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

****

Via Videoconference
March 1, 2023
Commencing at 1:02 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

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APPEARANCES

BOARD MEMBERS:

Julia Richerson, Chair
Wanda Figueroa Peralta
Jordan Burke
Catrena Bowman-Thomas (not present)
Patricia Bautista-Cervera
Marcus Ray (not present)
Kiesha Curry (not present)
Jeanine Lubuya (not present)
Elaine Wilson (not present)
Roger Cleveland (not present)

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1 CHAIR RICHERSON: Okay. Well, it
2 is about 1:00, so we're just going to jump
3 right in.
4 Leslie, I always -- if Leslie is on, we
5 would love for you to do a little welcome.
6 MS. HOFFMANN: I am on. How are
7 you on this beautiful day in -- here in
8 Kentucky? It's beautiful.
9 I was just going to say to everybody who
10 knows or doesn't know me, my name is Leslie
11 Hoffmann. I'm Deputy Commissioner for
12 Department of Medicaid Services, and I
13 proudly serve as one of Medicaid's racial
14 health equity champions and, on behalf of
15 Medicaid, would like to welcome each and
16 every one of you here today for the Cabinet's
17 March Disparity and Equity TAC.
18 So the Medicaid updates will actually be
19 later in the agenda. I'll turn it over back
20 to you.
21 MS. SHEETS: It looks like we have
22 four members on now. I have you,
23 Dr. Richerson; Wanda Peralta; Jordan Burke;
24 and Patricia Bautista-Cervera. If I'm
25 missing anyone, please speak up as we do not

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1 seem to have a quorum on.

2 CHAIR RICHERSON: And what is

3 quorum for us? Five?

4 MS. SHEETS: Quorum is six. You

5 have to have more than 50 percent, yeah.

6 CHAIR RICHERSON: Well, we will

7 hold on the approval of minutes, and we'll

8 look at quorum again after we have some

9 discussion.

10 MS. SHEETS: Okay. I can let you

11 know -- if more members jump on and we do get

12 quorum as we go along, I'll make sure to

13 break in and let you know.

14 CHAIR RICHERSON: Okay. Well, we

15 will just jump right into the agenda. The

16 agenda, again, is just (audio glitch) of all

17 of the prior minutes -- or the previous

18 minutes, the notes and ideas and things to

19 follow up on.

20 I don't know if it would be better to

21 take the agenda off of share screen, so we

22 can see each other better. Would that be

23 helpful?

24 MS. SHEETS: I typically do share

25 the agenda, but I don't have to. It's

1 completely up to the pleasure of the TAC.
2 CHAIR RICHERSON: Let's -- let's
3 take it down for a while. We can always pull
4 it back up. And then let's see. Let me do a
5 view, so we can -- okay. It's a little
6 easier to see faces so...
7 Okay. So first, I'll just put it -- I
8 put it as the first thing in old business,
9 which is the next chair. This is my last
10 meeting chairing. It's been fantastic, so I
11 highly recommend it.
12 Do we have any volunteers at this point
13 to be the chair for the next two meetings?
14 (No response.)
15 CHAIR RICHERSON: We'll bring that
16 back up a little bit later. Let me make sure
17 that's on. Next chair.
18 Okay. Well, Jordan and Patricia, who --
19 I'm not sure who else is on. I can't tell on
20 my screen who's here, who's on the TAC. But
21 anyway, speak now or speak at any point
22 during the meeting if you want to be chair.
23 Okay. So the next section is just the
24 review of goals and strategies that have come
25 up over the last discussion. So the first is

1 the immunization fee schedule updates. As we
2 mentioned, that children who are on Medicaid,
3 if they go to a provider that does not have
4 the Vaccines For Children's program, they're
5 mostly not receiving vaccines. They're told
6 to go elsewhere because the Medicaid fee
7 schedule for the immunizations themselves
8 don't match cost for providers. They're off
9 by just a couple of years, not way, way off.
10 So I'm not sure who has an update on that.
11 MR. DEARINGER: This is Justin
12 Dearinger. I'm the acting director for the
13 division of healthcare policy, and I've got a
14 couple of people on the line today, or with
15 us today, that oversee the --
16 (Brief interruption.)
17 MR. DEARINGER: Somebody's Gatorade
18 is in there -- but that oversee the
19 physician's fee schedule. And so we can --
20 we can look at that, and I'll have them kind
21 of talk about what we did to some of the
22 codes and if we had any updates on those
23 codes within the last couple of years on the
24 fee schedule.
25 CHAIR RICHERSON: I -- (audio

1 glitch). It may have not (audio glitch).
2 Say it again. I think Justin -- oh, there
3 you go. Yeah.
4 MR. DEARINGER: Yeah. I'm either
5 cutting in or out, or somebody is cutting in
6 or out. I'm not sure.
7 But I've got a couple of employees on
8 that deal with the fee schedule that contains
9 those fee -- those vaccine codes and -- Jeana
10 Jolly and Tom Young. And I'll let one of
11 them talk about how we've updated those
12 within the past -- within this past couple of
13 years on that fee schedule.
14 MR. YOUNG: Okay. I can give you a
15 little bit of information on that. We
16 have -- I have been the one updating the
17 codes on the physician fee schedule and the
18 preventive health fee schedule. And
19 normally, when one is -- is updated, they're
20 both done at the same time.
21 And we would make changes in those
22 when -- normally, it's a health department
23 contacts us, saying that the cost -- the
24 reimbursement is not covering the cost of
25 that drug. So we normally ask them just to

1 furnish the cost, and we change it.
2 I know when we added a lot of the --
3 these codes that we used to only cover for
4 children, and we have to now cover for adults
5 as far as vaccines. So in the past, we were
6 just covering for the -- you know, the --
7 providing a vaccine. We didn't -- they were
8 usually getting their vaccines through -- you
9 know, for free.
10 So any code that the health department
11 tells us that they're wanting to provide for
12 adults, we go in and add the -- the average
13 wholesale cost for those -- for adults.
14 CHAIR RICHERSON: So -- so yeah.
15 This TAC brought up -- I think in our first
16 meeting -- we're not the health department,
17 but we're also providers. And the fees for
18 those vaccines do not match cost for
19 pediatric offices. That's why they're not
20 providing them.
21 MR. DEARINGER: I know some of the
22 vaccines are federally reimbursable, and
23 so -- and some of them aren't. We've
24 increasingly asked -- because there's two
25 different things. You have the actual

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1 vaccine, which is usually on the -- through
2 the pharmacy side, and then you have the
3 administration fee, which is on our fee
4 schedule, which we reimburse for regardless.
5 So with the Vaccine For Children's program,
6 you know, we just had that fee for
7 reimbursing.
8 Erica Davis is on here. Erica, do you
9 know if we do anything through EPSDT or if a
10 child wants to -- I know we've talked about
11 this vaccine issue before. But is there --
12 is there anything that we have that -- that
13 would speak to that, do you think?
14 MS. DAVIS: Not for the EPSDT
15 program, but the CDC does release the cost
16 for vaccines for the private sector. So that
17 may be something that we could look at, to
18 just match what is on that CDC price list
19 with what we have on our fee schedule and see
20 what those differences are.
21 MR. DEARINGER: Yeah. We can
22 definitely take a look at that. And, again,
23 you know, it's on kind of a -- the actual
24 vaccine is kind of on a different fee
25 schedule. We do that through the -- through

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1 our pharmacy part, but we can definitely get
2 with that group and see if we can adjust
3 those payment amounts if they need to be
4 adjusted. One of the things that we'll look
5 at is what Erica just said.
6 Another thing we like to look at is
7 see -- we like to see what other states are
8 paying, also. It's surrounding Kentucky, so
9 we like to look at -- you know, and see what
10 Tennessee, Ohio, West Virginia, Illinois, and
11 Indiana are paying. And that's usually the
12 way we do a lot of our codes when we have any
13 kind of upgrade or increase in payment for
14 those codes.
15 So we can definitely take a look at that
16 and do some -- little bit of research and see
17 where we're at, if that's -- if that's an
18 issue, for sure.
19 CHAIR RICHERSON: Yeah. Yeah. And
20 thanks, Justin. So we have been talking
21 about this since the very first meeting, so I
22 would like to kind of get some -- maybe more
23 of a strategic action plan so that we can
24 maybe wrap this up in the next couple of
25 months.

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1 MR. DEARINGER: Sure.
2 CHAIR RICHERSON: So the issue has
3 been that it is primarily the pharmacy costs
4 that we've been talking about. The cost for
5 the pneumo vax, the cost for the Prevnar, the
6 cost for the actual medication just hasn't
7 kept up from the last update.
8 These costs often update yearly, and
9 it's a -- we feel like it's an important
10 equity issue for children on Medicaid that
11 cannot get their vaccine at their
12 pediatrician's office because they -- the
13 pediatrician isn't paid enough for the
14 medication.
15 I think the -- keeping up the admin fee
16 is also very important. But, usually, that's
17 not the sticking point with pediatric offices
18 because it's the -- those vaccines are so
19 expensive, that if the cost is even off by
20 ten percent, that could be $50, you know.
21 So we spoke last time also about even
22 though it may -- it may look like -- let's
23 see. How do I say this? It may look like on
24 some public list that it's about the right --
25 about the right payment for that medication,

1 you have to look at actually what people are
2 paying. You know, those costs are sometimes
3 averaged out and can be lower if you're
4 looking at a general reference sheet versus
5 what the actual cost is.
6 And so I suggested last time that when
7 you come up with an updated fee schedule,
8 that we run that through some high Medicaid
9 practices that are using purchased stock, not
10 Vaccine For Children, to make sure that the
11 changes that we make have the equity impact
12 that we want them to make.
13 MR. DEARINGER: Yeah. We can take
14 a look at that. One of the things to
15 remember is that those -- a lot of times,
16 costs, especially on the pharmacy side,
17 change -- will change throughout the year.
18 And in addition to that, different
19 providers get their medication from different
20 providers. So you may have -- you know, you
21 may have a pediatrician that's going through
22 one source, and their cost is, you know, $20
23 per vial. And another pediatrician is going
24 through another source. Their costs are $75
25 a vial.

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1 CHAIR RICHERSON: Right.
2 MR. DEARINGER: And so, you know,
3 we have to make sure we look at all of that
4 and take all that into account.
5 But yeah, we -- and I think we've done
6 some preliminary work by looking at some of
7 those things and how they fit. And I think
8 we did have an increase from last year
9 putting those things in place. If we're not
10 keeping up with the cost still, then we
11 definitely need to, you know, kind of try to
12 figure out a new method.
13 CHAIR RICHERSON: Yeah.
14 MR. DEARINGER: But, you know, we
15 do have to keep all those things in effect
16 and look at those things because we have to
17 be good stewards and make sure that our --
18 you know, to be honest, a lot of times when
19 we reached out, a lot of people said they
20 just didn't want to fool with it.
21 You know, it wasn't a moneymaker for
22 them, so they -- you know, a lot of the
23 pediatricians were just kind of pushing that
24 off. And that's something that we have to
25 look at, too. How can we -- you know, other

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1 than just, you know, increasing fees so that
2 they make money doing it, what other things
3 can we do to maybe help them to include that
4 as part of their service?
5 CHAIR RICHERSON: Right. And I'm
6 just talking about the people that have
7 vaccine in the refrigerator that they're
8 giving to other children in the building, but
9 they're not giving to kids with Medicaid.
10 Those are the only practices I'm concerned
11 about.
12 I think it's a whole -- like you said,
13 it's a whole different issue if people just
14 aren't giving vaccines. That's another --
15 another approach to that. But if we can just
16 keep kids in there getting the vaccine linked
17 with their visit, we feel like that's a
18 really important equity issue.
19 Do we need to talk offline about this,
20 too, or do you just want to give us a report
21 back, maybe an update before the last -- next
22 meeting? Or what do you think --
23 MR. DEARINGER: Yeah. Let me --
24 let me give you an update the 1st of April
25 and kind of let you know what we found out

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1 and what we're looking at. And I'll just
2 kind of -- I'll send it to -- not Erin. I
3 think she's out, but I'll send it to --
4 MS. SHEETS: Kelli.
5 MR. DEARINGER: Kelli. Yeah. I'm
6 sorry, Kelli. I'll send it to Kelli and have
7 her send it to the TAC members, if that's
8 agreeable.
9 CHAIR RICHERSON: Sounds good.
10 MR. DEARINGER: Awesome. Thank
11 you.
12 MR. YOUNG: Can I ask a question?
13 What -- if the problem with the providers --
14 if they're getting the vaccine through
15 Vaccine For Children, they're getting that
16 for free.
17 CHAIR RICHERSON: No. These -- oh,
18 I'm sorry. This is the providers that do not
19 do Vaccines For Children, the providers that
20 only have purchased stock vaccine, but they
21 have Medicaid patients as well. So they
22 just --
23 MR. YOUNG: Why would they not be
24 getting the drugs through Vaccine For
25 Children program?

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1 CHAIR RICHERSON: So -- yeah.
2 That's a very complex question. Vaccines For
3 Children can be a very labor-intensive
4 program. You know, it's highly monitored and
5 regulated, which is a good thing. But it
6 is -- it takes a lot of staff time to
7 administer a Vaccines For Children program.
8 If only 10 percent of your patients are
9 Medicaid, 20 percent are Medicaid, you're not
10 going to pay that much to make sure that you
11 have a -- can meet the Vaccines For Children
12 guidelines.
13 So it's the administrative burden, which
14 I know we've talked about in many settings.
15 I mean, it's a great program, but it's not
16 without its challenges. And if you're a
17 low-volume Vaccine For Children provider,
18 people may not feel like it's worth the time
19 investment for the practice.
20 All right. Well, thank you for that.
21 Anything else on immunization? So we'll get
22 an update around the 1st of April from Justin
23 through Kelli.
24 (No response.)
25 CHAIR RICHERSON: All right. The

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1 next thing we brought up last time was
2 transportation access. Jordan talked a lot
3 about challenges in rural Kentucky. I talked
4 about in urban setting, about access really
5 for specialty care, even just to get the
6 primary care office but certainly really
7 complicated care, trying to get people
8 transportation. We talked about the
9 challenges historically and currently with
10 federated.
11 We asked if this was something that we
12 should take to the MAC, and we were told no,
13 that it's more -- right now, you all would
14 prefer us to have the conversation within
15 this group.
16 So what -- what would be -- how can we
17 have a productive conversation about this
18 that is helpful for Medicaid from --
19 obviously with a health equity lens because
20 this disproportionately impacts people that
21 have less transportation.
22 So who from Medicaid wants to give us an
23 update on that?
24 MS. HOFFMANN: Justin, do you have
25 anything to add? I know we've been working

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1 on a lot of, in general, transportation
2 access right now specifically to behavioral
3 crisis, medical crisis, our mobile crisis,
4 which we can talk to you about that later.
5 We've also -- Justin's group, I think,
6 completed a SPA to remove the requirement
7 that -- or to remove the factor that if
8 there's a car or a vehicle in the home, he's
9 removed -- they've removed that; right,
10 Justin? And your SPA has been approved, so
11 that was a -- that was a plus.
12 MR. DEARINGER: Yeah. That was a
13 big barrier. So one of the things that we
14 had looked at for nonemergency transportation
15 to services were -- you would have someone
16 who was -- for instance, that was living with
17 someone else. And, you know, we find that
18 situation a lot, whether it be a relative or
19 nonrelative.
20 And the way the old regulation was
21 written, the way the old state plan amendment
22 was written, they took that household into
23 account, much like you would in a -- you
24 know, a family support case or something like
25 that where you looked at the whole household.

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1 So it really disparaged families who
2 were really down on their luck who didn't
3 have a place to live of their own by moving
4 in with other family members or friends for a
5 little while because, then, the people that
6 were taking them in were kind of deemed
7 responsible for their transportation. So
8 after looking at that a little bit, we made a
9 change to eliminate that requirement.
10 And so now, instead of it being a
11 vehicle in the household -- so before, if you
12 had a vehicle in the household at all, you
13 know, say somebody that is -- that's on -- a
14 Medicaid-eligible member who's on Medicaid
15 and has a lot of physical conditions and they
16 need to go to the doctor quite a bit and
17 they -- they can't drive, moves in with, say,
18 their mother and father and the mother and
19 the father have vehicles, then they're not
20 eligible for that transportation.
21 So we changed that to now they -- it has
22 to be -- the vehicle has to be in that
23 individual's name. So if you are a Medicaid
24 member and you have a vehicle registered in
25 your name, then you're not eligible. It

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1 doesn't matter who you're living with. It's
2 just the fact of: Do you have a vehicle in
3 your name?
4 And there's also a couple caveats to
5 that. So say you have a vehicle, and the
6 transmission goes out. You don't have enough
7 money to fix it. You still can't get your
8 appointments. All we need is a mechanic's
9 note and then you're eligible again.
10 Even if you have a vehicle registered in
11 your name, if we have a mechanic's note
12 saying that that vehicle is non-running, then
13 you're still -- then you're eligible again to
14 receive that transportation service.
15 And the third thing is a physician's
16 note. If you are driving a vehicle or if you
17 have a vehicle in your name and somebody
18 deems that -- you know, whether it's because
19 of seizures or vision or whatever the issue
20 may be, that you're incapable of driving that
21 vehicle and we have a physician's note
22 stating that, you're eligible for that again
23 as well.
24 So we think that we've -- that that
25 change in particular will help open up a lot

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1 of different avenues and open up that
2 transportation service to a lot of
3 individuals who were not allowed to take
4 advantage of that before.
5 CHAIR RICHERSON: That's great,
6 yeah. That's an issue that we find that
7 comes up quite a bit. Can we get a copy --
8 since the SPA is approved, can you share a
9 copy of the SPA?
10 MR. DEARINGER: Yeah. Yeah. We
11 can get that to you. Absolutely.
12 CHAIR RICHERSON: Great. So --
13 that's great. Then I think -- I don't know,
14 Jordan, if you want to talk about -- it still
15 comes down to reliability of federated, and
16 how do you all hold accountable a contractor
17 that you contract with? How do you get
18 appropriate feedback to know that it doesn't
19 work great?
20 Jordan, you want to chime in?
21 DR. BURKE: Yeah. I mean, that's a
22 tough one. I guess just your patients
23 really, talking with them about if -- you
24 know, with these things, if it's more
25 accessible.

1 Obviously -- I mean, for children,
2 obviously, none of them own a car. So does
3 that mean that, like, irregardless of their
4 parents -- you know, does that mean that
5 they're also -- does this work for them as
6 far as, like, this transportation thing? Are
7 they automatically included, or how does that
8 work with their parents?
9 MR. DEARINGER: So that specific
10 question that you just had to bring up is the
11 only one thing that is still not kind of set
12 in stone. The regulation is ready to be
13 filed and gone through, but that is the one
14 thing that we're still kind of waiting on a
15 decision about.
16 So the way it's written right this
17 second -- it leaves it kind of open in the
18 waiver, so we can go either way. But right
19 this second, I can't tell you whether or not
20 that that's -- that their parents aren't --
21 you know, if that knocks them out if their
22 parents have a vehicle or not. If you'll
23 give me about a week, I can tell you.
24 DR. BURKE: Okay.
25 MR. DEARINGER: Well, I can tell

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1 you what -- you know, it's an administrative
2 regulation, so it has to go through the
3 process.
4 DR. BURKE: Yeah.
5 MR. DEARINGER: But that's a good
6 question. That's something that we're
7 still -- that still hasn't been fully decided
8 but, you know -- yeah.
9 DR. BURKE: Yeah. I mean, that was
10 my main question through hearing it.
11 MR. DEARINGER: And I can't really
12 tell you a whole lot more because it's a
13 regulation that hasn't been filed yet. You
14 know, we haven't went through the
15 promulgation process, and so there's still a
16 ton of layers to go before that's actually
17 set in stone.
18 But everything else is kind of laid out
19 in the waiver, so that is kind of set.
20 That's the one thing that was kind of left
21 ambiguous in the waiver that we have some
22 autonomy on in the reg, and so that language
23 hasn't actually been -- we're still kind of
24 waiting on that.
25 DR. BURKE: So it sounds like it'll

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1 definitely increase the number of people that
2 can access it. As far as --
3 MR. DEARINGER: Absolutely.
4 DR. BURKE: -- actually, like, how
5 many -- when you look at, like, utilization
6 of that service, like, is it -- is there a
7 lot of people that are able -- like, are
8 there a lot of drivers that are just kind of
9 waiting for a patient or taking them to an
10 appointment, or is it kind of at capacity?
11 Or do you think by, like, increasing the
12 number of people that will be able to access
13 it, that you're going to get, like,
14 bottlenecks on the actual number of drivers
15 and stuff that you have for these people?
16 MR. DEARINGER: Yeah. I mean, I
17 think it -- the way the system is set up, we
18 have a vendor. Kentucky Department For
19 Transportation actually manages that, those
20 different companies that provide that
21 transportation. And so, you know, they base
22 it on kind of previous data.
23 And so -- but they know what we've done,
24 and so they've increased the number of their
25 contractors accordingly. And so it may be

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1 one of those things where it may be kind of
2 bottlenecked for a little while, just
3 depending.
4 But it usually really doesn't work out
5 that way. Sometimes it can. It just depends
6 on how quickly word gets out that those
7 people are now eligible and, you know, how
8 quickly people take advantage of the system.
9 If it steadily grows like it normally
10 would or people find out, you know,
11 through -- one way or another, through their
12 local DCBS offices when they go in; find out
13 through friends, through family, through
14 various other, you know, avenues and
15 resources and it kind of grows on that steady
16 incline, then that lends to no bottlenecks.
17 You know, they're constantly adding vendors,
18 and everything seems to work out really
19 smooth.
20 But if everybody kind of finds out about
21 it at once, which is always a possibility,
22 then there could definitely be some -- you
23 know, a few delays or bottlenecks in the
24 process.
25 But that's with anything that we do or

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1 implement. I mean, that's -- we don't really
2 know what's going to work out like that and
3 what's not going to work out like that.
4 I mean, because of the way it's set up,
5 they can't pay -- because I think they pay
6 the vendors when they -- you know, just for
7 kind of signing on. So they can't pay, you
8 know, too many of those people without having
9 the people to transport. So yeah, but it's a
10 quick process. I mean, it's not like it's
11 going to be bottlenecked for months and
12 months.
13 And hopefully, it won't -- it won't
14 happen like -- you know, hopefully it'll be a
15 steady increase. And they'll just continue
16 to add as it grows, and it'll be smooth.
17 That's our hope. And they're ready. I mean,
18 they know what's coming so...
19 DR. BURKE: If it -- I mean, again,
20 it's a good thing, that they'll have more
21 access and stuff. So, like, I mean, how are
22 you guys going about -- not just like through
23 word of mouth from, you know, each other.
24 But, like, how are we letting people know
25 that this is now, like, a service that they

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1 do have access to that they previously, you
2 know, didn't because of the restrictions?
3 MR. DEARINGER: So it's kind of a
4 multihead approach. So once the regulation
5 is finalized, we have all the vendors that
6 will be reaching out to some of the different
7 groups that they work with and deal with.
8 We'll have a -- send out a provider letter to
9 different providers. So when they go in to
10 their local health department, their local
11 pediatrician, their physician, that they'll
12 have some information there.
13 We'll have information online that talks
14 about that and then we'll reach out through
15 our DCBS office, also. We find that's a huge
16 key to the community, is our local DCBS
17 offices, because they have so much
18 communication with the client, you know, on a
19 weekly and definitely on a monthly basis,
20 that they communicate that with them as well.
21 DR. BURKE: Cool.
22 CHAIR RICHERSON: And then let me
23 ask about pickup. So I know that that's one
24 thing I hear a lot from families, is they get
25 dropped off at the hospital for their X-ray

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1 or whatever, but then they can't get back
2 home.
3 MR. DEARINGER: Well, that's --
4 CHAIR RICHERSON: It's supposed to
5 cover both ways; right?
6 MR. DEARINGER: Yeah. Yeah, it is.
7 It's supposed to be both ways. So I haven't
8 necessarily -- I mean, you know, we get lots
9 of complaints. We look into those
10 complaints. There is a formal process that
11 we look at. I haven't heard that that's been
12 a huge issue.
13 I wouldn't -- I'm not sure -- I don't
14 really understand why that would happen so
15 much, but we can definitely -- I mean,
16 definitely something we can look into to see
17 how many instances were reported, how many we
18 had, because that shouldn't be happening.
19 I mean, if a vendor is in the area, I
20 haven't heard that they're ultra busy to
21 where people have to, you know, wait long
22 amounts of times. I think that happens every
23 once in a while if somebody is in a rural
24 setting. Or if they're in concentrated areas
25 in Jefferson County, I think those things

1 have happened before. Even in Fayette
2 County, you get that sometimes.
3 But, I mean, I wouldn't think that that
4 would be something that happens a ton. You
5 know, you do hear about 20-, 30-minute
6 waiting times quite a bit. But, I mean,
7 that's just kind of part of the process
8 because vendors, you know, sometimes are
9 picking up other people in between and those
10 type things so...
11 But that's kind of -- I haven't heard
12 that as being an overarching issue, but we
13 can definitely check into it.
14 CHAIR RICHERSON: Anything else,
15 Jordan? I know you had told, you know, the
16 stories about those issues, you know, trying
17 to get kids to UK for specialty care and not
18 being able to get transportation.
19 DR. BURKE: Yeah.
20 CHAIR RICHERSON: Anything else?
21 DR. BURKE: It's similar; right? I
22 mean, I can get appointments but -- and it's
23 on both ends; right? It's both it being
24 available and actually being utilized, so
25 it's also taking advantage of that thing that

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1 is accessible. So that's also the problem I
2 ran into. Please, use it.
3 CHAIR RICHERSON: All right. Thank
4 you.
5 Anything else on transportation for
6 right now? So we'll get a copy of the SPA,
7 get follow-up on the question about the
8 children and the assignment of a car or a --
9 to the home. Anybody?
10 (No response.)
11 CHAIR RICHERSON: All right. The
12 next thing on the agenda is the community
13 health workers. Because the last meeting,
14 there was a comment that the SPA had been
15 submitted for feedback from CMS. So we're
16 excited about -- to hear any updates on that.
17 MS. HOFFMANN: I don't specifically
18 have an update. The -- I do know that it had
19 an effective date of July of 2023.
20 Does anybody know -- can anybody fill in
21 the gaps for us?
22 MS. PARKER: I mean, the SPA was
23 submitted.
24 MS. HOFFMANN: But we don't -- but
25 we haven't followed -- we don't have any

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1 additional questions or anything that we
2 still need to follow up on? Is that what
3 you're asking, Dr. Richerson, if there's any
4 follow-up since we submitted?
5 CHAIR RICHERSON: Well, when we
6 talked last time, it had been submitted only
7 for comments. It hasn't --
8 MS. HOFFMANN: Oh.
9 CHAIR RICHERSON: It hadn't been
10 submitted for approval. Has it been
11 submitted?
12 MS. SHEETS: It has been submitted
13 to CMS, yes.
14 MS. HOFFMANN: Yes.
15 CHAIR RICHERSON: And what time
16 frame do you expect for them to approve or
17 not approve?
18 MS. HOFFMANN: Kelli, can you
19 answer that since Erin is not on?
20 MS. SHEETS: Well, they -- let me
21 look it up real quick and see if I can find
22 out if it's on the clock. Give me just a
23 second.
24 MS. HOFFMANN: Okay. You're fine.
25 MS. SHEETS: Okay.

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1 CHAIR RICHERSON: And since it's
2 been formally submitted, can we see -- can we
3 see it yet, or is it still confidential?
4 MS. SHEETS: I believe it's still
5 confidential. Leslie, correct me if I'm
6 wrong.
7 MS. HOFFMANN: Let's see. That one
8 has not been approved; right? Let's not
9 share it just yet. I can ask about that. I
10 actually was not involved with that one.
11 That's why I have limited information. I'm
12 sorry.
13 MS. SHEETS: Okay. It was
14 submitted on February 7th, officially
15 submitted to CMS on February 7th. The end of
16 the 90-day clock is May 8th, so hopefully we
17 will -- it will be approved by then.
18 MS. HOFFMANN: Okay. All right.
19 Does that help, Dr. Richerson? So if it's on
20 a 90-day clock, then we should hear back on
21 or before the 8th of May; okay? And if we
22 have anything in between, we'll bring that
23 back. And I'm sorry that I wasn't sure
24 exactly where we were in the process.
25 CHAIR RICHERSON: Great. Okay. So

1 that'll be soon.
2 All right. Subspecialty access is
3 another topic that came up about there being
4 disproportionate access between people who
5 have commercial insurance and people who have
6 Medicaid for many specialists in adults and
7 children. And we felt like that was an
8 important equity thing to have a conversation
9 about.
10 So is that -- how in the past has
11 Medicaid looked at that? Is there -- are
12 there -- can we look at it with fresh eyes
13 and think about different approaches, now
14 that we have this TAC, to look at it from an
15 equity lens, with an equity lens?
16 MS. HOFFMANN: I'm going to ask
17 everybody again. Did anybody from our group
18 have a follow-up for the subspecialty access?
19 MS. PARKER: I can discuss -- this
20 is Angie Parker with Medicaid. I can discuss
21 it at a very high level.
22 You know, we get -- as far as network
23 adequacy, we do get reports each month -- I
24 think it's each month -- from the MCOs on
25 where their providers are and if they are --

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1 you know, obviously, we've had this
2 discussion where it's challenging for certain
3 areas of the state and -- excuse me, or
4 certain specialties and sometimes even
5 primary care or dental. And they do -- we do
6 get several reports submitted to us that are
7 reviewed by certain personnel that can see
8 whether or not their network is adequate.
9 Now, MCOs may also identify that --
10 well, they know that they're not adequate
11 for -- and they will ask for exceptions. And
12 they have to supply that information of why
13 they need an exception. So we occasionally
14 do see those types of reports as well.
15 I think we know we have this in
16 Medicaid. I know we have this in general
17 throughout the state in certain areas. If
18 you're wanting to know, do we know of one
19 specific specialty, I know dental is
20 always -- kind of comes to the top as far as
21 access to those specialty types.
22 I don't think really it's that much
23 different for other specialties than
24 commercial for Medicaid. Now, you may have
25 some providers who don't accept Medicaid

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1 members of a certain age or -- and those
2 types of instances.
3 CHAIR RICHERSON: Right. So I
4 think the conversation was we know as
5 clinicians that this is true; right? We know
6 that if an adult in Louisville needs to see a
7 rheumatologist and they have Medicaid, it may
8 be never. It may be nine months, may be
9 twelve months. But if you have commercial
10 insurance, you can see somebody in a week.
11 And so we know, as providers, that there
12 are discrepancies in access. And we know
13 that there are network adequacy reports from
14 the MCOs, and they don't match; right?
15 And so I think we have an opportunity in
16 this committee, in this discussion -- is how
17 do we look at that differently than we looked
18 at it in the past as a State and say no,
19 like, really, what are the issues, and what
20 can we do to break down some of those
21 conditions that exist, that we know exist,
22 but don't always show up in the data because
23 it's just one of those things.
24 But we definitely know that there's
25 discrepancies in child health as well as

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1 adult health in getting subspecialty care
2 based on whether or not you have Medicaid or
3 commercial insurance.
4 I don't think that's the question. I
5 think the question is: How do we as a TAC
6 help you as Medicaid -- because, you know,
7 that's kind of our role; right? -- to drill
8 down and to, you know, bring (audio glitch)
9 to light like that?
10 Does anybody -- I mean, I think these
11 are the hard questions; right? This is --
12 MS. PARKER: Yes. These are the
13 hard questions, I mean, when you look at it
14 as a whole, to your point, and whether or not
15 they can see a sick child within 24 hours or
16 a preventive visit within a month, which is
17 what their access standards are to be.
18 And, you know, there's a lot of ways to
19 review that, through complaints or grievances
20 or -- you know, not just looking at a network
21 adequacy report that we get from the MCOs.
22 But we can't work on anecdotal information.
23 CHAIR RICHERSON: Right.
24 MS. PARKER: So, you know, if there
25 are issues that arise with somebody getting

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1 into seeing a provider for whatever reason,
2 that's something we could look at. Because
3 we also have -- that you're probably familiar
4 with, if a person does not -- if they miss an
5 appointment.
6 So if they miss an appointment report,
7 the provider can go in there and put into
8 MM -- KYHealth-Net that Angie Parker did not
9 show up for her appointment on -- at 2:00 on
10 March 1st, didn't call, didn't give us a
11 reason or anything. And we track -- we get
12 monthly reports looking at that.
13 And we provide that information to the
14 MCOs that potentially they could reach out to
15 the member to say, hey, do you have a
16 transportation issue. What's going on? You
17 missed your -- Angie, you missed your
18 appointment with Dr. Richerson, like, five
19 times.
20 And so there are those types of things
21 going on. But as far as the access, people
22 not even being able to get in to somebody,
23 how do we track those? Instead of having,
24 well, we hear this, or we know this, that's
25 something -- you know, we do a survey. The

1 MCOs do a survey. They call and act like a
2 secret shopper and say, can I get an
3 appointment for my child at -- you know, they
4 have a fever and -- to see whether or not
5 they can get in at -- you know, within the
6 specific time frames.
7 Sometimes if -- and with those reports
8 and if a provider is falling out of that --
9 of course, it's just a sample size, too.
10 It's not the entire network. And if that --
11 you know, if they're falling out of that, if
12 they -- every time they call this doctor's
13 office to do a secret shopper and they can't
14 get an appointment, then, you know, they are
15 to educate the provider on that or to find
16 out what's the deal. Why -- you know, you're
17 supposed to be able to -- you're contracted
18 to provide services to our Medicaid
19 population.
20 So, you know, how do we address that?
21 That's a good -- that's a very good question
22 on how to get in to see somebody. If
23 somebody has -- I don't know -- something you
24 all would probably be better astute in
25 identifying but they need to be seen sooner

1 than six months from now, you know, do you
2 get on the phone to the provider and say this
3 doesn't work? You know, I need this --
4 CHAIR RICHERSON: Yeah. That's
5 what we do, which we don't have time to do.
6 But yes, that's --
7 MS. PARKER: Exactly. And I
8 understand that. So it's -- it's a problem.
9 And then again -- and I'll speak from
10 personal experience. Some people don't --
11 you know, they just say okay. They just
12 leave it there. Six months, I'll wait.
13 Instead of being an advocate for themselves
14 because they don't know how to do that, you
15 know. Hopefully --
16 CHAIR RICHERSON: And sometimes it
17 doesn't matter. You know, it doesn't matter
18 how hard the patient advocates. I have a
19 patient that was seen in the ER with a
20 thermal injury to their cornea. This is a
21 very serious injury.
22 MS. PARKER: Yes.
23 CHAIR RICHERSON: They were told to
24 see the ophthalmologist within one week.
25 They called the ophthalmology office, and

1 they said it'll be two months. We called the
2 ophthalmology office. They said that'll be
3 two months or three months. And so I had to
4 call the ophthalmologist. I had to get the
5 ophthalmologist out of a room; right?
6 So -- and I know that's anecdotal, but
7 it's constant. And so I think it behooves
8 us, of the people in power; right? We -- you
9 all pay the bills, and we write the
10 referrals. So how do we, and how do other
11 states look more seriously at this issue?
12 Because it's not new, but it doesn't mean it
13 always has to be this way either.
14 Does anybody else have --
15 MS. PARKER: I think we are looking
16 at it seriously. I mean, it is -- and I
17 appreciate, you know, it is definitely -- for
18 the Medicaid population as a whole probably.
19 But I think what sometimes people run
20 into -- like, you just had to call that
21 physician out of the office. Office staff
22 are trained to say this is what it is. This
23 is what I can do. I can't do anything more
24 than that. This is it.
25 So in order for -- you know, they would

1 have to go to a supervisor or maybe even the
2 doctor to say, okay, we need to get this
3 patient in sooner. They're not usually given
4 the latitude to work somebody in unless a
5 doctor already has their schedule -- and I
6 know I'm preaching to the choir here. I'm
7 sorry -- but already had it set up where they
8 can work people in but...
9 CHAIR RICHERSON: Right. Yeah. So
10 how can we help you all as a TAC?
11 MS. PARKER: What -- I'm open to
12 your all's thoughts and suggestions. I think
13 we are, very much so.
14 MR. DEARINGER: And I -- you know,
15 this is Justin again. I just wanted to kind
16 of say that this isn't an issue unique to
17 Medicaid recipients. You know, if I run out
18 of my -- some medicine I'm on and I call to
19 get a refill of that medicine and I need to
20 go into my primary care physician, it's
21 usually about a three to four-week wait for
22 me.
23 And if I'm out of that medicine, which
24 usually I don't know until I'm out, then --
25 and I say, well, I need this medicine for,

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1 you know, three -- and they -- you know,
2 tough.
3 CHAIR RICHERSON: Right. I'm just
4 talking -- that is true. You are absolutely
5 right.
6 MR. DEARINGER: But not just -- not
7 just in that situation but for every
8 situation. So when we look at all of our
9 different provider types, that's a complaint
10 we hear a lot. But it's -- so when we -- we
11 did some research, and it's not just, you
12 know, primary care physicians. It's not just
13 different specialists. It's everybody as a
14 group.
15 I mean, we're having that issue with
16 dentists. We're having that issue -- and
17 then when we look and we reach out to some of
18 the MCOs, and they're saying we're not just
19 seeing this with our Medicaid recipients.
20 We're seeing this with our private, too.
21 You know, everybody is having these
22 longer wait times, and it just seems like
23 maybe there is a lack of -- or a reduction in
24 clinicians, maybe. Maybe there aren't as
25 many clinicians per the population as there

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1 once were.
2 CHAIR RICHERSON: Yes. I think --
3 and that makes it even more complicated.
4 You're exactly right. And I'm really just
5 talking about the situations where we know --
6 I'm telling you this is true. I think yes,
7 it's anecdotal, but I can -- we call to get
8 these appointments, and they have different
9 scheduling criteria for Medicaid patients.
10 They have fewer slots for Medicaid patients
11 than they do commercially insured patients.
12 This is not new. Of course, it's worse
13 because of the issues. And it's true. It
14 happens in my family. You know, I call for
15 my daughter for an appointment for the
16 neurologist, and I can get it in a week. And
17 I call for my Medicaid patient, and it's four
18 months.
19 So I just want to reiterate that it
20 is -- all the things that you all are saying,
21 it's true. It's worse than it's ever been
22 probably. But there -- historically and
23 presently, there is lack of access for
24 Medicaid members compared to commercial.
25 And so we can keep thinking about it.

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1 We can -- I mean, it's been this way for a
2 long, long time, so that's why I'm sort of
3 like we can -- we can just keep letting it go
4 the way it's always been because it's too
5 hard to fix, which may be where we end up
6 because it's a tough problem. But I think we
7 do need to at least agree that it happens.
8 It really does.
9 MS. PARKER: Oh, yeah. I mean, I'm
10 not -- yes. I totally agree. I know it
11 happens. It is happening. And I think
12 Justin has hit that, and you asking us how
13 could we help solve this as -- you know, as
14 providers.
15 How do we get those providers' offices
16 who say, you know, I have certain criteria
17 that I only see ten Medicaid patients per
18 week so I've met my limit. How do we -- you
19 know, do we penalize those providers? And
20 the expectation to pay more, I mean, is that
21 the solution? There's --
22 DR. THERIOT: What do the contracts
23 say between the provider and the MCOs? I
24 mean, there's got to be language in there
25 about, you know, access.

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1 MR. OWEN: And this is Stuart Owen
2 from WellCare. Dr. Richerson, thank you for
3 bringing that up. And so, you know, all the
4 MCOs, we actually do have teams that weekly
5 identify care gaps, look at very detailed,
6 sophisticated reports.
7 But there are some -- you know, two
8 things. I mean, there are some provider
9 types that are just -- there's a shortage in
10 Kentucky, like pediatric psychiatrists,
11 rheumatology that you mentioned, also eating
12 disorders.
13 But the -- I guess, just -- you know,
14 maybe as far as a helpful thing, I mean, we
15 have to find a member care. If there's
16 nobody in network, we've got to do whatever
17 it takes. And I guess just one step is just
18 contact the MCO or ask the member to contact
19 the MCO. Because if they call our customer
20 services, then we're on it. You know, we're
21 working on it.
22 I know that's, you know, I guess an
23 extra burden for you, for the provider. But
24 that's one step anyway, is just ask the
25 member to contact the MCO customer services,

1 and we'll work on it.

2 CHAIR RICHERSON: And what would

3 they be able to do, do you think, your team?

4 What are some of the successes you all have

5 seen?

6 MR. OWEN: So good question. We've

7 got to find care. So if that means out of

8 network, we go out of network. And we

9 will -- wherever we can go. And in some

10 cases, like with eating disorder, we actually

11 go out of state to find a provider --

12 CHAIR RICHERSON: Right.

13 MR. OWEN: -- but anywhere in

14 network. And so we will offer -- and, you

15 know, another thing is just, frankly, some

16 providers don't want to participate in

17 Medicaid, for whatever reason.

18 And so we will offer -- it's called a

19 single case agreement. We've got this

20 situation. This member needs this care. You

21 know, we've got to do whatever it takes to

22 get you on board, to sign you up, you know,

23 to take -- to see them.

24 And so that's absolutely one thing that

25 all of us do. And, you know, just try to

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1 say, okay, just one time. Just one time at
2 least, you know, see this member. So that's
3 one thing we can do.
4 But we've got to be aware. You know, it
5 starts with the member or somebody alerting
6 us to the problem. You know, like I said, we
7 all track the reports. But specific cases
8 like that, if they call us, you know,
9 that's -- immediately, we're on the job
10 trying to find a provider.
11 CHAIR RICHERSON: So, Angie, is
12 there -- so I know there's the -- there's
13 that phone number. I forgot the -- I don't
14 know if it's an ombudsman line or -- what is
15 that phone number that people can call and
16 make complaints or make comments that we've
17 talked about in this meeting before?
18 MS. HOFFMANN: Is it CHFS.Listens?
19 CHAIR RICHERSON: Yes, that one.
20 MS. HOFFMANN: I've got -- yeah. I
21 did a report -- I've got a report from Erin
22 who's not here today, but I've got her
23 report. I can share that with you but didn't
24 see --
25 CHAIR RICHERSON: Well, is that a

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1 phone number we should tell people to call
2 about this issue so that you all get more
3 specifics or --
4 MS. HOFFMANN: I think the --
5 sorry.
6 CHAIR RICHERSON: -- how can you
7 get more information?
8 MS. HOFFMANN: The CHFS.Listens is
9 an email box; right, Angie?
10 MS. SHEETS: It is, yes. Sorry.
11 This is Kelli. It is.
12 CHAIR RICHERSON: So is there --
13 you know, when families come to us and say,
14 why do I have to wait six months for this,
15 can we also have them contact you all so that
16 you have these specific examples? Would that
17 be helpful? Or do you feel like you have
18 enough information?
19 MS. PARKER: Well, I think it's
20 something that -- you know, as Stuart
21 mentioned, having -- if they have an MCO, to
22 call the MCO. If they are a fee-for-service
23 member, they should call the customer service
24 or member service number that is on the back
25 of their card and let them know, so they

1 can --
2 CHAIR RICHERSON: And not so much
3 to get care but to get you all the data that
4 you need to look into it differently. How --
5 MS. PARKER: That would -- that's a
6 very good question. I mean, as far as if
7 they're contacting the MCO, that could be
8 something that potentially through -- if they
9 have it set up through their grievances
10 process, it could -- it may be already
11 identified that way, identified through
12 their -- which we do get reports on member
13 and provider grievances that the MCOs
14 receive.
15 CHAIR RICHERSON: Would that come
16 through your grievances, anybody from any of
17 the MCOs? Or would you just work on it and
18 not submit it as a grievance?
19 MR. OWEN: No. That -- yeah. That
20 would be captioned as a grievance. That's a
21 grievable. Pretty much anything is a
22 grievable. Any complaint or problem you have
23 is a grievance so -- but that would be
24 captured on it.
25 CHAIR RICHERSON: All right. So we

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1 have some work-arounds, having families call
2 the MCO. And if they call the MCO, it will
3 be listed as a grievance, so it will go up to
4 Medicaid.
5 Angie, what other -- you know, if you
6 had a magic wand and you could wave it, what
7 would you need -- what kind of information
8 would you all need to make decisions like --
9 even if you couldn't pay more but to say,
10 okay, well, really what the problem is, it's
11 a money problem or really -- you know, just
12 to define the problem better?
13 MS. PARKER: With my magic wand?
14 CHAIR RICHERSON: Yeah, with your
15 magic wand.
16 MS. PARKER: You're putting me on
17 the spot, Dr. Richerson. I mean, it's -- I
18 don't think that I can give you a specific
19 answer to that question because it's so
20 large. Because there's too many variables, I
21 think, to kind of really assign my wish
22 through a magic wand. You know, we --
23 CHAIR RICHERSON: Not even -- not
24 even to fix it but a magic wand to find -- to
25 identify the problem.

1 MS. PARKER: Well, it's like I
2 said. I think, you know, we do have the
3 grievances report that we can go back -- the
4 MCOs can look at as well and see if they're
5 getting those types of -- that information.
6 And if they are, how are they addressing it
7 with the provider?
8 You know, not knowing the specific
9 reason, per se, that the providers are, you
10 know, just setting up their policy, to only
11 see so many Medicaid -- you know, how we
12 address that, if that is an issue, it needs
13 to be addressed with the provider unless the
14 contract says that's all, you know, we are
15 going to be doing with -- that's all we're
16 going to be setting up.
17 It's a -- Medicaid is a -- a third of
18 the state is on Medicaid. And so you kind of
19 look at: So is a third Medicare and another
20 third commercial? So as I've heard the
21 commissioner say many times, we are helping
22 fuel the economy. And, you know, maybe
23 Medicaid doesn't pay as much as commercial.
24 But I worked in commercial insurance, and I
25 know they don't pay a lot either.

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1 So I wish -- what would I wish for,
2 that --
3 CHAIR RICHERSON: What would you
4 wish -- like, that we interviewed all the
5 practices that are not taking enough Medicaid
6 or -- like, is that how we find the answers,
7 to talk to the specialists and say, okay,
8 tell us what's going on, help us to
9 understand?
10 MS. PARKER: Well, I mean, yes. I
11 mean, I do know that there are surveys that
12 are done, that could be done if they -- if
13 providers will answer them. We do have
14 challenges with -- and I know they have
15 challenges, they being the MCOs, have
16 challenges with getting responses on surveys.
17 You know, I think anecdotally, we've
18 heard that, you know, we don't pay enough, is
19 probably the primary reason.
20 MR. OWEN: And I note also there's
21 a higher no-show rate with Medicaid members.
22 That's a big complaint. Providers schedule
23 appointments and then -- and even multiple
24 times, they won't show, and there's no
25 consequences with Medicaid members. They're

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1 protected fairly.
2 I know that was -- when you said
3 surveys, I remembered the -- I think public
4 health did a survey for dentists about a year
5 ago or so, and it was, you know, exactly
6 those issues. Why are you not -- and it was
7 everybody, trying to capture everybody. Why
8 are you not in the Medicaid program? Why did
9 you leave the Medicaid program?
10 And I know no-shows was part of it, but
11 I do recall that the response rate was pretty
12 low -- I don't know -- maybe 15 percent or
13 something which, by survey standards,
14 actually wasn't that bad.
15 But, I mean, that's -- you know, that's
16 a good idea. But I do remember for certain
17 it -- you know, lower reimbursement and high
18 no-show rate. So you're scheduling
19 appointments, booking appointments, and then
20 they don't show.
21 DR. THERIOT: Improving the
22 nonemergent medical transportation would
23 improve the no-show rate.
24 CHAIR RICHERSON: Yes.
25 MS. PARKER: I think we could

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1 hypothesize that would be. It would make --
2 it's sense. I mean, I can tell you that, you
3 know, at the last meeting when we were
4 talking about transportation being a big
5 issue -- you know, and we talked about that
6 the MCOs, they offer value-add services of
7 transportation to doctor's offices or bus
8 passes and that sort of thing.
9 So we are looking more into those
10 value-add services, particularly in certain
11 parts of the state, to see how -- or if
12 they're even being utilized. But I don't
13 have all that information yet on the
14 transportation issues. We know that's huge.
15 So once -- and hopefully when the
16 regulation is filed and we get that, that we
17 can see an improvement in that area as well.
18 CHAIR RICHERSON: Okay. So
19 takeaways from this conversation -- I'm not
20 sure. Do we have any takeaways from this or
21 any next steps?
22 MS. PARKER: That it's a work in
23 progress.
24 MS. HOFFMANN: This is Leslie, too.
25 We always would welcome -- like, if the TAC

1 wants to ask -- like, if the TAC wants to
2 bring things to us for us to research or look
3 at, too. It's just -- it's so huge right
4 now, and we're at the beginning stages;
5 right? It's so big. If you can just give us
6 specifics that we could start taking a look
7 at, I think most of this team on here would
8 be willing to start doing that.
9 DR. BURKE: I'd just say that --
10 CHAIR RICHERSON: And by --
11 DR. BURKE: You can go ahead.
12 CHAIR RICHERSON: No, no. Go
13 ahead.
14 DR. BURKE: So we know that, like,
15 for certain subspecialties, patients go out
16 of state; right? Like, they -- it's
17 impossible to get in within a reasonable
18 time.
19 So, like, pediatric gastroenterology. I
20 mean, sometimes when I call UK, they're like,
21 just call Cincy, you know, because the
22 time -- the timeline. And I'm sure there's
23 other adult specialties and things like that.
24 Obviously child psych, I mean, I don't even
25 know that I can get an appointment anywhere

1 in the state for one.
2 How much money goes out of the state, I
3 mean, just for those types of services? I
4 mean, like, obviously, paying everyone more
5 is not, like, an option typically; right?
6 But for -- I don't know -- select
7 services or things like that, whether it's
8 somehow enticing -- you know, there's
9 provider shortages. How much money is going
10 out versus how much -- you know, to entice
11 those types of subspecialists to be in this
12 state.
13 I mean, I don't know the numbers,
14 obviously. But, you know, if just from our
15 small clinic, you know, there's a handful of
16 patients, I'm sure statewide, that adds up to
17 a pretty sizable number over the course of a
18 year. So I would just be interested in
19 knowing how much -- how much money is going
20 to healthcare services that are offered in
21 the state but aren't accessible and have to
22 accessed elsewhere.
23 CHAIR RICHERSON: That's a great
24 one. Yeah. I send everybody to Cincinnati,
25 too, from Louisville for GI.

1 MS. PARKER: I experienced that --
2 CHAIR RICHERSON: And I guess, I
3 mean -- go ahead.
4 MS. PARKER: No. I was just going
5 to say when I worked in commercial insurance,
6 that was a big issue, pediatrics in general
7 really in the state of Kentucky. And I
8 always had to look at either Vanderbilt or
9 Cincinnati.
10 MS. HOFFMANN: And I'd mention,
11 too, coming out of COVID, I've spoken with a
12 lot of folks related to a GI specialty right
13 now, especially liver specialty, GI. There
14 are absolutely -- definitely a workforce
15 shortage right now.
16 And I think it was November, I tried to
17 schedule an appointment for a family member,
18 and we got to May the 25th from November. So
19 I finally -- after I've called around for
20 months and months, I've got it to April the
21 21st. So it's definitely a shortage.
22 And people coming -- this is just an
23 example of many things. Eating disorders is
24 another big deal coming out of COVID. But
25 folks who had GI and/or liver issues, kidney

1 issues who were, you know, not necessarily
2 getting out during the COVID time. And now
3 it's compiled, and everybody has -- there's
4 an enhanced need right now for some specific
5 specialties, if that makes sense.
6 CHAIR RICHERSON: So that's a
7 great -- Jordan brought up a great question
8 to -- as a research question. I mean, is --
9 when you said, like, specific questions, is
10 that specific like: Let's define the
11 discrepancy in Louisville on adult
12 rheumatology. Is that -- those types of
13 questions --
14 MS. HOFFMANN: Yeah. So -- sorry.
15 Based on what he said -- I was writing that
16 down. I don't know if I would know how many
17 from his personal facility or where he's
18 working that did not receive services that
19 could have in Kentucky and went to
20 Cincinnati. I don't know that I would be
21 able to tell that.
22 CHAIR RICHERSON: Jordan, you mean
23 in general, like across the state?
24 DR. BURKE: Yeah. I wasn't
25 meaning, like, at our just practice. But I'm

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1 sure that any time a patient -- and I could
2 be wrong, but I'm sure any time a Medicaid
3 patient from Kentucky accesses services
4 outside Kentucky, I'm sure there has to be
5 some kind of conversation across state lines.
6 I mean, I could be wrong but...
7 MS. HOFFMANN: Angie, I'm going to
8 ask you. If -- can -- or if the MCOs are
9 online, Stuart, are you able to tell if a
10 Medicaid member went out -- went from
11 Kentucky to Cincinnati because the service
12 wasn't available?
13 MR. OWEN: I don't know about that.
14 I do know that we contract with the border
15 providers, and I'd say all the MCOs do, like
16 Cincinnati, Vandy. Because you've got
17 members that are, you know, near the border.
18 It's actually just more convenient for them.
19 So we do -- you know, a lot of the border
20 providers we already contract with. They're
21 in network even though they're out of state
22 because it's convenient for the member.
23 You know, I mean, we have place of
24 service. I don't know -- I don't think that
25 the data would show couldn't get it in

1 network, went out. You know, other than --
2 you know, like the -- we can look at single
3 case agreements, obviously.
4 MS. HOFFMANN: Yeah. That's what I
5 had mentioned earlier. That's the only thing
6 that I could think of, but that's -- that's
7 usually because the service is not available.
8 The ones that I've been on here lately, the
9 single case agreements for eating disorders
10 have been because --
11 MR. OWEN: Right.
12 MS. HOFFMANN: -- it's not
13 available in Kentucky.
14 MR. OWEN: That's a perfect
15 example.
16 MS. PARKER: Well, as far as the
17 MCOs, my assumption is that all MCOs require
18 prior authorization for any service that's
19 out of network. So there should be a way to
20 get that information via a report of
21 out-of-network providers authorized.
22 And you could drill -- you know, I don't
23 know all of your systems, but that's
24 something that we could look at. And then we
25 may already be getting a report like that,

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1 and so I'll have to go in and look to see.
2 MS. HOFFMANN: Dr. Richerson, we'll
3 take a look at that and see if we can come up
4 with either a way to narrow that down or to
5 see if we might have a current report that we
6 could take a look at with Angie. Is that
7 okay?
8 CHAIR RICHERSON: Yeah. And that's
9 just -- you know, we're -- we don't know what
10 kind of -- we're not data people. So we
11 don't -- I don't personally know what kind of
12 questions that are good research questions
13 for you all to elucidate these underlying
14 access to specialty care.
15 So do you all have any suggestions of
16 things that we could ask for? Like -- you
17 know, like I mentioned that -- do you want
18 specifics like: Why can't we get a Medicaid
19 adult -- an adult with Medicaid into a
20 rheumatologist in Louisville? Like, is that
21 the type of questions? Or do you mean like
22 digging into the data questions, like Jordan
23 mentioned, or how -- what would be helpful to
24 elucidate this?
25 MS. HOFFMANN: I think to get

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1 started, we might be able to see if we can
2 narrow down the data on this partic- -- like,
3 overall, we'll see what we can come up with
4 on existing reports versus if the MCOs might
5 be able to narrow something -- and I'm not
6 sure.
7 I was just using Jordan's area as an
8 example and then thinking holistically for
9 Kentucky. I don't know if we can -- I don't
10 know if we can drill down to that, but we can
11 try. We can see what we've got.
12 DR. THERIOT: Or maybe we can look
13 at single case agreements and where they are
14 and what they're for.
15 MS. HOFFMANN: Yeah. We could ask
16 for that at the same time if we don't have
17 that somewhere, single case agreements and
18 what they're for.
19 CHAIR RICHERSON: I had never heard
20 of those, so that's --
21 MS. HOFFMANN: The ones that I've
22 worked on have been specifically for children
23 that have recently come out of COVID and
24 needing help with eating disorders, and we
25 don't have -- I've heard that we've got one

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1 that's trying to get going maybe in the
2 Louisville area, but we really don't have
3 anything right now.
4 CHAIR RICHERSON: Yeah. Oh, no. I
5 just had never heard of single -- we have
6 many children who need access to eating
7 disorders. We didn't know that there was a
8 thing called a single care agreement or
9 single case agreement. So that's good to
10 know for --
11 MR. OWEN: Yeah. It's basically a
12 one-time -- one-scenario arrangement
13 contract. You know, it happens with
14 emergencies, too, though. I just thought it
15 would skew it, you know, the Medicaid
16 members. I don't know. They're in Iowa.
17 They're in a car accident, and so they get
18 treated there at a hospital.
19 And so that -- so that's actually --
20 that happens as well, and so we've got to --
21 you know, have to do a single case agreement,
22 one-time scenario, sign a deal with you. So
23 that -- you know, that would kind of skew it
24 but...
25 DR. THERIOT: And, actually, you're

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1 right because the ones I work on are all for
2 private-duty nursing, and they're with
3 fee-for-service patients, you know. So it
4 would only be the fee-for-service part, so I
5 think the individual MCOs have their own
6 probably list of single case agreements that
7 they work on.
8 CHAIR RICHERSON: Okay. It is a
9 little bit after 2:00, so what I would
10 propose as the -- as chair, if there are no
11 objections, for us to move -- to save the
12 rest of the items in the goals and strategies
13 review and move on to the racial equity core
14 team updates, minority health report, and
15 division of quality and population health
16 updates so that we can get some -- make sure
17 we have time to get those updates from
18 Medicaid.
19 Are there any objections from anybody on
20 the TAC?
21 DR. BAUTISTA-CERVERA: Before you
22 move, Dr. Richerson, we talk about the review
23 of fee scheduling for vaccine providers, but
24 this is for the ones that don't offer the
25 vaccines for Medicaid patients.

1 But I would like also to propose the
2 revision of fee schedule for VFC providers.
3 Just recalling the number that JCPS health
4 director has shared with us, that only 67 VFC
5 providers actually provide -- you know, there
6 are a lot more. I cannot recall at this
7 moment the number, the exact number of VFC
8 providers in the whole Louisville area, but
9 only 67 do provide vaccines for VFC kids.
10 So -- and one of the main propositions
11 for this to happen is that the reimbursement
12 for those providers is really low. In a case
13 that the reimbursement for medical
14 examination or the well check for a kid, it's
15 better reimbursed, and that's being done but
16 not the vaccination. And this could explain
17 the low vaccination rate that prevails in the
18 JCPS population.
19 So I would just add, if possible, just
20 to check on that and see if it's up to date.
21 And since we're going to do a review of fee
22 schedule, I would just propose that.
23 CHAIR RICHERSON: And do you -- so
24 you mentioned the number of VFC providers.
25 So was your question, like, the -- to look at

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1 the admin fees that VFC providers get? Is
2 that what you're asking?
3 DR. BAUTISTA-CERVERA: The
4 reimbursement.
5 CHAIR RICHERSON: Yeah. So one of
6 the challenges, and you know, is the admin
7 fee, you know, is a set fee and then we get
8 the medicine for free. But the overall admin
9 cost, there's no payment for that. So paying
10 a nurse -- part of the FTE for a nurse to run
11 the program in the office, that's not
12 reimbursable for -- it's not a paid thing.
13 It's just a cost of doing VFC.
14 So just -- you just would like to have
15 the -- what the current admin fees are, and I
16 think Judy knows those off the top of her
17 head. But, Judy, do you know the --
18 DR. THERIOT: I do sort of off the
19 top of my head. I think it was $27.46, is
20 what you get for the first shot and then you
21 get, I think, $9.80 for a subsequent shot.
22 Let me find where that's written somewhere.
23 Yeah. $27.49 for the first shot and then
24 $9.80 for the second shot.
25 DR. BAUTISTA-CERVERA: And this is

1 the updated fee that has -- this is the last
2 one?
3 DR. THERIOT: Yes. This is the
4 current one. I'm not sure when it was
5 updated.
6 DR. BAUTISTA-CERVERA: Could you --
7 could you check on the date and just let us
8 know whenever you get the chance?
9 DR. THERIOT: Let's see.
10 CHAIR RICHERSON: Thank you very
11 much.
12 DR. BAUTISTA-CERVERA: Thank you.
13 CHAIR RICHERSON: So do we have
14 quorum yet?
15 MS. SHEETS: No, we do not.
16 CHAIR RICHERSON: Okay. Thanks.
17 Okay. So the next three items on the
18 agenda -- four items, I'm not sure who wants
19 to take which topic, so you all can just jump
20 in.
21 MS. HOFFMANN: Dr. Richerson,
22 Danita and Angie are taking one and four, if
23 that's okay.
24 CHAIR RICHERSON: Yeah.
25 MS. HOFFMANN: And Leigh Ann and I

1 are doing two and three together, so you'll
2 get one and four from Danita.
3 CHAIR RICHERSON: Okay. Great.
4 DR. THERIOT: It looks like the
5 $9.80 was updated in 2018, and the $27.49 was
6 2020 -- 2022. I'm sorry. 2022.
7 DR. BAUTISTA-CERVERA: Thank you.
8 MS. COULTER: Okay. This is
9 Danita. I'm just going to do a quick update
10 on the racial equity action plan goals. As
11 far as the racial action plan -- with the
12 racial action plan, we have goals that are
13 both enterprise-wide as well as
14 division-wide.
15 And with the division goals, we have
16 obtained the dates -- the quarterly reporting
17 dates that we will be reporting to
18 Commissioner Lee. So those dates are
19 available for the TAC members to participate
20 in, so we can share those dates and those
21 invitations with you.
22 Those are going to be on Monday, March
23 27th; June 26th, and on February the 18th.
24 Those first Monday dates are going to be from
25 3:00 to 3:45. And then when we move into

1 December, that's going to be from 11:00 to
2 11:45.
3 And those will be -- when we share those
4 GARE tool activities, that all the divisions
5 have uploaded their strategic goals. And
6 they will be sharing the updates on their
7 progress, what that progress looks like, and
8 each team will provide a presentation. Five
9 to seven minutes, they'll provide to the
10 commissioner on what they specifically plan,
11 where they are, and any barriers or
12 challenges that they may have had.
13 When we talk about the enterprise goals,
14 as far as the goal that we set for the
15 updated language for the MCO contracts, that
16 was effective at the beginning of January.
17 The RFP language, that was also effective at
18 the beginning of this year as well.
19 Also, I seen that there was some plan
20 for CMS -- CMS drafted language for the new
21 CMS waiver, and I think Deputy Commissioner
22 Hoffmann has updated on that previously. So
23 as far as the racial action plan, those are
24 the updates for that.
25 I can move into the MIC. I do have a --

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1 some information on a timeline for a
2 PowerPoint if I can share my screen shortly.
3 CHAIR RICHERSON: Sure.
4 MS. SHEETS: Give me just a second,
5 Danita. I'll make you cohost.
6 CHAIR RICHERSON: And then, Danita,
7 if you can just give us -- after those
8 quarterly dates come up, just at the
9 following TAC, just kind of give us a high
10 level of what was -- happened at those
11 meetings.
12 MS. COULTER: Oh, they have not
13 taken place yet, and so --
14 CHAIR RICHERSON: Right. Just at
15 the next -- you know, the next TAC after the
16 next quarterly meeting.
17 MS. COULTER: Okay.
18 MS. SHEETS: You are cohost now,
19 Danita. You should be able to share.
20 MS. COULTER: Gotcha. Okay. Can
21 you see the screen?
22 Okay. So just a quick reminder of what
23 the MIC is, the Medicaid Innovation
24 Collaborative. You know, it is -- it's
25 structured so that we can bring the state

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1 partners together so that we can come up
2 with, you know, an innovative way so that we
3 can address the issues that some of our
4 Medicaid teams are facing when it comes to
5 addressing the needs of our Medicaid
6 enrollees or participants.
7 The first cohort involved behavioral
8 health themes. With this specific cohort, we
9 are addressing the social determinants of
10 health. And in this cohort, it includes
11 Iowa, Kentucky, Nevada, and New York.
12 Our goal for this team -- for these
13 teams are that we want to identify and
14 develop solutions to address the health
15 disparities, you know, for our members, and
16 we're looking at quality improvement
17 initiatives, service provision, payment
18 structure, and specifically data/technology.
19 I have listed on this slide the link to
20 the MIC page. And if you -- I can also drop
21 that into the chat. But if you go to their
22 website, there's a wealth of information
23 about the MIC team, those partners, and some
24 lessons learned from that first
25 collaborative. So it shows you some very --

1 some interesting details on the work that
2 they have done, how they came to where they
3 are, and why we are interested in this
4 initiative.
5 Where are we now with this -- with the
6 MIC work? What they first -- the first steps
7 that they done was that they sent out a
8 survey to all the states that are involved to
9 some of the participants. They selected --
10 did a random selection, and they asked them
11 some questions about social determinants of
12 health, about their specific food needs. And
13 then there was some general questions about
14 some chronic conditions and just got some
15 information back on those surveys.
16 At the beginning of January, we met with
17 the MCOs to talk to them about the MIC
18 collaborative, what our goals were for the
19 MIC, and specifically asked them, you know,
20 what their goals were with equity and social
21 determinants of health. They provided us
22 with some PowerPoints on what they were
23 doing. We talked to them about our goals in
24 the equity and determinants of health bridge
25 in specific.

1 We held the MIC kickoff where Kentucky
2 provided to the MIC team what our goals were.
3 We specifically identified those with the
4 team to tell them, you know, these are the
5 things that we want from this MIC
6 collaborative, which was for them to help us
7 with those things that we listed on that
8 first slide.
9 What they've asked from us was that we
10 provide to them two individuals from the MCOs
11 that would be their contacts. Each of those
12 MCO contacts have very distinct roles. One
13 will be the champion, and one will be the
14 liaison.
15 One sort of works within the MCO
16 organization to sort of champion what the MIC
17 goals are, to make sure that they are on
18 board. And then the other role is going to
19 be more involved of what -- the MCO
20 collaborative and participate more in the
21 meetings and the actual things that we're
22 going to be doing as we move along the way.
23 We had a recent meeting with some other
24 states where they gave us some information on
25 some research that has been done with some

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1 other Medicaid participants, with some ideas
2 about ways that they have met social needs,
3 medical needs for some participants, some
4 ideas such as medically-tailored meals and
5 information such as that.
6 All this is information that we can
7 provide to you all as well. When we receive
8 these resources, we keep these internally as
9 sort of a resource repository for our teams
10 to share.
11 The next steps that we are going to be
12 doing is that we're going to have a series of
13 technical assistance meetings. Technical
14 assistance is going to be with two
15 representatives from our IT, since the
16 technology piece is going to be important for
17 us. So we've identified those two
18 participants, and it's going to be a series
19 of IT meetings along with our policies and
20 procedures.
21 Before those meetings get started, on
22 Friday, we're going to have our research
23 readout and request for information feedback.
24 That meeting is going to be recorded, and we
25 are happy to share that meeting -- the

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1 results from that meeting with you all so
2 that you will know firsthand.
3 And the other piece that is important
4 for this group is that Angie and I just had a
5 meeting with the MIC team, and they would
6 also like members from some of our
7 stakeholders to be involved with this
8 collaboration. So they're going to create an
9 email to solicit that membership. So when we
10 receive that communication, we will send that
11 out.
12 I'm not sure at this point how many
13 members that they want, but when we have that
14 email, we'll send that out so that we can
15 have your voice included as we go through
16 this innovation collaboration.
17 The other thing that I think that's
18 important to share with you -- and it is on
19 down on this agenda -- is what the MCOs are
20 doing, and I think that it fits in with this
21 part on the agenda.
22 So I talked to you about the meeting in
23 January where the MCOs provided us what their
24 strategies are as far as equity and social
25 determinants of health. With the information

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1 that I'm sharing with you right now, it's not
2 meant to say that this is all that they're
3 doing because it's hard to capture what
4 they're doing in a PowerPoint. So, you know,
5 this is just a high level of some of the
6 information that we captured.
7 The four categories that are important
8 in the work that they do are, you know, the
9 interventions and referrals and, of course,
10 those community partnerships and the work
11 that they're doing towards their
12 organizational improvement. And what we all
13 find important is the data capacity. Some of
14 the highlights that --
15 CHAIR RICHERSON: Can you put your
16 slides on slideshow, so it makes it's a
17 little bit bigger?
18 MS. COULTER: Oh, it's not on
19 slideshow. I am so sorry. Is that better?
20 CHAIR RICHERSON: Okay. It was
21 fine until the last one, and it's hard to
22 read the little --
23 MS. COULTER: I am sorry,
24 Dr. Richerson. Are you seeing -- which
25 screen are you seeing?

1 CHAIR RICHERSON: I am seeing a big
2 screen. Then we have the next slide
3 viewable. So those two, just the slide --
4 MS. COULTER: There we go. Is that
5 the correct slide?
6 CHAIR RICHERSON: Perfect. Thank
7 you.
8 MS. COULTER: I apologize for that.
9 Okay. So on the right, this is just
10 where I captured some of the things that they
11 shared in their PowerPoint presentations, and
12 this is just not from one MCO. It's just
13 capturing several of the things that they all
14 shared, just highlighting, you know, their
15 ability to capture some of the SDoH
16 information on their dashboards, how they are
17 using some inclusivity and diversity
18 measures, their integration of the Kentucky
19 Minority Health Report, and things like that.
20 Then I just broke this down a little bit
21 by the MCOs. Two of the six of our MCOs are
22 already NCQA health equity accredited. So we
23 felt like that is worth mentioning to this
24 TAC.
25 But the next few slides just kind of

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1 break down by the MCO, very high level, just
2 a few of the things that they do. So I --
3 just, you know, with Aetna, this just
4 mentions how they use the community health
5 workers in their networking. And as far as
6 their internal processes, how they have this
7 health equity committee.
8 With these, I don't want to use a lot of
9 the time, since we've had quite a bit of time
10 already on our first pieces of information.
11 There is a table that was created, and I can
12 share that with this TAC. I think that will
13 probably be a better use of the time, and we
14 can move on to the next part of the agenda.
15 CHAIR RICHERSON: Thank you.
16 Thanks. That was great information, and
17 we'll look forward to hearing more from
18 the -- as things proceed.
19 Any questions?
20 (No response.)
21 CHAIR RICHERSON: Thank you. And
22 then the GARE tool and the health equity
23 infographic, any updates on that?
24 MS. HOFFMANN: So two things,
25 Dr. Richerson. The health equity

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1 infographic, just for the sake of time, I can
2 send that to you again. It's the same one we
3 had before. We had just updated it after our
4 last meeting.
5 Based on some things that Danita has
6 told you that we've recently done, we may
7 want to update it just a tad more. We did
8 update it for you but then we had those
9 kickoff meetings and things with our big MIC
10 group.
11 So I can go ahead and send that to you.
12 But, again, I think you might want it to be
13 updated again. I think that was sometime the
14 middle of January that we last updated it.
15 And then for the GARE tool, as you
16 remember, we sent out just a sample GARE tool
17 and I think a short video a couple of
18 meetings ago. And I've asked Leigh Ann
19 Fitzpatrick to come and speak to you about
20 the GARE tool and our mobile crisis
21 initiative.
22 I'm kind of using that as my first real,
23 like, going forth with the GARE tool and how
24 can we use it and what changes can we make
25 from it and looking through that lens.

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1 And so I've asked her -- it won't look
2 exactly like the document that we've sent you
3 as an example because she's actually put it
4 in, like, a presentation for you. So it'll
5 look a little bit different. Same questions;
6 right?
7 And I asked them, our team, to put in
8 the things that we've changed in red so that
9 you can see how fluid and what a living
10 document that we've got going on.
11 So, Leigh Ann, do you want to go ahead
12 and start that? And one other thing. It's
13 pretty lengthy. So if we -- Dr. Richerson,
14 if she gets along in the time and you want us
15 just to send the rest of it out for
16 questioning, that's fine, too.
17 So go ahead, Leigh Ann.
18 MS. FITZPATRICK: Can you make me
19 cohost, so I can share, please?
20 MS. SHEETS: You are, Leigh Ann.
21 MS. FITZPATRICK: Oh. Oh, there I
22 am.
23 CHAIR RICHERSON: Thanks,
24 Leigh Ann. And if you -- I don't know how
25 much time would you -- how much time would

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1 you like, or how much time do you need?
2 MS. FITZPATRICK: Well, just if
3 it -- I don't know. Just tell me if I'm at
4 time because I could probably talk about
5 this, you know, for a long time.
6 But are you seeing -- are you seeing the
7 slideshow? Okay.
8 CHAIR RICHERSON: We're seeing the
9 slides plus the preview. So if you want it
10 from beginning, that might --
11 MS. FITZPATRICK: Yeah. How --
12 Danita, how did you do that to make it large?
13 MS. COULTER: I selected swap view.
14 MS. FITZPATRICK: You selected
15 what? Oh.
16 MS. COULTER: Swap view.
17 MS. FITZPATRICK: Got it. Thank
18 you.
19 So just a little background. I won't go
20 into a lot of detail in the background
21 because we can send this out, and you'll be
22 able to read it a little bit more.
23 But September 2021, we received an award
24 from CMS for a mobile crisis planning grant.
25 The grant was awarded to 20 states. We

1 already have these services within our state
2 plan, but we realized that we needed to do
3 some research and kind of beef those up and
4 better describe and define these services.
5 One of the major accomplishments that we
6 had is in a need assessment. It's on our
7 website for you to view. It's a lengthy
8 260-page document, but it really -- we had to
9 look and see where we are as a state and
10 where we are -- looking for those services
11 and how we're already providing those
12 services right now.
13 So due to the needs assessment, what we
14 did is we -- that drove every decision, any
15 conversation. Any thoughts that we had is
16 we -- we went straight from our needs
17 assessment. We did extensive community
18 outreach for that, interviews, everything.
19 So we have developed a comprehensive
20 Kentucky model. We call it our mobile crisis
21 intervention services that we hope -- we hope
22 that will come in place in October of 2023.
23 Some other things that -- what we did is
24 we had developed a Kentucky Crisis
25 Co-Responder Model. It's a CCCR. Right now,

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1 what we are doing is -- oops -- is we are --
2 we are talking with our community
3 stakeholders. We have interviews set up,
4 focus groups set up. We're reaching out to
5 anyone and everyone that we can to help us
6 build the best co-response model in the
7 state.
8 And that's -- I'll give you a sneak
9 preview. This is our future model.
10 MS. HOFFMANN: Leigh Ann, I'm not
11 seeing an advanced slide. Is that me, or is
12 that -- is everybody seeing Leigh Ann advance
13 slides?
14 CHAIR RICHERSON: No. You're
15 right. They're not advancing.
16 DR. BAUTISTA-CERVERA: No
17 advancing, just the first one.
18 MS. FITZPATRICK: So you're still
19 on the first one?
20 MS. HOFFMANN: Yes.
21 MS. FITZPATRICK: Well, what am I
22 doing wrong?
23 DR. BAUTISTA-CERVERA: Go to your
24 lower right. Right by the volume, there is,
25 like, a screen, if you click in there maybe.

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1 MS. FITZPATRICK: Okay. Do you see
2 it now?
3 DR. BAUTISTA-CERVERA: No.
4 CHAIR RICHERSON: No.
5 Now -- now it switched.
6 MS. FITZPATRICK: Okay. So do you
7 see the future MCI model?
8 DR. THERIOT: Yes.
9 MS. FITZPATRICK: Okay. I
10 sincerely apologize for my lack of technology
11 skills.
12 So this is our future model. It is --
13 and as you know, we have 988 centers that is
14 in twelve of our CMHCs. Once a -- once it is
15 determined that a mobile crisis dispatch
16 needs to happen, this is where it's going to
17 come in. We are working on the triage of
18 what would constitute a mobile crisis
19 dispatch. So this is our plan for the
20 future. And right now, we hope to have this
21 implemented, like I said, in October.
22 All right. So the GARE tool. You have
23 a blank copy that is going to look totally
24 different, like Leslie said about this. But
25 what we did is -- the GARE tool, it seeks to

1 eliminate racial inequalities and advance
2 equity. One thing that I have noticed when
3 we went through this -- and this is the
4 second time I have gone through the GARE tool
5 with a certain initiative, but it really
6 makes you think.
7 Are you really thinking of every corner
8 and every type of person and every -- every
9 community with this initiative? Are we
10 addressing every community, you know, with
11 this? Or are you looking at, oh, I didn't
12 think about that. Oh. It really does make
13 you think.
14 When I first looked at this and I
15 thought, yeah, we are. We're doing
16 everything right. We are considering
17 everything. But once you got into the tool,
18 you're like, oh, no, we're not. So it was a
19 very good learning tool.
20 Our -- this right here, what we're going
21 to show you, is a living, working document.
22 We update this -- we've updated it. We've
23 created it and then updated it once and then
24 we'll go back to this as well.
25 Because of the GARE tool, our

1 communication plan has really changed and has
2 really grown and the different ways and the
3 different populations that we're going to
4 reach out to people. So I think our
5 communication plan has definitely grown a lot
6 larger than we thought it was going to.
7 But we have the six steps for the GARE
8 tool, and we'll go with the first step.
9 Determine proposal, results, and desired
10 outcomes. So as you can see, there is a lot
11 of red, which is a good thing because we're
12 learning. The first -- and what's in black,
13 like here, is what we had in our first
14 responses.
15 And in our second -- you know, after we
16 reviewed it again, we realized, wow, we've
17 got to realize that there's no wrong door.
18 No person regardless of any type of gender
19 equity, income, social status, where they're
20 from -- all Kentuckians can benefit from this
21 service.
22 We really talked about data, and we need
23 to realize that the data needs to drive our
24 outcomes and drive what we do to update our
25 plan and our program.

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1 The second question is: What does the
2 data tell us? Now that we know -- we've
3 decided, okay, we need these data points. We
4 need this part. What's it going to do for
5 us? It is -- we did originally -- yes, it
6 is. It's going to be statewide. But we
7 realized neighborhoods, cities, regions
8 across the commonwealth, we need to look
9 about service delivery in those areas.
10 The initiative takes into consideration
11 race, socioeconomic demographic factors on a
12 local level to ensure the unique
13 characteristics, and what are the communities
14 that we need to meet. We said yes, we're
15 doing it. Now we've got to think about,
16 okay, we said we're doing it, but how are we
17 doing it. And this needs to be a more
18 in-depth answer.
19 According to the U.S. census, the
20 breakdown of racial demographics in Kentucky
21 was 8.6 percent black or African-American,
22 1.7 Asian, 2.2 percent two or more races, 4.2
23 percent Hispanic or Latino. While black or
24 African-American individuals represent nearly
25 9 percent of Kentucky's population, we looked

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1 at which counties had the highest population.
2 Jefferson at 55; Christian, 54; and Fayette
3 at 52.
4 And with the question of, what does the
5 data tell us, is there any data about
6 existing racial inequalities do you know that
7 might be driving these, and what's driving
8 these inequalities? And yeah, we know
9 there's inequalities, but what are they? How
10 is the data going to help us address those
11 inequalities and assist those people of
12 Kentucky?
13 We -- as you can see, we had barely any
14 type of answers to the question the first
15 time around. And the second time around,
16 wow, we really thought about it. Why aren't
17 all the other communities besides the white
18 community not seeking services?
19 Mistrust and fear of treatment, we
20 learned. Perceived discrimination in the
21 healthcare system. Maybe a family member or
22 friend was treated a certain way, and they
23 don't want to be treated that way. Cultural
24 stigma. Lack of evidence-based practices in
25 mental health treatment due to limited

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1 diversity medical research.
2 Barriers related to social determinants
3 of health like transportation. I know we
4 talked about transportation earlier in this
5 meeting. When we did the needs assessment,
6 that was the one thing that really came out,
7 was transportation. These people might need
8 the services, but they cannot get to the
9 locations to get those services.
10 And with -- of course, with the
11 pandemic, how that's opened up things and how
12 we are seeing telehealth as well.
13 There is a shortage of behavioral health
14 providers for the diverse communities, and I
15 don't believe that is -- Medicaid can answer
16 that question or solve that problem.
17 I know I'm -- I graduated from UK with
18 my master's in social work, and I know the
19 social work program is really bringing on
20 diversity incentives and initiatives to bring
21 on those people to the college of social work
22 and -- but how -- the question is: How do we
23 bring those providers to Medicaid? Where do
24 we get those providers? That's the question.
25 And some -- in a lot of meetings with

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1 other states, I asked those questions. How
2 do you get those minority providers to be a
3 provider, you know, go in that direction?
4 Because you don't want to go into mental
5 health or behavioral health for the money
6 because that's not it. You go in for other
7 reasons. It's in your heart and -- you know,
8 so it's hard to determine who of those --
9 sorry. The wind got me. Yes, like I said.
10 CHAIR RICHERSON: I think that
11 might be just -- I was going to say that this
12 might be a time for a break because we can
13 always pick this up at another meeting. I
14 don't want to rush through it because this is
15 amazing content.
16 And so I'm wondering: Would that make
17 sense, to kind of hold here and keep it on
18 the agenda for next time to talk -- so we
19 have some time to talk about it more because
20 it's such great information.
21 MS. FITZPATRICK: Uh-huh. Okay.
22 CHAIR RICHERSON: I'm just --
23 especially that last slide was just, like --
24 you hit, like, so much fundamental --
25 MS. FITZPATRICK: Yeah. I've only

1 gone through half of the presentation so...
2 CHAIR RICHERSON: So I don't -- I
3 guess it wouldn't make sense to send it out
4 so we can read beforehand but -- unless you
5 all think that would make sense. But we'll
6 keep it on the agenda for next time maybe and
7 so -- kind of recap and then start at that
8 next slide.
9 MS. HOFFMANN: That's fine. We can
10 just finish the second half of the
11 presentation and then we'll send it out to
12 you. How about that?
13 CHAIR RICHERSON: Okay. That
14 sounds great. Yeah. I want to -- I want
15 people to be able to have time to ask
16 questions and everything, too.
17 MS. HOFFMANN: Yeah. We kind of --
18 because this was going on at kind of the same
19 time that our GARE tool was coming about to
20 complete -- you know, to complete one of
21 those as a sample, we just really wanted to
22 use mobile since we're trying to meet the
23 need of the entire Kentucky population with
24 this, even the uninsured. So we thought this
25 would be a good model to start using towards

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1 the GARE tool.
2 And when I speak of that, it's the
3 behavioral health group within Medicaid.
4 Every other division has also got their own
5 priorities going on and GARE tool
6 initiatives. So we've got lots going on in
7 Medicaid right now and the other departments
8 that lead up to the Cabinet.
9 CHAIR RICHERSON: That's great.
10 And then as -- after we have a chance to hear
11 the rest of this one, then we'd love to
12 continue to hear as other GARE tools are
13 being implemented. I think that's great
14 information for us to be able to hear and
15 then give feedback on.
16 Just looking at the rest of the agenda,
17 I know Vivian -- we reviewed the minority
18 health report, or we received it, but we
19 haven't really -- oh, yes. We did talk about
20 it, I think, a little bit and -- oh, no. We
21 didn't talk about it.
22 We talked about community conversation
23 ideas last time. So I listed all those
24 community conversation ideas, and I think
25 they were community conversations that might

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1 be planned by DPH. But I don't know if
2 Vivian is on the call today, or we can hold
3 that as well to a future meeting.
4 (No response.)
5 CHAIR RICHERSON: I don't hear
6 Vivian.
7 The next section is a recap of the
8 division of quality and population health
9 with just follow-up from the last meeting, so
10 I don't know if we have anybody to give that
11 update.
12 MS. HOFFMANN: Angie, are you still
13 on?
14 MS. PARKER: I'm sorry. What was
15 the question regarding population health?
16 MS. HOFFMANN: It's "e" on our
17 agenda.
18 MS. PARKER: Which -- I don't --
19 CHAIR RICHERSON: It's just things
20 to follow up from the last meeting.
21 MS. PARKER: I don't remember.
22 CHAIR RICHERSON: So one thing was
23 on -- you know, we've talked a lot about
24 demographic data, race and ethnicity data.
25 MS. PARKER: Oh.

1 CHAIR RICHERSON: And how can we --
2 we know that it's limited, but how are you
3 using it? How can we help you use it and
4 look at that to be able to advance the equity
5 conversations?
6 MS. PARKER: Well, I mean, when
7 we're looking at all of our reports, we are
8 looking at how we can address that.
9 CHAIR RICHERSON: And then maybe --
10 maybe the question, then, is: What reports
11 can you all bring to us to share with us so
12 that we understand some of the issues around
13 disparities and equity?
14 MS. PARKER: I'll have to do some
15 more work on that, and maybe by the next
16 time, I can have something that I could
17 share.
18 CHAIR RICHERSON: Great.
19 And then in the last meeting, there was
20 something called the health disparities
21 initiatives that we were going to learn more
22 about. Do you know what that was in
23 reference to?
24 MS. COULTER: So this is Danita.
25 That was the Medicaid Innovation

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1 Collaborative that I just provided the update
2 on.
3 CHAIR RICHERSON: Okay. Is there
4 anything else under the health disparities
5 initiatives?
6 MS. COULTER: Nope. That is it.
7 CHAIR RICHERSON: Great. And then
8 any other updates from the equity and
9 determinants of health branch manager?
10 MS. COULTER: Nope. That is it.
11 CHAIR RICHERSON: Okay.
12 And so in organizing this agenda, it was
13 hard for me to know where to put the
14 categories. So the racial equity core team,
15 what do you all cover versus the equity and
16 determinants of health branch? Where does
17 the racial equity core team fall?
18 MS. HOFFMANN: We have a core team
19 for Medicaid which, if you remember, Jodi
20 Allen and I kind of started that. This was
21 prior to us having a population health
22 division under Angie or even having Danita
23 come on board as our branch manager.
24 So I've been staying involved kind of as
25 Medicaid's champion, but the population

1 health group is kind of taking -- starting to
2 take over and take the lead on the racial and
3 health equity. Does that help? I'm sorry.
4 CHAIR RICHERSON: Yes. Yes. Very
5 much.
6 MS. HOFFMANN: It's confusing
7 because we were so lucky -- you know, we got
8 the support to actually develop that division
9 and that branch. We were very lucky to do
10 that in the midst of us trying to make
11 change, so that was a very positive thing.
12 CHAIR RICHERSON: No. That's
13 great. So I can -- we can, in future
14 agendas, include the racial equity action
15 plan and the -- all of the things under
16 equity core team under --
17 MS. HOFFMANN: Yes.
18 CHAIR RICHERSON: Under that
19 same --
20 MS. HOFFMANN: Yeah. Because we
21 all met together today and decided who was
22 going to do what, so it's fine.
23 CHAIR RICHERSON: That's good.
24 Okay.
25 All right. So we are to new business.

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1 Or is there any other old business? I'm
2 sorry.
3 MS. HOFFMANN: The only thing I
4 had, Dr. Richerson -- sorry. Am I on mute?
5 No. Okay. I did have Erin to send me a
6 report on the CHFS.Listens. That's your "f"
7 that was on that agenda.
8 CHAIR RICHERSON: Oh, yes. Thank
9 you.
10 MS. HOFFMANN: And there was --
11 it's not horrible. It was 135 reported CHFS
12 calls or emails. The big -- from me looking
13 at this report -- it's a very simplistic
14 report. There was 35 related to service
15 inquiry. This is not racial and health
16 equity specific. 24 to member services.
17 Member services inquiry was 10, and 5 to
18 billing.
19 So that was 75 that I just gave you out
20 of 125. So nothing really that stood out to
21 us related to -- specific to racial and
22 health equity, if that makes sense.
23 CHAIR RICHERSON: Yep. And it's
24 hard -- especially after that last slide that
25 was covered with the GARE tool, sometimes

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1 it's hard to tease out. Some of those things
2 may be related to racial and health equity,
3 so I guess it's -- it could be. But at this
4 point, I guess it's hard to know. Thank you.
5 Anything else under the old business or
6 updates?
7 (No response.)
8 CHAIR RICHERSON: And do we have a
9 quorum yet?
10 MS. SHEETS: No. I'm sorry,
11 Dr. Richerson. There is still --
12 CHAIR RICHERSON: Okay. Thank you.
13 MS. FIGUEROA: During the last
14 meeting, we discussed the issue of access
15 for -- access to bilingual services.
16 CHAIR RICHERSON: Yes.
17 MS. FIGUEROA: And we wanted to
18 look at the trainings that are available to
19 become health interpreters, certified court
20 and health interpreters.
21 So I would like to know if there is any
22 follow-up in increasing those opportunities
23 across the state. Even though that we see a
24 higher concentration of English language
25 learners in some areas of the state, but I --

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1 we provide services in western Kentucky, and
2 we have seen an increase in the number of
3 Burmese families and Spanish-speaking
4 families that have moved in the area.
5 And we would like to expand in the
6 capacity to provide services, but we -- we do
7 need more interpreters. It's been very
8 difficult to get certified interpreters, and
9 maybe this is an area that we can help move
10 the needle, for lack of a better word, in
11 increasing capacity for those training and,
12 therefore, increasing access to treatment.
13 CHAIR RICHERSON: Great. Thank
14 you.
15 So any -- where can we assist Medicaid
16 in moving forward with something like that?
17 MS. HOFFMANN: I don't have
18 anything specific to answer for you. We
19 do -- well, we have -- we call LEP
20 interpreters, which have to be certified in
21 the Cabinet. But I don't know what to tell
22 you right now about providers. I'm guessing
23 the MCOs all provide interpreters if needed.
24 I don't -- I don't have any answers for that
25 one, if anybody else on Medicaid's team has

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1 an answer.

2 CHAIR RICHERSON: So I think

3 there -- maybe there are two questions. One

4 is: How can we get more people trained? Is

5 there any capacity within Medicaid to create

6 that opportunity? Was that one of your

7 questions, Wanda?

8 MS. FIGUEROA: Yes. And also the

9 issue of reimbursement, you know, having MCOs

10 paying for translations and for the time

11 spent if we have staff doing that as part of

12 additional duties. I think it will help

13 tremendously to attract more people from the

14 community if we know that we would be able to

15 get reimbursed for those translations.

16 CHAIR RICHERSON: Great. So maybe

17 those can be -- those can be under follow-up

18 for next time. So is there capacity within

19 Medicaid? How can we get more people

20 interpreted with Medicaid's kind of

21 support --

22 MS. FIGUEROA: Correct.

23 CHAIR RICHERSON: -- financially

24 with creating opportunities? And the other

25 is -- and as you know, Leslie, not all the

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1 MC -- we can't get interpreters paid, for the
2 most part, with the MCOs. There's some
3 access, but it's not where we want to be as a
4 state, I'm sure, as far as ease of access and
5 knowledge of how to access and all of that.
6 So we had skipped those under the old
7 business, so those can be --
8 MS. HOFFMANN: Back on.
9 MS. FIGUEROA: I think that should
10 be an expectation in their contract, that
11 they pay for those services. Because that's
12 the only way that you can provide access
13 through health care --
14 CHAIR RICHERSON: Yeah.
15 MS. FIGUEROA: -- for those
16 individuals.
17 CHAIR RICHERSON: Right. And we're
18 required, you know, under -- we're required
19 by law to have interpreters, but it's not --
20 it's a very expensive and often unpaid --
21 very expensive and unpaid. But we can't
22 function without them.
23 MS. FIGUEROA: Right.
24 CHAIR RICHERSON: So you have to
25 have them. Yes. Extremely important.

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1 And also in that same category, there
2 was comment about -- when Dr. Straub was
3 involved, and there was an immigrant health
4 workgroup. And somebody was going to try to
5 dig up some minutes to see what the
6 recommendations were because that sounded
7 like a really good community forum process
8 so --
9 MS. HOFFMANN: So, Dr. Richerson, I
10 did follow up on this one. Unfortunately,
11 we've lost Dr. Straub, or
12 Commissioner Straub. She's no longer with
13 us, and hopefully she's retiring on a beach
14 somewhere, probably not.
15 I did reach out to the acting deputy
16 commissioner -- no, not deputy. She's the
17 acting commissioner, Lisa Dennis. She said
18 that she thought that that was something that
19 previous Commissioner Straub had worked on in
20 her consulting world.
21 So she's going to reach out to her.
22 They still are in contact, and she's going to
23 reach out and see if she -- I tried to get
24 her to come to the meeting today. But, of
25 course, it wasn't on her calendar, so she

1 didn't know to come.

2 So yeah, she's going to reach out, and

3 her name is Lisa Dennis. And she'll reach

4 out and see if she can get some information

5 related to the immigrant health worker

6 report.

7 CHAIR RICHERSON: Fantastic.

8 Great.

9 Okay. So we have about six minutes.

10 Anything else under old business?

11 (No response.)

12 CHAIR RICHERSON: I just put under

13 new business I think it would help the TAC to

14 understand the Medicaid organizational chart

15 and all of that, so maybe just 30 seconds at

16 the next meeting, just kind of outlining

17 that, kind of how Medicaid falls, so that we

18 understand when we're advocating or talking

19 about issues. So we know who all the players

20 are. We have --

21 MS. HOFFMANN: I'm sorry. Did

22 you -- I'm sorry. So you want a Medicaid --

23 like our organizational chart? Is that what

24 you said?

25 CHAIR RICHERSON: Yeah.

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1 MS. HOFFMANN: But do you want
2 it -- would it be helpful for you to see
3 from, like, Cabinet down? I think we've got
4 that.
5 CHAIR RICHERSON: I think so.
6 Yeah. Whatever you think would be helpful to
7 help us.
8 MS. HOFFMANN: Well, it's hard to
9 understand if you don't work in it every day.
10 CHAIR RICHERSON: I know. I was on
11 the website. I was like, I -- I'm not sure
12 what I'm looking at.
13 MS. HOFFMANN: Yeah. I think we
14 have one. I think -- so you have all
15 these -- the governor and then you have all
16 the cabinets. And then all the cabinets have
17 secretaries and then it starts coming down.
18 So we're the department under the -- our
19 secretary.
20 Yeah. I'll see what I can get for you.
21 CHAIR RICHERSON: So just real
22 quick, it sounds like we don't have any
23 recommendations to the MAC this time.
24 Dr. Bautista, were you able to attend
25 the MAC meeting, or do you have the next one

1 on? Do you want to give us any updates on
2 that?
3 DR. BAUTISTA-CERVERA: I attended
4 the MAC meeting. They talk about the high
5 morbidity on maternal, especially racial
6 groups being affected, and the changes that
7 Medicaid has been doing to follow up for a
8 year instead of just the first 90 days. So
9 that's a really good thing.
10 And, also, Dr. Schuster mentioned -- she
11 talk a lot about the short staffing that the
12 whole State -- the Commonwealth is suffering.
13 And she proposed some things to help, you
14 know, retain people that is becoming health
15 providers, particularly physicians but
16 everybody else, nurses and mental health
17 specialists. Because the shortage, it's
18 affecting everybody.
19 CHAIR RICHERSON: Thank you.
20 And then we have general discussion left
21 and volunteer for chair and then our next TAC
22 is listed there, May 3rd from 1:00 to 3:00.
23 So any general discussion or volunteers
24 to be the chair for the next two meetings?
25 MS. FIGUEROA: You're doing a

1 fantastic job. Do you want to continue it?
2 CHAIR RICHERSON: No, no, no.
3 That's fine. I did mine.
4 MS. FIGUEROA: Yeah.
5 CHAIR RICHERSON: No. I resign.
6 So, Wanda, does that mean you'll do it?
7 MS. FIGUEROA: Not this time. Next
8 time. I have so much --
9 CHAIR RICHERSON: Okay. Who wants
10 to do it next? Jordan?
11 DR. BURKE: Would Dr. Bautista like
12 to go from co-chair to chair?
13 DR. BAUTISTA-CERVERA: I cannot do
14 that. You know, I need a lot more
15 experience, so I would like to witness you,
16 Dr. Jordan, and then maybe next time after
17 you.
18 DR. BURKE: Yeah. I'm trying to
19 learn from Dr. Richerson myself so...
20 CHAIR RICHERSON: So was that a
21 yes, Jordan?
22 DR. BURKE: I can give it a try. I
23 feel like I'm fairly high-functioning and
24 attentive, so I can give it a go but...
25 CHAIR RICHERSON: Well, it's nice

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1 because the minutes are all transcribed so
2 just -- that's where all the content comes
3 from so...
4 MS. FIGUEROA: That's right.
5 CHAIR RICHERSON: Fantastic. Okay.
6 And we are at 2:59. Any other business?
7 MS. FIGUEROA: New business. One
8 issue that I would like to -- for us to
9 consider is a discussion about the juvenile
10 justice system and access to behavioral
11 health treatment and support, health care in
12 general for minority youth.
13 They are overrepresented in the juvenile
14 justice system, and there are so many issues
15 and -- there is a current bill, HB 3 with
16 sweeping changes to the -- our juvenile
17 justice system.
18 But as much as this is a safety issue,
19 it is essentially a health issue as well.
20 And I wonder if this will be a good area for
21 us to consider exploring: What are the
22 barriers to effective care? What can we do
23 about it? If there any statistics that can
24 point to what our health system needs are in
25 order to address the problems that we are

1 having. So I just want to put it out there.
2 There is --
3 MS. HOFFMANN: I can give you a
4 short amount of information. This is not
5 necessarily specific to racial and health
6 equity, but it's all juveniles. There's two
7 bills out there. One, for us to provide
8 services or Medicaid to children that are in
9 confinement or institutional type of
10 settings. And then there's one that's a
11 little bit less, like maybe just for
12 substance use services. I'll have to take a
13 look at that.
14 If you all have heard me speak before,
15 we've got an incarceration amendment sitting
16 at CMS that we're hoping will be approved
17 soon, and that is to provide substance use
18 services to people that are incarcerated.
19 MS. FIGUEROA: Yes.
20 MS. HOFFMANN: But right after we
21 submitted that, we immediately started
22 working with the DJJ, juvenile justice
23 system, to see what we could do on the
24 confinement side. But we did slow down
25 because CMS hung the incarceration amendment

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1 up for quite some time.
2 But I do want to let you know that we
3 are looking at -- in general, trying to take
4 a look at juvenile justice and what Medicaid
5 can do to try to help that department with
6 those members that are in confinement.
7 So we've got a couple of things. We've
8 got a mental health institute in Louisville
9 that's coming up that's kind of -- that's one
10 of the focuses. That's not until May. I
11 just wanted to tell you that if you're
12 interested in it.
13 There's an omnibus act that's out there
14 right now in the federal world that says that
15 they -- the Federal Government wants us to
16 cover juvenile justice and confinement by
17 2025, I believe. But we're going ahead and
18 taking a look at that now.
19 As well as -- we've got an MST pilot
20 that's going on right now, where Medicaid
21 partnered with all of our sister agencies to
22 provide a multisystemic therapy three-year
23 pilot. I've got three providers in the
24 three-year pilot. We are having an
25 independent evaluator to take a look at it

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1 and see if we can sustain it.
2 But it's children that are in Medicaid
3 from age 10 to 17, and it is an intensive
4 therapy to provide to the child to keep them
5 out of any type of juvenile justice system
6 and to keep their placements within home.
7 So we've got tons of things going on
8 right now. Could I address one specific area
9 right now? No. But just wanted to let you
10 know that there are many bills and federal
11 initiatives that are driving what we started
12 about two years ago but slowed down because
13 CMS was unable to move forward on any
14 approvals to cover those services at that
15 time.
16 But I've just recently met with CMS --
17 and I'll quit talking here in just a second.
18 We've recently met with CMS and 12 other
19 states that have those same, similar types of
20 amendments in with them. They have over 50
21 1115s to get through, and they have 12 that
22 are specific to incarceration.
23 I believe we're first in line. So they
24 didn't tell me that on the call the other
25 day, but I'm pretty sure that we were the

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1 first that submitted that amendment.
2 So I can tell you more very soon. I've
3 asked for a one-off with CMS to talk specific
4 to Kentucky but want to make those changes.
5 I just wanted you to know that's something we
6 want to do.
7 CHAIR RICHERSON: Great.
8 MS. FIGUEROA: Thank you for that.
9 CHAIR RICHERSON: Okay. Is there a
10 motion to adjourn?
11 MS. FIGUEROA: Motion.
12 CHAIR RICHERSON: Any opposed?
13 (No response.)
14 CHAIR RICHERSON: So we'll adjourn
15 by acclamation. Thank you all so much for
16 the conversations.
17 DR. BAUTISTA-CERVERA: Thank you.
18 DR. BURKE: Thank you.
19 (Meeting concluded at 3:06 p.m.)
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1 * * * * * * * * * * *

2 C E R T I F I C A T E

3

4 I, SHANA SPENCER, Certified

5 Realtime Reporter and Registered Professional

6 Reporter, do hereby certify that the foregoing

7 typewritten pages are a true and accurate transcript

8 of the proceedings to the best of my ability.

9

10 I further certify that I am not employed

11 by, related to, nor of counsel for any of the parties

12 herein, nor otherwise interested in the outcome of

13 this action.

14

15 Dated this 15th day of March, 2023.

16

17

18 *\/s/ Shana W. Spencer*

19 Shana Spencer, RPR, CRR

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