he should be good to go now.

MS. FOMBY: Okay. Perfect. All right. Hello, everybody. My name is Bethany Fomby, and I am our manager of health promotion outreach/services. I manage our -- what we refer to as our empowerment team, which is our social determinants of health team here at Anthem.

And so we decided, just due to respecting everybody's time within the five to seven-minute timeframe, that you'll notice we do focus a lot on our empowerment team throughout the presentation, but it's just a glimpse into what we do. We have many, many different initiatives and ways that we tackle social determinants of health among our membership and aiding our community. So next slide, thank you.

So to help our members achieve optimal health, we must all work together to eliminate obstacles to health. So starting

out with this scenario, I want you to imagine this: You just learned that you have a high-risk pregnancy with complications. You find out that due to this, you're going to have to quit your job, you're going to go on bed rest. Your spouse actually has to lose their job, as well, due to trying to take care of you. And you have four kids at home, and your spouse is trying to take care of those four children, you, and you now have a mountain of bills piling up and no way to pay them. So who would you turn to? Who would you go to for help when it comes to this situation? And a lot of people don't have anyone to go to when it comes to this.

So with that said, this is not a scenario for one of our members. This was actually their reality. We will refer to this member as Sauron, and she was a high-risk pregnancy, lots of complications, had to go on bed rest, of course, couldn't work. They had four young children at home, all under the age of six, while she was pregnant with their fifth child. And when

she was referred to our empowerment program, you know, lots of needs identified, and so we really wanted to make sure that we were addressing social needs, and then, of course, those wraparound services. So, next slide.

So as part of our health plan model, we take a whole health and a health equity approach. Whole health used to, you know, focus on physical health and behavioral health, and it's moved to include social determinants of health.

Due to recognizing the importance of this, we actually developed, in 2018, our empowerment team to work alongside our behavioral health and our physical health case management teams. To lead to better health outcomes, we believe everyone deserves access to quality healthcare, healthy foods, stable housing. Without focusing on that whole person health, there's no way that you can -- it's kind of like all the legs to the system to -- if one goes out, you're going to fall down, right? So, like, if you have a physical health

need, you know, that can result in behavioral health needs due to depression. You could have social needs because you can't work, like this member. In reality, if you don't address all of them, it's just going to be a repeating cycle. So next slide, please.

So I mentioned our empowerment team, which we really see as the heart of our SDoH strategy, our social determinants of health strategy at Anthem. Our team is made up of community engagement navigators that are also certified community health workers, and they work one-on-one with members to address social needs. We often co-manage with our physical health or behavioral health case management because, like we said, you know, it's typically if you have one need, often, the others follow.

But our goal for our empowerment team is to empower our members. That way, we're promoting independence, you know, empowering instead of enabling. We're equipping them with the tools to tackle any future barriers that may come in their way. We don't want

it to be where they're dependent on us, but that we are preparing them for anything that may come in the future. So next slide.

So this goes over our process a bit. So referrals come from multiple sources. Members can actually self-refer. We get community organization referrals. Our internal case management teams will refer to us for more critical SDoH needs.

Once those referrals come in, we're assigning to one of our CENs, or community engagement navigators. They are going to, upon that very first initial outreach, screen for social determinants of health needs because we find often that the referral reason may be one or two things, but it's very rare that someone has one need. Typically, there's several needs around the same time. So we want to make sure we're identifying and addressing all of those needs, and not just those that the member may be most worried about at that time.

Once we've screened, we've identified those needs; we're going to set goals based

on those needs. And then our navigator is going to work with them and follow-up and, you know, try -- like, we're going to help them reach those goals. Whether it's through connecting to community resources that we've built relationships with using our platform, the community resource link that allows us to search for local resources that we're also -- our members have access to, as well. So that's one of those tools that I was talking about for preparing them for the future, so they can use that if they have anything come up then, and leveraging Anthem, you know, benefits and resources.

Now, with this -- so going back to our member that we're referring to as Sauron, of course, like I said, the first call, a lot of barriers were identified. Throughout the member's enrollment in our program, our CEN or our navigator was able to connect the member to DentaQuest and EyeQuest to find local providers for her and her children. We were able to assist the member with redeeming our Anthem transportation benefit. This allowed her

husband, since she really couldn't get out; her husband was able to go to community resources and food banks, the grocery store to utilize their, you know, SNAP or their food stamp benefits. And then we were actually able to utilize our empowerment housing assistance, as well, which we'll cover in a moment. So next slide.

So as you'll see here, our navigators have assigned territories. We wanted to make sure we're covering the entire state and not leaving any area out, especially those rural communities that sometimes do get left out or have very few community resources. And they're using these territories so that they can go in person, offer those wraparound supports for members, but they're also building relationships with community organizations to help have that direct contact to be able to refer to one another and support our member in a really efficient way, versus, you know, giving a -- here's a 1-800 number and good luck.

So we want to make sure that we're connecting them, that we're following with

them throughout those steps. And then, we're also educating those organizations on what we have to offer, but learning more about what they have to offer the members. So between that and working with the members, we've seen that time in the field, and going out and meeting with these organizations and our members has made a really big impact. So next slide.

Okay. So earlier, like I said, I'd mentioned about our member, Sauron, who utilized our empowerment housing assistance. She was facing an eviction and utility disconnect. And with the utility disconnect, you know, that may not even matter if you're getting evicted because you can't pay those rental arrears.

So as far as our empowerment housing assistance goes, we've actually been able to -- this is our metrics from last year. We had a total approved requests of 754. And you'll see the total amount spent and the different assistance provided. We actually, last year, helped many families gain housing or remain housed. We actually prevented a

foreclosure, prevented different evictions, utility disconnects. I mean, we did multiple things with this, and it's constantly progressed from last year even to this year, and we're really excited to see the impact we're going to continue having. Next slide.

So with our value-added benefits: You know, some of our benefits are going to be for adults, but as anyone knows, especially as parents, if a parent or guardian is being assisted, it's going to have that trickle-down effect, and it's going to impact those kids, that household, just honestly the entire community as a whole. And actually, where we had mentioned that Sauron had utilized the transportation assistance, you know, again, if she wouldn't have had access to that, the food banks that they were able to go to that we connected them with, other community resources they were able to utilize for utilities, you know? Future bills that came because, you know, maternity -- or bedrest is not a one -- you know, a one-week thing, and so they

had to utilize community resources throughout that, and we were able to assist with that. And then also getting to that grocery store to use their SNAP benefits. So next slide.

So with this, you'll see the impact of 2022 when it's in relation to our empowerment team. But we actually not only doubled our referrals from 2021 to 2022, but we actually quadrupled the number of successful case closures with those successful needs met, social needs met upon that case closure. Our highest needs met that you'll see here were food, housing, and transportation. Food needs met actually increased by 329 percent from 2021 to 2022. And then, our housing needs met increased 376 percent from 2021 to 2022.

