DEPARTMENT OF MEDICAID SERVICES
HEALTH DISPARITY AND EQUITY
TECHNICAL ADVISORY COMMITTEE

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Federal Certified Realtime Reporter

COMMISSIONER LEE: Welcome, everyone, to the very first meeting of the Health Disparity and Equity Technical Advisory Committee meeting. I'm very glad that you all are here with us.

And I think to get the meeting started we are going to kick this over to Cabinet Secretary Eric Friedlander to welcome you and say a few words.

Secretary Friedlander.

MR. FRIEDLANDER: Thank you, Lisa, Commissioner Lee, I appreciate it. And I want to welcome folks to this first meeting of our Health Disparity and Equity Technical Advisory Committee. I know you have probably talked to some folks about what this committee does.

And Medicaid is a big program. A third of Kentuckians, more than a third of Kentuckians, one out of every three receive their healthcare coverage through Medicaid, right about there. And that's a massive number and it is a huge piece of healthcare in Kentucky.

And we have, in the Cabinet, set up

what we call the things that we are looking at. So just to let you know, this is a part of a broader strategy within the Cabinet to make sure that we are addressing issues of equity in all our programs.

So we have a vision statement that really talks about communities and individuals living up to their full human potential. We then have five values underneath that supporting everything that the Cabinet does.

The first value, the first pillar as I call it, is equity; actually, racial equity. And we focus on racial equity to talk about the intersectionality of so many things that impact across the spectrum of the population in Kentucky.

Our second pillar has to do with resilience. Some of you may know that I was the chief resilience officer for the City of Louisville, best government title ever, for several years while I was working for local government. And resilience really was, that work that I was doing in Louisville was, kind of what we would look at for who it is that

we serve and the populations that we serve and the thread that runs through all of that, which is trauma, response to trauma, secondary trauma, and really working on that within the Cabinet.

The third pillar, it relates directly to Medicaid, we talk about our programs, Medicaid, SNAP, healthcare, and all of those kinds of things, and we always talk about that more as it relates to an individual but not how it relates to economic development and economic support for our communities. Basically, you wouldn't have a healthcare system without Medicaid. You wouldn't have a child care system in the state without our child care program. How many more food deserts would we have if it were not for SNAP? We talk about that in that context. And then how we support our employees here at the Cabinet to get to living wage and things like that, those discussions that we have.

And then the how do you get to health and wellness, which is the fourth pillar, unless you address the other three,

right? You can't have that discussion about health and wellness unless we are talking about it within the context of those values that the Cabinet is trying to promote.

And then, finally, kind of the operational excellence piece, which actually we can talk about this being a part of how do we know our systems internally to make sure that we are supporting the work that we say we want to do. So in the area of racial equity, inequity in particular, it is how do we build these systems within our systems to make sure that we are supporting that value across our systems. And Medicaid, being by far the largest program within the Cabinet, we need to have advisors, we need to have folks that help us look at our data, look at our information, challenge us as we talk about what it is that we can do better.

So your role within the Technical Advisory Committee, essentially it is to advise Medicaid on issues related to health disparities and equity. This is what we bring you all together to do, to help us with and how we address that. And, again, make

recommendations, hold us accountable, challenge us, that's what these groups are designed to do. So we invite you to do that.

It is an important piece. We have, within our equity pillar, we have folks who are developing racial equity plans for all of the departments in the Cabinet. We have -- you will hear from Vivian Lasley-Bibbs later on, who is the Director of our Office of Health Equity in Public Health.

But this is a Cabinet-wide initiative. And this is a reflection of that initiative. So I welcome you all. I invite you to give us your feedback, and I invite you to challenge us and hold us accountable as we work to make Medicaid as equitable across our system, not only for recipients but for providers, as we possibly can.

So thank you. I'm excited to begin this work with you all, and I hope that we all learn together. So with that, I will turn it back over to Commissioner Lee.

COMMISSIONER LEE: Thank you, Secretary. I would just like to echo the words that the Secretary just said.

You know, challenge us, hold us accountable.

You know, as he stated, the department covers 1.6 million individuals in Kentucky right now. We believe before the public health emergency is over we will even increase that number to 1.7 million based on the eligibility numbers that we are looking at on a regular basis.

And we know that we have challenges when we deliver the healthcare to our members. We know that there are shortages in some of our workforce areas that we need to address. And we're hoping that you all can help us figure out what we need to do to increase those workforces, especially as it relates to health disparity and equity, both racial equity and regional. We know that some Medicaid members have challenges because they are not only living at or below the federal poverty level, they have many chronic diseases, they have multiple issues, healthcare issues.

And one of the charges I think this committee can assist with also is breaking down those stereotypes and misperceptions of

the Medicaid members. We know that Kentucky ranks about 44th in the health rankings across the nation. And that ranking does not include just only Medicaid. It is the entire state. And we are hoping that the work that this committee does actually spills over into other populations that we do not serve in Medicaid, all of those individuals who maybe have commercial insurance. And we hope that some of our work, again, it is going to lift this entire state up rather than just the Medicaid population.

But we do have lots of information, lots of data that we will be glad to share with you to help drive some of those policies or recommendations, those questions. We also work with a lot of our state university partnerships, and we have just embarked on a new project with several of our universities that specifically look at some disease states in the Medicaid population and they also look at equity among the delivery of services on several of those projects.

So, again, welcome. We are very excited to have you help us and guide us to

improve the health status of those we serve. And I think that we have quite a few staff on here from Medicaid that is going to help you on this journey.

And I will kick this off to Senior Deputy Commissioner Veronica Judy-Cecil to say a few words and assist with introduction of the rest of the Medicaid team. Veronica.

SR DEPUTY COMMISSIONER JUDY-CECIL: Thank you, Commissioner. And it is a pleasure to be a part of this and to work with you all. As they mentioned, we are here to support you. We're so grateful for this opportunity. And I look forward to working with you over the next months and possibly years as we strive to improve the program.

I would like to then turn it over to Leslie.

DEPUTY COMMISSIONER HOFFMANN: Hello. I think we are going to go through our member introductions, or do you want me to go ahead and go with the state introductions first, Veronica?

SR DEPUTY COMMISSIONER JUDY-CECIL: Yes, let's have Medicaid introduced.

DEPUTY COMMISSIONER HOFFMANN: Yep. So my name is Leslie Hoffmann. I'm the Deputy Commissioner for Medicaid. And I'm the champion for change in the Medicaid department.

And I will kick it over to Jodi Allen.

MS. ALLEN: Good morning, everyone. I'm Jodi Allen. And I'm a behavioral health specialist with the Department for Medicaid Services. And I am also one of the core team champions for the racial equity initiative in Medicaid.

MS. PARKER: Hello. I am Angie Parker. I am the Director of Quality and Population Health within the Department for Medicaid Services. I look forward to hearing what you all have to say. And I will be talking about -- more about my division here in a little bit. Thank you.

SR DEPUTY COMMISSIONER JUDY-CECIL: Other Medicaid staff who would like to introduce themselves. Dr. Theriot.

DR. THERIOT: Hello. I'm Judy Theriot. I'm the Medical Director for

Kentucky Medicaid.

MS. RICHARDSON: Good afternoon. My name is Amy Richardson. And I'm the Director of Fiscal Management here within Medicaid.

MS. DUDINSKIE: Hi. I'm Jennifer Dudinskie. I am the Director of the Division of Program Integrity in Medicaid.

MS. SMITH: Hi. I'm Pam Smith. I'm the Director of Long-Term Services and Supports within Medicaid Services.

MR. DEARINGER: Hello. I'm Justin Dearinger, the Acting Director for the Division of Healthcare Policy in the Division of Medicaid.

SR DEPUTY COMMISSIONER JUDY-CECIL: All right. I believe that is all of the Medicaid staff.

DEPUTY COMMISSIONER HOFFMANN: Okay. So we will go ahead and move to the members. And for the members, I will give out the names on our list. And tell us your name and why you are here today, why you are participating. So first is Wanda Figueroa.

DR. FIGUEROA: Okay. Hi. Good

afternoon. I'm Dr. Wanda Figueroa. And I am the President and CEO of River Valley Behavioral Health. So, essentially, I am a behavioral health provider.

I am pleased that this committee came together to address these issues. I feel like I have -- I was born into this advocacy. And I'm both -- by my personal experience and the work that I have done over more than 20 years in behavioral health and healthcare in general, I think it is the right step to bring different community leaders to address these issues. So I am very hopeful and look forward to working with you.

DEPUTY COMMISSIONER HOFFMANN: Okay. And next I have Thomas Bowman.

(No response)

DEPUTY COMMISSIONER HOFFMAN: Okay. Patricia Bautista.

DR. BAUTISTA: My name is Patricia Bautista-Cervera. I'm a physician in public health, master's. I work for La Casita Center. I'm the health empowerment coordinator at this grass roots community

organization that serves and accompanies the Latinx community in Louisville, Kentucky. The migrant community is our main community. And I am here to learn and advocate and support as much as I can.

SR DEPUTY COMMISSIONER JUDY-CECIL: Wonderful. Next I have Marcus Ray.

MR. RAY: I apologize. I'm on the road working a funeral service today. But my name is Marcus Ray. Can you hear me?

DEPUTY COMMISSIONER HOFFMANN: Yes.

MR. RAY: Yes, okay. I'm the state President for the NAACP. And I'm excited to be here. I think a lot of times when these programs take place they don't always make it out to all of the communities. And, so, I'm here to kind of bridge the gap and make sure that the information and the services are received in the community like they are intended, as this committee forms and puts together. Thank you.

DEPUTY COMMISSIONER HOFFMANN: Wonderful. Thank you. Next I have Kiesha Curry.

MS. CURRY: Hi. I'm Kiesha Curry.

I'm from Paducah, Kentucky. And I have been a Medicaid recipient. I am currently working as a behavioral health consultant for a long-term care facility. And I am just excited about being a part of this board, that I can advocate and add whatever input I can into this situation. I appreciate the opportunity. Thank you.

DEPUTY COMMISSIONER HOFFMANN: Thank you, Kiesha. Okay. We have Jeanine Mbela. I'm sorry. Mbela (pronouncing).

MS. MBELA: Yes, Mbela (pronouncing).

DEPUTY COMMISSIONER HOFFMANN: Thank you.

MS. MBELA: Hi. My name is Jeanine Mbela. I'm from Congo and an immigrant. I am a CNA, a certified assistant nurse. I have referred many people to one of the members of Medicaid to help the immigrant find Medicaid and some medical assistance.

So I'm glad to be in this committee to be able to advocate and bring some insight for the immigrants who are coming from other countries, especially French country. Yeah.

DEPUTY COMMISSIONER HOFFMANN: Thank you. Elaine Wilson, please.

MS. WILSON: I'm Elaine Wilson. I'm the Director of Diversity, Equity and Inclusion for Somerset Community College. I'm also a student with the College of Social Work at UK in a doctoral program, which we mostly study issues of social justice.

And, so, I am here to represent people who are caught in the health disparities and equity issues so that they may, too, have a voice and an advocate. Thank you.

DEPUTY COMMISSIONER HOFFMANN: Thank you so much. Roger Cleveland.

MR. CLEVELAND: Good afternoon, everyone. As she said, my name is Roger Cleveland. I'm a professor in the College of Education at Eastern Kentucky University. And in the past I have done a lot of work around education equity, but also know, working in schools, universities there is a direct correlation between academic achievement and academic disparities and health disparities. And, so, this is an

interest to me, and I'm here to support.

DEPUTY COMMISSIONER HOFFMANN: Thank you so much. Mr. Cleveland was the last on my list. If I've left anybody out, please speak.

SR DEPUTY COMMISSIONER JUDY-CECIL: I don't think we heard from Julia Richerson.

DR. RICHERSON: Yes. Thank you, Veronica.

Hi. I think I'm officially on the list.

SR DEPUTY COMMISSIONER JUDY-CECIL: You are.

DR. RICHERSON: Okay. I'm crashing your party.

I am Julia Richerson. And I'm a general pediatrician in Louisville, Kentucky. I have been a pediatrician in the state for almost 25 years, first in Jackson County and now in Louisville. And a great deal of my professional work has been around health disparities before we said the word "racism," right? We just talked about disparities out of context for -- and still do often.

So I am actively involved with our

Kentucky Primary Care Association, which is the membership organization for community health centers and rural health clinics across the state, developing our work in diversity, equity and inclusion across our systems, which is so important for our families and patients we work with.

I work full-time as a pediatrician. 100 percent of my patients are covered by Medicaid. About 30 percent speak English. So I have a very diverse population. And I'm very interested and excited to work with these amazing partners. And I'm most interested in identifying the current policies and procedures that maintain the disparities. Because I think when we try to work on disparities, if we are not at that level of depth it is going to be hard to succeed.

DEPUTY COMMISSIONER HOFFMANN: Thank you so much. We are happy to have you as well. Sorry. Veronica, I will turn it over to you for the committee --

MS. BOWMAN: Hi there.

SR DEPUTY COMMISSIONER JUDY-CECIL:

I think we have one more.

HOFFMANN: Yeah. I apologize.

MS. BOWMAN: That's okay. Hi. Good afternoon. Catrina Bowman with Northern Kentucky Community Action Commission. I'm the Executive Director there. I've worked with Community Action for over 20 years working with this population and seeing how Medicaid has changed over time and just excited to be a part of the conversation and look, as Dr. Richerson said, at the policies and the practices and how they impact our families. So thank you.

DEPUTY COMMISSIONER HOFFMANN: Thank you so much.

SR DEPUTY COMMISSIONER JUDY-CECIL: Okay. I do believe that is everyone.

DR. BURKE: Hi.

SR DEPUTY COMMISSIONER JUDY-CECIL: Oh.

DR. BURKE: I believe I should be on there, too.

SR DEPUTY COMMISSIONER JUDY-CECIL: Yes. You are, you are.

DR. BURKE: All right.

SR DEPUTY COMMISSIONER JUDY-CECIL: I'm sorry. Our list is hopping around. I apologize for that. Go ahead.

DR. BURKE: Making sure. I'm Jordan Burke. I'm a pediatrician in Eastern Kentucky at Primary Care Centers. I'm a general outpatient pediatrician but also provide hospital coverage for, like, hospitalists, newborn coverage at Hazard ARH.

I'm just excited to learn from you guys and try to bring some perspective and, you know, advocate for more of the rural part of Eastern Kentucky and try to bring both differences and similarities from kind of the things that we are trying to overcome and help people with. So, yeah.

SR DEPUTY COMMISSIONER JUDY-CECIL: Thank you. And I think that is everyone. Sorry. The list that we have, when we move it, it losses people, so apologize for that.

Thank you, everyone, for -- you know, what we tried to do in creating the committee is to bring lots of diversity, both racial, gender, geographic. And, so, I don't know if you noticed, as everyone was

introducing themselves, we have tried to gather people from throughout the state and in the different areas. So we are very excited about that. That doesn't typically happen, so we were very intentional about that.

I wanted to talk a little bit. This is a brand new TAC, is what we call it, Technical Advisory Committee, we do call them TACs. Medicaid has a Medicaid Advisory Council that is created in statute and mandated, actually, in federal law. And, so, we have in Kentucky statutes a Medicaid Advisory Council and also in Kentucky statutes we have various Technical Advisory Committees.

This committee was created by Executive Order, as the Secretary mentioned. And, so, it is a little different. But what we are hoping is that we connect the work that you all do to what is going on with our Medicaid Advisory Council. Because we think that this is a piece that is sort of missing from the conversations that happen with our other TACs. And, so, we are going to see how

we can bridge that, the work that you are doing into the other work that is going on.

We recommend. And, so, we are here to serve you all. And, you know, this is your committee. We will make recommendations, but I certainly want you all to make the decisions on how you want to operate. We do recommend that in these initial months that maybe you meet at least every other month. And we are going to try to be very mindful of everyone's schedules. And we are happy to continue this virtually if that's the will of the committee. And certainly we understand that that is very convenient right now. We have been able to do that throughout the pandemic for all of our MAC and TACs. They went virtual and they remain virtual. And what we have seen is that participation has increased significantly as a result of that, both in achieving a quorum of the members but also the public. So we have had a lot of great participation by maintaining a virtual presence. So we will work with you all on, you know, how you want to meet and try to,

for those who are interested, we could even potentially do hybrid meetings, so if you want to come in to an in-person meeting we would still offer a hybrid virtual option. So we can talk about that. But we, I think again for the initial ramping up for this committee, we do recommend every other month. And, so, we will continue to do that. But, you know, we will definitely want your input as we schedule those.

The other thing is that we -- it calls for an election of a Chair and Vice Chair. We kind of like to call them Co-Chairs. You know, we anticipate a lot of work from this committee and we understand that you all have your other day-to-day work that you are doing, which is amazing work and keeping you very busy. So we thought the election of Co-Chairs would then sort of maybe soften the load on one person and can offer as a backup when somebody is not available.

So at the next meeting, you all can think about whether you want to nominate yourself for a Chair, a Co-Chair position.

We will take those nominations and then at the next meeting we will open it up for a vote of the membership.

So to do that, if you are willing to serve in that capacity, what we do is ask you to send your self nomination to Erin Bickers. I know you have her e-mail address. She is the one who has been contacting you. And just make note of that. We will send out a kind of final call for nominations prior to the next meeting and as a reminder and hopefully an encouragement for you all to do that. So that will happen at the next meeting.

The Medicaid Advisory Council and the TACs operate under their own bylaws. And, so, we recommend that for the structure of this committee, that you all also adopt bylaws. We are going to share the MAC bylaws that we have now. And it basically, you know, just kind of helps establish attendance and how the meetings are to be run and, you know, just gives some structure. So we will share those bylaws with you.

And upon election of Co-Chairs,

then we can then discuss, you know, what changes you all might want from those bylaws. And we're happy to help make those changes, and then we can present that at a meeting for you all to adopt. So we will work on that and we will get those bylaws out to you all so you can review it in the interim.

You know, one of the goals of this committee is to make recommendations, is to help us identify what can we do differently, what can we change, what can we -- what new things can we do. And, so, you know, we are going to ask that you all present some recommendations. And although you are not officially attached to the Medicaid Advisory Council, we are hoping that in conversations with the Chair of the MAC, who is Dr. Beth Partin, that perhaps that this committee could report up and present those recommendations to the MAC as well.

But those recommendations are things that, you know, we are interested in reviewing and implementing and discussing. Several of you mentioned that, you know, you really want to look at the policies and

procedures. And we do, too. I mean, that's why we are here. We want to know what can we do different to, you know, to breakdown the barriers and the inequities and disparities that are across our state for our members. So, you know, we will continue to work through that process and just look forward to those recommendations.

And then a report. So, again, right now the Technical Advisory Committees that are established in statute report up to the MAC and they provide a report at each MAC meeting. We would like to see maybe a similar approach, to have this TAC provide a report to the MAC on a regular basis.

But for now we understand, you know, this is all new and very much in its infancy. And we look forward to, you know, working with you all to get you up and running and start really digging into the data, digging into the information, having discussions and sometimes probability very difficult ones, to help, you know, move the needle for our members.

So that's just a little bit of the

committee's structure. Does anybody have any questions about anything I said or how we are moving forward? I'm happy to take those.

MS. BOWMAN: Hi there. One question I have, just about the recommendations. You said they will go up to the Medicaid Advisory Council. And then, you know, what will happen from there with those recommendations?

SR DEPUTY COMMISSIONER JUDY-CECIL: Wonderful question. Because you are not an actual TAC in statute that reports up to the MAC, it is just really sharing that recommendation to them. The way that that process works is the MAC will endorse the recommendation and then we will respond to it within 45 days. We are not really going to be beholden to that process and instead, you know, we will take those recommendations directly.

And, but, we will provide, you know, response to that; I think, you know, your recommendations are deserving of that. So we will take those and consider them and then follow-up on them to provide,

you know, is it something that we can do, if it is not what are our barriers. But that is a great question.

Any other questions just about kind of the committee structure?

DR. RICHERSON: Yeah. This is Julia. Is there a plan to have this in legislation as well?

SR DEPUTY COMMISSIONER JUDY-CECIL: I believe there is. I don't want to speak ahead of anyone. But I think our interest is that we do get it into the statute so that it is, you know, something that will continue on regardless of the Administration.

MR. FRIEDLANDER: Yes. This is Eric Friedlander. That is our plan. We proposed legislation last time; it did not get introduced. We are going to propose legislation again this time. Hopefully it will be introduced and get through the channel and processed.

And I want to echo something that Veronica said there, which is: With the MAC, with the TAC, even if statute, all of these recommendations will come to Medicaid,

including the recommendations from this group. And we do respond to those recommendations by what is possible and what's not. And that is the structure of the MACs and the TACs, even the ones in statute. So I just want to be clear on that. You all are not -- this TAC is not in any way doing anything differently from the work of the others.

SR DEPUTY COMMISSIONER JUDY-CECIL: Any other questions?

(No response)

SR DEPUTY COMMISSIONER JUDY-CECIL: Okay. Well, it is my pleasure to turn this over to Vivian Lasley-Bibbs, Director of the Office of Health Equity for the Department of Public Health, who is going to give us a statewide equity update.

MS. LASLEY-BIBBS: Good afternoon, everyone. I'm going to try to share my screen. And hopefully you will be able to see what I see.

COMMISSIONER LEE: We can see it.

MS. LASLEY-BIBBS: Can you see it? Great. So is it advancing? That's the next

thing. Nope.

COMMISSIONER LEE: It advanced. We now see "The Kentucky Office of Health Equity was established in Fall of 2008."

MS. LASLEY-BIBBS: All right. Great. I do apologize. I've got three screens and different monitors, so my system gets a little slow sometimes. So that is why if you all let me know that it is not advancing, that would be helpful for me.

Just a little background about the office, for those of you who don't know me, some of you in this group do. Our office was officially established in 2008 by former Commissioner William Hacker, who kept saying we talk about disparities but we really don't look at the why and what is causing those. So he established what was called at that time the Center for Health Inequities with some state dollars within public health to fund that office. So in 2008 to 2010 that is how that office was supported.

Moving forward, 2010 to 2016 we were supported from federal dollars from the Office of Minority Health, DHHS and then

other smaller grants along the way. And from 2016, moving forward, our office has been supported by the CDC Public Health Cooperative.

Currently, we have been given an opportunity to do some really exciting work in the Office of Health Equity, being a recipient of the CDC health equity grant to do some work with immunization and vaccine updates and also addressing health inequities within our most probable and marginalized populations.

So we are doing exciting things in the office. We are building up our infrastructure and staff and really doing some exciting programming across the state.

So our office really has what we call five areas, strategic areas that we focus on, which is always raising awareness around health equity, making sure that we have the latest and greatest research that is going out to and translating and disseminating that to populations so they can understand it, and then making sure that if they are participating in some of that

community-based support, that we are always making sure that there is an evaluation component to it to show the impact of our work.

We also do cultural, humility and sensitivity training. We also work with our leadership so they can understand what health equities -- using health equity means. What does that health equity framework look like. How do we make that an underlying foundation, principle in our strategic plan. How do we make that an internal part of our work.

And then we also want to make sure that access to care is so important in the work within our health and health system and the experiences that our communities are having within those.

So just working definitions here. Health disparity and health equity. I still find that people confuse the two, and I think Dr. Richerson hit on it when she said we sometimes want to focus on the disparity, not realizing what drives that disparity, which are the inequities that are the, what we call those, root causes and midstream causes, root

causes that impact communities.

So the disparity is just -- we express that in a number or a rate. And it is the difference between individuals and groups that is unfair because it is caused by some kind of social or economic disadvantage. And then health equity is obtaining an opportunity for all people to have the greatest health potential, no one is disadvantaged because of their social position or socially determined circumstance.

So just so we are all on the same page here, disparate health outcomes have been linked to all of these. I don't have to read them for you. You recognize that a lot of those intersect. And then when we think about health equity, it exists across many dimensions as well, race, gender, ethnicity, social connectedness, sexual orientation.

So when we talk about equity, you know, there's the rule of thumb, some people want to see liberation at the end of this picture, which is where that fence is moved altogether, but right now I want us to talk about, when we talk about equity, it is

not just about making sure that we provide some folks with what they need and that we have addressed the issues. That last box, that last figure is what I want to kind of focus on, is the reality of where people are, the reality of where people are finding themselves in communities.

And that is what our office is trying to raise awareness around, trying to get our folks to think about how that is impacting populations when we have public health programming and how we can connect across this Cabinet to do better population health work.

So by achieving health equity, the social determinants of health are those things where you live, learn, work, play, and even where you pray. And we want to address social determinants of health by using population-based interventions, using targeted methods for the folks that are in the areas and communities that have the greatest unmet needs. And we need to do that by understanding those root causes, what are those upstream factors, those systemic

structural institutional things that are either historically having -- impact the communities or have been put in place even recently that are driving that disparity gap even wider and perpetuating health disparities within the communities.

So one way we do that is by looking at the minority health status data report. And we are required by statute to produce that report biennially. And we have done that since the office's inception. That dates back to 2011, the first one was done.

What that document does is really kind of gives communities, our external partners and our internal programming folks within the Cabinet, to see where those disparities lie and what is really impacting communities. And we have that -- I don't want to belabor you with data because you are going to have people after me coming to talk about data and that is not what we are here for. It is to really just talk about all of the information we have captured. But I want you to know how that data is used.

When we look at the minority health

status report, it is kind of divided up into sections. We look at demographic data. We look at social risk factors that impact health, those health risk factors themselves and those risk factors as they impact health and poor health outcomes.

And I have listed the link for our web page, if you want to go onto our web page and see the different reports that are there, see some of the work that we are doing in communities. So I hope you do visit our web page.

So I just wanted to give you -- I know this may be small to some, depending on what device you are looking on. But just to give you an example of what you might see in our report, about the demographics we collect, we talk about where most of our minority populations live and reside within our state, we talk about the makeup, the population, we talk about some social risk factors, we talk about healthcare.

Your health outcome is solely linked to whether you are a home renter or you are a homeowner; research has shown that.

Other health risk factors, looking at populations that are overweight or obese. And we are also looking at disabilities within our state. 35.1 percent of adults in Kentucky have some sort of disability. And that is information that over the years we have began to incorporate in our minority health status report, collaborating with folks outside of the Department for Public Health to be more comprehensive and then try to be more inclusive in painting a broader picture to what is happening related to the health of our population.

And then health outcomes, of course. I don't have to tell you that Kentucky, you have already heard the ranking of where we are with our health, I don't have to tell you that we have -- we're number one in the country for lung cancer and the other cancers within specific demographics. Also, we have a large percentage of our population, minority population, with diabetes. So there are other things that you will find there as well. But I don't want to belabor you with all of the data.

This is the slide that I like. So we get all of the information we can but I think we will use it later. That's not what we want to do. What we are doing now is gathering as much information as we can and using that information realtime to be able to do something to impact communities right now and not somebody else's job after we leave or ten years down the road, five years down the road. We want to use the information now. And that is why this group is so important, that we are pulling all of this information together for you to give you a big picture of what is happening in the population, the Medicaid population, across the state.

The different lenses that you bring, the different perspectives that you bring to the conversation I think are going to be invaluable. And I also wanted to say where we are moving forward with equity. I'm proud to say that Secretary Friedlander has really pushed all of the departments within the Cabinet to look at racial equity to see what we are doing internally, not only with health equity but with racial equity as far

as what internal policies we have, programs, structures, barriers and challenges that we are experiencing as a department that would impede the work that we need to do, not only within our own agency but how we do that work in our community. If we don't understand it ourselves, we can't address it. We can't help our external partners understand the needs and to give them the capabilities and tools that they need to do that equity work.

So I love this slide. When I talk about upstream, I'm talking about the policies that shape communities. I think about those things that impact communities, structural racism, discrimination, all of the other isms, classes of sexism, genderism, all of those things. And then I think we have gotten stuck in the midstream, which is talking about social determinants, you know, housing and education and access to good paying jobs, liveable wage, a healthy and living environment, clean air and water. We all know those things. But I think we've gotten kind of stagnant and really not wanting to talk about the real issues, such

as the upstream.

And I'm hoping this committee can really talk about some of those upstream things that impact health. Because we've focused so long on the downstream, just putting a Band-Aid on things and addressing some of those chronic conventions without really being able to close the disparity gap because we are not having the harder conversations as to the why.

So I just want to leave you with that. To address the health disparities and address those inequities, we really have to come together, and I think that is what we are doing here, to address what are the real drivers. And then unjust circumstances, whether they are based on race, gender, income, ethnicity, social conditions, they all need to be eliminated. Because everyone deserves the best possible health regardless of your zip code. Because we all know that your zip code many times determines your health versus (inaudible).

So I'm hoping that I didn't go too fast, but I do want to be respectful of the

other presenters after me. So I definitely am going to be hanging around if you have specific questions pertaining to what I have just presented.

So, Veronica, I will turn it back over to you.

SR DEPUTY COMMISSIONER JUDY-CECIL: Do we have any questions for Vivian? And thank you, Vivian. I know that this won't be the first time you present to this committee, so we look forward to your participation as well.

Any questions for Vivian?

(No response)

SR DEPUTY COMMISSIONER JUDY-CECIL: If not, I will turn it over to Leslie.

DEPUTY COMMISSIONER HOFFMANN: Hello. I am looking -- I need to -- Erin, can you allow me to share? It says host still has disabled.

MS. BICKERS: I just made you a co-host, Leslie. I'm sorry. I had made Jodi a co-host earlier. My apologies.

DEPUTY COMMISSIONER HOFFMANN: Oh. That's okay. Let's see. Let me make sure I

have got the right one. Okay. Can everybody see my screen?

MS. BICKERS: Yes.

DEPUTY COMMISSIONER HOFFMANN: Okay. I am going to leave it in this mode. I have the same problem that Vivian does, in that I have a delay with the three screens and being remote. So I am going to leave it in this mode if that's okay.

Okay. So we have done some wonderful work here in the Department of Medicaid. And we want to just give a big shout-out to our team, and I wanted to give you several updates related to our initiatives. Some of this you may have already heard related to Ms. Bibbs or Secretary Friedlander's information related to the Cabinet.

So CHFS tasked DMS with creating a racial equity plan. And that would roll up to the big CHFS plan, so we all roll up to their pillars. That includes normalizing, organizing, and operationalizing.

I think normalizing was one that we really recognized right off the bat in

developing that shared language. That was a big deal for us to get started with, increase awareness, collect and disaggregate data. In organizing we are going to conduct equity training, implement racial equity core group, and develop external partnerships. And then in operationalizing, to develop the racial equity plan, use racial equity tool in decision-making, and to determine accountability mechanisms.

And this is kind of long, but I wanted to share it with you. And we have actually cut it down. We have kind of developed what kind of our purpose and mission was towards this plan. So I want to read that.

"The Department for Medicaid Services is committed to becoming a racially equitable organization. Our work will include a focus on internal development as a single state agency serving 1.68 million Kentucky Medicaid members, as well as our external development in relation to Kentucky's healthcare continuum. Additionally, DMS will be an organization

embedded in learning and cultural humility that encourages self-awareness and participation in the enhancement of racial and health equity."

And with the alignment of the pillars, we have equity, which is advancing our racial equity to promote an equitable and fair Commonwealth for all Kentucky members; health and well-being, which will eliminate inequity that compromises the health and well-being of our Kentuckians and provide an equitable Commonwealth for all citizens regardless of race, color, religion, sex, national origin, age, disability, or genetic information.

Structural economic support is support and serve Kentucky Medicaid members by utilizing DMS's financial management and reimbursements to Medicaid providers to leverage our racial equity practices and in turn yield immeasurable health and welfare gains for our Commonwealth.

Resilient individual and communities, to promote racial equity within underserved communities across the

Commonwealth, to eliminate disparities in trauma and build resilient and thriving communities across Kentucky.

Operation of excellence is to provide equitable services for all of Kentucky's members and to ensure that the healthcare needs and welfare of Medicaid members are met without inequities.

DMS racial equity enterprise goal themes. So these are our themes that we are working on currently and have been for quite some time in DMS. Number one is the use of a government alliance on race and equity, G.A.R.E., tool across all departments for accountability, racial equity in hiring, racial equity in procurement, and I will add other contractual agreements or MOUs that we may have.

And number four is a Medicaid innovation collaborative. We call that MIC. And it is a state cohort participation. I wanted to tell you a little bit about that. We applied for this opportunity and we were chosen. We will be in the second cohort. The Medicaid Innovative Collaborative is a

collaborative and a program that enables Medicaid programs to identify and implement market innovations that advance health equity and provide Medicaid beneficiaries with opportunity to achieve their fullest potential for health and well-being. And as I said earlier, we were lucky to get into the second cohort. In the second cohort, we will be partnering with New York and Nevada. Oftentimes lessons learned and other opportunities to hear from other states are really -- are good to make positive moves towards the future.

Our area of focus with Nevada and New York will be social determinants of health. They have different cohorts and we just happened to be paired with New York and Nevada with social determinants of health as it relates to health disparity and equity.

So just some other things. And I don't have to go through all of these. But because we are part of this cohort and we did, by the way, reach out to our Cabinet level folks and met with them to ensure that this all rolls up to the pillars before we

said yes about participating, it is to identify and define health equity priorities in Kentucky, to hear from beneficiaries through the original research conducted by MIC, review national source curated list of vendors informed by health equity priorities, beneficiary research, and MCO collaboration, share these solutions with managed care plans, providers, and other key stakeholders in Kentucky, receive technical assistance to change policies, incentives, and requirements to accelerate change, and to support our MCOs to identify and develop strategies to advance health equity efforts.

The four main goals of the innovation group is community engagement, which is a special emphasis on lived experience of Kentucky beneficiaries, providers, and community members; collaborations, which are shared best practices with other states; technical assistance, which is benchmark development, data, policy levers, and implementation support; innovative strategies is to help states and MCOs meet new complex health

equity goals.

And with that said, I'm going to turn over this slide to Jodi Allen, who is on with me today.

MS. ALLEN: Good afternoon, everybody. I'm so glad to be here with you all. I want to share a little bit with you about what we are doing in each division area with regards to the racial equity action plan. So I just listed out for you all here the different divisions within DMS.

And, so, Leslie spoke about the enterprise goals, which are the overall goals that all of DMS are working towards. But each division was also tasked with applying that health equity lens to look at their day-to-day operation and the work that they do on the day-to-day and how can we enhance racial and health equity across the board and within our divisions.

So I just gave you an example here, a couple of examples of the goals. So all of the divisions are creating these health equity goals and objectives using the smart goal strategy. And, so, a couple of examples

are the behavioral health team. DMS behavioral health team will incorporate equity language into all MCO contracts and behavioral health initiatives. And this is aligned with the procurement enterprise goal that was mentioned earlier. And in the pharmacy area, DMS will collaborate with MedImpact and Magellan to analyze pharmacy claims data with regards to race and adherence to medications within a therapeutic category. DMS will review a subset of pharmacy claims data and determine disparities among adherence rates with regard to race. DMS will coordinate with MedImpact and Magellan and review results from 2021.

So this is aligned with the normalizing task in the DMS racial equity charter. So we are trying to, in all of our work together, we have the over-arching enterprise goals and the charter that is guiding us, but each of our areas specifically are lining up with those.

It has really been a neat experience to watch this come together across the board. I mean, every area is so

different with regards to the day-to-day operations and work that is done, and it has just been a really cool experience to be a part of this.

So some of the initiatives that are in progress right now. We are working on the government alliance on racial equity accountability tool, which we refer to as the G.A.R.E. tool. Basically, this is a guided conversation. When I think of a tool, I don't think of a guided conversation. But it is an exercise so that each division sits down and talks through these guided questions. And really, honestly, it is just a way of holding our divisions and ourselves accountable in really being inclusive with all of the decisions that we are making across the board. So we are hoping that the full implementation of this tool, all divisions will be using this by the end of the year, and we are definitely on track for doing that and meeting that goal.

Also, we have created a racial equity core team SharePoint site. So our core team has gotten together and we decided

that we really needed to get organized and try to find ways to communicate with each other about our divisions and what we are doing, the ways that we are meeting our goals, sharing resources to help us reach those goals as well. So that is another thing that we have done that has been really helpful.

Also, we know that, according to the CDC, and this is just one example of a disparity, but black women are three times more likely to die from a pregnancy-related cause than white women. And when we think about maternal health disparities, we have got some really great news. In June 2022, recently the Department for Health and Human Services and CMS announced that Kentucky's request to expand post-partem coverage through Medicaid and CHIP was approved. A handful of states were approved for this, which is just great news for all women in Kentucky. So now post-partem care for women is expanded from 60 days to 12 months following the birth of a child. So we are really -- our hope is that we are able to

close that gap significantly with women in Kentucky.

Also, through the CCBHC, which is Certified Community Behavioral Health Clinic, initiative, is our way in Kentucky of attempting to integrate behavioral health and primary care for all Kentuckians, no matter race, ethnicity, or complex health profile, just as Vivian had stated, that everyone has an opportunity for good health and health.

So the CCBHC initiative is the way that we are working towards that in Kentucky. And that's ongoing. And we are really looking forward to getting some great data and seeing more how that is working in our state. Obviously, this is an initiative regardless of the ability to pay or payor source for all Kentuckians. So closing the gap again on those health disparities in Kentucky.

Also, DMS is involved in a mobile crisis initiative planning grant. And that is a way for Kentucky's effort to streamline and integrate and improve crisis response services across the state to all Kentuckians,

again all Kentuckians. A component of the MCI planning grant is to be culturally and trauma informed as well as reaching all people regardless of their ability to pay, regardless of the complexity or the nature of the situation that they are dealing with, regardless of race, ethnicity. So that is also definitely a way that we are working towards closing that gap as well.

So the SMI 1115 amendment initiative. Through CMS we have the ability to apply for a 1115 waiver, which would allow us a little bit more flexibility with regards to offering services in our state and to try out some new ways of providing care. And then we need to look at how did we do financially with that project or with those services and how we did that differently.

So we are applying for an SMI 1115 amendment through CMS. And in that application we plan on including supportive housing, supportive employment, and recuperative care as community support services to address those social determinants of health. This is all pending CMS approval,

of course. But we are really excited about this initiative and applying, gathering information so that we can really help people in our state to meet those social needs that they have in order to have better health outcomes. So the tentative application will be submitted to CMS December of 2022.

I'm going to hand this over now to Angie Parker. And she is the Director of the Division of Quality and Population Health. She is going to share a little bit about the equity and determinants of health branch.

MS. PARKER: Good afternoon. As Jodi stated and as I told you earlier, I'm Angie Parker. I'm the Director of Quality and Population Health within the Department for Medicaid Services.

And it is a -- the creation of the equity and determinants of health branch just started in July. So this is -- very excited. And this branch is within the Quality and Population Health. The areas of focus -- and as you can see we are already doing a lot of work in the Cabinet and Medicaid, and this is another piece of that that I'm very excited

to have been -- to be a part of. There was a re-organization in July and this branch was added to Quality and Population Health in order for us to utilize the information from this TAC and other areas in which we can continue to improve the health disparities and equity and social determinants of health of the Medicaid population.

So the three examples of the important areas of focus was to assist with the implementation of the racial and health equity action plan that Jodi just talked about and Deputy Commissioner Hoffmann, to work to address racial and health disparities and enhance health equity for all of our Medicaid members and to hold DMS accountable for racial and health equity initiatives.

So this is in the early process, so we are in the midst of developing this and hiring staff. And we look forward to providing you all some additional information once this gets rolling a little bit more. Thank you.

DEPUTY COMMISSIONER HOFFMANN: And I am muted. I'm sorry. I will go ahead and

put up our contact information there. So that is Veronica and myself and Angie Parker and Jodi Allen. And then I will go back, if there are any questions.

This will be made available to you. I know we've given you a lot of information today. Just as Jodi said, though, each one of our divisions have been working individually. So at some point if you want to hear about some initiatives from maybe one particular division, we can let you know. We have kind of just combined everything together right now for where we are.

Our first real big milestone will be 12/31 of this year in getting all divisions to complete and finish the G.A.R.E. tool. So...

And this PowerPoint will be made available. I will have -- ask Erin to send that out to everybody on the call today.

Any questions?

DR. RICHERSON: Hi. This is Julia. I don't know if this is possible. But just for the members of this group so that we can maintain sort of that big picture, is there

any way to do kind of a driver diagram that has kind of everything on one page? I know it would be overly simplistic, but it would kind of be like place holders for us to kind of put all the puzzle pieces together. I don't know if others would find that helpful or not. But you all are doing such amazing work. It would be nice for us to keep it all in motion at the same time.

DEPUTY COMMISSIONER HOFFMANN: Yeah. I think we could work on some type of summary for you and let you know as we proceed along with our goals. Some of our goals, for example the Medicaid Innovative Collaborative, which so far has been very helpful, it will go on for eight -- it can go on for a long time, but I think we at least have them for 18 months. So you will hear us talk about what we are learning in relation to those initiatives as we go to our meetings.

Jodi and I participate in a couple of their spotlights. It has been extremely helpful related to maternal health and youth with behavioral health issues related to

health equity. So...

Did I answer your question? And, yes, I think we can come up with something.

MS. ALLEN: If you have a specific format that you think would be helpful, I would be happy to take a look at that if you want to send it to me.

MS. WILSON: This is Elaine Wilson. Could we possibly have a blank of your G.A.R.E. tool. I would like to see what all that includes, please.

DEPUTY COMMISSIONER HOFFMANN: Yes, ma'am. What we can do is send you out a link. And, Jodi, I believe you have a short video that we have kind of been utilizing as well.

MS. ALLEN: Yes. And that way -- and the website information as well. There is a tool kit and some website information and a helpful video. Of course, love to share.

MS. WILSON: Thank you.

DEPUTY COMMISSIONER HOFFMANN: Thank you. And, so, on the agenda after our discussion and questions we just had the next

meeting is November the 2nd, as Senior Deputy Commissioner Veronica Cecil mentioned, just for the committee to kind of communicate the needs and goals and tasks and election of the Co-Chairs.

DR. RICHERSON: I have one other -- two other questions. One is, can we get all of the 2023 dates set so we can hold our schedules?

MS. BICKERS: I'm currently working on that schedule.

DR. RICHERSON: Okay. And then -- and this is not a question to be answered, but maybe just kind of come up over the time -- over our time meeting together.

You know, I mentioned we have all been doing this work for many, many years. And we know more. We understand things differently now. So, you know, I think every decade is a new opportunity to really get to where we want to be.

But I would love to know from your all's perspective and even the perspective of the members of the committee, why aren't we there yet? You know, what really -- what are

some of those things -- I think we know a lot of them in our head. But articulating those and really naming those I think would be really helpful for me to know where people are in thinking about this work and it might help us go deeper with our recommendations more quickly and move forward more quickly.

So that's just something to throw out for future conversations, just like why are we still talking about this, right? You know, if -- but if it was easy we would have moved on and be more equitable and have improved health for -- across the state. But, so that.

And then just I always like being inspired by other people, you know, in different states of -- if there are some examples of situations or whether it is big P, policy or practices, or across the country where people have been able to achieve some really good successes in improving disparities.

DEPUTY COMMISSIONER HOFFMANN: Okay. And I think Jodi and I could work on that. We could reach out to the

collaborative that we are working with now, if you are interested in other states. I know there has been, at least Hawaii, Arizona, West Virginia and, I want to say maybe, Ohio, I can't remember the other one, but they have all had, like, what they call spotlight report outs where they have told what they learned and what they still need to work on and the good work that they have done.

So one of the issues is that I feel like for Medicaid, since we serve one out of three Kentucky members and it is 1.68 million, that's a lot, right, it is identification and finding where those areas are that we need to address and make things better. So...

DEPUTY COMMISSIONER CECIL: Dr. Richerson, along with that, if you all know of bright spots going on in a community somewhere else, both in-state and out of state, you know, we want to hear about that. And, you know, how can -- you know, what can we learn from that? And how can we tailor that to our residents? I think we have to

recognize, too, that, you know, one shoe doesn't fit all. So we might have to develop, you know, actions that tailor to individual communities. And we have not -- I think that is part of our promise as a state agency. We don't always do that. Some of that is we have limitations. But we should talk about it and we should consider it. And, so, maybe we -- you know, the shoe size for a rural area is not the same shoe size for an urban area. And even among two rural communities the shoe size isn't the same.

So we would love to have those conversations with you all because you are in the communities and you are across the state and, you know, we would love that perspective. And, again, if you all have these bright spots that are going on, either in the country or the state, we would like to highlight those and have those conversations.

DR. RICHERSON: Uh-huh.

DEPUTY COMMISSIONER CECIL: Since Veronica mentioned, too, if you have needs that you would like to address with us, like

a few things you have come up with today, but as we move forward you can reach out to us and let us know what those needs might be, whether it be, you know, data or an easier diagram to follow or anything like that. We would be happy to work with you.

DR. FIGUEROA: Could we get a copy of the presentations --

DEPUTY COMMISSIONER HOFFMANN: Yes.

DR. FIGUEROA: -- so we could go over and kind of reflect on it and give some feedback maybe?

DEPUTY COMMISSIONER HOFFMANN: Yes. I think we've got at least three things or more to send out. We will send the G.A.R.E. tool, the video, I think we have got a simple tip for G.A.R.E. tool, and then we will also send you the presentation that we just gave.

DR. FIGUEROA: Uh-huh.

DEPUTY COMMISSIONER HOFFMANN: And then we will work on something simpler, maybe a summary of some sort of how we can show you what Medicaid has going on. Again, if you in the future want to look at any of the specific divisions or we could probably ask

sister agencies, too, if you would like to hear from another agency besides Medicaid.

DR. FIGUEROA: Uh-huh.

DR. RICHERSON: You mentioned earlier that the MAC hasn't maybe spent as much time on these issues in the past. Could you -- did I understand that correctly? And do you have any thoughts on why or sort of what is going on there?

DEPUTY COMMISSIONER CECIL: You know, I -- oh. Go ahead.

SECRETARY FRIEDLANDER: I will be happy to try. I will tell you that the first discussion about equity, and specifically racial equity, at the Cabinet for Health and Family Services occurred in February of 2020. So though -- that -- that acknowledgment, that work began then, which is a shame. But it is true.

DR. FIGUEROA: Uh-huh.

SECRETARY FRIEDLANDER: I will tell you, while we were in the midst of COVID, and we were seeing health disparities in terms of outcomes, I was sitting in the Governor's office and he turned to me and he said,

"Well, Eric, you need to fix that." And, of course, my answer there is, "Okay," understanding all of the complexities.

But it is something we need to work on and we need to work on it together. And my response to why haven't more Medicaid programs across the country been very specific in their approach to health disparities, particularly racial health disparities, is exactly because Medicaid programs are so big. And when we talk about systemic and institutional racism in structures, we need to be cognitive of the narrative, the pushback, the divisiveness of political environments.

And, so, all of those things are real. It's all real. But we have work to do. And that's what I hope we will do together. And Medicaid is a giant system, right, that reflects the systems within which we exist, the healthcare system. All of those things are still reflected within our programs and systems. We need to work to make sure our systems are not perpetuating, preserving, and assisting what has been

institutional and systemic issues across the Commonwealth.

COMMISSIONER LEE: And I think I would add to that, you know as the Secretary said, Medicaid is a huge system, 1.6 million individuals served in Kentucky right now.

And how do we use our data? You know, that's the other question that we need to ask. And how do we get reports out into the communities, into the hands of those individuals who can help us look at that information on our claims system to say here's what we see is going on. Sometimes it is very -- you know, we can pull claims and pull reports all day long. But unless we get them to a level that is consumable, that individuals can actually look at and understand, it is a little bit difficult to make those changes and to know what to look for.

So I think that that's one thing that I am very excited about this committee is, you know, I think the variety and the expanse of individuals that we have on this committee is going to help us look for those

or identify specific reports that we need to start looking at as we go forward.

And, also, individuals complete a Medicaid eligibility application. And race and ethnicity is not a required field. So our eligibility information is not quite complete to be able to tease out some of those different race and ethnicity of the individuals enrolled in Medicaid. So that's another issue that we can definitely look at. You know, can we get to that information on our claims data? Most likely. We may be able to get to it. But I think that's the other question we need to answer, is how accurate and how complete is our data, our eligibility information for the individuals that we serve, and how do we get that to be more complete and more accurate.

DEPUTY COMMISSIONER CECIL: Yeah. I think along those lines, we have not really had the resources or support to be able to do it. We are technically -- you know, our -- like you all, our day-to-day is so, you know, overwhelming at times. It feels like we are on the defensive more in just trying to keep

people covered. And, but, now with the support of this Administration, with some things going on at CMS, I think with expansion of diversity, inclusion and equity, you know, both at the community and corporate level has now given attention and the ability to provide the resources necessary to take a look at this and focus on it.

So, you know, I would say that the MAC and TACs have been primarily focused on that, you know, day-to-day, how do we just get services to people and how do we keep them covered. But now we're able to spend a little more time and which, you know, is necessary and has been necessary for quite a long time. But now we have the resources and the structure with our re-organization to devote that attention to where it needs to be.

COMMISSIONER LEE: And we have leadership support, too, is a, you know, massive amount of having that support to be able to. When I first came back to the Cabinet after a brief retirement the Secretary -- one of the first questions the

Secretary asked me is: How do we improve the lives of those we serve? And that's the question that we need to continually ask ourself as we move forward. And it is not -- you know, we don't break that out by race, by ethnicity, by gender. It is everyone. How do we improve those lives? But we know that there are disparities in the delivery of healthcare in the state, and that is what we have to identify and breakdown those barriers and make sure that we are serving everyone that is enrolled in Medicaid and improving their lives in an equitable fashion.

DR. RICHERSON: Sorry I keep asking questions.

But it would be helpful for me and probably all of us to know, what are the tools that we have at hand? So, for example, asking for a common PIP or, you know, like asking for data reports. Just talking about that at some point would be helpful I think to help us know, you know, what is it within our area of influence and what are some of the typical tools. And then we can be creative beyond that. But, you know, we -- I

know there are mechanisms within Medicaid that changes are made typically. And, so, understanding those in a really comprehensive way I think will help us be effective.

DR. FIGUEROA: I have a question, and I don't know if this is the right time to ask the question, but it is more of a reaction to information that was presented.

And it has to do with what is the role, what do you think is the role of managed care companies in advancing health equity? Because once a person, let's say, is covered through Medicaid, and I agree it is very complex, the Commonwealth is hiring these managed care companies to determine what services are appropriate, whether they should be receiving services and for how long.

And I saw something about supporting MCO, managed care companies (inaudible). And, frankly, as a provider I see them as more part of the problem than the solution. So I don't see -- you know, we spend an extraordinary amount of time trying to get people authorized to receive services.

And so -- and that has -- is -- impedes access to healthcare. Also, the disparity in how behavioral healthcare providers are treated, of course, with -- versus primary care.

And, so, that adds to the problem, when we don't make them accountable. And, so, I don't know if their contract has some teeth that will require them to report on that or be part of the solution --

DEPUTY COMMISSIONER HOFFMANN: This is Leslie. I'm sorry.

DR. FIGUEROA: -- (inaudible), the level of influence. I'm sorry. Go ahead.

DEPUTY COMMISSIONER HOFFMANN: I'm sorry. I was just going to mention, and I didn't mean to cut you off, I apologize.

But we are currently working on that now and have drafted language to add into the contracts. One of our enterprise goals is to add language into all contracts, policies, procedures, procurements, and everything going forward. RFPs, anything like that will include language to hold them accountable.

Part of the problem, even with other states as well as ours, is trying to figure out how to get the information. So that is one of the things that we have already identified and asked the collaboration to help us with, tell us how other states who are MCO states are able to get this information and to get those reports accurately and timely for us to use, correct? So those are the things that we are working on. We have, like, enterprise goals and then we have the Medicaid Innovative Collaborative that is helping us to identify that with the MCOs. And, like I said, last week we worked on contract language.

So the complexity is mostly I think with the making that identification. So a lot of times we are trying -- if you heard me mention in the collaborative, we have abilities to get to other databases, large databases. And how do they extract that information and those kind of things.

So we are hoping that all of that will be identified. But that is one of our goals to work on, our enterprise goals.

DR. FIGUEROA: Good to know. Thank you.

SECRETARY FRIEDLANDER: I would add one other -- a couple of other things.

One is, the managed care organizations should be concerned with population health and specific population health. And we need to continue to make that an expectation of ours so we can see improved performance.

On the behavioral health side we have taken off and kept off prior authorizations relative to behavioral health. But outside some of the purview of Medicaid, we know we have to have and promote more diverse candidates to become behavioral health providers. So the Department for Behavioral Health is working on providing additional training and additional support so that we can have diversity within our provider population that then is a better reflection of the population of the state.

So there are other initiatives outside of Medicaid which we can talk about here as well --

DR. FIGUEROA: Right.

SECRETARY FRIEDLANDER: -- but that need to be a part of the overall discussion. So I think that that's an important piece to remember.

DR. FIGUEROA: Thank you.

DEPUTY COMMISSIONER CECIL: You mentioned authorization of services. I know Dr. Theriot, our Medical Director, has been working with both Cabinet level medical directors and the managed care organization medical directors to look at, you know, prior authorizations, what service is being prior authorized, is that necessary, you know, and trying to dig into that a little more.

-- examples are always helpful to us. So if you have specific examples of services that you believe it is creating a barrier, you know, we want -- this is exactly the forum to talk about that so that we can take that back and really have a conversation about our -- have we created a barrier, an unnecessary barrier to a service? So those are the things that, you know, we would love this committee to take up and have those

conversations about. And, you know, in terms of what can you all effect, you know, well, if you don't ask for it you don't know, right? So, I mean, if you all identify things and make recommendations, that's what we are here for. We want to move the needle for our members. We want to address those inequities and disparities. And we can't do that unless we have some, you know, expertise to help guide us on how to do that.

And, so, you know, I think pretty much everything is on the table in terms of what is it that you all think we need to do as a system, as a, you know, Medicaid program; you know, we're certainly interested in hearing that.

And, you know, the data, whatever data you need to determine that or to help inform your work, we can work with you on that. I mean, we want to make it available to you. So anything that you think you might need, we're happy to try to get for you.

DR. FIGUEROA: Uh-huh.

DR. RICHERSON: I know traditionally TACs are not encouraged to talk

about fee schedules and money and payments and...

But we all know that often -- say, for example, I have a long list of children who have rampant caries that need oral surgery and they are being scheduled in December and January because access is an issue and absent of access they say that the payment issue is the issue and that's why we can't get these kids with, you know, very serious illnesses treatment.

So is that off the table for TAC discussions? Or how do we handle when really we find that it is a, say, a provider payment issue?

DEPUTY COMMISSIONER CECIL: Yeah. I don't think it is off the table. And, in fact, those conversations are going on right now in some of our TACs. And we're doing a deep dive right now into dental rates and services. I know one of the problems is workforce. So, you know, I think there's like 80 oral surgeons in Kentucky. That's a workforce issue.

So, you know, I think it is

definitely on the table of you all to discuss and provide recommendations on.

COMMISSIONER LEE: And I think it's definitely on the table. And when we look at those fee schedules and those rates, a lot of times it is just a request to do a wide sweeping, across-the-board raise. But is there something else that we can focus on? Is there one service that is missing that would help? Is there one code that we need to look at or a couple?

And as Veronica said, we have about 80 oral surgeons in the state. That's not Medicaid enrolled. That's just 80 oral surgeons. We had a really good dental presentation that I would be more than happy to share with you all related to where the access issues are as it relates to dental. But, then again, when we look at the dentists in the state and those that accept Medicaid, it is higher than it is in other states, our reimbursement schedule for our dentists is, for our children is approximately 105 percent of commercial insurance. And, also, only 50 percent of the individuals in this state

have dental insurance, so there is another issue.

So we just need to figure out the workforce. Because when you have two schools, two teaching schools that only graduate I think 250 dentists a year and most of those out of state, how do we find, recruit, and retain providers within the state and what is it that we can partner with?

Because it is not just a Medicaid issue. It is a state issue. Because we rank, I think, 47th or 49th in dental care. And that's this entire state. So what other areas, such as that, you know, the dentists who are graduating and why are they moving out of state versus staying in and what can we do to increase the number of dentists that actually graduate from our teaching schools is I think some questions that we can ask.

But definitely yes, rates and fee schedules and covered services definitely a discussion on the table.

DR. FIGUEROA: Thank you.

DEPUTY COMMISSIONER HOFFMANN:

Okay. Does anybody have any other questions or discussions or comments?

(No response)

COMMISSIONER LEE: Well, we are very excited about the work that this committee can help us with. And, again, you know, we are here to help gather reports, look at information for you to be able to make recommendations for improvements. And we look forward to working with you to just give you the tools that you need to help, as the Secretary said, help us be accountable and transparent.

So, again, just reach out and let us know as we go forward with future meetings what it is that you think that we could look at, as far as our claims data and our enrollment information, that we can start pulling data for you all to look at and help us be transparent and accountable for our members and our providers.

SECRETARY FRIEDLANDER: Yes. Thank you for joining us to really improve the healthcare of all Kentuckians and to reduce the disparities that we see across

populations. It should not be and we need to do everything we can to make it not so.

DR. FIGUEROA: Yeah. Thank you.

COMMISSIONER LEE: And I think those are perfect words to end the conversation today. Thank you, Secretary.

DR. FIGUEROA: Thank you all.

COMMISSIONER LEE: Thank you all.

(Proceedings concluded at 1:28 p.m.)

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C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Health Disparity and Equity Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 8th day of September, 2022.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR