TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Disparity TAC/Department Updates

Department for Medicaid Services
Division of Quality and Population Health
07/16/2025

Old Business

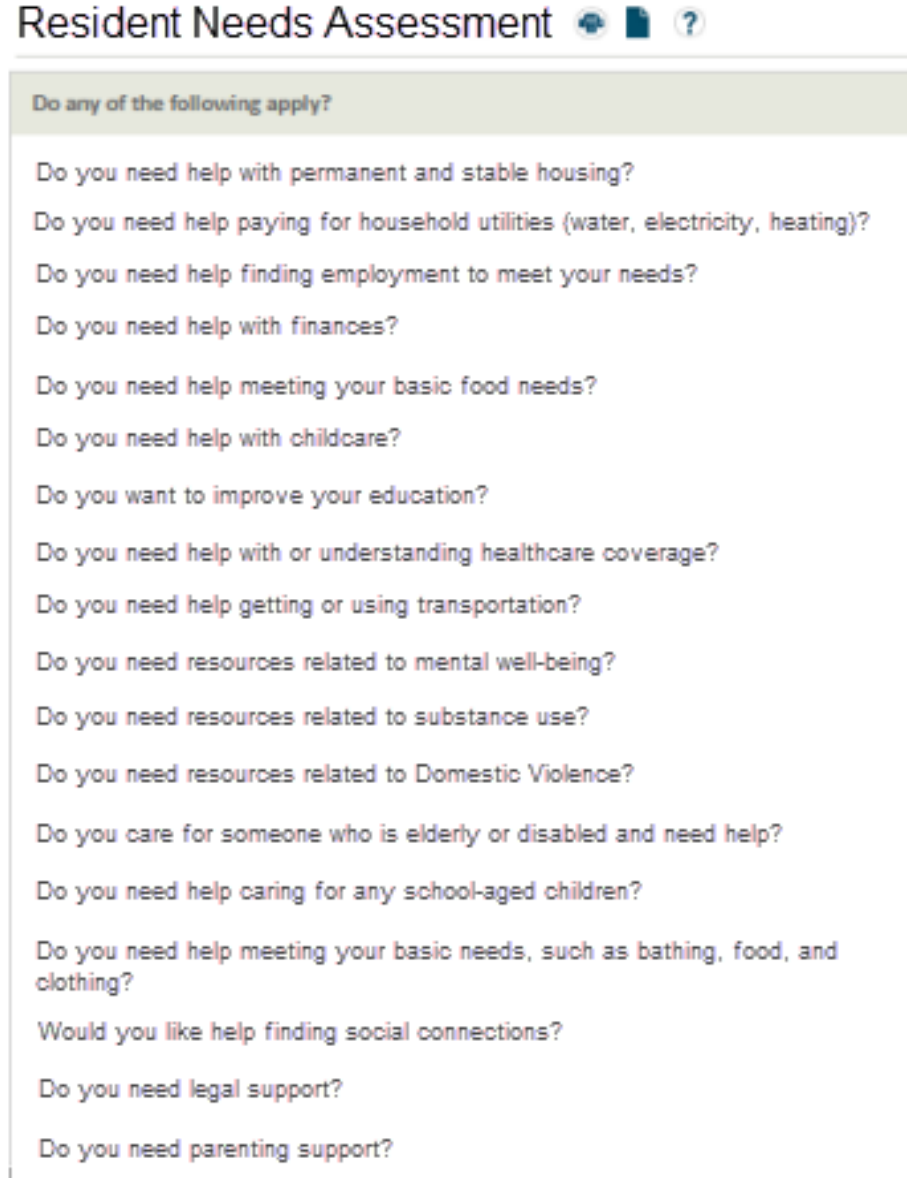
Department for Medicaid Services (DMS) Updates:

- Transportation/Social Determinants of Health (SDoH) Assessment
- Demographic data (race and ethnicity) reporting and equity
- Community Health Workers (CHWs)
- Interpreter Medicaid Access Flier

SDoH Needs Assessment

- On Worker Portal (DCBS eligibility system) for application, renewal, and case change
- On the Self-Service Portal (www.kynect.ky.gov)
- Through kynect resources directly (www.kynect.ky.gov/resources)
- On paper Medicaid applications
- On the paper renewal documents

Would you like to take a needs assessment to connect you with local community support resources/services/programs, such as housing, utility, or transportation assistance?



1. Which best describes your housing situation?

a. CRITICAL I do not have stable housing
b. CRITICAL I am temporarily living with a friend or family member
c. CRITICAL I am currently not paying my rent/mortgage and in danger of eviction
d. IMPORTANT I am paying my rent/mortgage, but it is unaffordable (over 30% of income)
e. IMPORTANT I am currently utilizing a rent/mortgage assistance program
f. STABLE I pay my rent/mortgage without difficulty

The kynect resources Needs Assessment: KY Medicaid Application

Commonwealth of Kentucky
Cabinet for Health & Family Services
Department for Community Based Services

kynect Resources Needs Assessment

The following is an additional resource needs assessment that is **voluntary** and does not impact your Medicaid benefits. This assessment helps us to identify and understand other needs you and your household may have that can impact your health and connect you with community resources/services/programs that may be helpful, such as transportation, utilities, food, childcare, etc. You may review your results by logging into your kynect account at https://kynect.ky.gov/resources or by calling 2-1-1 to be referred to community resources/services/programs.

Any additional household members may complete their own individual needs assessment by logging onto their kynect account online at https://kynect.ky.gov/resources or by calling 2-1-1.

Circle the letter that best describes your situation:

1. **Which best describes your housing situation?**
   a. I do not have stable housing.
   b. I am temporarily living with a friend or family member.
   c. I am currently not paying my rent/mortgage and in danger of eviction.
   d. I am paying my rent/mortgage, but it is unaffordable (over 30% of income).

15 Languages!

Medicaid Application (English)

Solicitud de Medicaid (Español/Spanish)

Demande pour bénéficier de Medicaid (français/French)

Ubusabe muri Medicaid (Ikinyarwanda/Kinyarwanda)

Medicaid Application（医疗补助申请/Mandarin)

मेडिकेड आवेदन (नेपाली/Nepali)

Ombi la Medicaid (Kiswahili/Swahili)

Заява на участь у Medicaid (українська/Ukrainian)

ng ký Medicaid (Tiếng Việt/Vietnamese)

5

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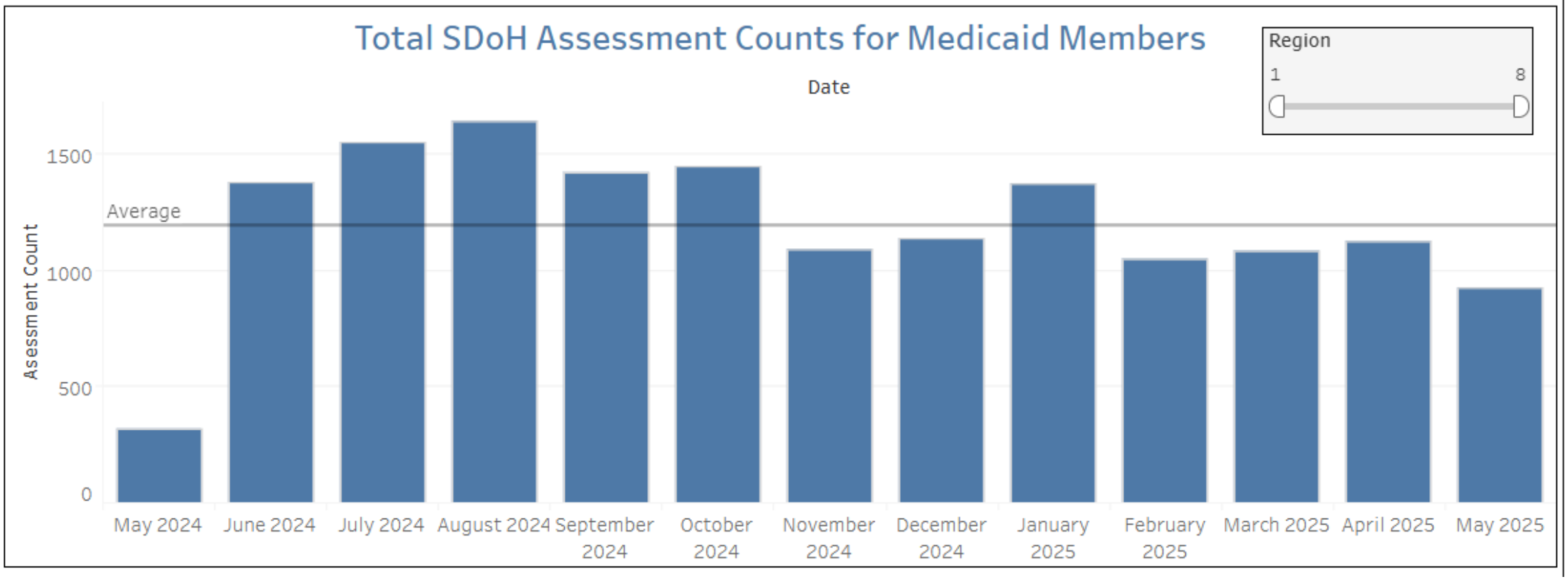
DQPH SDoH Medicaid Data Dashboard



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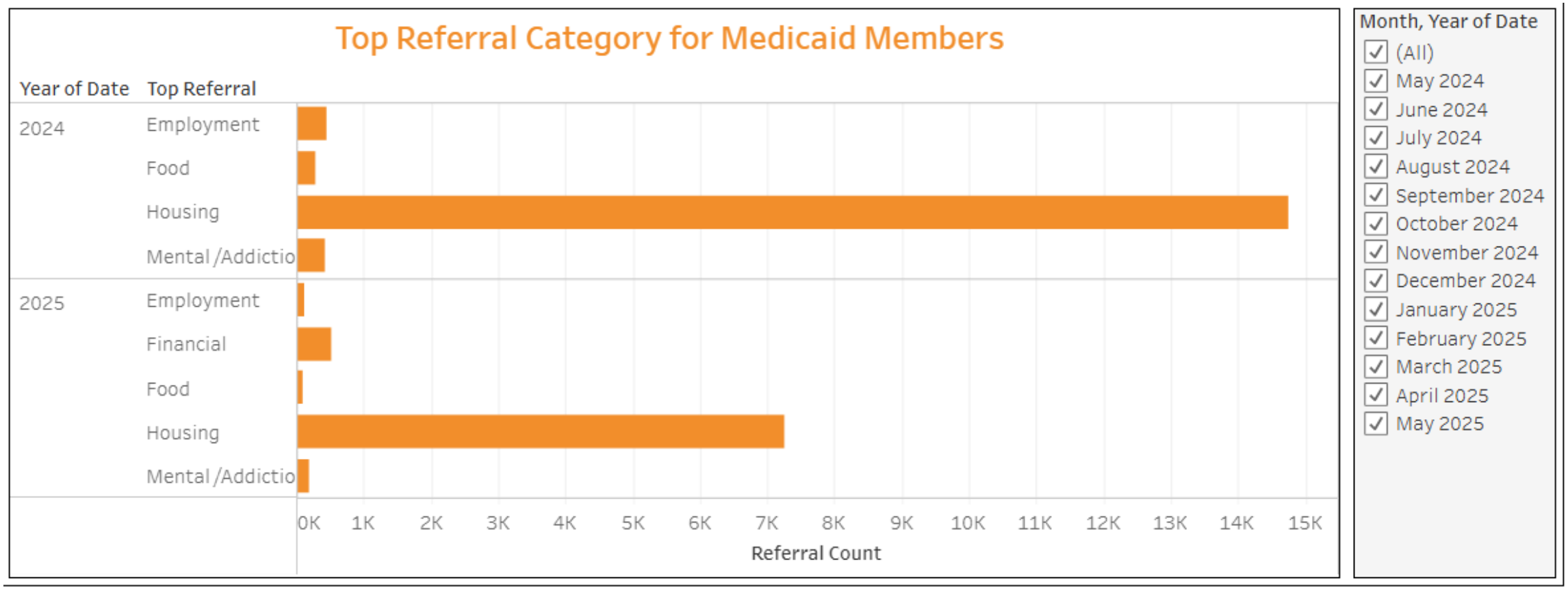
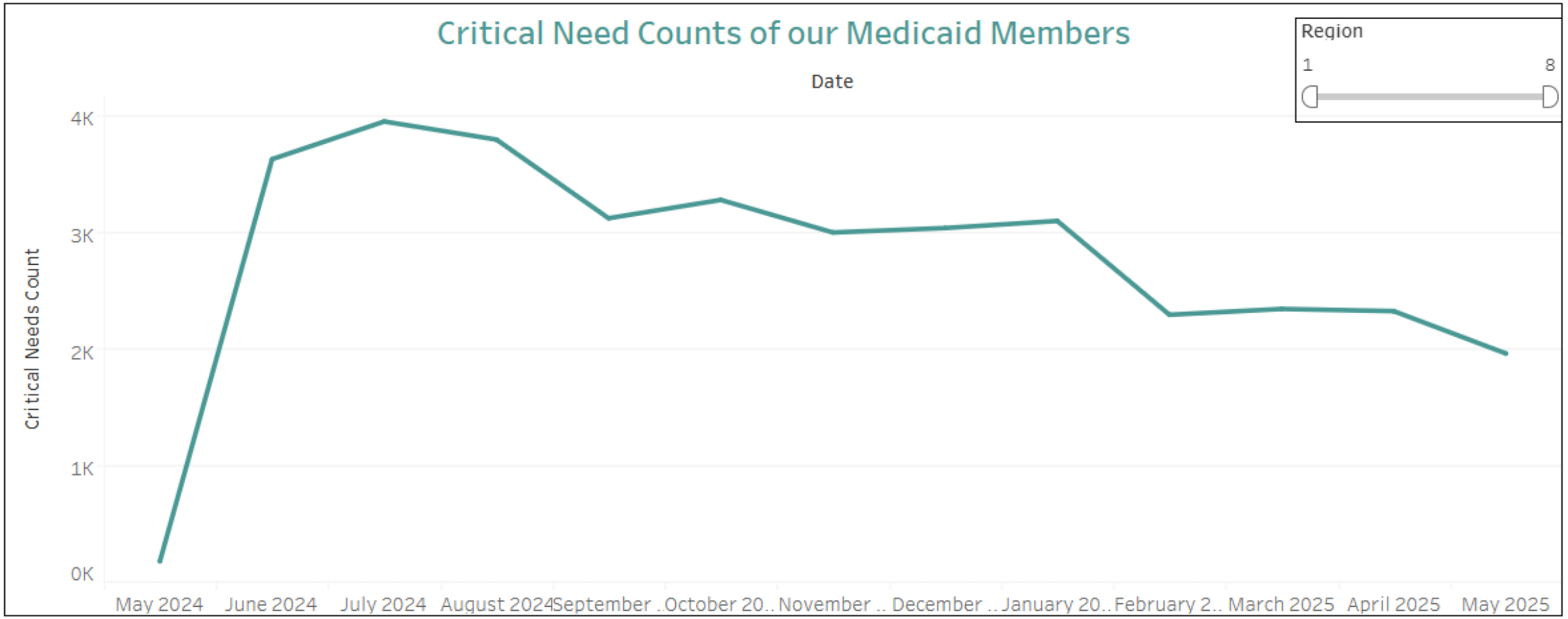

Top Referral Category for Medicaid Members
Year of Date
Top Referral
2024
Employment
Food
Housing
Mental /Addictio
2025
Employment
Financial
Food
Housing
Mental /Addictio
0K
1K
2K
3K
4K
5K
6K
7K
8K
9K
10K
11K
12K
13K
14K
15K
Referral Count
Month, Year of Date
(All)
May 2024
June 2024
July 2024
August 2024
September 2024
October 2024
November 2024
December 2024
January 2025
February 2025
March 2025
April 2025
May 2025



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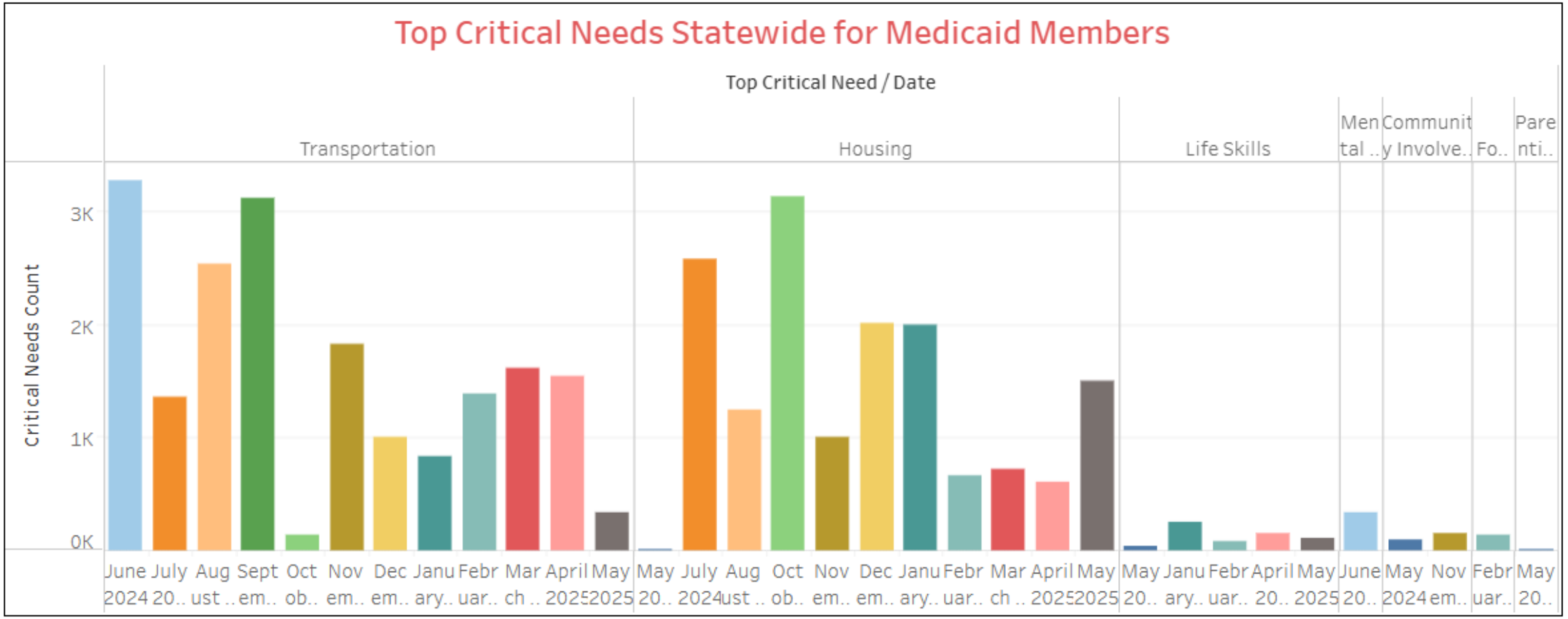
Top Critical Needs Statewide for Medicaid Members



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SDoH Dashboard Enhancements

- In Progress: Addition of Demographic Details of Race, Ethnicity, Ethnicity Type, Nationality, Gender, Age, Primary Spoken Language
- In Progress: Addition of Identified Critical Need vs. Important Need
- In Progress: Addition of Homelessness Indicator
- Next Steps: Partner with the Office of Data Analytics for creation of a Citizen Facing Dashboard for community partners

Demographic Data Reporting

- Monthly Reports for member demographics to be applied to the SDoH Dashboard
- Quarterly Medicaid Enrollment Demographic Report- To be utilized to assess the demographic data received for SDoH to compare if representative of population or any disparities

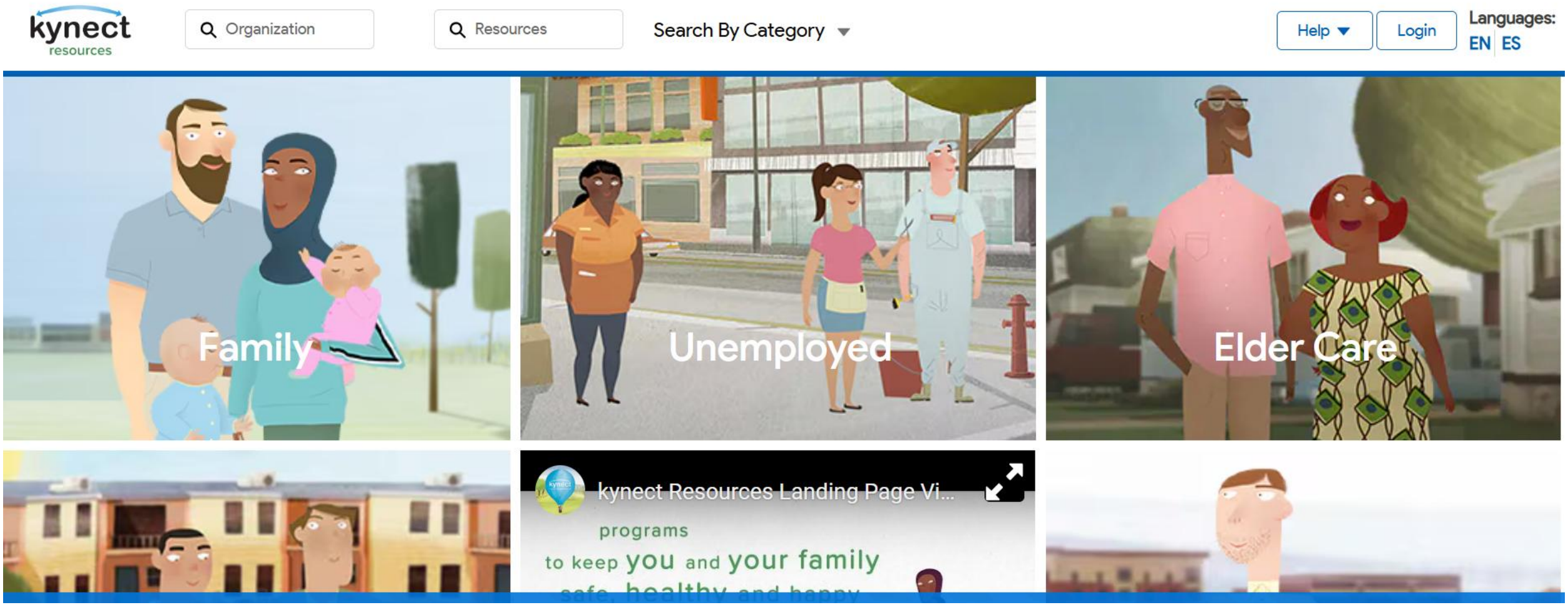
Metric C: Total Number by Race and Ethnicity	
Race	**Count of Individuals**
White	1,138,660
Black or African American	210,222
Unknown	105,615
Asian	19,828
American Indian or Alaskan Native	2,386
Native Hawaiian or Other Pacific Islander	1,799
No Response	5
TOTAL	**1,478,515**

Ethnicity	**Count of Individuals**
Non-Hispanic or Non-Latino	1,303,961
Hispanic or Latino	101,822
Unknown	72,732
TOTAL	**1,478,515**

NOTE: Metric C is an unduplicated count for both Race and Ethnicity.

Transportation Access

- Issue: SDoH Dashboard Identified inconsistency of high level of need for transportation but low utilization of referrals for services.
- Solution: DMS to leverage contract with the Department of Transportation to have all 16 Regional Transportation Brokers onboard to the kynect resources platform for better knowledge of NEMT services to members and easier, streamlined process to access.
- Status: System enhancements are being conducted on kynect resources that would impact project, once implemented we will meet with Transportation to discuss next steps.



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Transportation

Search By Category

Help

Login

Lang
EN

Displaying 30 results

GoKY

Transportation Information Clearinghouses/511 Services

3.6 Miles

Connect

Kentucky Transportation Cabinet

Emergency Road Service

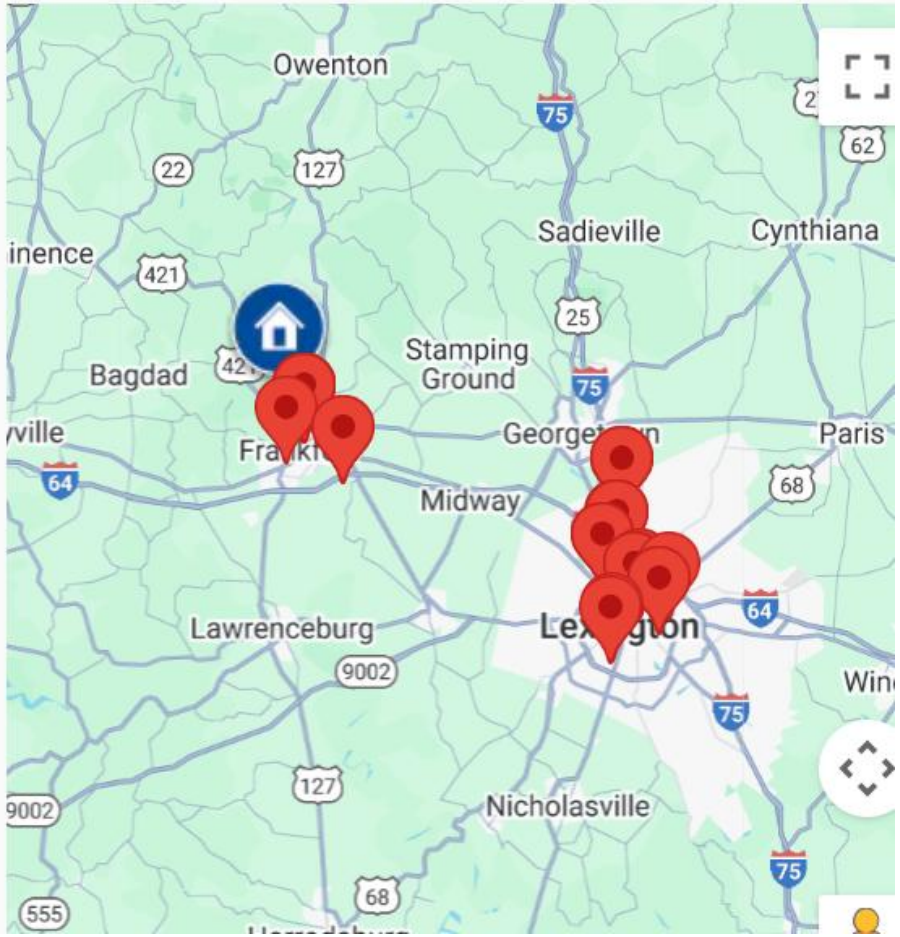
3.6 Miles

Connect

KENTUCKY TRANSPORTATION CABINET

SAFETY ASSISTANCE FOR FREEWAY

Connect



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Kentucky Transportation Cabinet

Emergency Road Service

3.6 Miles

Connect

Safety Assistance for Freeway Emergencies (SAFE) Patrol sponsored by State Farm is a free roadside assistance program to assist stranded motorists and improve highway safety when the unexpected occurs on major Kentucky interstates, parkways and prominent roadways.

Share

https://transportation.ky.gov/Pages/Home.aspx

200 Mero Street, Frankfort, Kentucky 40601

Emergency Road Service

3.6 Miles

Connect

Safety Assistance for Freeway Emergencies (SAFE) Patrol sponsored by State Farm is a free roadside assistance program to assist stranded motorists and improve highway safety when the unexpected occurs on major Kentucky interstates, parkways and prominent roadways.

https://transportation.ky.gov/Pag...

200 Mero Street

Hours

Mon -

Tue -

Wed -

Thu -

Fri -

Sat -

Sun -

Notes

Monday through Sunday 6:00 am to 10:00 pm

Qualifications

Location Instructions

Qualifications

Fees

Qualifications

Benefiting

Income Eligibility

Location Instructions

Next steps

For motorists traveling on Interstates: I-24, I-64, I-65, I-71, I-75, I-264, I-265, I-165, US 23, KY 80 Parkways: Louie B Nunn, Wendell H Ford, Western Kentucky, Edward T Breathitt, Audubon, Bert T Combs Mountain, Hal Rogers, Martha L Collins Bluegrass, Julian Carroll Purchase

What to Bring

Transportation Instructions

Parking Instructions

Special Location Instructions

Languages

Share

Frequently Paired Together

Office of Vocational R...
Vocational Rehabili...
3.4 Miles
Connect

Office of Vocational R...
Supported Employ...
3.4 Miles
Connect

KENTUCKY DEPART...
KENTUCKY WORK...
16.5 Miles
Connect

Related Services

Kentucky Transportati...
Emergency Road S...
3.6 Miles
Connect

KENTUCKY TRANSP...
SAFETY ASSISTAN...
3.6 Miles
Connect

KENTUCKY TRANSP...
TRIMARC FREEWA...
3.6 Miles
Connect

Medicaid Interpreter Access Flyer

Resource guide for Medicaid providers on how to access interpreter services offered by the Managed Care Organizations (MCO)s.

DMS and partners are currently developing a resource guide for how members can quickly access interpreter services.

January 2025

Better Communication, Better Care

Helping Medicaid Providers Connect with Language Services

The Kentucky Department for Medicaid Services is committed to ensuring language access services are available for members.This includes connecting providers with language access and interpreting services.

Languages other than English.

Deaf or Hard of Hearing.

Visually Impaired individuals.

When possible, language needs should be determined prior to a medical appointment to ensure appropriate arrangements have been made to accommodate the patient's needs.

How the process works...

MCOs have interpreters available for their provider and member call centers, including services for deaf individuals. They also connect providers at the office level with interpreters for their members. In-person translation services are preferred and should be provided whenever possible.

1

When scheduling an appointment...

Determine if patient has a language access need.

2

Language Need Identified

Identify the patient's MCO and determine next steps.

3

Assess MCO Policy

Contact MCO to make a request.

4

Provider Contacts MCO

Confirm services with MCO.

AETNA	HUMANA	PASSPORT BY MOLINA	UNITED HEALTHCARE	WELLCARE
1-855-300-5528	877-320-2233	800-578-0775	866-293-1796	InterpreterRequests@wellcare.com 877-389-9457

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To ensure that interpreting needs can be met, kindly submit requests at least five business days before an appointment.

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Community Health Worker Utilization Quality Focus Study

Study Aim

To quantify access to CHW services among the Kentucky MMC enrollee population and to identify disparities and opportunities for improvement.

Background

The Kentucky Medicaid community health worker (CHW) program requirements for CHW services and reimbursement are governed by 907 KAR 3:310 (Kentucky General Assembly, 2025). Section 6 of 907 KAR 3:310 states, “Reimbursement for community health workers services shall be via appropriate codes that comply with relevant existing rate methodologies utilized by the department” and specifically references the Medicaid Physician Fee Schedule (Kentucky CHFS, 2025). CHWs may be directly employed by a Medicaid managed care organization (MCO; Kentucky CHFS, 2024a). MCOs will also reimburse providers for CHWs, as determined by the provider’s contract with the MCO (Kentucky CHFS, 2024a). The providers who may order CHW services include physicians, physician assistants, nurse practitioners, certified nurse midwives, dentists, optometrists, or “any other clinician type included by the department” (Kentucky General Assembly, 2025; Kentucky DPH, 2025).

Part I: MCO-employed CHW Services

Objective #1 – MCO-employed CHW Services: Profile Kentucky MMC enrollee receipt of MCO-employed CHW services, including health system navigation and resource coordination health education, promotion, and coaching for preventive care; facilitation of a care plan intervention; and SDoH referral and follow-up.

The measurement period begins January 1, 2025, to include only those managed care plans with serving Kentucky MMC enrollees starting January 1, 2025.

Eligible population: All MCO enrollees in each MCO care management information system.

Measurement period: 1/1/25–6/30/25.

Revised the study measurement period to include only those MCOs active during 2025

Part II: Provider-Billed CHW Services

Objective #2 – Provider-billed CHW Services: Profile Kentucky MMC enrollee claims for CHW services billed by providers, by provider type.

Eligible population: All MCO enrollees with claims for the provider types that may bill for CHW services.

Measurement period: 1/1/25–6/30/25.

Updates

- Racial Equity Core Team
- Medicaid Innovation Collaborative
- Division of Quality and Population Health (DQPH) updates – new projects

Racial Equity Core Team Updates

R.E.C.T Meetings:

- Medical Director, Dr. Theriot presented on disparities experienced within certain populations (ex: maternal health morbidity and systemic racism in school aged children.)
- Featured video clips targeting unique barriers faced by individuals with the goal to promote engagement and new approaches to addressing disparities (autism in school aged children; the effects of addiction).
- A DMS division is highlighted each month to present their work as it relates to identifying and addressing barriers to care.
- Continued encouragement of G.A.R.E. Tool utilization (Government Alliance on Race and Equity) – a form and process used to integrate equity into decision making when implementing changes to policies, practices, programs, and budgets.
- Most recent meetings, DMS started researching and evaluating required and optional equity related provider trainings held by the MCOs.

Population Opportunity Planning & Evaluating

Purpose: The Cabinet for Health & Family Services (CHFS) is committed to becoming an organization promoting optimal health and wellness for all. Realizing this ambitious goal will involve a concentrated effort on both internal development and external aspects of development. Our strategies will continuously evolve as we strive for operational excellence. The document detailing our goals, objectives, accountability measures, and progress should continually evolve as we identify opportunities for growth and success. Aligning program and service goals to the CHFS pillars and strategic plan ensures integrated service delivery that maintains quality and accountability to our partners.

CHFS Visionary Goals

1. G.A.R.E Racial Equity Tool will be utilized and reported by 100% of branches by 06/30/2026.
2. DMS will enhance hiring practices, addressing both racial and intersection identities by 06/30/2026
3. DMS will implement strategies to ensure diversity in procurement and resource allocation (i.e., small business owners, women-owned, rural vendors) by 06/30/2026.

Population Opportunity Planning & Evaluating

In response: DQPH proactively embedded the G.A.R.E Tool into the division standard operating procedure to be used by all DQPH staff when implementing new projects.

Enterprise Visionary Goal #1: The G.A.R.E Racial Equity Tool will be utilized and reported by 100% of branches by 06/30/2026.

Objective (High-level goal)	Domain/Indicator	KPI (How will you measure progress?)	Target Date (s)	Responsible	Status
Strategic Goal (mid-to long-term) **Training will take place for team leads on how to use the G.A.R.E. racial equity tool.**	Leadership Commitment Training & Education	All racial equity team leads are trained to use the tool.	06/30/2026	All Divisions of DMS	Ongoing
Specific Action Steps: Training all staff to ensure understanding and proper utilization of the tool.					
Tactical Goal (short to mid-term) **Identify an area of operations within each branch to utilize the racial equity tool in a decision-making process.**	Monitoring & Evaluation Strategy Development & Goal Setting	All branches will identify an area where they will apply the use of the racial equity tool.	06/30/2026	All Divisions of DMS	Ongoing
Specific Action Steps: The G.A.R.E tool will be used at the beginning of each project/initiative and reviewed throughout the project/initiative until completed.					
Additional short-to mid-term goals **Branches will report the use of the racial equity tool to the team leads and division leadership.**	Leadership Commitment	All branches provide a completed racial equity tool to team leads and division leadership.	06/30/2026	All Divisions of DMS	Ongoing
Specific Action Steps: Usage of the racial equity tool needs to be implemented and documented within the Divisions and the Department.					

Medicaid Innovation Collaborative

2024-2025 Pilot Project July 2025

Supported by the Center for Health Care Strategy

Food as Medicine Pilot #1

- **Attane Health and Anthem Pilot- April 2024-September 2024**
  - 66 members in Louisville with a diagnosis of Diabetes were provided $145 in grocery credit to purchase items on Attane's platform. The 1500 items available, included produce, pantry, spices, and storage containers.
  - Monthly Nutrition Coaching was optional and included supporting members in making improvements in care, behavioral changes, and surveys (pre/post program).
- **<u>Outcomes:</u>**
  - 70% reported **increased fruit and vegetable consumption**;
  - 74% reported **trying new foods**;
  - 37% reported **eating fewer unhealthy foods**;
  - 37% **cooked more at home** than prior to the program.
  - 52% reported that their **health improved** during the pilot;
  - 90% who participated in coaching reported that it **improved their nutrition knowledge and the management of their health**.
  - **Lower rate of poor A1c control**, at a statistically significant level, for pilot members (39.5%) versus the control group (47.3%).

Food as Medicine Pilot #2

- **FarmboxRx and Passport Pilot- June 2024 - Nov 2024**
  - 165 members in Louisville with a diagnosis of Diabetes and poor A1C. Each participant received 6 boxes (3 Pantry & 3 Produce) delivered to their home. In 2025, this pilot was expanded to an additional 200 members.
  - The boxes contained health education materials covering a variety of topics. Topics included Diabetes Eye Exams, Continuous Glucose Monitors, recipes, and more.
  - Dare to Care Food Bank and Play Cousins Collective supported 8 in-person events for participants. Events included health education, healthy cooking demos, and group exercise. Plus, attendees received supporting tools, such as food journal and veggie peeler.
  - MCO care management staff and FarmboxRx provided telephonic support and reminders. Participants were also offered transportation assistance to in person events.
- **Outcomes:**
  - 77% reported improvement in blood sugar since beginning program;
  - 91% reported improved access to healthy food through the program;
  - 93% felt more confident in managing their blood sugar; and
  - 88% reported a positive influence on their eating habits and healthy meal prep skills.

Housing Pilot #3

- **Samaritan and Aetna/Humana- 6/2024-6/2025**
  - 157 Members in the Louisville area who have unsecure housing. Participants referred through community-based organization. Platform provides incentivized engagement. This includes health appointments, inquiring about resources for food, housing, transportation, harm reduction supplies, and pharmacy access.
  - Supports include assistance with scheduling doctor appointments, transportation for various needs including pharmacy, connections to resources, harm reduction supplies, food, and more.

- **<u>Outcomes:</u>**
  - Average of 90% were engaged with program. 93% of case management goals completed.
  - Plans reporting needing more time to determine outcomes related to participants and the return on the invest for health outcomes.
  - Member story #1- Mother of 3 which completed 11 action steps. She reported it increased her ability to budget income and will help her reach goal of financially stable. She received resources to assist with mortgage payment.

Housing Pilot Member Story #2

Success Story: Overcoming Housing Insecurity

Challenge

42 yr old male with an immediate need for housing, financial stability, and health support

Story:

Initial Contact:

- Location: Member's aunt's house, member's residence at time of interaction
- Actions: CHW enrolled in Samaritan Pilot Program. Together, they set goals focused on finding housing and maintaining his doctor appointments. Each month, the member reviewed resources and completed goals. The CHW also shared his story on the platform to garner additional support.

Ongoing Support:

- Actions: The CHW provided a list of low-income housing options, supported the member in following up with landlords, assisted in securing a landlord who accepted the Section 8 voucher, ensured inspections were completed, facilitated furniture donations, and helped the member participate in a goodwill program for a furniture voucher.

Impact

- Member Gratitude: Expressed appreciation for the Samaritan Program and CHW resources.
- Stable Housing: Successfully moved into stable housing.
- Ongoing Support: Continues to participate in case management services.

Highlighting the power of collaboration and community support.

17

MIC Pilot Final Reports

- The Center for Health Care Strategies which supports the MIC pilot projects has released case studies for the two Food as Medicine Pilots:
    1. Partnering to Provide Digital-Driven Nutrition Services: Attane Health and Anthem Blue Cross Blue Shield - Center for Health Care Strategies
    2. Improving Diabetes Outcomes Through Home-Delivered Healthy Foods and Education: FarmboxRx and Molina Healthcare - Center for Health Care Strategies

- A report will be released in the fall for the Housing pilot.

DQPH Updates – Equity Projects

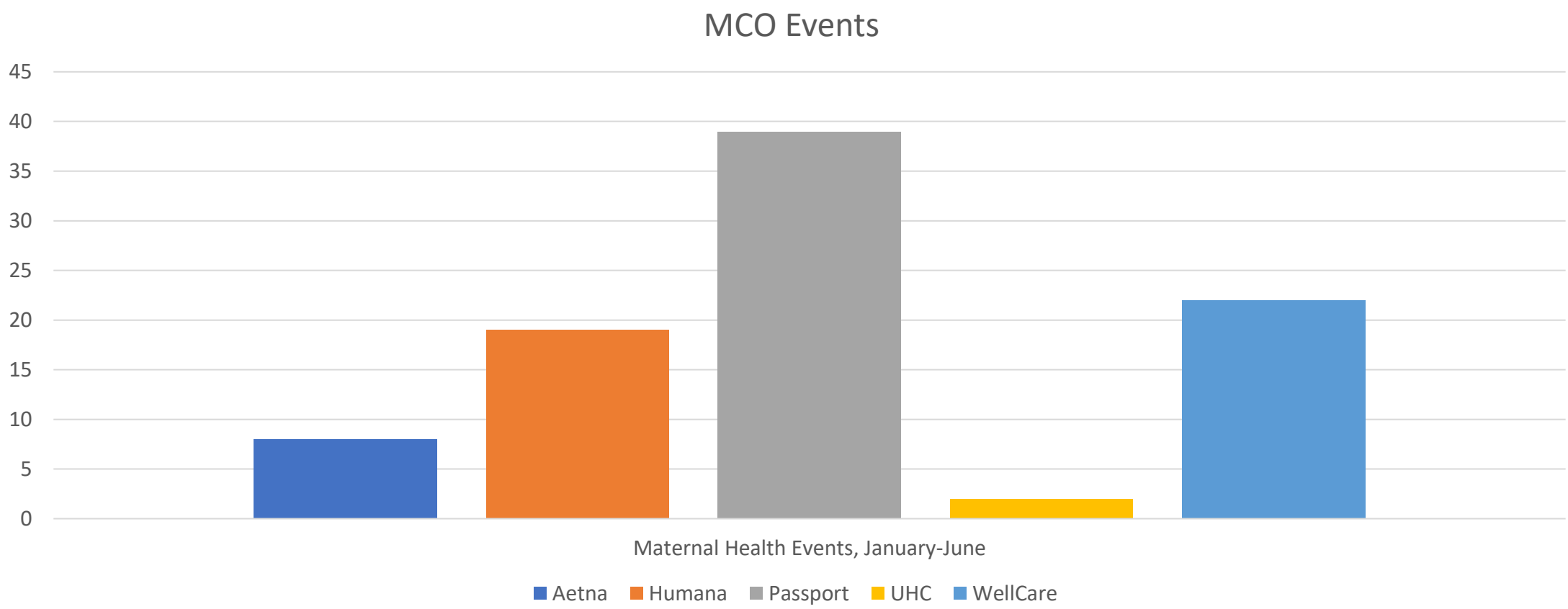
MCO Community Events: monitoring and analyzing of MCO held community events.

- Analysis of the number and content of MCO events targeting SDoHs.
- Identification of opportunities for DMS to engage with event attendees.

Maternal Health Community Events: DMS will review and highlight community events related to prenatal, postnatal, and early childhood care as part of the activities for the MCO Community Events project.

- 95 maternal health events from January to June across all 5 MCOs, featuring 67 baby showers
- Other events held include Self Care Training for Parents (Aetna), Maternity Baby and Kids Expo (Humana), Black Maternal and Infant Health Symposium (Passport by Molina), Dollars for Diapers Drive (United Healthcare), and Fun Fair for New and Expectant Parents (Wellcare).

Analysis of MCO Held Community Events



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Value Added Benefits

Value Added Benefits (VABs) : extra services offered by the MCO plans which are not part of the State Medicaid Plan (ex: gift cards for well-check visits, resources for general education development (GED) coaching and testing support, housing/utilities assistance).

Intent is to improve the overall utilization of offered VABs:

- VAB utilization was <1% for 2024, there has been a slight increase in 2025, but overall numbers are still low
- Analysis includes a review of the reward redemption process and discussions aimed to simplify redemption requirements.
- Identification of trends in utilization and held events or other outreach efforts.
- MCOs are currently working towards onboarding to the KYNECT Resources website.

Opt-in Text Messaging

Opt-in Text Messaging – Medicaid application to be updated to allow applicants to opt-in to receiving text messages from their assigned MCO upon approval of Medicaid benefits.

- Limit delays and barriers related to communicating case management, benefits, and resource opportunities to Medicaid recipients.
- Improve VAB utilization with a goal of 1-2%
- Increase case management enrollment and activities for top chronic conditions as determined by DMS.
  - Hypertension
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Asthma
  - Cancer
  - Diabetes

Kentucky's 1915(i) State Plan Amendment- The RISE Initiative

- RISE stands for recovery, independence, support, and engagement.
- The 1915(i) RISE initiative provides services to adults with a primary diagnosis of serious mental illness (SMI) or co-occurring SMI with addiction.
- The 1915(i) RISE initiative is administered jointly by DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID)

TEAMKY 1115 Recovery Residence Support Services Demonstration

Authorizes Medicaid reimbursement for non-clinical support services that help individuals with Substance Use Disorder (SUD) stabilize in community-based recovery residences. These services promote independent living, sustained recovery, and system reentry.

TEAMKY 1115 Health Related Social Needs Recuperative Care Pilot Program

Authorizes Medicaid reimbursement for short-term, clinically appropriate housing and support services, also known as medical respite, for adults experiencing or at risk of homelessness who need recovery support following hospitalization or a planned medical procedure.

Thank you!