And, you know, we don't plan on stopping there. We have plans to have a greater impact. We're looking to invest in initiatives and strategies to reduce SDoH barriers and just help our members and their families live happier lives. Next slide.

So we are currently working with

homeless shelters in-person, food pantries, including those in schools. I mentioned our community resource link earlier, and that is trackable, secure, prompt connections through a referral system. And from the beginning to the end of the cycle, we're able to report information about the process, use that information to advance, you know, our future initiatives and strategies. Just constantly trying to see where we can get better and how we can help more members. Next slide.

And that is the end. Thank you very much. And does anyone have any questions?

(No response.)

MS. FOMBY: Perfect.

MS. GRIGSBY: Thank you. I believe Passport has offered to go next.

MS. DERRICK: Yes, thank you. Is it possible to share? Would you mind adding me?

MS. SHEETS: I'm sorry, this is Kelli. I was just talking away on mute. Are you going to be sharing the slides, Shannon?

MS. DERRICK: Yes, I am. Thank you.

MS. SHEETS: You're cohost, and you should be good.

MS. DERRICK: Okay, wonderful. All right. Thank you so much. So my name's Shannon Derrick. I'm the manager within our care management team at Passport by Molina Healthcare, and I'm excited to be able to share with you all today about some of the amazing work that we're doing within the housing and food insecurity areas.

So we've got many methods with which a member could reach out to us and share their concerns or their needs around food insecurity. So they're always welcome to call member services, and our member services team utilizes Molina Help Finder -- this is also referred to as Aunt Bertha in some circles -- to be able to identify resources in somebody's specific community that could provide them with those additional resources.

In addition to that, we have value-added benefits. We've included the link for you all here. And this gives the

members the ability to earn gift cards for multiple preventative services. So one example of this would be all members are eligible to do an annual dental exam, and that would be a $50 gift card that they could use. And they're welcome to use that gift card to address things around food and housing insecurity, as well.

My team is located in our care management department, and this is for members who maybe have those more complex needs. They need something more elevated than a single conversation or a couple of resources around SDoH. We identify these members in a lot of different ways.

So we have a stratification, and it does include SDoH needs, like homelessness. And with our stratification, we're really looking for those members who are stratifying as high or moderate needs so that we can make that outreach and try and reach them and engage them in services.

Providers are able to make referrals, and I use providers very broadly. So this could be a medical provider, a behavioral

health provider; it could also be a nonprofit in the community that's working with people. We really want it to be an open door. If somebody has a need, we'd like to be able to know about it and support them.

And then, our members themselves can make referrals. So they can call member services. They can e-mail us, and we are more than happy to reach out to them and engage them in services.

This really is an integrated model. We're looking at that whole-person approach. We're wanting to make sure that we're not only addressing the medical and behavioral health needs, but also social determinants of health that can really impact health in the short term and in the long term.

So I know we're part of the Children's TAC today, so I think it's really important for us to talk about the fact that we see Passport members as their entire family. So if we've got a child who maybe doesn't have super high physical or behavioral health needs, it doesn't mean

that they can't access those care management services that the family is struggling with social determinants of health. We really are going to address that entire family's need. There's not a single one of us that is part of a family that's operating solely on our own, so it's important to really have that wraparound model.

And as part of care management, there's also the opportunity for us to add additional people to that member's team as is appropriate. So we've got community connectors. These are our certified community health workers. They are working with people on a long list of things, including social determinants of health. They're also supporting them in organizing their appointments, getting to provider appointments.

We have our housing specialist. This is a team that is specific to housing needs. So they are working with members who are experiencing homelessness, who are experiencing housing insecurity. They also work with someone once they're housed to

help make sure that they are able to maintain that housing, as that is just as important.

And we have our peer support specialists. So these are members of our team with lived experience who can really be that additional support long-term for members.

And we are really looking at those member needs and doing assessments. So we're doing our health risk assessment. We're doing a social determinant of health assessment as we are having those initial conversations with our members to kind of figure out what kind of wraparound services would best support them.

We're also connecting them with things like TruConnect phones and other community resources. Because, as was mentioned earlier, most of our members who have those SDoH needs are not coming in with just one. We really are needing to look at what other barriers are in place. So it's not just housing insecurity or food insecurity. They might need reliable

communication so that they can reach out to those resources. We might need to talk more about transportation.

So one of the other really great things that we've got going for our members is the Molina one-stop help centers. So we've got five that are active locations right now: Bowling Green, Covington, Hazard, and Owensboro. These are really nice facilities where a member can go in; they can meet with people, sit down and talk with people. And there are computers in the lobby area that will allow our members to be able to fill out some of those applications to have that safe place to go in and have those conversations.

Our one-stop help centers also are offering classes. So there are expungement clinics, baby showers, health education. So this really can be a way that they can get out in community and engage, not only with us but with other people in the community -- other members in the community.

All right. I won't read you all of this, but I think it's important to always

root our work in the member themselves. And so I do want to share just a little bit about one of our families, Deja. So we were contacted by the local school district, who said that they had a concern with one of their families not having enough food. We were able to connect this family to Ashlee. She was a pediatric -- she's a pediatric care manager with us. And this was during Covid.

So while we deal with food insecurity all the time, we still are dealing with it. During this time, the family had tested positive for Covid, and they had that extra barrier. They were struggling to be able to get out into the community and access food. So Ashlee was able to secure them food by the end of the day. By the next day, she had other food secured for them. And this was all through using community partners, talking to people in that member's community.

And I think one of the really wonderful parts is if you've worked with someone with food insecurity before, you

know that a lot of times they can get canned goods. And canned goods: They're nice, and they definitely meet the nutritional qualifications, but that hot meal, that hot meal can be really important. And Ashlee was able to secure hot meals for the family, as well. This got them through the quarantine period. They were able to secure food on their own through their SNAP benefits at the grocery going forward. And I think this is just an example of how Passport can step in and support our members on a regular basis.

And it's also that relationship with our partners. So, in this case, it's just a beautiful example of having that partnership with the local school system who then knew to call us and ask for that additional support and help with the family.

I did want to make sure that I shared with everybody these are the best ways to get in touch with us. So if we've got members, they can always call member services. They can e-mail for care management services. And then for

providers, their referrals to care management on our website, and this can be returned either via e-mail or fax. So we are always open to referrals, and there is truly no wrong door for our members to get to us to find that support. Any questions that I can answer?

MS. GRIGSBY: Thank you.

MS. DERRICK: Thank you, I appreciate it.

MS. GRIGSBY: Humana has offered to go next.

MS. CLEMENTS: Hi, thank you so much. And I will be sharing my slides, so thank you in advance for giving me permission to do that.

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

MS. CLEMENTS: Thank you. Okay, are you guys able to see my screen?

(No audible response.)

MS. CLEMENTS: Thank you. All right. Hi, I'm Leslie Clements, and I am the brand-new newly-created role with Humana's Healthy Horizons team here in Kentucky. I

am an associate director for our health equity strategy, and I'm thrilled to be here with you all today.

I wanted to share with you all not only some work that we're doing around homelessness and also food security, but really all of the wraparound supports that Humana makes available to our members. And I thought I would start by sharing this model that you see on this slide. We all know that healthcare is complex. There are a lot of inputs, and there are a lot of outputs, and I think this slide does a nice job of showing just how complex it really is.

What you see on the left-hand slide, those are Humana associates. Those are folks that are really rallying around our members. And what you see on the left-hand slide are examples of some of the resources that we also want to make sure our members are aware of that are available out in the community.

And because we know that it is so complex for those members, they always have

a care manager. And so that care manager is really in the middle of this, side-by-side with our members, helping them address their social determinants of health through our comprehensive care support team that you see on the left. So we love to leverage this team with all of the information that they have, but also our digital health and analytics tools that we have at Humana to help identify and address the needs that our members have.

We also, of course, make sure that we understand what our member's goals are. So what are their preferences and their goals to be able to achieve their best health? And so that way, we know that we can actively engage them as whole participants in their care.

Like a lot of the other folks have already shared on the call here, Humana, too, has several value-added services and expanded benefits that we make available to our members, many of which are focused on social determinants of health. So I won't go through all of these today out of respect

for your time, but please do let me know if there is anything that you want to dive into, and I can offer additional detail about those.

But specifically, today, I wanted to talk about those that do support social determinants of health. So a couple that I'll call out here, and there is a link on this slide, and I'm happy to share that with anybody that would like it. But when you think about the fact that this is the Children's Health TAC, I'll call out a couple that are specific to families and children.

We have Humana Beginnings, which is a resource that we make available to all of our new parents and new babies. If a member is in need, we offer a portable crib or a car seat, meals after delivery because we do know indeed that that is a very vulnerable time when families are in need of that kind of support.

Some other things that I'll call out that are on the slide here, we offer post-discharge meals and fresh fruit and

vegetable boxes for our members, again, when we know that that's a particularly vulnerable time. Lots of other resources that are on the slide here. Again, I won't go into all of them.

I will call out the last one that's on the list, though, Healthy Behavior Rewards through Go 365. So I mentioned that we really want to make sure our members are active -- actively engaged in their own health and well-being. And so, one way that we help do that is through our Go 365 Healthy Rewards Program. That's a wellness program that offers our members opportunities to earn rewards for taking healthy actions.

And so, on the right hand of the screen, what you can see are several examples of the kinds of activities that our members can engage in to earn rewards. And then, once they do earn those rewards, they can go out to the Go 365 mall, and they can make purchases to, again, continue to help advance their health.

One of those things that they can

purchase are e-gift cards. And again, you can use those gift cards to support social determinants of health. Specifically, there is an Uber gift card. So we know transportation can be really challenging for many of our families. And so that's an example of how some of them might leverage their Healthy Rewards Program.

When it comes to addressing food insecurity specifically, we've got a number of nutrition-related benefits that we make available to our members. We're always trying to evaluate how well those are working, how well they're meeting the needs of our members. Are they easy to use? Are they improving health and quality of life? And then we make enhancements where we can.

I've got a few examples here on this slide of ways that we are helping address food insecurity for our Humana Healthy Horizons members here in Kentucky. So, you know, some folks have talked about SNAP. We want to make sure that if we have a member or a family that's eligible for SNAP, that we're helping them complete those

applications. We know it can sometimes be complex, and so we help them navigate that.

We've heard a lot of folks on the call talk about partnerships with local food pantries and food banks in the members' areas. So we, too, have tight relationships with those pantries and food banks, and we try to support them with resources, as well, to really help the whole community.

We do assist our members with transportation when they need to obtain food and necessary items for their daily living. We have a great program with Amazon where we can offer half-price membership. And again, you can use your SNAP to purchase food items and get free delivery for those things.

I already mentioned some fruit and vegetable boxes for some of our members that might meet the qualifying criteria. I've already talked a bit about meals that we make available to families postpartum. So we work with Mom's Meals to help folks in that situation or other discharges from the hospital. And we've got a Farmers Market Dollars program that we help educate our

members on and help them identify those hot meals that we talked about earlier.

Housing, of course, is also a challenge for many of our members. And so we work to support them and the communities where they live by really trying to proactively engage with those members and the agencies that work with them to help prevent homelessness. And then assist with eviction diversion and secure sustainable, affordable housing for our members.

So on the left-hand side, you can see what that approach looks like. So it really is about, you know, how do we find those members that have these kinds of challenges? Whether that's looking at our claims data. We've got some excellent digital tools that help automatically bring those members before us and help us understand what their needs are, and then we can route them to the appropriate place at Humana to offer them help. Of course, our case managers are very actively involved in this with the assessments and the referrals that they're able to make.

And then, of course, we know we have to identify and build key partnerships with community-based organizations. So we have a lot of those partnerships throughout the state. And then we help identify, maintain, and I think very importantly, advocate for sustainable resources and additional revenue streams that might be available in the state for housing programs.

We've got a lot of great success stories I'll very quickly highlight. Nationally, Humana has been very involved with addressing food insecurity, housing needs, and social determinants of health for several years now. And housing, in particular, since 2021, we put a lot of investment into that. Across the nation, we've invested more than $50 million to create affordable housing capacity, that includes here in Kentucky. And our care service team is also partnering with one of those affordable housing units here in Louisville to pilot some opportunities to offer additional wraparound services to the people that live in that facility.

We also have a community management team and a population health team, and they work very closely with our community health workers to deploy similar wraparound service events across the state. We're hoping to do at least one per region this year. And an example of an investment that we make here locally is a $10,000 grant to support the Fayette County Public Schools' McKinney-Vento Program, which, again, specifically is focused on homelessness for children.

As we've already heard several folks on the call say, you know, when we think about social determinants of health, oftentimes, we know our members have lots of needs. So this slide goes into some of the transportation resources that we're making available through value-added services, but also through some pilots.

I won't go into all of these, but one that I think is really cool that we've recently launched is what we're calling our Doula Dash pilot. So this is similar to Uber or Lyft, where your driver can take you

where you need to go for your appointments, but those drivers are trained by professionals and doulas. And that person can assist with transportation, but also provide child care while the parent and their child are going to their necessary appointments. And then you can see some other examples of some transportation needs that we're helping address through various benefits and through pilots.

The final resource that I'll share is our Workforce Development Program. You know, obviously, employment is one of the most critical social determinants of health that our members face because it provides access to many, many other resources. And so some of the program specifics that you see on the left-hand side will make sure that our members that want to participate in this program have access to a coach to really help them through navigating everything that's available to them.

And then, there are some eligible benefits on the right-hand side. And a lot of those are value-added services that we

offer to any of our members, but if you are working on -- if you are part of our Workforce Development Program, you have access to some additional resources, and our employment coaches help our members navigate those things.

We, too, have a lot of awesome stories that we would love to share about members that we've been able to support. Wish I could share all of them, but I'll share this one. This is a real member. It's not her picture, but this is a story of a real member who identified -- who we were able to identify needing some financial and food support.

In her case, she was out of work because she'd had spinal surgery, and so she needed support with both of those things. And so our amazing social determinant of health coordinator reached out to that member, helped them complete a needs survey. We learned that they had fallen behind on some of their utility bills. They needed assistance with finding food resources, so our social determinant of health coordinator

was able to help with that. And that member walked away saying, hey, you know, our food resources that were provided to her really helped her and her family be able to eat without concern, and pay their utility bills, and start to get back on their feet.

And the last slide that I'll show are examples of some of the other initiatives that we have here in Kentucky supporting social determinants of health. I won't go into what everything that you see on the slide, but you can see these are great examples of some of our partnerships and different initiatives. Things that we've been able to do after a disaster.

One thing that I want to show, though, on the left-hand side that I'm particularly proud of. You know, not only do our Humana associates engage with our members, but they really care about our communities where those members live. And so, in 2022 alone, we had over 4,000 Humana employees track 53,000 community volunteer hours in Kentucky alone. And they donated their own dollars, $1.3 million last year.

And many of those dollars went to organizations supporting social determinants of health.

And, of course, the Humana Foundation is also very involved with Kentucky, and they were able to invest more than $14 million to nonprofits across Kentucky in support of health equity and social determinants of health last year, as well.

And I'm happy to take any questions if there are any.

MS. GRIGSBY: Thank you.

MS. CLEMENTS: Thank you.

MS. GRIGSBY: I think we have a couple of the MCOs left. I think WellCare and United. Would either of you all like to go next?

MR. OWEN: This is Stuart Owen with WellCare. Not to jump ahead of United in the alphabet, but I guess I just did. Let me share my screen. Sorry about that, United. I apologize.

MR. IRBY: That's okay, no worries. We'll go next.

MR. OWEN: You know, we're last all

the time with the W, so it's nice to not be last once. Can you all see the presentation?

MR. IRBY: We can, Stuart.

MR. OWEN: All right. Thank you, appreciate that. So first of all, homelessness, and of course -- and by the way, it's neat listening to the other plans talking about all the stuff they do. I know we all do a lot of great stuff, so it's really interesting to hear.

You know, of course, it begins with the data. You know, you've got to identify what the needs are, and so we have a gigantic database. We have a community engagement team that uses -- we have internal data sources. We also have a lot of our community partners that we contract with to give us data, and then also, the public. There are quite a few publicly available sources regarding social determinants of health.

And so here's just an example, this slide, we kind of rank counties by social economic status. And this is basically, you

know, poverty level, unemployment, education. And so we've got our members, you know, for each county you can see there on the left. And then to the right, you can see we actually have the social determinants of health needs, you know, broken down to a county level.

And then we have different partners. These are essentially our community engagement partners, and we pay -- have them on contract, essentially. And they are required to help identify social determinants of health needs, address the need if they can, and if they can't, to let us know. And so we have a network of those across the state, and that's just an example of that.

And then, you know, we have our -- along with this, we have our community connections helpline that we launched in 2014 where literally anybody can refer anyone for a need, whatever the need is. Obviously, we get referrals from providers. Certainly, you know, like, our community partners or members. Anybody can call, and

literally, just call our connections -- community connections helpline. And so we immediately will be working, you know, can we address the need? Who can address the need? Whatever it is, and of course, this obviously includes food and homelessness, which we're talking about.

And so then, here's an example, you know, some data on the referrals that we've had.

And so regarding homelessness specifically, we're a founding partner with an entity known as Hotel Inc. They're in the Bowling Green area, and they help members who are experiencing homelessness, and particularly, during episodes of care. And so they help them in many different ways, you know, basically get back on their feet. As you can see there, it could be food, transportation, access to docs, you know, I mean, obviously, navigating the healthcare system is a big challenge for a lot of people. Care management, and then we have, you know, I have an example here.

There's a woman who was struggling

with addiction who lost custody of her kids. They were living with relatives, and she entered through a community mental health center, CMHC referred her to Hotel Inc. That got her on the road to getting treatment, and then eventually, she was reunited with her kids. And, you know, over a year later, still with her kids. She was still getting outpatient treatment but still with her kids.

And then for our partners, we actually track because we want to see, you know, I mean, we're funding them. Well, is it making any difference at all? Is it moving the needle? Is it helping? Is it not? You know, we're constantly identifying, and every year we kind of revisit our contracts with our community agencies and see who's really doing something, who's helping.

And so, like, Hotel Inc., for example, over time, 23 percent reduction in ER visits. Some of these are people that have, you know, benefited from it -- 18 percent reduction to flu visits,

67 percent reduction in inpatient admissions, cut in half readmissions, which is a key thing.

And on the next slide, we've got another similar partner, Welcome House, that's in northern Kentucky, does the same thing very similar to Hotel Inc. And then, you can see we've got the data there, as well. Twenty-two percent of the WellCare members that have benefited from Welcome House have found sustainable housing. Forty-eight percent went to a PCP, 43 percent reduction in inpatient visits, 33 percent reduction in ER visits. And this is, you know, we track this over time, the numbers.

And then, you know, our care management team, as well. Here's some initiatives that we have. We've got a Housing for Homeless initiative with care managers. We have refugee assistance. And I believe that's definitely in the Bowling Green area, as well, for certain. Project Release: Individuals being released from incarceration, obviously, they need, you

know, they're going to have social determinants of health needs, and housing, you know, is a critical one. So it's our care management team, as well, is involved.

And then transitioning to food insecurity. These are some examples that we have. This is one from last year, Fulton County. Well, it's a food desert area. And, especially, we're talking about fresh food, and, you know, of course, that's a critical thing with anybody is eating, you know, we're all supposed to eat our veggies and fruits. But, you know, a lot of individuals, you know, particularly the Medicaid population, maybe haven't been accustomed to that, you know? And so, we partner with Fulton County Farmer's Market to launch this initiative to get fresh produce and teach about fresh produce and the importance of it. And to, you know, provide it, we help fund that.

In Florence, Kentucky, you know, there's a food pantry, as well, that we've partnered with; Owensboro, as well; Owen County; Water into Wine, which is kind of

interesting. They were actually getting into the carbon readmission -- carbon footprint reduction thing, converting their heating sources to bottled gas, and establishing a community garden, which is pretty cool. So that's one of our partners there.

There's a couple that I want to call out here, as well. Fresh Rx for Moms, which launched over five years ago. It's all about getting, again, healthy food, produce to Medicaid moms and then teaching. And, you know, they also include actually home-delivered meals, but actually teaching about the importance and, you know, with their kids, as well, and how to eat healthy.

And then, Black Soil Kentucky specifically connects black farmers, but they were kind of monitored -- or mentored by Fresh RX for Moms. And so they launched this similar initiative for black farmers in getting produce to urban areas, which is really cool. And it also includes, you know, meal prep and delivering meals.

And then another one, and then this

final -- here's a photo here from a woman at the Fulton County Farmer's Market. She's saying, "I love vegetables," holding a sign there. And that's just a reminder to all of us on this call that we need to eat our veggies, so that's why that's there.

And any questions?

(No response.)

MR. OWEN: All right. I'll stop sharing.

MS. GRIGSBY: All right. Thank you. All right.

MR. IRBY: All right.

MS. GRIGSBY: Thank you, guys, all. And, United, it's your turn. Last but not least.

MR. IRBY: Perfect.

MS. GRIGSBY: Yeah.

MR. IRBY: Thank you so much. I'll present our screens -- or our slides here, so let me just go ahead and share.

All right. Would somebody mind to confirm that you can see my slides?

MS. GRIGSBY: Yes.

MR. IRBY: All right, thank you.

Well, I'm Greg. I'm our chief operating officer for the Medicaid plan for United here in Kentucky, and I really appreciate you letting us have a few minutes to talk a little bit about how we engage our members.

I think the things that you're going to hear from every MCO and what we've heard today is that our No. 1 interest is making sure that we understand the patients' needs. We're going to use data. We're going to use interactions from the patients and our members, and we're going to collect those needs, and we're going to allocate those in a system. We're going to look through that and analyze it, and we're going to connect them to community resources.

So we're very similar. We've got really helpful data tools that can help to collect all of the data that we have from our members, whether it's through a file, through community resources, or through the actual interactions with members. And we are going to aggregate that data, and we're going to learn a little bit more about those members and what needs they actually have.

We, like everybody else, we have a member-centric coordination approach where we want to make sure that we understand who the patient is that we're talking to and connect them to the right community resources. As we've done that, we've seen these five top needs from our members that are nonmedical. We've seen financial needs, nutritional needs, housing, transportation, and family circumstances. So I'm happy that we're able to focus on nutrition and housing today.

Before I get into our approach, I want to talk a little bit about our team. Our team takes a really personal approach to how we engage with members. I am a foster parent to a sweet eight-year-old boy. My son was removed from custody of his biological parents because of all of these needs that you see here. They did not have access to transportation. They were experiencing homelessness. They had nutritional gaps. They had family issues. They had financial issues. And because of that, that led to a host of issues for the

children. They did not have access to the care that we would want to provide our members. They didn't have access to the community resources that a lot of us take for granted.

And so I can say on a very personal level that I very much understand the impact that social determinants of healthcare have, not only on an individual, but a generational impact on families. I am happy to say that my son's biological family they are getting their mental health needs met at this point. They are addressing some of their social determinants, as well. And so I'm watching that story be rewritten.

So I'm happy to be a part of that, but I say that just so that you understand our team takes this very, very personally and very seriously, and we're honored that we get to be a part of this.

So we'll talk a little bit about homelessness and how we engage members who are experiencing homelessness. So a couple of key bullets here that I will not read through all of them, but we start with

responsive interactions, meaning as members reach out to us, we're learning more about them, and we are addressing the needs that they tell us. And then, we are doing proactive case management.

So you'll see some different tools that are listed here that we utilize. We see a hot spotting-tool, health risk assessments, things like that. All of that just to say, we learn about our members up front. We understand their needs, and we help connect them to resources that will benefit their lives.

You'll see the words close loop process here. What that means is as we refer members to our community partners, we're hearing back from the community partners on whether that connection was successful. So we're using an outbound call system to make sure that the member did get the services that they need. If not, it allows us the opportunity to follow up with the member or that community partner.

We're doing targeted housing navigation through individual referrals. So

we've got folks on our team who are dedicated to health equity and SDoH. And so those folks are helping to make those targeted navigation.

And then, we'll talk a little bit more about this, about our strategic community partnerships and investments. But you'll see a few folks listed here -- or a few community partners listed here. The point behind this is that we understand that healthcare exists in an ecosystem that's much larger than us. So we believe very much that we are part of a community of resources, and we hope to partner with the community.

Our enrollee services director is also on the line today, and so she'll talk a little bit about some of our partnerships, but just in general, we do see this as a collaborative approach.

On that thought, there's a couple of national partnerships that our organization is involved with: The National Healthcare for the Homeless Council. This is a board that we sit on. This is something that we

support, and this is an organization that is focused on helping folks who are experiencing homelessness and ending homelessness.

Another organization that we partner with is A Call to Invest in Our Neighborhoods. You'll see that acronym, ACTION. So this is another organization that we partner with. Honest, this coalition, it constitutes more than 2,300 organizations and businesses. And so this is one of our national partnerships, as well.

One thing that we are focused on: Not only how we engage members who are experiencing homelessness, but we're also focused on how to prevent homelessness from occurring to begin with. As we look at our members, we understand that there's certain contributing factors that can make them susceptible to future homelessness, and we're trying to mitigate those needs. A couple of the things that we are doing, you'll see preventative partnerships here.

So No. 1, we're working with the

Goodwill organization. We are sponsoring expungement and reintegration clinics. Through this partnership, we've seen more than a thousand folks have their records expunged, and they're able to reintegrate into the job force because of that. They have more access to housing resources because of that. And so that's one of the partnerships that we are really committed to and really excited about.

You'll see the On My Way tool. This is a tool that's focused on people who are entering adulthood. So I think of -- I think of folks who are exiting childhood. A lot of times, they are coming through, whether it's a justice-involved member or potentially a DSS-involved member. This tool, it helps to develop skills that are necessary for adult life.

We also have some of our staff members who are participating on housing boards. So all of these things are ways that we are contributing to preventing homelessness, not just addressing it when it's there.

So, Ashley, I'd love to let you talk a little bit about some of our community partnerships as it relates to homelessness.

MS. HOBBS: Thanks, Greg. One that I did want to identify or highlight for our homeless population is our White Flag Initiative. So we provided free laundry services in the Corbin, Kentucky area.

In addition to the laundry services -- so folks could come in and get free wash and free dry. We also had other health-related services available. So they were able to get any immunizations, other health screenings, work with the community health worker on any SDoH-related needs. And then, in addition, provided healthy snack bags, so they were able to take some food with them after they did their laundry.

MR. IRBY: Perfect. Ashley will talk a little bit more about some of our community partnerships as it relates to nutrition and food insecurity, but you can see the different organizations that we have highlighted here. This is just a handful of partnerships that we've built throughout the

Commonwealth. So -- and we intend to continue that.

When it comes to food insecurity, you'll see similar processes. Members are able to reach out to us with these needs, and we try to identify those proactively, as well, as we interact with folks through our case management opportunity -- or our case management interactions. We also try to help our providers understand the resources that exist, which is one of the reasons I'm glad to be on this call. We want every provider on this call to understand that your MCO is able to help you solve some of these gaps. If the member needs help, please give us a call. We are able to help with those needs.

So some of our program solutions for folks experiencing food insecurity, we are offering a few weeks of meals after a discharge for members with certain diagnoses. We're also doing that after birth for new moms, making sure that they're coming home to some healthy, quality meals, that they don't have to think about that.

We also offered nutritious meals as a Covid vaccine incentive. That was one thing that we had offered last year, and that seemed to work well.

You'll see similar items here in the bullet, so I'm not going to read these through about how we identify these needs and close them, but I will talk about some of our strategic community partnerships. A couple of weeks ago, I had the opportunity, along with my team, to volunteer at the Dare to Care food bank or food pantry. Dare to Care is a Louisville organization, and they are doing some really interesting things for the community. I was really impressed with the way that they are trying to innovate the space, and I've never heard some of the things that they are doing.

So rather than a standard model of taking in canned goods, giving out canned goods, they're taking those canned goods, and they're repackaging them into ready-to-heat meals. So it's a much more family-friendly -- it's a much more person-centered way of helping people by

using those products and making them ready-to-eat.

Another thing that they're working on is a dehydration process. They've had to go through lots of approvals all the way -- I think they mentioned they had to go through NASA approval for some of this process. But what the dehydration process does it allows them to dehydrate the meal, and anybody who has access to a hot water source, they can rehydrate that meal, and it becomes a nutritious and appropriate meal for them or their family. So for a person who's experiencing food insecurity or homelessness, for that matter, just the ability to walk into a gas station and have access to a hot water tap that allows them to have a meal.

And so I'm really impressed with what Dare to Care is doing. It's a partnership that we're going to continue to grow into, but I wanted to take a moment on this call really to just plug their organization. Like I said, they are Louisville based, and for the folks who are on this call who are

in Louisville, as you have patients come into your practice and they express needs around their food insecurity, I would encourage you to keep this organization in mind as a potential resource in the community.

So, Ashley, I'll pivot over to you again to talk a little bit more about some of our other partnerships that we've maintained in the food space.

MS. HOBBS: Thanks, Greg. So looking at our work around food insecurity, obviously, you can see we have very different community-based organizations that we've partnered with across the Commonwealth to really lift up and support the great work that they're already doing.

One of them that I wanted to highlight for this section was around Need More Acres. So they're based out of Allen County. We're really excited to support their Food is Medicine program, and this is for individuals experiencing food insecurity, chronic conditions, or any health -- other health-related factors to

increase the consumption of fresh foods.

At the end of this program, I can say of the over 1,200 participants that were involved, 100 percent saw an increase in fresh food access, 92 saw an increase in consumption of the fresh foods, and 88 percent reported an improvement in their primary health goal. So we're really proud of that and continuing that partnership with them.

And then the other one that I was very excited about. Kind of plug their organization for you all, as well, is Lend-A-Hand. So it is a food and basic needs pantry that's located in Knox County. It just recently opened a couple of weeks ago, so if you have any clients, patients, members in that area, feel free to send them that way, as well.

MR. IRBY: Perfect. Thanks, Ashley. Any questions for United?

MS. GRIGSBY: Thank you. I am completely amazed and --

MS. SMITH: Me too.

MS. GRIGSBY: -- excited about what

I'm seeing -- all of these -- all of your organizations do. As a provider who deals with a lot of these families, this is such great information for how you guys are bridging the gap for so many of these families, so thank you.

MS. SMITH: Yeah, I had no idea that all of these services were available. I don't know where I've been, but we see families who need a lot of these things, and I would've not had any idea that -- I mean, I know of some of the things, like transportation, and, you know, some of the nuts and bolts that get them to our center for appointments and so forth that they can get through their, you know, Medicaid benefits.

But I wondered, and then anybody can speak to this, I wondered if there's anything -- I mean, I can't imagine what it would be after hearing everyone speak -- if there's anything that you guys are routinely asked for that you find to be a gap for families? Like, it just seems like you're covering almost every base I can think of.

MS. FOMBY: I would say the one thing I noticed the most is just the resource deserts. In rural areas, it is so hard. That's one reason I am really thankful that we've been able to develop stuff that we can offer the members directly because we do have members in very, very rural areas that have limited to no resources. Like, you might have one food bank --

MS. SMITH: Yeah.

MS. FOMBY: -- covering three counties, and because of that, they may limit it to a family can only go once a month to get food. And, you know, we know food --

MS. SMITH: Yeah.

MS. FOMBY: -- from a food pantry once a month is not going to be able to help the family. So not long-term anyway.

MR. IRBY: Yeah, I think that's a really good observation. I think as we design our programs, equity is at the front of our mind, and oftentimes, geography is a contributor to equity gaps. And so, as we start to think about our solutions that

we're implementing, we are definitely taking geography into play.

So Ashley talked about one of the food pantries that had just opened. This was one of the initiatives that United was grateful to support and to partner with this organization, but it was in one of those places. And so I think as we look at some of these rural areas, I mentioned this while we were presenting, but collaboration is key here.

And so what I would say is as you see needs, the more we can communicate them in forums like this, I think the better. Because you've got a group of folks -- I don't look at United exclusively here. You've got a group of MCOs who are really ready to partner with you to help solve some of those gaps. And I think we accomplish a whole lot more together.

And so even just the simple act of mentioning that, I think it's a really positive start, and I think the more that we can communicate and collaborate, the better off we'll all be and the better we'll be

able to serve members.

MR. OWEN: Yeah, what Bethany and Greg said. Absolutely, because, you know, we can do initiatives to help, but, like, what Bethany's indicating, it's gotta be sustainable, you know?

And so, one of the things that we, in 2022, that WellCare has launched some community collaborative councils where we try to get all of the stakeholders, you know, civic leaders, community leaders, and actually host events to kind of get everybody together, and brainstorm, and identify, you know, what the needs are in the area and who can do what.

This is kind of a new thing that we started last year because, you know, it's not just one MCO, you know, like Greg was talking about. I mean, it takes, you know, a big coalition, basically. And so that is, it's absolutely critical.

MS. SMITH: I want to give a chance for anyone to speak about any of the gaps I mentioned, but I did have one other question for really anybody. And that is if a member

qualifies for, you know, their insurance or their, you know, MCO, do they automatically qualify for all these programs, or do they sort of then have to go through processes to apply? And I'm assuming there's probably some kind of application process for some of them that's separate, but that was another thing that was going through my mind more broadly as everyone was speaking.

MR. OWEN: Most of it's just calling customer services. You know, like for the value-added benefits that address those determinants of health and stuff like that. You know, there are some where there has to be criteria. For example, like pregnant -- the mother's pregnant to get a stroller.

MS. SMITH: Right.

MR. OWEN: But for a lot of them, it's just simply call our member customer services line and go from there.

MS. FOMBY: And for Anthem, similar to what Stuart said as far as when it comes to the value-added benefits. It -- you know, there may be things, like, that are specific to pregnant moms or children, but

as far as, like, our empowerment program, any member that has Anthem Medicaid automatically qualifies if they have a social need.

And whether it's, like I said before, as far as referral wise, they can come from anywhere: The members self-referred, the providers, community organizations, internal. So we want to make sure that we're not setting, you know, any limitations there to who we're going to be able to assist. Because social determinants of health do not discriminate and they do not pick certain populations to, you know, have an impact on, so.

MR. IRBY: Yeah, for United, it's similar. So the benefits that we've talked about, there's not a separate qualification process for us. It's really just a: Let's identify the need, let's connect with our customer service or case managers, and let's see how we can solve that need.

One tool that I will bring up here since we're talking to a group of physicians. Within our provider portal,

you'll see a community cares option. This is your opportunity to interact with actual case managers for your patients. And so this is an opportunity as you see needs, if you use that tool, you can actually connect with the case managers. This is something that I don't think we have a lot of utilization on, but it's a good referral mechanism.

MS. GRIGSBY: Thank you, all. I'm just looking at the comments in the chat.

"As someone who grew up in a small rural area, one of the challenging things people in these areas find is that it's often urban solutions that are trying to be applied to rural problems. The people being served always need to be at the forefront."

MR. IRBY: Can I give a, for instance, on that?

MS. GRIGSBY: Sure.

MR. IRBY: That is such a good observation. Before I worked directly in the medical space or the healthcare space, I worked with medical transportation. And you hear Uber and Lyft referred to at times on

how they can be an extender for medical transportation needs. This was one of the key ways that we saw disparity in access between rural and urban communities. Uber and Lyft they're going to be fantastic in Louisville. They're going to be pretty good in Lexington. They are not going to be helpful in the eastern part of your state.

And so I 100 percent agree that there's no one-size-fits-all solution to SDoH or healthcare needs. And that's where I think making sure that we take a member-centric focus. It eliminates some of those disparity gaps.

MS. CLEMENTS: Yeah, here, here to that, Greg. I think that, you know, as you guys saw, we had Humana, all of the MCOs on this call; we're really trying to take that member-centric approach and offer a variety of value-added benefits. But at the end of the day, there are still gaps, right?

You know, for the broader population, and I think, you know, we've spoken a lot about rural Kentucky experiencing many of those gaps. I think, ultimately, it would

be excellent to see, you know, Medicaid as a whole be able to reimburse more of these kinds of social determinants of health support services. But in the interim, this is how we're trying to address some of those gaps is taking that kind of member-centric approach.

MR. OWEN: I wanna throw in on that note; that just reminded me, and I don't know if everyone's aware that community health workers will be a Medicaid-covered benefit. I think it launched 7/1/23, and so this is literally we, the MCOs, will pay providers. Providers can hire community health workers, and they address social determinants of health. So we will be paying for that.

And I think it's -- I mean, it really is, you know, a lot of the legislation gets passed during sessions. And some of you don't know what's the value of it, but I think this is definitely going to be, you know, very valuable and actually help move the needle in addressing social determinants of health.

And I know when the bill was passed about a year ago, I think there were 100 certified community health workers in Kentucky. It's probably grown since then, but anyway, that, I think, is going to be really critical.

MS. SMITH: So, can I clarify? Are you saying that if, like, a physician's office wanted to hire someone to help link -- to help you guys link them to resource -- patients to resources, that service would be reimbursed?

MR. OWEN: Yeah. There's three CPT codes that will be on -- they're -- DMS is about ready to put them on the fee schedules, from what I understand, that you will be able to bill. And it's doc offices, different providers; I don't recall the whole array of providers, but literally, you can have a CHW on staff, and they can provide these services. And it's how many members -- basically caseloads. There's a CPT for one patient, and I think two to four, five to eight with different rates, but they will be billable Medicaid-covered

services.

MS. PARKER: I have a presentation -- this is Angie with Medicaid. I have a couple of slides that I can show you all that -- I don't know if you want to take the time now or not, regarding CHWs.

MS. GRIGSBY: Yeah. Well, and one of the things I think that we're talking -- I mean, we can certainly do that now, but we're also asking for a DMS report on social determinants of health in September's meeting. So I don't know if you want to share this now or if you feel like that would fit into that conversation.

MS. PARKER: Oh, it would be -- it could potentially be, but I can go through this real quick if you have the time. We're doing this presentation -- Justin Dearinger and myself are doing this presentation for a -- and I don't remember what they stand for, but an organization next Tuesday, so I have all this information now.

MS. GRIGSBY: Okay.

MS. PARKER: Ready to go.

MS. GRIGSBY: Okay.

MS. PARKER: Well, hold on. I gotta get back to -- okay. Here we go. Kelli, if you can give me access, I can share.

MS. SHEETS: Give me one minute.

MS. PARKER: Okay. All right. Let me get this, and then, there we go. So the presentation, I won't -- I can bore you, I guess. But basically, initially giving you a quick overview of Medicaid. We serve 1.7 million members. Forty percent of those are expansion. Over half of Kentucky's children are enrolled in Medicaid. We have 69,000 enrolled providers. We have a $15.1 billion total budget.

So in 2022, in the legislative session, House Bill 525 passed, and -- which meant for Medicaid by January 1st, 2023, to seek approval from CMS for services delivered by community health workers to be reimbursed. And that was to include public-private partnerships, and by January 1st, 2023, no person shall represent himself or herself as a CHW unless certified. And certification requirements are to be -- were to be incorporated in the

administrative regulations.

Here are some of the activities that went on. We collaborated with public health. We had stakeholder engagement meetings. State plan amendment was submitted to CMS in February of 2023, and we received approval in March of 2023. And service began July 1st, and then I've -- so July 1st, 2023 is when the CHW services will start to be reimbursed.

We've also, in additional activities, get to roll this out. We did evaluate the budget impact. We engaged the MCOs, as Stuart has talked about. We developed FAQs, there are provider notifications, and we have information on our website.

Qualifications for a CHW: They have to be a legal resident, be employed as a community health worker in Kentucky, be at least 18 years of age, and they must meet and maintain certification or recertification requirements.

The certification: They have to complete a competency-based training program and documentation of successful completion

of a minimum of 40 hours of verifiable mentorship. This can be through the Department for Public Health.

Eligibility based on experience. Education requirements, and services they can provide: Preventative services, health education and promotion, facilitate provider communication, patient education, and other approved services by DMS.

So who can offer CHW services? Approved practitioners or physicians, physician assistants, nurse practitioners, certified nurse midwives, and dentists.

And the types of providers who may bill. There's a list of all of those: AODE, behavioral health -- BHSOs, CMHCs, FQHCs, a health system, group of physicians, a hospital, a local health department, a primary care clinic, a rural health clinic, or another Medicaid participating provider that is approved by Medicaid.

And here are the billing codes that Stuart was mentioning. There are the three codes. CPT 98960, that's for one patient and $22.53 for 30-minute increments. CPT

code 98961, which is for two to four patients, and it's $10.88 per patient with a 30-minute increment. And then CPT 98962, five to eight patients, and that's $8.03 per patient for a 30-minute increment. This is limited to two units per week per member. No more than 104 units per calendar year. And these particular codes are going to be added to the dental fee schedule, as well, so dentists can also bill with these codes.

There are other requirements for CHWs. They cannot enroll as an independent Medicaid participating provider. They must be related to a medical intervention outlined in the individual's care plan. They will not be reimbursed if they are being paid via federal funds; reimbursement is included in a per diem or cost settlement type payment; or if they're employed by a managed care organization. CHWs are not eligible for WRAP payments.

Additional MCO miscellaneous information: MCOs will reimburse, and they also may hire -- which they do hire CHWs for their care management programs. There is no

requirement for the provider to see the patient first; however, the patient's file should clearly document the need for the service. Fee-for-service Medicaid will reimburse for CHWs, and there are no place of service requirements or restrictions for CHW services; however, there is no reimbursement for transportation.

So that is a very down-and-dirty presentation of CHWs. Any questions?

MS. GRIGSBY: Okay, thank you.

MS. PARKER: Now, we do have this information on our website, as well.

MS. GRIGSBY: Okay, thank you. Any other comments or questions before we go onto new business?

(No response.)

MS. GRIGSBY: Thank you, guys, so much for all of these presentations. Very helpful information and pretty awe-inspiring to me. I'm amazed at what's going on.

Okay. New business: We wanted to just -- we had talked last time about having a DMS report on social determinants of health as our agenda for September 13th's

meeting. Is that still okay? I know last time we didn't have a lot of folks from DMS because you all had a conflicting meeting, so I just wanted to make sure that was still okay as our main agenda item for September's meeting.

MS. PARKER: Well, I guess I need to look. I mean, we can certainly work towards that for sure. When you -- it's a very broad subject.

MS. GRIGSBY: Mm-hmm.

MS. PARKER: So are you wanting to -- what are your expectations for this presentation when it comes to social determinants of health?

MS. GRIGSBY: Yeah, I think -- and certainly other members can correct me, but we certainly wanted kind of a follow-up on resources and statistics, particularly around homelessness and food insecurity. Am I recalling that correctly, other members?

MS. SMITH: Yes.

MS. GRIGSBY: Okay.

MS. PARKER: I can also share with you we just, in the Disparity TAC, we did a

presentation on transportation that you might be interested in, as well. I was hoping you would say that because I already have something on that.

MS. GRIGSBY: Okay. Then, yes, that would be delightful.

MS. PARKER: But we will see what we can do for homelessness and food insecurity. Like I said, we just did a presentation on transportation and the issues in Eastern Kentucky.

MS. GRIGSBY: Okay.

MS. PARKER: We didn't -- it wasn't a global for the state, but there was a reason behind that because that's where the -- where -- we targeted that area because 50 percent of the population are on Medicaid.

MS. GRIGSBY: Okay.

MS. PARKER: So that's why we targeted Eastern Kentucky, but we'll look to see what else we can add to that.

MS. GRIGSBY: Okay. Yeah, no, that would be very helpful information. Okay. Under general discussion, future topics:

This is certainly something that we can discuss when we talk about -- if we want to stay after and talk about next month's agenda -- or next meeting's agenda, but I didn't know if anyone had any compelling things that we felt like we needed to add given today's presentations.

(No response.)

MS. GRIGSBY: Okay. Would we -- my thought is that we wait on any recommendations to the MAC until after the presentation in September. Would you all agree with that?

MS. SMITH: That sounds good.

MS. GRIGSBY: Okay. MAC meeting representation: When is the next MAC meeting?

(No response.)

MS. GRIGSBY: Kelli, are you still there?

MS. SHEETS: I am. I'm looking to clarify just to make sure. I think it's the 17th?

MR. OWEN: Twenty-seven -- I think it's July 27th.

MS. SHEETS: Yes, you are correct, July 27th. Thank you, Stuart.

MR. OWEN: Sure.

MS. GRIGSBY: And again, that's a Thursday, which is my clinic day. So I don't know if I need to get farther ahead so that I can block clinic schedules, but I didn't know if anyone would be available to attend the MAC as our representative. I think, Courtney, you also have clinic on Thursdays.

MS. SMITH: I do. I know that --

MS. GRIGSBY: I know Alicia went last time, I think.

MS. SMITH: Yeah, that's what -- I think so.

MS. WHATLEY: Yeah, I can attend in July. Obviously, mostly just to listen since we don't have any recommendations --

MS. GRIGSBY: Okay.

MS. WHATLEY: -- but I'm happy to share that with the group.

MS. GRIGSBY: Okay. Thank you.

MS. SMITH: Thank you.

MS. WHATLEY: Mm-hmm.

MS. GRIGSBY: Our next meeting is September 13th from 2 to 4. If the two members would like to -- and Kelli would like to stay on to kind of clarify the agenda for the next meeting. And then, I will take a motion to adjourn unless there is any other discussion.

MS. SMITH: Thank you to everyone for your presentations, though. It was awesome.

MS. GRIGSBY: Yes, it was wonderful. Thank you. Do I have a motion to adjourn?

MS. SMITH: I'll motion to adjourn.

MS. GRIGSBY: And a second?

MS. WHATLEY: I'll second.

MS. GRIGSBY: Okay. And I assume we're all in favor, so if you guys could just stay on, and Kelli. Thank you all for being here, and thank you for your presentations. And thank you for all the hard work you're doing.

MS. SMITH: Mm-hmm.

MR. OWEN: Thank you all. Everybody have a great evening, and remember to eat your veggies.

MS. GRIGSBY: I'm going to go home

and eat a vegetable in your honor.

(Meeting adjourned at 3:34 p.m.)

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CERTIFICATE

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

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

Dated this 27th day of July, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR