CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
DISPARITY AND EQUITY
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
January 4, 2023
Commencing at 1:00 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Julia Richerson, TAC Chair

Wanda Figueroa Peralta

Jordan Burke

Caterna Bowman-Thomas

Patricia Bautista-Cervera

Marcus Ray

Kiesha Curry

Jeanine Lubuya

Elaine Wilson

Roger Cleveland

MS. BICKERS: Good afternoon. It's just now 1:00, so we'll give it a few minutes to clear the waiting room.

MS. RICHERSON: Good afternoon.

MS. BICKERS: Okay. As far as committee members go, I have Wanda, Julia, Patricia, Kiesha, Roger. Did I miss anyone while they were signing in, or is anyone logged in on a phone number?

(No response.)

MS. BICKERS: Okay. We'll need one more before we can establish a quorum. And I will scroll through to make sure I didn't miss anybody. So we'll give it just another minute longer.

Okay. I don't see any more committee members at this time. If you want to go ahead and start, if anybody else joins I will stop and let you know.

MS. RICHERSON: Great. Thanks. Thanks, everyone, for joining this afternoon. And is Leslie on? I didn't see.

MS. HOFFMANN: I am. I'm on.

MS. RICHERSON: Oh, great. Would you like to say a few comments of welcome before

I get started?

MS. HOFFMANN: Yes, yes. That'd be fine. So welcome and good afternoon to everybody. My name is Leslie Hoffmann, I'm the Deputy Commissioner for the Department of Medicaid services. And I proudly serve as one of Medicaid's racial and health equity champions. This is our third official Health Disparity and Equity TAC, very exciting. And DMS is very excited about partnering with this TAC in 2023. So I have updates later, Dr. Richerson, and we can share those later.

MS. RICHERSON: Great. Thank you, Leslie. I thought, as part of my welcome, since -- you know, it's so hard, we're not in person, it's hard to get to know each other. I wanted to do just a quick icebreaker for the TAC committee members, and so we'll just do something silly, like your favorite holiday dessert. Just say your name, your day job or your advocacy work, whatever you want to say, and then just your favorite holiday dessert. And I see Roger, are you -- would you like to

share?

MR. CLEVELAND: My favorite holiday dessert -- probably sweet potato pie. As you all know, I'm a professor in the College of Education at Eastern Kentucky University.

MS. RICHERSON: Thanks. Patricia, I see you, what about you?

MS. BAUTISTA-CERVERA: Hello, everybody. I'm Patricia Bautista-Cervera, La Casita Center, Health Empowerment Coordinator. My favorite dessert -- apple pie with ice cream.

MS. RICHERSON: And I can't tell -- it's hard for me to tell on my screen who else is here. I don't know, Erin, can you tell me who's here?

MS. BICKERS: Wanda, how about you, you want to go next?

(No response.)

MS. BICKERS: She was logged in, did we lose her? How about Kiesha?

MS. FIGUEROA: That's me.

MS. BICKERS: There you are.

MS. FIGUEROA: I forgot to unmute myself, I'm sorry. I'm Wanda Figueroa, I'm

the CEO of RiverValley Behavioral Health. And my favorite dessert is a Puerto Rican flan, which is a custard very similar to crème brûlée.

MS. RICHERSON: Thank you. And then, Kiesha.

MS. CURRY: Hi, my name is Kiesha Curry, and I am a social worker with Signature HealthCARE Services out of Louisville. And my favorite dessert is lemon cake with a scoop of vanilla ice cream.

MS. BICKERS: Jordan just joined.

MR. BURKE: I'm sorry. I was having trouble finding the link.

MS. RICHERSON: Oh. So, Jordan, we're just doing quick introductions, and then your favorite holiday dessert.

MR. BURKE: Say that again, sorry.

MS. RICHERSON: Oh, just a quick introduction for yourself, and your favorite holiday dessert.

MR. BURKE: Got it.

MS. RICHERSON: So you're next, you're up.

MR. BURKE: Got it. Favorite holiday dessert -- just a quick introduction, too?

MS. RICHERSON: Sure, yeah.

MR. BURKE: Jordan Burke, pediatrician at Eastern Kentucky at Primary Care Centers. My favorite holiday dessert -- probably, dirt cake, you know? It's got that Oreo and stuff like that. It's probably my go-to. I can only eat so much of it, but it's solid.

MS. RICHERSON: Great. Has anybody else jumped on, Erin?

MS. BICKERS: No, ma'am, but you do have a quorum now. If all of your committee members can turn their cameras on, you can establish a quorum and approve your minutes from last week.

MS. RICHERSON: Okay. Before we -- I want to do a little bit more on the welcome before we jump in to that. So I'm Julia Richardson, pediatrician, Family Health Centers, community health center here in Louisville, and this -- it's always about the cookies for me, but this year, my daughter and I made gingerbread cookies,

which we've never made before, so those were good. So that's my new favorite.

I wanted to just as part of my welcoming, we're taking turns on being chairperson. This is my -- I'm taking my turn, so I just wanted to give you a little background for the members and for DMS. So first, when I was thinking about the, you know, as part of the welcome to this meeting, when I was kind of thinking about the agenda, the way I laid it out was kind of the first half is DMS kind of talking to us, updates, things like that. And then, the last half will be us more driving the conversation about what our priorities are. I think it's both important for DMS to kind of give us those windows of how to contribute what's going to be meaningful for you. We want to give you information that you can use because we've got plenty of feedback, but we want to kind of frame it in a way that you can use it most effectively.

And so giving us sort of this first half of the meeting, telling us what's going on with your work. And as you're talking,

kind of try to pull that out when you're giving us your updates, like if you can think of any questions for us to give really specific feedback and anything that would be really helpful to, you know, facilitate the conversation.

And then, the same thing when we're doing, you know, some of the new business and general discussion. Trying to help us both understand how we can help each other, because clearly, we are all on the same page. We want to do the same work, but how do we most effectively communicate in a way that is actionable for Medicaid's work?

So I wanted to kind of say that up front. The other thing I wanted to say, the process for -- that I'm going to -- that I did for this meeting, and I think I chair one more, and then we -- and then I'll -- unless somebody wants to chair next time. I'll chair one more, and then we'll rotate.

So the minutes are amazing, I love having the full transcript. It's great. It makes it easier to go back and remember what everyone said, so hopefully we get that

again, right? Do we get the full transcript again for next time?

MS. BICKERS: Yes, ma'am. We have a court reporter who logs in, and we also send her or him, depending on who's on, the full recording --

MS. RICHERSON: Okay.

MS. BICKERS: -- and they do a full transcript from that.

MS. RICHERSON: Great. So basically to prep this agenda, I just went through the prior transcript and pulled out all of the things we said we were going to follow-up on or we want to talk about at the next meeting. So that's how we created the agenda for this time, it's basically based off of the last meeting minutes.

Going forward, I think it will be helpful -- after the minutes come out, maybe I'll meet with DMS so that we can run through the minutes and pull out what you all really want to report on, pull out what sort of from the minutes came up as priorities, and make sure that, you know, that would be appropriate for the next

meeting. But also, at the end of this meeting and throughout the meeting, throw out ideas if you want to talk about them next time, so we capture all of that for the next meeting agenda.

Ideally -- with the holidays, time ran short, so I wasn't able to really get the agenda out to the group to give feedback on specifically. So the goal will be about a month before the next meeting we'll get the agenda out to everybody with feedback so we can formalize the agenda at least two weeks prior.

MS. BICKERS: Dr. Richerson, if I could just hop in really quickly.

MS. RICHERSON: Yeah.

MS. BICKERS: As long as -- so Medicaid is here to assist, but this is your all's meeting. We're happy to have e-mails back and forth with you on the agenda and items you'd like to discuss.

MS. RICHERSON: Yes.

MS. BICKERS: The best plan of action is for you to e-mail the TAC as a whole --

MS. RICHERSON: Yes.

MS. BICKERS: -- to discuss the agenda items that they would like to see, so that way --

MS. RICHERSON: Yeah, I'm going to do that like a month before.

MS. BICKERS: -- yes, ma'am, but that way it ensures that if you do that in an e-mail forum, it would keep us within the law and the guidance of our open --

MS. RICHERSON: Right.

MS. BICKERS: -- records policy and open meetings.

MS. RICHERSON: Okay.

MS. BICKERS: So I would suggest -- and I can send you a list of all the TAC members and their e-mail addresses. And then we can make sure that we, you know, we can jump in and help as needed but --

MS. RICHERSON: Right.

MS. BICKERS: -- DMS typically, outside of the first couple of meetings, we don't gear the agenda to what we want, it's what you guys want to see.

MS. RICHERSON: Right. Right, but I

think it will help me know what we want if I can have that conversation with DMS after we get the minutes back. Because, you know, there might be 20 things we say we want to follow up on, and I want to have that conversation with you all. It's easier for me to set the agenda if we can have that conversation. And then like I said, a month before then we'll send it out to the whole TAC with plenty of time for feedback. Obviously, you can -- anybody can e-mail suggestions for the agenda, and we always have the open discussion and general discussion time.

I just -- in my experience setting up this agenda, there were a lot of things that would've been -- that I'm like, oh, I wonder if DMS has time for this. Is this, you know, is the staff even going to be available at the next meeting? Those are the types of things I'd like to get clarified before we send the agenda out with DMS.

Great. And then, I know -- I'd hoped to have attachments sent out. I think just

the agenda went out, the attachments didn't go out. So I'm wondering, is there a place on the website for this TAC that we can hold documents, or is that not possible?

MS. BICKERS: You can send me any attachments, if you send those to me before the meeting, I'm always happy to screen share if needed.

MS. RICHERSON: So those were just the things that they had gone out before, so I didn't send them back to you because they were things that had already been sent to us. They were just those -- the last meeting minutes, the minority status health report, and the quality strategy for Medicaid. Those were things that were discussed at the last mending that we wanted to send out. So, yeah, I don't have them. We were hoping to have those sent out, but is there a place on the Internet?

MS. BICKERS: The website. Your webpage. Anything that's presented in the meetings and shared are uploaded to the website, and anything that are shared in your meetings, I try to send out to you

within a couple of days of the last meeting so that you have that.

MS. RICHERSON: Perfect.

MS. BICKERS: If that's something that you want me to reshare during the next meeting, you just have to let me know so I can have it pulled up and ready to be shared.

MS. RICHERSON: Perfect, yeah. So I'll just put on the agenda, "attach documents," and that way you'll know which documents to send out. And then, if we can get these three documents put up on that TAC website, maybe put the link in the chat so everybody knows where that is, that would be great.

So for -- just for kind of governess, I think those are the only things that I want to go over. Oh, the only other thing was some TAC's do have bylaws. I'm not -- if anybody would like to establish bylaws, that's fine. I don't feel very strongly about them right now personally, but we can talk about that.

In prior administrations -- actually,

the prior administration, they told us that TAC bylaws didn't stand, and so we weren't able to use them. So I didn't know, because they said that we can only go by what's in the actual KRS. So I don't know, this administration might have different feelings about the bylaws, but I don't know how DMS feels. Leslie, do you have any opinion on the bylaws?

MS. HOFFMANN: I'm not sure about the bylaws, we do abide by the KRS. Erin, do you know if each TAC establish their own individual bylaws?

MS. BICKERS: No. They go by the MAC bylaws, which were shared when the committee was first put together. I can resend those out for review.

MS. RICHERSON: Okay. Yeah.

MS. BICKERS: I know this TAC meeting is slightly different. It's not required to report to the MAC, but I believe it was stated that they would like to report to the MAC to bring some of the issues they find moving forward.

MS. RICHERSON: Great. So we won't

worry with any bylaws. Okay. Unless somebody wants to -- they can bring that up.

Okay. So, yeah. Just to regroup, so the way I set the agenda, the first half of the agenda is working -- mostly DMS reporting, so that we can understand where to plug in our feedback and our comments. And then, the second half is some new business and general discussions, so more of a open discussion about our perspective on equity, and hopefully provide information that's helpful for Medicaid.

So we will establish the quorum, so I think quorum is established. The next thing is approving the minutes from the previous meeting that were e-mailed out. And so, is there a motion to approve the meeting of November 2nd?

MR. CLEVELAND: So moved.

MS. RICHERSON: Great. Is there a second?

MS. CURRY: I second it.

MS. RICHERSON: Thanks. Any other further discussion or changes to the minutes?

(No response.)

MS. RICHERSON: I'm hearing none. All those in favor of approving the minutes, say aye.

(Aye.)

MS. RICHERSON: Great. Any opposed?

(No response.)

MS. RICHERSON: All right. So we have approved our prior minutes. So if you look at the agenda, the old minutes, again pulled from the prior discussion that we had at the last meeting. So I thought it would be helpful to review the health equity infographic and get updates from that. The MIC, if there are any updates from that project we talked about last time. The GARE tool, and then have some time with Vivian to talk about our goals and strategies and review those. So who is going to do the health equity info graphic?

MS. HOFFMANN: So --

MS. ALLEN: I will.

MS. HOFFMANN: -- sorry.

MS. ALLEN: Yes. This is Jodi Allen, yes. I'm a behavioral health specialist

with the department for Medicaid Services. I am going to give an update on the infographic, and actually, going over the infographic is going to cover one, two, and three.

MS. RICHERSON: Great.

MS. ALLEN: So I'll give you a little bit of an update, just as far as a back story, just as a reminder. I'm really proud and excited to be a champion for the racial equity core team for DMS. And all of this came from the cabinet level initiative to create a racial equity action plan. So DMS has created one of those, and we are working on implementing and going forward, making lots of great progress. We had a meeting this morning with the community of practice cabinet-wide, and it's really exciting to hear all of the things -- the initiatives that are pushing forward through this racial equity action plan. So that's a little bit of the back story and kind of what's guiding all of this.

Let me share my screen. Can you all see that?

(No response.)

MS. ALLEN: Okay, great. So this is just kind of an infographic that gives you a quick snip picture of all the things that we're doing within DMS towards the enhancement of racial and health equity. So it goes over our vision, the pillars, the cabinet vision -- we kind of covered that last time -- our overarching equity goals. And I will tell you that across the board, all divisions within DMS are working towards each of these goals.

So integrating equity and policies, creating a diverse and inclusive workforce, hiring equity focused vendors, fostering understanding of racial and health equity. So all of these things are happening through our racial equity action plan across the board. So those are our overarching goals.

Some of our progress that I wanted to update you on, all DMS divisions have been trained in the GARE tool, which is the Government Alliance on Racial Equity tool, which is an accountability tool for racial and health equity. All of us have been

trained, and all of us have submitted our first GARE tool implementation. And so we met that goal that was set for the end of the year, and so we met that goal, which is really exciting. And so now, we're in the process of regrouping as a core team, and discussing our next steps and what's to come as we continue to use that accountability tool with all of our initiatives across the board.

Another thing, obviously, we created new programs to expand postpartum coverage, that's ongoing; integrated care; enhancing mobile crisis, which we have finished the mobile crisis planning grant. And now, we are moving towards the implementation phase of the mobile crisis, which is going to include meeting the needs of all Kentuckians, regardless of ability to pay, regardless of severity level and need, and just meeting people where they are in their needs.

Expanding services for the severely mentally ill, and we're doing that through the 1115 SMI waiver. We actually submitted

our rough draft to CMS at the end of the year to enhance services for individuals with SMI, and we're also in the process of applying for additional waiver authorities to expand services, so those things are ongoing.

We've also created an Equity Determinants of Health Branch within DMS, and you're going to hear from them in just a little bit and some of the updates from that area, so that's really exciting. A lot of this racial equity core team work is going to actually be moving to that area, so we expect them to really take more of lead role in all of this as it goes forward.

So full implementation of the GARE tool across the board. You'll hear a little bit about the CCBHC, which is also an integrated way that we are enhancing health equity in Kentucky.

Let's talk a little bit about the Medicaid innovative collaborative, so the MIC, which is going to be a state cohort. We are participating in a state cohort that is focused on racial and health equity,

specifically in the area of social determinants of health or social drivers of health. There are also other terms now that are being used for social determinants of health, but that's going to be the focus of the Medicaid innovative collaborative as it specifically relates to DMS in Kentucky.

And so we've added a state, so it's Kentucky, Nevada, New York, and Iowa, and our kickoff is actually going to be this month. So we are meeting not only with our team, our core team that's going to be responsible for this Medicaid innovative collaborative cohort, but also all the states. So we're hoping to get that completely kicked off this month and up and running, so that's really exciting and is moving forward.

And I believe that that is all of the updates, as far as the racial equity action plan and the initiatives that are going on right now in DMS. Do you all have any questions?

MS. RICHERSON: Can you -- I know it's so much and it's so many moving parts,

but can you think of even just say, picking the MIC, for example -- or the MIC, what role can we, as the TAC members, what kind of information can we give you -- kind of feedback that would be helpful, for example, in that, or any element, anything that you've talked about?

MS. ALLEN: Julia, that's a great question, and I will tell you that as we are moving forward and as we do this kickoff, I know that there's going to be a need, definitely for community partnership and involvement in that way. And that is definitely a very specific place that we're going to need your all's help, guidance, feedback, and even information.

MS. RICHERSON: Great. Yes, so as that moves forward, you know, just any, you know -- and as specific as possible, so we can give effective feedback or contributions.

MS. ALLEN: I appreciate that, yeah. We'll definitely keep that in mind as we are just really in the beginning phases with that for sure.

MS. RICHERSON: And Dr. Cantor asked if the MCO's can be included in the collaborative.

MS. ALLEN: Yes. And they will be, yes. Yes, they will be -- they will be included. There's already some pre-conversations and conversations moving forward with that, and working with Angie Parker in that area, as far as the MCO involvement and inclusion.

MS. RICHERSON: And then, can you scroll back up to the top?

MS. ALLEN: Sure.

MS. RICHERSON: Just so we can get -- so we talked about the MIC. Oh, the GARE tool.

MS. ALLEN: Yes.

MS. RICHERSON: So will we get -- discuss the results of what you all find using the GARE tool? Is that a way that we can -- can we help there in anyway?

MS. ALLEN: Yes, I think that that would be a great place for us to have some discussion. I know that the next racial equity core team, that's going to be a focus

is on the GARE tools that were submitted, maybe taking a -- reviewing those, taking a look at what more is needed, and getting some feedback.

MS. HOFFMANN: Might be a good idea, Jodi, too, that we -- we could show an example, like for our behavioral health team --

MS. ALLEN: Yeah.

MS. HOFFMANN: -- you know, we had one particular focus, and so we could show you the one that we did, or if you want to see another division's, we can get that, or --

MS. ALLEN: Yeah. Just to get some feedback, yes.

MS. HOFFMANN: -- I've mentioned before, if you want to hear from other departments in the cabinet, we could bring some of their information, as well, or have them to speak in the (indiscernible).

MS. RICHERSON: I think that would be interesting. Is there a division that you think we would be able to provide, you know, the best communication with, or that we can

be most helpful to?

MS. HOFFMANN: Well, Jodi and I have both worked on the behavioral health one, so we probably know that one the best. Everybody did a really good job --

MS. RICHERSON: Yeah.

MS. HOFFMANN: -- in all their areas, so I would just think we'd like to present that one since Jodi and I are very familiar with that one.

MS. RICHERSON: Great.

MS. ALLEN: And I think once we have a little bit more review time with the core team, that would probably be a good place to see, you know, where do we need feedback or some guidance from you all.

MS. RICHERSON: Great. Thanks, Jodi.

MS. ALLEN: Sure.

MS. RICHERSON: Any other questions?

MS. HOFFMANN: Sorry, Dr. Richerson. I just wanted to mention, that I met with Beth Fisher, I think she's on today, and one of her main focuses is going to be to promote in the communities, on all of our social media platforms, about the good work

that we're doing. And the infographic will update that, basically, of all the things that Jodi spoke about today.

MS. RICHERSON: Great. Okay. So lots of ideas for future discussions. Does anybody have any questions on the core team's work, or the action plan, or anything on the infographic?

(No response.)

MS. RICHERSON: All right. So we will move on to spend some time with Vivian to pick up where we left off on our committee goals, strategies. Where should we go today, Vivian?

MS. LASLEY-BIBBS: So, Dr. Richerson, I can give you information on the minority health status report.

MS. RICHERSON: Okay.

MS. LASLEY-BIBBS: I put the link in the chat, it is up on our web page, it is on the Internet. It is being presented to LRC, the Legislative Research Commission. The 2021, is available, not just the executive summary, but the full report.

We also have a supplemental that's

coming out with additional data that we thought -- that was very interesting, and it was just too much to put in the minority health status report, it would've been too large. So additional data is there in the supplemental. It's still being reviewed, it hasn't been finished yet. It will be coming in the next week or two, it will be put up, hopefully.

And then, we're currently starting to work on the 2023 minority health status report, which will be due in October for review, and then will be presented to the legislative committee in January of 2024.

So we're already digging into new data to kind of define and see where some of those gaps still are, and where new gaps may be presenting themselves, and where we're still kind of in a holding pattern with the way that (indiscernible).

We're also trying -- we're working with the data services vendor to try to have some community conversations, asking where we are in providing services to our stakeholders and to our community. We'd be

happy to have some input from this group as to what some of those questions are that we might be looking to have answers to. What do we want to know? What do we feel like we don't know enough about? So that will be helpful if we have our data support services vendors allowed to have these external conversations.

So looking forward to some input there from this group as to what you'd like to know from our constituents, as it relates to services, as it relates to programming, as it relates to our visibility, as it relates to all of those different things. So that's where we are with that.

It kind of ties in with the CHFS listens. So we're trying to have our own listening sessions at DPH, but if you feel like there's a lot of crossover here with collaboration between these departments and the different racial equity core teams, and all the initiatives that are very similar there, that are coming out with some of the inequities across the state. I think it would be helpful for us to work together on

this. And I have two separate things going out, maybe we can combine those in some way, because I know how people are with (indiscernible). I'm that way sometimes if I get too many, I'm like, what is this one about and how is it different from this one?

MS. RICHERSON: Yeah.

MS. LASLEY-BIBBS: And if they're saying the same thing, I pick and choose, sometimes, which one that I respond to, so I don't want that to be an issue with this group. So that's my ask, if you guys are interested in (indiscernible), kind of formulate what some of those community conversations might look like.

MS. RICHERSON: Great. Hey, Vivian, I could -- I can -- you're cutting out a little bit. I don't know if it's just for me, I don't know if you can adjust your mic.

MS. LASLEY-BIBBS: It's up all the way.

MS. RICHERSON: Oh, that's much better.

MS. LASLEY-BIBBS: I'm going to -- I have to lean into the microphone. I have to

lean into the microphone for my laptop, so I apologize. I need a new one. That's all I'm going to say, I need a new one. Can you hear me better now?

MS. RICHERSON: Yeah. Yes, much better.

MS. LASLEY-BIBBS: All right. So I have three screens, so I'm moving back to my main screen. Maybe that will help, too. All right. So did you hear most of what I said, Juilia, or do I need to repeat it? Did everybody hear most of what I said? Jodi?

MS. RICHERSON: Yes.

MS. LASLEY-BIBBS: Okay, great.

MS. RICHERSON: I'm wondering if we could pick one of those things that you mentioned, or a couple of them, and give you some feedback now I think you had mentioned -- here, I was making notes. Some things that -- I think you said, what are some of the things that we as a community want to know, or --

MS. LASLEY-BIBBS: Right.

MS. RICHERSON: -- what did you say?

Can you rephrase that?

MS. LASLEY-BIBBS: Yeah, so what we're trying to do is kind of have a conversation with our stakeholders and community partners as to, you know, what are we doing well? What are we not doing well? What are some of the gaps they see, as it relates to services, as it relates to programming, as it relates to just being visible? And what is it that we're missing with our staffing?

When we talked about this morning in the community of practice core teams, the diversity of our staff, and how we want to make sure that we're more inclusive in our hiring and the diversity of those that we hire to reach the populations that we serve.

So we're very interested in hearing from the community and what they envision and what they see that that would look like. So those are some of the areas, Julia, that we're really going to be focusing on, and if there's additional areas that this group would like us to focus on or additional

questions that Jodi and her team might want us to put into this community conversation, as I call it, then that's what we need to know.

And then, I was just reiterating that I don't want us to be duplicating efforts. If we can do this together, or if there's some things that we can -- from this group -- that we can combine in hours, we'd be more than happy to do that, so.

MS. RICHERSON: So I'm wondering if we can take a minute right now, if you wanted to lead us in a discussion about -- so you said, program, services, eligibility, what's working, what's not working, because I'm sure we could all contribute to that conversation. Would that be okay if we jumped into that a little bit in a way that's helpful for you?

MS. LASLEY-BIBBS: That's fine, all right. And when we think of social determinants of health, are we really addressing those needs for the community? Are we forgetting about those? Are we doing an adequate job? Can we do a better job in

incorporating the social determinants of health in the work that we do? Because if that's where we're going to be doing midstream work, then we need to start talking and having that conversation around it, so.

MS. RICHERSON: Great. I don't know if anybody wants to jump in, or if we want to do a talking circle of some sort so we all contribute, or would anybody like to jump in and talk about something that's working or not working from your perspective as you work with people who have Medicaid?

MR. BURKE: Yeah, I mean. I don't know. There's a lot of different departments and things, so I'm not sure exactly what does and does not fall under your area, but I know where I'm from transport is a huge one, right? So if I have a need for a patient to see a subspecialist, pediatrics subspecialty care is two hours away, right? So it's not like a public transport thing, there is Medicaid transport that they can set up, but it's -- at least what most patients tell me, they

have to have days or weeks in advance in order to plan it, and so it's not the easiest thing to truly coordinate.

And so if I do get them an appointment, and their car breaks down the day beforehand, they don't have the means to get that fixed or to find an alternative way or to pay for a different ride, and so they end up missing it. And then, you know, it's an appointment that's been three or four months out already, and then they have to reschedule it. And then -- so I hear that story, you know, probably once every other week, at least, if not every week. And so at least from my perspective, transport's definitely a big one.

MS. LASLEY-BIBBS: Yeah, we hear that a lot.

MR. BURKE: I'm not sure what the best way to fix that is but, I mean, that's definitely an area that I know out here that we definitely struggle with. Especially for kids, because again, I don't have anywhere closer that I can send them to.

MS. LASLEY-BIBBS: So can I ask a

question about telehealth as an option, do you utilize that, Dr. Burke?

MR. BURKE: There are some places and locations, like endocrinology has -- I know at UK has some things that they'll do through telehealth. The issue is that like if I'm sending a kid to UK, it's typically for something that they need to be evaluated in person, whether it's cardiology with pediatric echo, or they need to see a neurologist, which I feel like they really like their hands on exams.

Or, you know, if they are -- there are avenues and some subspecialists where telehealth works fairly well. And I think Pikeville has something set up where they're able to do telehealth through over there, and so we can get them in there. And so there's options, but there's definitely room for improvement.

MS. LASLEY-BIBBS: I was just looking at some new data that has come out that was showing that a majority of the folks -- well, not quite the majority, but I think it was around 40 percent of the people during

the pandemic utilized telehealth and thought it was very helpful and useful for them. And that if they didn't have that option, they wouldn't have been able to have that continued care through the pandemic, so just -- I was just throwing that out there as a conversation --

MR. BURKE: Yeah.

MS. LASLEY-BIBBS: -- piece, if you think that that's something that we should kind of continue to talk about in this group as being something that we might want to consider as a gap. And, you know, where people can't have access, telehealth is an opportunity when they don't have direct access with transportation being an issue, so.

MR. BURKE: Yeah, for sure. And, I mean, I think at least through -- I guess what they have setup at Pikeville, right, they have a location where people will come in and they will do telehealth from that location. Because I know for me, if like a lot of my patients if they were to do -- have like a telehealth appointment, they

still need the means, like Internet, electronic device to actually connect, someone to help them figure the system out -- it's through an app -- things like that. You know, for the sake of other people's schedules to have it in a timely manner, you know, there's outlying locations that can help coordinate that, that would probably be useful.

MS. LASLEY-BIBBS: So transportation's a big one. Anyone else think of things they want to know about related to either Medicaid services, or to staffing, or to some of the other things related that we can incorporate as it relates to social determinants, as it relates to racial equity, as it relates to equity in general?

MS. BAUTISTA-CERVERA: I would second what Dr. Jordan just mentioned, and I am in the CD, and I think Dr. Richerson would be the best witness to these missing appointments, for not only for the pediatric population, but for all the population. The lack of transportation within the Latino

community is one of the biggest problems, and if we add to this cultural misunderstanding and barriers of language or literacy, the problems get compounded.

But I think with the huge need for flu vaccines at this moment, with the severity of the transmission of influenza, I think transportation and the availability and the access to flu vaccines, it's going to be big trouble for the population that I accompany with La Casita Center.

MS. LASLEY-BIBBS: Dr. Bautista, just a question around communication, we talked about how that messaging is getting out. We talked about the literacy level and language. Is there something we could do better as it relates to communication and things that we're getting out to these communities as far as messaging, or is that something that you think we've done a pretty good job on, or we need to improve that?

MS. BAUTISTA-CERVERA: You know, with La Casita Center we produce our own videos and our own infographics and we work with Family Health Center. We have been

partnering with them, not only for the medical assistance, but we share a community health worker that speaks Spanish, so it's serving both organizations and it's serving this specific community. So we are working as a team, and I do -- I'm the one that makes the videos and the infographics and puts the voice to them, because we need to pass on the information that we're receiving. And we use the CDC information and whatever we find in the Public Health Department of Kentucky.

MS. LASLEY-BIBBS: Okay. So you're able to do it in-house, is that the same situation for everyone else, to do things in-house? I know our state system is a little bit different with communications, but there's some other folks on the call, too -- on this call -- that may think we need to do a better job of communicating. Just a question, and you said something else about CHW's, which I'm very fond and is very near and dear.

Someone else was trying to say something. I thought I heard someone trying

to chime in.

CHW is becoming kind of that bridge now to connect communities to services and to programming. So, you know, at CHW right now we're thinking about sustainability funding for them through kind of a blended approach through Medicaid and another funding source. So, you know, do we see CHW being something we want to ask community folks about, or do we think there's enough information we have already about their usefulness, their accessibility to communities, how we can better support them?

I'm just throwing ideas out here, you guys. I'm trying to get some direction on where additional questions we can kind of ask our communities when we go out and talk with them. I think one of the questions is how -- are we listening? And how can we listen more effectively, and how we can be we be more effective in hearing what they want? Do they feel like it's a brick wall? Do they feel like it's getting through? Is there another way they can -- they should be communicating their issues or concerns? I

mean, we're assuming a lot when we go out to talk to communities already, so.

MR. CLEVELAND: Vivian, what are you all doing currently to get voice from the community?

MS. LASLEY-BIBBS: Excuse me? Dr. Cleveland, I didn't hear you, I'm going to lean in a little bit.

MR. CLEVELAND: I said, what are you all doing currently just to get input from the community folks right now?

MS. LASLEY-BIBBS: I'll be honest, it's usually, Dr. Cleveland, convenience where we already have either grant funding, or where we're already working in communities. We're not reaching out to new communities like we probably should, meaning a new group that we haven't touched before. And that's where some of the folks hopefully on this committee can help us kind of get into places where we haven't been able to get in before, where we're not currently providing a program of service, or -- but we know that that's a voice that needs to be heard, right?

MR. CLEVELAND: Yes.

MS. LASLEY-BIBBS: So for example, we're doing a lot within the Louisville urban metro area. We're also doing Lexington, and we're doing eastern Kentucky and our rural areas, but we're not hearing much from western Kentucky -- the western part of the state. I think that's a definite gap where we're not getting enough input from those folks on that end of the state, and then we can do better just within our central and northern Kentucky area, too. So I hope that answers your question a little bit, Roger.

MR. CLEVELAND: Yeah, I was wondering. Thank you.

MS. LASLEY-BIBBS: Yep.

MS. FIGUEROA: What do you need from western Kentucky? How can we facilitate that communication, because I echo the concerns that have been expressed in regards to transportation. Transportation is a barrier that they need access to treatment and to prevention care.

Also, the language and cultural

competency. We focus a lot on creating a language competency, and I think that we don't do enough in regards to competency, and those are two distinct competencies that need to be developed in our systems of care. So my question to you is, how can we -- how can I facilitate, from our region in any way shape or form, that communication?

MS. LASLEY-BIBBS: So great question. One of the things that I think I really want to be a little more sensitive and be aware of, is the need for those bridge builders, those connectors, those CHW's in western Kentucky. I think we've done a great job with Homeplace and making sure that they're in the eastern part of state, but we really don't have as much coverage for CHW's in the western part of the state, and how they can be great connectors.

As far as the language and competency piece, what does that look like for you when you say competency from the provider side and the systems of care side, or competency that the community would like to see? So which one, Dr. Figueroa?

MS. FIGUEROA: I think it's both.

MS. LASLEY-BIBBS: Okay.

MS. FIGUEROA: I know people, for example, who wanted to become interpreters and there was a lack of training to become court appointed or certified interpreters, and that's a missed opportunity. And that's something that we could help develop a public campaign.

And in our social networks, we have advisory councils for our services and clients and community leaders participate. And we have a person that works with communities -- Latino communities across the state, and so he has a pulse for that community. It's a great opportunity for us to expand in that particular area.

We have a growing Burmese community and they lack services. Also, we recently opened the doors to the Afghan refugees, and the cultural competency and linguistic competency was a challenge and continues to be.

And so those are some of the things that I would like to see, that perhaps we

can work together or influence other systems in the state that could offer and build that capacity in that particular area.

Nothing can substitute the value of sitting together and inviting the community to express their concerns, and how they can be -- how can they have a greater voice, a stronger voice in the development of services? Service mapping, for example, would be essential, with an emphasis, again, in cultural competency. And it could be -- it's not just ethnicity, but sometimes we're talking about age groups, talking about different areas that we need to address in communities that are marginalized.

So I think that for one, as a CEO, I believe that our organization is still (indiscernible), but at the same time, even though that we have strategized and we have expanded our search for bilingual employees, and increased the number of opportunities for cultural competency training, and that's something that we have to do across the systems.

MS. LASLEY-BIBBS: So definitely I

hear you saying you already have some advocates and boots on the ground that can help with these conversations when we really want to find out more about -- definitely a population we're missing the mark on, and I'm saying to be totally transparent, is our refugee population, our Burmese and our African refugee population. We're just not able to get in and have those conversations that we need to have to find out how we can best support them.

And definitely doing more with our social competencies -- I hate that word. Dr. Figueroa, I'm going to be honest, I don't like that word, "competency," because I don't think that we ever are culturally competent. I think that --

MS. FIGUEROA: Right. Yes. What would you prefer?

MS. LASLEY-BIBBS: -- the medical community still uses it. I know that's something that providers look for, but we're trying to put a health equity lens to the current class standards and culture competencies that are out there on the OMH

web page. So we're looking for states to kind of pilot some of the --

MS. FIGUEROA: Yes.

MS. LASLEY-BIBBS: -- things that we're doing --

MS. FIGUEROA: Yeah.

MS. LASLEY-BIBBS: -- but stay tuned for that because I think people are wanting to change some of those a bit to have more of a health equity focus. And take a deeper dive into what those really look like.

So I agree with what you're saying. I do think we need to have more interpreters, and what we can do to help facilitate that at the state level. If there's anything that we can do based out of this group, I think that would be great, as well. So I appreciate your comments --

MS. FIGUEROA: I -- yeah. Since we're having this conversation, I think language matters and I understand what you're saying. At the same time, it's like, what would be an appropriate way of calling things?

And I have to say, I like using the

word competence for this reason, because as professionals, we don't want to be perceived as incompetent or that we're missing something, right? And it's easier, and it takes the message across that you are not competent when you have not developed those skills, okay? And so it puts back the responsibility on those individuals that are providing services in order to develop the skills and talent, and also to work in adverse areas.

So I know that this is a work in progress, and as I said, language matters, but I just wanted to give you a little bit of perspective of how I can use it in that manner.

MS. LASLEY-BIBBS: I appreciate it, appreciate it. Anyone else have comments? I've got a lot of different things down here: Access, transportation, communication, language and social competency, and then working with specific populations. We haven't talked about our seniors, if we feel like we're doing enough with that demographic. Are we doing enough

with some of our other groups?

I mean, we can slice and dice it a number of ways, but I do think our seniors are sometimes forgotten, and we do have an aging population, you know, longer than the previous ten years or 20 years prior, we're living longer. So anybody have --

MS. RICHERSON: Who works with seniors? Kiesha, do you work with seniors, no? Anybody else? Kiesha, do you have any specific senior focuses?

MS. CURRY: Yes, I do work with seniors, I'm a social worker, but I don't deal with the financial piece of it, as far as the Medicaid and Medicare and what not.

MS. FIGUEROA: For behavioral health in particular, one of the biggest problems that we have in providing services to seniors is that -- say that our regulations -- Medicare regulations, that allows only like psychologists and licensed social workers to provide services and get reimbursements for that. I know that currently there is Congress-passed legislation that would allow licensed

professional counselors to provide services. So what's happening is even though we have therapists and we have other people that have licenses, Medicaid accepts them as providers, but Medicare does not. And that really compromises access to services.

And so that's one area that it seems there was a solution, but it's a partial solution because they don't get paid at the same level, even though they have the same kind of training. This was a matter of basically trade organizations that got to the table first and kind of controls who can provide services or not, it has nothing to do with quality.

But that's an area that I think we're looking at providing services for seniors. We have to take a look at, from a provider point of view, what are some of the barriers that we have in providing services to seniors?

And so if something is not allowable at the state level, perhaps that's something at the federal level that perhaps we should take a look at those regulations and do

something at the state level to build equity.

MS. LASLEY-BIBBS: Noted. I just want to throw, you know, the other demographic that we can build on a lot is our LGBTQ+ population, and are their voices being heard? And then, you know, any other demographic that we feel like we should be really tapping into.

I don't want to monopolize the time, Julia. I want to give Danita Coulter a chance to say something, because she's with the health equity branch within the cabinet within Medicaid. So, Danita, if you have anything you want to add. I don't want to hog the whole conversation because we're in this together. So if you have any thoughts or ideas, please share. I know I'm putting you on the spot, maybe.

MS. COULTER: I think, actually the group has not been introduced to me yet, and so they don't know my role. I think we were kind of going out of order, so I guess we can use this time to introduce myself to the group, and if Angie wants to jump in first,

so she can sort of talk about how the group was restructured. I think -- I don't know, Dr. Richerson, I don't know if we're out of order on the agenda.

MS. LASLEY-BIBBS: I don't know if we're at that point yet. Yeah, I don't want to supersede Julia with the agenda, so if --

MS. COULTER: Yeah, so I will defer at this time.

MS. RICHERSON: Well, great. I'm just loving the discussion. We don't -- we can -- this is all under committee goals and strategies anyway, so it all will fit, but we can hold if you want to, Danita, until later in the agenda.

MS. LASLEY-BIBBS: I just want to add one other thing, Dr. Richerson, before we move on, is that when you say what equity issues are trending, of course, racial equity is always a topic now having the heart of conversation around the upstream new causes, but things that we're still hearing is that we're still in the pandemic. We still have a lot of misinformation and things going out around COVID vaccines, and

our numbers still need -- in certain populations -- still need to increase as far as vaccine updates and increasing vaccine confidence.

So I still don't want us to forget that we're still hearing that from communities. So I just want us to keep that in the forefront, too. And not just COVID, but immunizations in general. We're in a flu season that's just blown up and people aren't getting their flu vaccines either.

So those are some, I think, pressing issues that we still need to kind of remember as we have conversations. So I'll defer back to you now, Julia.

MS. RICHERSON: Great. Well, thank you for leading that. I just had a couple of things to add under our -- and this, I think, all falls under committees, and goals, and strategies review. So just to go back to what Jordan said, even in the middle of Louisville, even though I'm in the south end, transportation is still probably our number one issue around achieving health goals from our perspective, you know, not

their goals at home, but as far as accessing health care and services, huge. Huge, huge.

I think we all know that federation is not an effective way to provide transportation to Medicaid recipients. We have known that for decades, I think, and to me, it's sort of like an elephant in the room. Because we all know that you call them, they don't show up, they go to the wrong house, you have to have all this notice, and it's certainly -- I don't even know that it would take somebody two hours, Jordan. I can't remember when I was in Jackson County if I could even get federation to take somebody that far.

So I think we don't even have to have a listening group to know that that is going to be the biggest thing people talk about. And I know when we work with families, especially families that are -- that everybody wants to know what's the problems, right? Talking to refugee families, talking to families that are on Medicaid. They've told us for years what's wrong, so it's hard to go back to them and say, so tell us

what's going on, when we know what's going on and haven't responded effectively to what they've told us.

So I think that as we are asking Medicaid recipients what they see the challenges are, I think we have to go in and say, we know what you've been telling us, and no, we've not been able to fix it yet, but we still want to -- you know, how do you have that conversation with somebody that's already been telling you what's wrong. So I think that's a challenge with listening.

So anyway, transportation, huge issue, even in Louisville. I think that if, as a group, if that's the one thing that you get from the TAC, is transportation is a huge issue, and we're happy to try to help get you more information if you need that, or help figure out what the issues are, but huge.

Okay. Access to care: I know you talked, Vivian, about vaccines. Access to vaccines is a huge issue. Access to vaccines, and it's not -- it's because there's nobody to give people the shot,

right? We're in a nursing shortage, they can't just go to Walgreens, right? You have to get your appointment online, even if, you know, Medicaid covers the vaccine, there's barriers. You can't just walk into Walgreens and get a flu shot, you can't just walk into the health department in Jefferson County. You have very limited hours to get the vaccines, so even though we hear about people -- there's vaccine hesitancy, honestly me, ten people a day I can't give a vaccine to because I don't have nursing staff and I can't send them anywhere. So we have to pay attention to that access issue.

Subspecialty care: If you have Medicaid and you want to see a rheumatologist, it's like you have zero access. My husband, private insurance, wanted to see a rheumatologist, one week, right? So access to subspecialty care is extremely important because it is very different.

Same with GI. If you have Medicaid in Louisville, and you want to see GI, maybe in the summer. And if you have commercial

insurance, it's next week, and so that's gotta be a payment issue, you know? There's a lot of reasons why subspecialists don't want to take Medicaid, but that's something to definitely look at.

Just to share: Our stories at Family Health Center, we were very limited in our cultural and linguistic maturity, for lack of a better word. Every person that came in that needed an interpreter, it was like, oh, what do we do, you know? This is 15 years ago.

We opened the door to interpretive services, of course we have to pay it all ourselves, and that transformed our cultural competence, using the competency word. Because if you don't have language access that creates -- bias isn't even the right word, but if you don't have a way to provide interpreter services easily, then that patient becomes a problem, right? To the front office, to nursing, to the doctor, that patient becomes a problem if you don't have language, and Medicaid in Kentucky doesn't pay for interpreters. So another

elephant in the room: Many states do.

MS. FIGUEROA: Yeah.

MS. RICHERSON: And so I think a really serious look at Medicaid paying for interpreters.

And then you mentioned the CHW's. I think, like you said, I think Kentucky led the way, right? For decades we at Kentucky Homeplace. We have -- we told the story from the beginning, so I would hope that we have enough stories and enough data to show that in our state it's crazy effective, and that we just need to -- and it's cheap. It's cheap, and it changes lives, and so I hope that we can continue that progress that we've been inching along with.

Because the other thing is, if you want SNAP in Louisville, 30 minutes minimum on the phone, 45 minutes sometimes. Maybe you get hung up on, maybe you don't. People can't access SNAP. They can't access WIC hardly. And so that's why we need community health workers, right? To help because our systems are so hard to navigate.

And it was different when I was in

Jackson County, I could access those services really easily. There was, you know, smaller scale maybe, I don't know. But so again, community health workers is our band-aid, right? Because our systems are too complicated. If it's easier to navigate systems, we wouldn't need to figure out how we're going to pay for community health workers. So a lot of that is just reiterating what others have said, but I think that -- I just realized during this conversation how we didn't change as an organization until we aggressively paid for interpreters, and that led us to be able to approach the situation of somebody who you can't communicate with completely different. And now, I think families -- many families come to us, not to see me, but because we have interpreters, right? And then that made me a better doctor because I know -- I just have a lot more experience. So I think that could go a long way around paying for interpreters.

MS. FIGUEROA: The other thing is differential pay for a bilingual clinical

staff, because that works -- that helps to retain them, and to even encourage some individuals who are willing to work in a particular field that we struggle to have professionals.

MS. RICHERSON: And that goes right to DMS workforce ideas.

MS. FIGUEROA: Right.

MS. RICHERSON: That's great. That's a great point. All right. Well, I hear a pause so I'm going to move onto new business. And we are at 2:05, okay.

So there's some informational things on here, as well, and then some more discussion things. So we'll start with the CCBHC. We had brought that up just a little bit at the last meeting and people wanted more information, and so who's going to tell us about that?

MS. HOFFMANN: That's going to be me. And I realize this is new business, we usually have new business and then we give you the information the next time, but I'm pretty familiar with CCBHB and some of the other items on here, so I thought we would

go ahead and give you what we have. Let me see if I can share my screen.

And this is a presentation that we gave -- let's see -- I think we gave it out to the SIAC, the State Interagency Council, maybe a month or so ago. So I'll just go over this, so CCBHC stands for Kentucky's Certified Community Behavioral Health Clinics.

I'm going to give you a little bit of background because sometimes it gets a little confusing. This is actually an initiative that started back in 2014 when our sister agency at the Department of Behavioral Health applied. Congress enacted a program to test a model to improve behavioral, as well as health access, and integrated care. So it was any type of care that could be provided. It was kind of the first time that they were really trying to start talking about integrated health care and increasing access.

In 2020, Medicaid received information that we were selected, along with Michigan, from this 2014 application.

So it got a little confusing because we had to take the 2014 application and we were not allowed to change anything. So we had to use that '14 application, so I think for lack of reasoning, approximately ten states were giving the award at that time. One or two did not stay in the demonstration. And so then later CMS said, "Hey, we've got some funds to go ahead and start maybe in two more states." So we started with Michigan.

So we were selected and our go-live date, which there was a lot of prep because of 2014's information, CMS wasn't quite prepared in 2020 to get everything together and start working. So we did have a little bit of lag time for our go-live, which was 2022, January.

And then in 2022, also, through the Safer Communities Act, Congress extends and decided to expand that demonstration through 2028. So we have -- it originally was eight quarters, and now it is going to extend through 2028.

What is CCBHC? They provide a comprehensive -- must provide a

comprehensive range of mental health and substance use disorder services. CCBHC's are available to any individuals in need of care. CCBHC's will provide care regardless of the ability to pay or their place of residence. Some services that CCBHC can provide -- and I'll just run through these quickly -- crisis services, screening, assessment and diagnosis, treatment and planning, outpatient, mental health and substance use services, primary care screening and monitoring, targeted case management, psychiatric rehabilitation, peer support and counselor services and family supports, intensive community-based mental health care for members of the Armed Forces and veterans, particularly those in rural areas.

With this integrated care this was very much an initiative that CMS wanted us to ensure that we meet all of the needs of all populations, such as making sure that we reach the elderly community, we reach the less fortunate, we reach the communities that are definitely in need, like the

veterans groups and LGBTQ, and all of those different groups that we need to start addressing. So this was our -- really our first integrated initiative for Kentucky.

Our current CCBHC demonstration agencies, and I know this gets confusing again, based on the 2014 application, four of our community mental health centers, which are our CMHC's -- not to be confused -- were in the original application. So they in turn also ended up being four of our CCBHC, this is the only four we have through the demonstration period. So it's Seven Counties Services, North Key, New Vista, and Pathways. So at this time, we are not -- have not received guidance of when and how we can expand to other providers, or other CMHC's, or other providers in Kentucky.

Whoops, I'm sorry, I hit the wrong number, I think. That's it. So Dana McKenna runs this program out of Medicaid under our behavioral health initiatives group, and we partner every day with our sister agency, the Department of Behavioral Health, and Dr. Robbins has been very much a

part of that. I don't know if she's on, but she's very much a part of this group, and we meet on a regular basis every week.

So is there any questions about CCBHC, or any follow-up that you might want from that?

MS. RICHERSON: Thank you. And what age -- are you going down to like two and three-year-olds, or is this adult focused?

MS. HOFFMANN: I don't believe there was an age limit on this group, I think it was for anybody in need.

MS. RICHERSON: As it's being operationalized, do you know if they're hitting the full age range?

MS. HOFFMANN: So we just started in January of 2022, so we're just now -- CMS is going to require quite a few quality measures, and so we've been working through that with our community health centers. And so I might be able to provide more information on that later if you would like.

MS. RICHERSON: I think it would be helpful. We know that as far as looking at equity issues, behavioral health is such an

important piece of the puzzle, and looking at -- it'd be interesting to see what kind of data they're looking at. Are they breaking it down with race and ethnicity, age. So maybe, yeah. Just a preliminary --

MS. HOFFMANN: I can see what we have. I think we've talked about this before, our current system is not wonderful related to the data, I can give you some data. What we end up -- a lot of times are submissions that say, "other," and so that's not gonna give you a whole lot of data.

Like for behavioral health -- I think we looked at that in the past, and I think we had like 80 percent participation, but then 50 percent, I think was not -- either not accurate, or listed as other, or blank, so some of the fields were blank.

So this is a great initiative, we're very excited about it. We're looking forward to coming out of demonstration and hopefully add this to the state plan, if permitted to do so, and so a very good group to work with.

MS. RICHERSON: Any questions on the

CCBHC's?

MS. FIGUEROA: I have to say that we are looking forward to being part of that group later on, we were not part of the original.

However, three years ago we applied for a CCBHC grant directly to the federal -- to SAMHSA, and we were granted that. And we established a CCBHC in seven counties, and it has been a game changer because it really removes -- it allows people to access services, especially services that they otherwise would not have access to: 24/7 mental health mobile crisis, MAT services, the integration of physical health and behavioral health is such a wonderful way of -- it's refreshing to see that system in place. So we look forward to being a part of that.

And I think that the Department of Behavioral Health is doing a fantastic job in securing that designation for the commonwealth.

MS. RICHERSON: Thank you, Wanda. The minority health or status health report,

Vivian gave us the link to that, and it's in the chat if you didn't see it. I don't know if you wanted to give us any high level, anything you want to -- oh, Vivian's gone. Anything you -- anybody else speak to the minority status health report or health status report? Sorry.

(No response.)

MS. RICHERSON: Well, we will review it. We've got the link and we'll keep it on for next time if people have questions or comments on that.

Great, okay. And then the equity and determinants of health branch manager; did I get that title right?

MS. PARKER: Yes. Hello. I am Angie Parker. I am the director of quality and population health, and as Vivian had mentioned earlier, we do have a branch manager for our equity and determinants of health branch, which is Danita Coulter. And she actually started on November 2nd, the date of the last meeting, so she's been here a little over two months.

And we, within the division of

quality and population health -- this is a new division within Medicaid that was established in July of 2022. And so I have been working feverishly and getting this division set up, and with four branches: One being the equity and determinants of health, one, quality, one, population health, and one, research and analytics.

So I will -- and all of these things kind of fit together as you would imagine, but we are, because this is a disparity TAC, I wanted to introduce to you -- Danita Coulter to you, and who you all would probably be working with as you've discussed partnering and identifying areas in which you have noticed and where we could put potentially focus, because we know we can't work within a bubble and everything that touches the health of our enrollees is equity -- should be equity driven. So, Danita.

MS. COULTER: Hi. Thank you for that, Angie. My name is Danita Coulter, and as Angie said, I came on board in November. I am familiar with working with the

enrollees with Medicaid. I came to this department directly from the University of Kentucky. I was working with what was called The Kentucky Injury Prevention and Research Center, working specifically towards injury prevention and prevention of injuries that would sort of guide policy that would control those injuries and sort of create policies that would prevent those injuries. Sort of the same thing that we're doing towards this equity work.

So before that, I spent ten years working for -- I'm sure some of you are familiar with Community Action Council -- where I worked very closely with many of the enrollees with the Kentucky Medicaid program. So some of these challenges that I've heard you mention today, like with the transportations and language barrier and all of those things, so I've witnessed those first-hand with those enrollees and work with them to try to accomplish ways to meet these challenges and barriers. So I'm happy to be in this position to work with like-minded people who are creating ways to

address these barriers.

The Medicaid initiative collaborative -- we do have that kickoff scheduled on January the 12th, and that one question about working with the MCO's, we will be working closely with you all to get your feedback. Angie has scheduled a meeting with you all working on providing some pretty detailed information on what we've been doing as a group and what we hope to do with you all in the future, you know, to collaborate and identify some other partners.

So you have my name, you have my information. I look forward to working with you all and sort of picking up where Jodi and Deputy Commissioner Hoffmann left off with this great work. So thank you.

MS. RICHERSON: Thank you. Thanks for your introduction, nice to meet you. Is there -- since we have some time at the meeting today, is there anything that we could offer, Danita, for you to help you in your work thus far? Any questions for us or feedback that we can give you?

Oh, you're on mute.

MS. COULTER: The information that I've been hearing and the feedback that I've been hearing from this group -- I've been taking notes, and of course the minutes are available. And our team meets pretty regularly so that we can find ways to act on what we've heard from these groups. So right now, I think that I'm fine, but we will let you know if there's anything that we need further, but thank you for asking.

MS. RICHERSON: Let me ask you, if we took to the MAC, for example, you know, a competence of evaluation of federation, and what's working and what's not working, for example. Would that be helpful? Is that a role that the TAC could play that would help to get the transportation issue -- not prioritized, that's not the right word, but brainstorming to try to find some solutions, or is there a role like that that we could play?

MS. COULTER: I think --

MS. PARKER: Go ahead.

MS. COULTER: Go ahead, Angie.

MS. PARKER: Well, I mean, I don't know that that's a recommendation you would need to make to the MAC at this point. With the discussion we're having today -- and we, you know, as DMS, we do recognize that transportation has been a huge problem, and how we address that is -- it's something that we can also target or focus on on our end. You know, access to care, in general, for -- you mentioned that a commercial insurer can get in quicker than a Medicaid, you know? That's -- we're aware of that, so how do we fix that? And it comes down to providers. And there's a lot of pieces and parts and puzzle pieces --

MS. RICHERSON: Right.

MS. PARKER: -- that we all have to determine what we can fit together and where we need to focus.

But I think at this point, we will, you know, things that I got on my list, and Denita probably has the same, is transportation; telehealth, how to utilize that and we know there are gaps in that; the access to subspecialty care; access to

vaccinations; and interpreter services.

So -- which is on the next -- which is 5D, its quality strategy for Medicaid and review of equity focus. All of these things are a focus. It's how much you, or we -- I say, we -- contribute, as far as our time and efforts and energy, because there are so many things and so many people. Where are -- where are people working on certain things? Who is working on certain things? Is there somewhere out there people already working on transportation? We are. I can tell you that we already are. We haven't got an easy fix yet, but we do appreciate the feedback from this.

And I can tell you, one of our biggest challenges in identifying, is data of those persons of race and ethnicity, and trying to drill down on -- because as Deputy Commissioner Hoffmann mentioned earlier, people either don't check the box, or they say, other. So, you know, it helps us -- it does not help that we aren't able to identify those areas for racial equity because we don't know.

So how do we fix that? How do people feel comfortable of even filling out and checking that box? Because data helps drive a lot of what we do and what we intend to do. And anything that you all, as a group, can help us identify -- or the people that you serve -- identifying their race and ethnicity will also help in the data, and to determine, okay, where are our biggest barriers to care and for what groups?

We can all anecdotally, come up with information or, you know, what we think is the issue, but data really does drive a lot of what we need to be utilizing to also focus.

MS. RICHERSON: Great. Thank you for that. And also, thinking about, like you said, a lot of the feedback and discussion that we've had today is fantastic. It's not news to you all.

And so, how can we provide information that is different in some way or more -- I guess, looking at the role of this TAC, how do you feel, like just ideas moving forward, how you feel our voice is most

helpful? Because again, you all know these things, and you don't need us to tell you again, but what could we tell you, in what ways? So -- and I don't know the answer to that, but any ideas you all have on how we can most effectively use our voice for you all would be great.

MS. PARKER: Well, yes. And we know these, but we also need to hear it from you all, too --

MS. RICHERSON: Okay.

MS. PARKER: -- I think is very helpful, and that's why we have this TAC.

MS. RICHERSON: Good, good. Well, we want to be helpful.

MS. PARKER: So how we can work together to resolve some of these issues and some ideas you may have, as you said, to help with transportation.

You know, we're a collaborative group here, and we all have different ideas, and we're outside -- I like to think outside the box, type things.

So, yes. We appreciate this, and that's why, you know, the conversation today

does help strengthen what we already know, but at this point -- so it's, what are we going to about it?

MS. RICHERSON: Let me ask you a question on the data, so for example, I know Jordan and I, where we are at F -- are you at FQHC or Rural Health Clinic, Jordan?

MR. BURKE: RHC.

MS. RICHERSON: Yeah. So at FQHC's and RHC's, we have that data, right? So we collected race and ethnicity data. So it probably -- Wanda, you probably have it on yours, so there are those of us -- we have the data. So pilots on looking at data -- could be -- because we have it in matching lists, something like that -- could be an innovative way.

Second thing I wanted to bring up is NCQA, I believe, is starting to require that data. And what -- is that going to force CMS then to make it a force field, or what do you know about that?

MS. PARKER: Well, that's a good question because NCQA -- yes, they are opening up their accreditations and measures

regarding health and racial equity. And all of our six MCO's are NCQA accredited, so this is something that, you know, they would also have to make sure that they are focusing on, as well.

And with our quality strategy -- everything we do, actually, within the department is focused -- or equity is a part of that. Through our RSP's, through our procurement, through our MCO contracts, you know? I believe that deputy commissioner mentioned this in a previous meeting that everything we do has an equity portion to, or focus to what we are doing. And ensuring that that is on the forefront.

But how CMS will take this, it's hard to say, because as you said, we can't make people fill the -- check the box because it is something that they can just move on past. But I wasn't aware that FQHC's and RHC's are able to track this information. So, yes, I think that would be a very great idea to kind of see some of your data and what you're seeing, as well.

MS. RICHERSON: And then, the other

thing, you know, in the quality improvement world, you know, you kind of deal with the data you have a lot of time. And is there a way to, you know, deal the data we have and make some -- try to make some observations? You know, and it's not a research project, but make some quality improvement observations that could inform some of the work that, I think people are holding off on because the data's not good. But there is some data, you know? Like you said, I think, is it 50 percent you have? I know some of the MCO's have said maybe they have 50 percent race and ethnicity data. And that's better than nothing.

MS. PARKER: Yes.

MS. RICHERSON: I don't know from DMS's perspective, do you feel like you could move forward making some observations or, you know, using the data that you already have?

MS. PARKER: Yes, I mean, we are looking at that. And, you know, we do request -- we have a Covid report each MCO does and it's broken down by race and

ethnicity if they're able to obtain that. And I know that each MCO is also working to get that information in different avenues, whether or not if it's a member who calls in, if it's a question they can ask, you know, for other reasons, but -- so, yes. I mean, they are all working toward in assisting with obtaining that information, but there's no easy fix, so.

MS. RICHERSON: Right. Yeah. I just feel like a lot of times it's a barrier to moving forward because people feel like we don't have enough data so we can't look at --

MS. PARKER: I think we have enough data, let's put it that way. I mean, you have to, you know, I'm not a statistician, but you have to evaluate the amount that you have and, you know, there's ways around that, to figure out the percentage of this, that, and the other.

But, yes. I think we have some data that we can come with some conclusions or at least hypothesize about. Like I said, you know, a lot of things we talk about is

anecdotal, but that anecdotal usually turns into definitive.

MS. RICHERSON: And I know that this group --

MS. PARKER: We just don't have the numbers, specifically.

MS. RICHERSON: Right. And I know this group definitely would -- wants to be involved in looking at that data, so I don't know if there is anything that you have for the next meeting or could bring.

MS. PARKER: There might be, I can look at that, but we are -- Danita just talked about -- we're meeting with the MCO's. They each have, you know, what are they doing regarding equity? And kind of getting a general idea, and working with the Medicaid innovation collaborative, as well. But I might be able to have some data for you by then, I would like to. And -- but I'll know more after January 13th.

MS. RICHERSON: Great. And then, a really important point in the chat, Miranda said that, you know, these -- they're arbitrary boxes, right? So people have a

hard time checking the boxes when they don't feel the race and ethnicity labels describe them.

DMS convened a workgroup last summer focused on immigrants where we discussed changing the wording of the race and ethnicity questions and responses. Do you know about that workgroup, Angie? That would be good to get some feedback from that. I don't know, Miranda, can you share who you worked with?

MS. BROWN: Hi. Yes. We -- I think Commissioner Miranda-Straub convened it, and maybe Lisa Lee was also involved, but it was a workgroup specifically focused on how immigrants experience the Medicaid application, and ways to make it better. And so that was one of the issues we discussed, was how that question is asked in the response options.

And we looked at, you know, immigration from the census and how they have studied how to ask that question effectively, and we pulled some of their data and testing on how to ask about race

and ethnicity. And I'm not sure what flexibility the state has to reword that, but it is something that we explored in using evidence that has been collected and studied. So I would still really be interested in seeing that changed.

MS. PARKER: Yeah. I knew it was being considered and/or worked on, but I think, Miranda, you bring up a good point, what we can change, you know, what DMS will allow us to change is the question. So, yes.

MS. RICHERSON: That's great, Miranda. I don't know if we can get -- I'm sorry. Yeah, Miranda. Who did you say you worked with, or who led that?

MS. BROWN: Commissioner Marta Miranda-Straub has been involved in convening those meetings.

MS. PARKER: But she's now retired. So Lesa Dennis is now the commissioner over at DCBS, so she may have some information on that.

MS. RICHERSON: Sounds like it was a really good conversation with the community.

I bet there was a lot of good information. I don't know if there's any way to access that. I don't know, Angie, if you could talk to Miranda -- Marta's the new person.

MS. PARKER: I'll see what I can find out.

MS. RICHERSON: Okay. Thank you. And then the quality strategy for Medicaid, we talked about that last time. And then just to help us understand, as a group -- as a TAC, what areas that you're -- just telling us what areas you're focusing on the qualities -- in the quality strategy that we might need to know about.

MS. PARKER: Well, you need to know about all of it, actually. I mean, but, you know, this is a dynamic document, and we do have a specific page, or area for -- it's called Health Disparity Initiatives. So we do have, you know, part of this strategy are initiatives and addressing health disparity, equity, social determinants of health. But it's all -- of all the measures that we look at, as I mentioned earlier, equity has a piece of everything that we do.

So, I believe, Erin did forward the quality strategy to you all after the last meeting. So, you know, I know it's not your favorite thing to take time to read, but there are certain, you know, I would think -- just look at some of the areas, and, you know, the goals and measures that we're looking at.

And, you know, if you read a good book, you read the first part, and then the middle, and then the end, you might be able to figure -- it might be helpful if you don't want to read the cliff note version of it, but.

MS. RICHERSON: Great. And we'll resend that after the meeting and put it on the TAC website so we have easy reference, so when we want to look at it, it will be there.

Great. The next thing we asked for an update on, so we talked about CHFS listens. The -- I guess it's a phone -- it's just phone, right? It's not e-mail, or is it both? I can't remember who talked to us about it last time. So they said that

they get phone calls and people connecting, and we were wondering, based on what they're hearing right now, if there are any equity issues to share with us?

MS. HOFFMANN: Erin, do you want to speak to that? I'm sorry.

MS. BICKERS: Yes. I actually receive all of the CHFS listen e-mails that go for Medicaid issues. I can reach out to the ombudsman -- excuse me -- pardon me -- ombudsman's office to see if they keep and run and track any reports. It is an e-mail. We do sometimes get voicemails sent from them, but they're not as frequent as the e-mails.

I can tell you, just from my personal experience of dealing with those on a daily basis, I don't see any equity trends or issues that seem to be consistent. A lot of the times it's providers who can't log into the system, members looking to make sure their active, or access, you know, looking for a dentist in their area.

A lot of times, we've got to check -- we're not sure which patient this goes for.

It's a lot of those types of things, but I will reach out to the ombudsman's office to see if they have a report they can run to see if there's any trends that they see that don't necessarily always come across my desk.

But they do send me a hundred percent of the Medicaid issues, and I filter those out to staff, have them addressed, and we filter those back through the ombudsman's office.

But a lot of times it's providers reaching out, they've locked themselves out of the system, they're having issues with an MCO, recertification issues, those type of things, but I will reach out to the ombudsman's office. And if you want to put that on your old business in the next agenda, I'll see if there's any kind of report or feedback that I can get from the ombudsman's office.

MS. HOFFMANN: So the CHFS listens, Erin, I'm just making sure, I haven't seen any related to equity, so for health -- racial and health equity, so I'm guessing

each department, like Medicaid, is divvied out those that they receive, right, from the ombudsman's, so --

MS. BICKERS: That would be my guess.

MS. HOFFMANN: -- we wouldn't have all of them, we would just have the Department of Medicaid's within the cabinet.

MS. BICKERS: Yes, ma'am. That is correct. That's why -- I'll reach out to them and see if they track those in any way that they can run a report, and can follow-up for the next meeting.

I may or may not be on the next meeting, just depending on when baby decides he wants to come, so I will make sure that Kelli has that information.

MS. THERIOT: And maybe, Erin, I'm thinking maybe the patients that had significant complaints about LGBTQ issues, those probably came from that line; is that correct?

MS. BICKERS: Yes, ma'am. I believe I've sent you two of those issues --

MS. THERIOT: Yeah, okay.

MS. BICKERS: I wouldn't necessarily

say that's trending.

MS. THERIOT: Right.

MS. BICKERS: It's not something I see frequently, but I'll reach out to them.

MS. THERIOT: Thanks.

MS. RICHERSON: Great. Thanks, Erin. Yeah, and even trending might be too strong of a word, just -- what health equity issues are you hearing, maybe is the -- a better term there. Just so we can have a chance to reflect on those and provide feedback as a TAC.

Great. Okay. Immunizations: This was one real specific thing that I brought up before around equity, is immunization fee schedule updates.

So just to recap, many pediatric providers that provide care with Medicaid families participate in the vaccines for children program, but many do not. And they do not vaccinate those kids. They send them someplace else for the vaccines. They might do the well check or see them for a sick visit, and then send them elsewhere because they say that the fee schedule isn't in line

with their costs. So they have purchased vaccine in their refrigerator that they give to commercially insured kids, but not to Medicaid insured kids.

And in the past, Lisa Lee, this was a top priority. Well, not Lisa, but -- oh, shoot. Another woman in Medicaid, it was a priority and she, several years ago, updated the fee schedule really effectively, but then time has passed and the fee schedule is again out of date. And we wanted to try to get those in line so that a child under Medicaid doesn't have to leave and try to start knocking on doors and try to get their vaccines.

So, and I think, Judy, I know you had started to look into it. I didn't know if there were any updates or next steps on that.

MS. BICKERS: Erica, are you on the call?

MS. DAVIS: Yes, I'm on. I wanted to ask, Dr. Richerson, is it a question of increasing the rate for the administration of the vaccine, or the cost of the vaccine?

MS. RICHERSON: So the first issue is the cost of the vaccine. And I think the administration rate is an issue, but I think, first and foremost, it's the medication fee.

So I recently -- earlier this year -- I saw child for a vaccine only, or maybe I saw him for a sick visit, I can't remember. And I said, oh -- they said they were going to have to come back here for vaccines because our pediatrician won't give them to us because they say, you know, I can't get them there. And so I thought, "We're going to fix this." And I called the pediatrician's office, and I said, "Oh, no, no. The fee schedule is all updated. I promise you that you're going to get paid." And the office manager pulled it up and she said, "We cannot give vaccines if we're going to lose this much money per vaccine."

And I think there's also some historic information when the fee schedule was way off, so the pediatric offices didn't even look at it, but there for a period of years it did really match what their costs

were, and it's just now outdated.

MS. THERIOT: I think we brought this up with Justin, it was probably several months ago now because -- right, the cost when you look at it look okay, but it's just out of date now.

MS. RICHERSON: It's not way off, it's just --

MS. THERIOT: It's not way off, yeah.

MS. RICHERSON: -- just enough, you know, $10, $20 here and there, but businesses, like doctors' offices, will not just take that hit of, you know, $100 here and there for a set of vaccines.

MS. DAVIS: I'll take the issue back to Justin and see if there's any work that he's done specifically on it. And if it hasn't moved forward very much, then it'll be a priority of mine.

MS. RICHERSON: Thank you. And then I think once you all look and you think that it's where it needs to be, I think you need to vet it with some doctors' offices to make sure that the costs you have researched are the -- in reality what they're paying. You

know, just to vet it before you put it into stone so it doesn't have to be changed twice.

The next thing on the agenda --

MS. BICKERS: Dr. Cantor has her had raised, sorry.

MS. RICHERSON: Oh, I'm sorry, Divya.

MS. CANTOR: Yes. Thank you. I just wanted to --

MS. RICHERSON: I think you're cutting out.

MS. CANTOR: -- the payment for the vaccinations. I was talking with Dr. Harrington -- oh, am I cutting out? I'm going to turn my camera off, I'm having bandwidth issues.

MS. RICHERSON: Okay, yeah. You sound better with your camera off.

MS. CANTOR: So let me try that. The -- I was talking with Dr. Harrington in the Department of epidemiology about specifically the patients, especially with the FQHC's, and we were noodling around how to be able to better inform the providers about payments, and just wanted to throw

that out there that it is recognized to us that there's --

MS. BICKERS: Dr. Cantor, you're still cutting out. If you could either send me an e-mail for the TAC, or drop it in the chat. We're only catching about every other fifth word.

MS. CANTOR: -- the payment around all of the vaccinations. I do recognize the fee schedule needs to be updated, but perhaps some better practices around how to be able to code and get the full payment. Oh. I'll put it in the chat. I'm so sorry. Oh, gosh. Darn it.

MS. RICHERSON: Yeah. We're only hearing every third word. And this -- and that may be a different topic. This is for non-FQ clinic people -- non-VFC providers, rather. This is an issue for non-VFC providers. We are all VFC providers, so I think this might be another topic, but I couldn't really hear, so not sure.

Okay, great. And then the next thing on the agenda is community health workers. People had wanted to hear what's going on

with the DPH funded program, and possibility of expansion and how that's going to be paid. I don't know if there's anybody on the call still that can talk about that.

(No response.)

MS. RICHERSON: Anybody?

MS. PARKER: This is Angie with Medicaid. I can't talk to the DPH funded program. I can talk to adding community health workers within Medicaid.

MS. RICHERSON: Okay, please.

MS. PARKER: That's basically it. No, we have submitted a request to update the state plan amendment a few weeks ago to pay for community health workers, and there's certain criteria around that. So we're still waiting on CMS about that. Obviously, if a community health worker is part of the DPH funded program, we would not be reimbursing, as well.

MS. RICHERSON: Right.

MS. PARKER: But it is, you know, if a provider, such as yourself, hired a community health worker they can bill for two particular codes, and it would be paid

if the state plan amendment is approved.

MS. RICHERSON: Oh, interesting. So is that SPA available for public review, or is it private?

MS. BICKERS: No, ma'am, it's not at this time. It's over to CMS for an informal review.

MS. RICHERSON: Okay.

MS. BICKERS: And then once that we get their feedback, we'll be submitting that for their formal review. We like to have things informally reviewed so that way it makes it a lot easier to get it approved within their 90 day time frame, but that is not typically something that is shared with the -- until it's approved by CMS.

MS. RICHERSON: Great, okay. Oh, good. Well, we're excited to hear what happens.

Okay. So we are at ten minutes. We have ten minutes left, and I think a lot of our general discussion fell under our committee goals and strategies. So that's fantastic, but we do have a general discussion place holder always on the

agenda. This is a time, if there's a new issue that you want to talk about in the future, or bring up now for conversation we have time to do that. Any topics?

MR. BURKE: Fairly unfrequent occurrence, but it does come up at times. And this may or may not be fully true, but I've encountered it a couple times. I have infants that come in, like, they're supposed to come in for a two-month well check, but they come in at like seven weeks old, so they're not quite at that two month threshold, but they're old enough to get their vaccines. So after six weeks, you can technically get their vaccines, and so they'll be like seven and a half, like eight weeks, but not quite two months old and they can do the vaccines, but I was told that technically, even though per guidelines they could get the vaccines at that point, like Medicaid wouldn't cover the vaccines on that day, and so, I mean, I could do them, but that's like basically the same thing, right? The clinic's not actually going to get paid if we do the vaccines today versus three

days from now. And so for family convenience I'll do them, but again, it falls back to the transport. Like, I can't have that family come back next week. Like, I can't ask them and it's unnecessary, like medically I can give the vaccines today, but from payment standpoint -- it's unfortunate that that is a knock, either against us for doing it, like even though I'm following guidelines versus, you know, the family if I asked them to come back next week. It just feels like kind of unnecessary.

MS. THERIOT: Can you send in examples of that so we could --

MR. BURKE: Yeah.

MS. RICHERSON: I think Judy needs rejected payments. Is that what you need?

MS. THERIOT: Yes, because I think, I mean, we give shots early all the time. At least I used to when I saw patients.

MR. BURKE: Yeah.

MS. THERIOT: And we were reimbursed, so.

MR. BURKE: Yeah. And I'll check in on it. I mean, that's just -- I went to do

it before, and I have done it before, but was told that if we did it, like we wouldn't. So I'll actually check in on what actually happened once it was done to see if there was any issue with actually getting reimbursed or not, but I've definitely been told that a couple times.

MS. THERIOT: Plus, I think from being in -- are you talking about VFC immunizations, or --

MR. BURKE: Yeah.

MS. THERIOT: Okay.

MS. RICHERSON: I think that's a really important point, Jordan, because I think there's a lot of beliefs around those payment windows for EPSDT visits. So if a two-year-old comes in at two yeas and four months, or if they come in at one year and, you know, 11 months, like what's the window that's paid?

I think there's a lot of historical, not misinformation, but confusion, and that would be a great thing. And I don't know, Judy, if we can get that information from Medicaid without getting rejections. Like

for a statement from Medicaid that says, if you're close enough, we're going to pay, or something. I know you're not going to say that.

We used to have really strict windows when we were Solsource Passport, there were very particular windows, but I've been under the impression that those windows don't exist under anymore.

MS. THERIOT: Yes. I don't think they do. I can look into that. I do -- the biggest problem I had is if you were, you know, four days early for your four-year-old shots.

MS. RICHERSON: Right.

MS. THERIOT: And it was the school systems that, you know, they were the ones that were saying, no, this isn't appropriate, and demanding that the child be re-immunized. And, you know, so it wasn't Medicaid or anybody, it was, in this case, Jefferson County Public schools. And so we, in that case, we had to write letters and, you know, do all of that stuff to make --

MR. BURKE: Yeah.

MS. THERIOT: -- the kid didn't have to be re-immunized.

MR. BURKE: And those ones are legitimate as far as like, you know, we don't do an MMRV before four. We don't do the (indiscernible) before four. We don't give your first MMR and your first hepatitis A before 12 months. Like, that's following CDC recommendations, things like that, unless there's special circumstances, obviously. But like, the one where, you know, you do follow, like it's at six weeks.

MS. RICHERSON: Yeah.

MR. BURKE: But those were the ones that were like why -- and again, I'll check and try to confirm that that was an issue, whether for or against, but it was definitely somewhere along the line it was a problem at some point. I'll check to make sure it either is or isn't resolved.

MS. THERIOT: Yeah. Because I also do a lot at six weeks, you know? They're there, you do it, and they're okay.

MS. RICHERSON: But it's not just your practice, Jordan. I think practices

across the state do have those same -- they'll reschedule patients --

MS. THERIOT: Yes.

MS. RICHERSON: -- because they're a day too early for their nine-month checkup, and there aren't any shots at nine months, so you just need a check-up, so that would be a great clarification point.

MS. THERIOT: Great.

MS. RICHERSON: Thanks. Any other general discussion ideas?

(No response.)

MS. RICHERSON: All right. And then it doesn't seem like we came up with any set recommendations to submit to the MAC, unless I'm forgetting. It looks like we didn't.

And then Dr. Bautista has graciously volunteered to try when she can to attend the MAC meetings, and the next one's January the 26th at 10:00. And then you can give us an idea of what some of the other discussions that were health equity or could have been more focused on health equity, and that gives us some idea as to what they're talking about. We meet again March 1st at

1:00 p.m. Any other business?

(No response.)

MS. RICHERSON: I'm just gonna read what Dr. Cantor said. She said she was sorry about her audio. "I believe there's an opportunity for improved education about payments for vaccines as it relates to FQHC's." So we'll follow up with her to collaborate on that, specifically around FQHC's.

We are at time. Is there a motion to adjourn?

MS. BAUTISTA-CERVERA: I motion to adjourn.

MS. RICHERSON: Is there a second?

MS. FIGUEROA: I second.

MS. RICHERSON: All those in favor, say aye.

(Aye.)

MS. RICHERSON: Motion passed by acclamation. So thanks for everyone's time, and we'll meet again in March. And then whoever wants to be chair next -- I'll do it one more time and then I shall resign as chair and somebody else can do it.

(Meeting adjourned at 2:47 p.m.)

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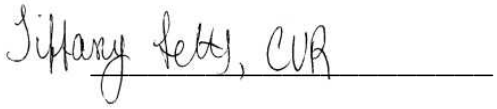
CERTIFICATE

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 10th day of January, 2023.



Tiffany Felts, CVR