DEPARTMENT OF MEDICAID SERVICES
PRIMARY CARE TECHNICAL ADVISORY COMMITTEE

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10:00 a.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Stephanie Moore, Chair
Dennis Fouch
Barry Martin
Michael Hill (not present)
Brandon Hurley (not present)

MS. BICKERS: Good afternoon. This is Erin with the Department of Medicaid. It is not quite 10 o'clock, and the waiting room is clearing out, so we will give it just a moment before we get started.

Okay. Good morning. Can everyone hear me?

MS. MOORE: Yes, thank you.

MS. BICKERS: Okay. Quiet bunch this morning. It is 10 o'clock and the waiting room is cleared.

Stephanie, I saw you, Barry, and Dennis log in, did I miss any other board members? I know we have a few members joining today and I want to make sure I didn't miss anybody when they were logging in.

MS. MOORE: I don't believe that I saw Brandon Hurley who is a new member of the TAC, and then we have one position. We are working to add a physician member to the TAC and we have one physician who is considering that invitation and will hopefully get back to me soon on that.

MS. BICKERS: Okay, great. I can keep an eye out. I also don't see where Brandon has logged in, but I can keep an eye out for you.

MS. MOORE: Okay. So with three of us, Erin, would that establish the quorum?

MS. BICKERS: Yes, because there is three of the five. Sorry about that. I was counting.

MS. MOORE: Thank you very much. With the quorum established, Barry, Dennis, do either of you have a motion to approve the minutes from the prior meeting?

MR. MARTIN: I will make a motion to approve the minutes.

MS. MOORE: Thanks, Barry. Is there a second?

MR. FOUCH: I'll second.

MS. MOORE: All right. Since there are three of us, I agree, so that motion will pass.

So moving on to old business, updates on the PHE/wind-down

redetermination. Is there someone from DMS who could provide that update for us today?

MS. CECIL: Good morning.

MS. MOORE: Hi.

MS. CECIL: This is Veronica Judy Cecil, Senior Deputy Commissioner for Medicaid. Nice to see everyone this morning. I've gpt a short presentation. Let me get this started and shared. I won't take too much of everyone's time. Let's see here.

Okay. So, and if you attended our stakeholder meeting this may look a little familiar because I'm just, sort of, recycling. Nothing has changed since last week. But if you haven't, hopefully this is providing you with some great information about where we are right now with unwinding. Just a reminder that we are maintaining some flexibilities during the unwinding and restart of renewals. They are really mostly focused on helping us handle the workload because, you know, having not done a renewal in three years

and restarting that causes a great deal of additional work or increased work on our eligibility workers.

So a couple things that we have done and wanted to highlight that I think are most effective that help our members is: 1) if you're a long-term care 1915(c) waiver member, you can have your renewal due date extended up to three months. The reason for this is because their renewals typically take -- they are a little more complex and take a little more time to gather information and, so if the member hasn't responded to the notice that we sent them, they can take up to three months to submit that back to us.

And then for the rest of the population of Medicaid, we are giving them a one-month extension. So if they haven't filed -- haven't submitted the response to the notice -- the renewal notice -- then they can, by the time they're due date comes, we can extend for an additional month.

And then, just a reminder, if it

is a child, we did automatically extend that child's reneal for 12 months ,so, you know, we really wanted to keep our kids covered and, what we see is they generally come on and off because of a renewal, but they always are typically eligible. So we had high, high eligibility rate, renewal rate, with our child renewal, so we did that.

And then in December, to help our workforce, we did redistribute active renewals. By that, I mean if we weren't able to go out and automatically renew the individual based on our trusted data source, we wanted to keep from having them to take an active approach to their renewal, and that means that our workers wouldn't have to process that case, so we then redistributed them for the rest of the unwinding period. So if you are really interested in all -- what all of the flexibilities are, we do have a tracker on the unwinding website.

The other thing to note, because I couldn't recall if we had talked about

this in our last meeting, CMS, it did notify states that the flexibilities they've approved are actually eligible to extend to December 31st, 2024, which I think is just great news, because one of the things I think CMS and states have realized, is that some of our flexibilities are common sense things that we should maybe do permanently, so they are thinking about those things in how to implement them on a permanent level. Not all of them, they are taking the time to review each and think is this something that we want to implement permanently.

How that affects Kentucky, we are still evaluating because there is still a lot of detail to that that we need to get in with CMS to make sure that we are following their respected guidance. They were really broad in announcing this so we are still working on that and we will keep folks updated on what that looks like going forward.

Just to note that our 1915(c) home and community-based waivers

flexibilities are a bit different and we have been tracking those a little bit separately, but all of that information is also on the unwinding website. There have been separate stakeholder meetings around the waivers as information changes, it is not a monthly thing, but just as information changes.

For now, I will say that the only change from reporting this previously is that the Model II Waiver has been approved with an effective date of February 1, so that means that all of those now are now permanent -- or anything that was contained in that Model II is now permanent. If anybody has a question about how this may affect you, certainly, we have frequently asked questions on our website and you can see on the right we have an email address specific to the 1915(c) waivers and a phone number, so a provider or member could call that if they need to understand how that affects them.

As noted, and what we continue to see and show every month, is a decline

in our Medicaid enrollment, not unexpected because we knew under the three-year continuous coverage that -- continuous enrollment -- that folks probably were becoming ineligible due to income primarily, lost of a category, loss of eligibility. So not too surprising, obviously, we are making sure that as people terminate, especially if it is for lack of response to a notice, which by the way, is about 60 percent of our terminations, we are still trying to contact those folks and make sure that they have coverage. That is, sort of, what we are most interested in seeing.

This looks a little busy, but I will explain it to you and you will get these slides are don't feel like you have to absorb it all now. I'm not going to go through every one. But what we have been showing folks every month is the CMS monthly report that we are required to file on the eighth of the month following the renewal month.

So for May, that was June

8th and for June that was July 8th, and so on. CMS, at the end of last year, updated their guidance to us, which is always fun, and changed our reporting requirements, and have asked us to report the 90-day period following the renewal month, and any cases that were actually processed that were pending when we made the original CMS report.

So on the left-hand side here, is that original report re-filed. On the right-hand side is updating the numbers after that 90-day period. This report, then, gets filed 90 days plus 15 days after the end of the renewal month. So as we move forward following that 90-day period, on the 15th of the next month is when this gets filed. These are all on our website now, even the updated reports and we will continue to update them.

But just as an example, let me walk you through May so you understand what you are seeing here, originally we reported 80,673 people renewed, going through renewal; 37,182 were approvals;

34,124 were terminations; and we had pending at the time, the end date, which was May 31st, 2,698 who were pending processing. That means somebody filed something, submitted something in response to their renewal, and the state hadn't had a chance to process it.

In that 90-day period following May 31st, we were able to process 2,659 of those pending cases and so all of these numbers changed. The approval number went up, which is great; 38,552; termination number went up, too, 35,413; we still, at the time of pulling this data, we still had 39 pending. So this is data reported, and I'm going to have to use my fingers -- May, June, July, August -- through end of August, so at that time we had 39 pending. So, you know, again, you can walk through this, maybe you can't get to sleep at night and want to take a look at it, you can kind of see each month how those pending cases were processed.

MR. MARTIN: Veronica?

MS. CECIL: Yeah?

MR. MARTIN: What caused the uptick in September? We had an uptick on renewals and is that just kind of the timing?

MS. CECIL: No, no -- so, thank you for the question. For us to implement that 12-month automatic extension for children, we pushed cases with children in it to September, and then distributed them across the rest of the unwinding period. So that's why we have a large number in September.

So in the approval bucket there are a lot of children, obviously, because we automatically just renewed them. But that is why that is so much higher.

MR. MARTIN: Okay.

MS. CECIL: So and you'll see October is high again, too, for that reason. And we dropped in November, December, because we had made a intentional decision because those are months that have a lot of holidays, to make that a smaller caseload already, and then as I mentioned in December, we also

pushed renewals based on that redistribution.

So still tracking at, in fact, we just completed the number for October, we haven't updated this yet for that 90-day processing, but here, just noting that we are still tracking the reinstatements. If a member was terminated and is able to come back and give us the documentation we need to make the redetermination and they are eligible, in that 90-day period -- reinstatement period, we will reinstate them back to the original termination date with no gap in coverage. So important to always know, if you have somebody come into your office, they had just been terminated in that 90-day period, we still could possibly get them covered. So important to have a conversation with them about responding to that notice still.

So looking at the most recent month, January, 121,236 individuals were up for renewal. We have a very small approval and termination number and that

is because we have, you know, extended based on our extensions, extended a lot of folks, so that is why there is a big extension number there.

And then just a reminder, we have a Democrat -- demographic data report that is on our website. Starting in September we started reporting a couple of demographic metrics, so race, ethnicity, age, and gender. And then we break down, in the report by county, approvals and terminations, so if you are interested in the counties that you serve and you want to go out and see what does that look like, you have that information available to you. The other thing we do is that we kind of track this to make sure, like, for instance, children, just because we are automatically extending children 12 months, doesn't mean that they won't terminate during that period of time. Possibly, they turn 19, or they moved out of state, or their parent or guardian came in and asked us to terminate their Medicaid coverage because maybe they have

coverage in some other way.

So, but we always look at those particularly and go back and look at the actual cases to make sure that it was processed correctly and we weren't unintentionally terminating a child.

But this also helps us track at the county level if we see wide variation, in especially terminations. Is there something we need to be doing in that particular county to make sure that folks are, you know, responding to notices, are aware of the renewals, and should we do some additional outreach for that.

A reminder on our website --

MS. MOORE: Veronica, can I ask a question?

MS. CECIL: Yeah. Sorry, Stephanie, go ahead.

MS. MOORE: So, and I can go to their website after the meeting, but I just wondered, is the end that you start with or any percentage on there? Because, you know, this appears to be raw numbers, and so for instance, we take care of

Madison County, but also Jackson County, and the population of those two counties is very, very different. So am I losing, you know, does the outreach need to be in Jackson County even though the number is smaller, but it is a higher percentage of their covered wise. Do know what I'm asking?

MS. CECIL: I do. And we look at the rate based on the population. So you are absolute correct. There are two different numbers based on the population -- the Medicaid population of who is going through renewal, so we look at it by rate so we can capture that. Great question.

So again, lots of information. You guys, we encourage you and hope that you pull down some of these and post them. As members come in, maybe they are sitting in your waiting room, giving them information about their renewal and reminder that those are happening, and this particular one, like this middle one, the second from the left, is a really

great one to give really high-level information. Perhaps they were just terminated and so this far left one is about reinstatement and what they can do to get reinstated.

So just lots of information out there, it's also in Spanish. If there's anything we can do differently, we are still open. The unwinding is still going on. So not too late for us to generate a new informational bulletin or flyer for you if there's one that you think is needed.

Reminder for providers, that in Kentucky HealthNet that members' renewal date is on there. If you don't see a renewal date, it's because they are categorically eligible and they don't have an annual renewal. So we do have some members that don't have annual renewals. Their Medicaid eligibility is covered because of their being in that category. Foster children are an example of that. So if there is no renewal date on there, no problem. They are not subject to

renewal at the time, and then they can, just for the ones that you see the renewal date on there, if your long-term care, your information is in Clocks, or if you are a waiver member, the information is in the MWMA.

Always want to plug qualified health plan, because as people roll off of Medicaid due to income, we really want to make sure that they are covered. Maybe they are covered by an employer insurance plan, but if not, we want them to go out and choose that qualified health plan so they maintain coverage.

The open enrollment period for that closed, but the good news for Medicaid, members that are rolling off, there is a continuous unwinding special enrollment period. So if, at any time, between March 31st, 2023, and December 31st, 2024, and this has not been updated, my apologies, we just got approval to extend that to December. Any time within that period of time, that Medicaid member -- the previous Medicaid member can

go and check a box and say, I lost Medicaid, and that will open up the ability for them to choose a qualified health plan outside of open enrollment, and outside of that qualifying life event. So losing Medicaid is a qualified life event, but you only have about 60 days to go out and choose that plan. So during unwinding, you know, we are trying to make sure that everyone understands, if you lost Medicaid, you are not covered, don't worry about the open enrollment period. You can go out and do it anytime during this period of time.

So the good news is that as we saw Medicaid enrollment trend down, we see qualified healthcare enrollment trend up. We had, in my understanding, the largest enrollment during open enrollment so that is amazing. 75,821. This blue line is last year, 2023, so you saw that there was actually a decline. So this is a great trend up that we hope to see maintained throughout the year.

Sorry. There is our website.

Again, lots of information. All of the reports, the CMS reports, updated reports, demographic report, frequently asked questions, stakeholder meetings that we have every month, they are all recorded. We know it is probably hard for you all to get -- excuse me, at 11 a.m. to jump on a call, but it is recorded for you to watch later if you are interested in staying up-to-date.

Just a reminder, Twitter, Facebook, and Instagram, we post really current information. You don't have to do all three, just one. We share the same information across all three platforms. So if you haven't liked us or followed us on one of those, we would appreciate you doing that.

And then again, just trying to remind folks that there is a lot of information out there and we hope that it -- you can access that and understand it. I will stop there.

Sorry. I did not stop. There we go.

MS. MOORE: Additional questions on unwinding? All right.

So moving on to WRAP payments and how the new system is going. I was not on the last call, so I'm anxious to hear how people's experiences have been.

MS. CECIL: Sure. I'm happy to take that, too. We had our meeting December 8th. Really, it was actually kind of a fairly short meeting in terms of agenda items. Prior to that, and some time in mid- to late-November, there was a problem with encounters coming in and generating a WRAP, it's funny how things start to bubble up. You hear one thing and then you hear it from another provider. And what we did discover is the file coming over from the MCOs was delayed for various reasons, and so that was delaying the generation of the WRAP. The good news is it wasn't a systemic issue or any problem there. They quickly caught up, and, I believe, resolved following that.

We did talk about the new

reconciliation process. Still, if any providers out there -- this should have been -- this should have been sent out to all providers now, so if you are having any trouble navigating that reconciliation process, that was our first iteration. We are certainly happy to take feedback and see if there is anything we need to tweak for it. But that is out there and hopefully providers are able to utilize those tools that are available to them to reconcile their claims with their WRAP payment.

The next meeting is March 14th. One of the things we did discuss, and I think I've mentioned this on this call is we did procure a vendor and we will work on implementing a new claims processing vendor, so it is called MMIS Now. The new name is the Medicaid Claims Administration and Financial Solution -- MCAS is our acronym, because you can't be in Medicaid without an acronym. MCAS was originally slated to go live early in January of next year. We just completed requirements on

it, and so we already know it is going to be delayed so we are probably looking more in the second quarter of 2025. So we still don't have a lot of -- we are still working on the design and don't have a lot of information yet to give to providers on it, but we do hope that -- and plan -- when we are at a place when we can walk through it with providers, we will be reaching out to have those meetings so folks can understand it, and we will be happy to bring a specific presentation to this group especially about how the WRAP is going to look through that new system. So that is, you know, something that we will continue to have on our radar and present to you all when we have a chance.

MS. MOORE: Do you anticipate that that new system will be able to do bulk uploads of claims or is it still going to be a one-at-a-time process?

MS. CECIL: I can't answer that question, Stephanie, yet.

MS. MOORE: Just know that we, in our hearts, Sammie, I think you would

probably jump in and agree with me that that would be helpful to people.

MS. ASHER: I agree. Yes. Thanks, Stephanie.

MS. CECIL: Okay. I have noted that and I will get that back to the implementation team.

MS. MOORE: Because I think that that, you know, from what I have heard from my team, is that you want to go out and collect that WRAP that is doable, but then you are in this situation where, particularly now with the cost of labor, you know, considering what am I actually going to collect versus what it is going to actually cost me to complete that process. So I know we've had to hire one FTE dedicated just in managing that process for us. We hope it will yield more than we are paying them --

MS. CECIL: Right.

MS. MOORE: But that remains to be seen, so.

MS. CECIL: Okay, no. I appreciate that. I know that I just

hesitate to talk specifically about the system yet. My understanding, is that we are trying to mirror what is going on in Ohio. And my understanding, is our providers are very happy with the way WRAPS are generated -- paid and generated in Ohio. Again, you know, just a little early to talk about specifics. But I will take that back.

MS. MOORE: Thank you.

All right, so, moving on to new business. We did work with DMS to talk about a new TAC schedule, meeting schedule, and hopefully those dates have been shared with you. We really intended to mirror the meetings of the MAC. So we will be meeting three times this year. We are hoping that we can make those meetings a richer experience for all participants and keep our schedules a little free.

So veronica, we are going to turn it back over to you for new business from DMS. Sorry we didn't give you much of a break.

MS. CECIL: Thank you. I wanted

to show if folks weren't able to be on the MAC, the Commissioner did a presentation of accomplishments, and -- this won't take very long, but I did want to show -- let's see here. Just, you know, we always have this Medicaid at a glance. So we're over 1.5 million; $16.8 billion for state fiscal year 2023. We continue to grow. This year it is, like, 17 -- this 2024 state fiscal year is going to be, like, 17.4 billion, so that continues to grow. But this is what I really wanted to show you.

This is not an exhaustive list. So these are things that we did, that we kind of consider, sort of, major changes to Medicaid. So this doesn't include all of the other little things that we took care of or policies we might have changed from 2020 to 2023. And I am not going to go through all of these. We will send this presentation out so folks can look at it.

But a couple things that I did want to note. We eliminated co-pays. We

didn't get a lot of acknowledgement or discussion, it just, like, happened. And some of that is because we had waived them during the public health emergency and what a lot of folks don't realize is, we just carried on because we made that permanent. So that made sense to us and we were appreciative, and at that time, Senator Alvarado sponsored the legislation to put it actually in statute, because we know it's the provider that has the administrative burden of collecting those, so it comes out of your rate and so we thought, why are we doing that? So that was a big one.

The other thing is the postpartum. So we, you know, expanded coverage of postpartum from 60 days to 12 months. Another no-brainer. Why would we stop covering, you know, someone who just had a baby after 60 days, when they've got a lot of necessary care that needs to happen. So now they have that 12 months coverage following postpartum.

We -- another couple of other

things that you all are certainly aware of. Community health workers we started covering and reimbursing. We also got approval for a state plan amendment for Treat No Transport, and what that means is if in ambulance or emergency services responds to a call and they actually perform some type of treatment, but they don't transport the individual, they can get reimbursed. Makes sense. You know, because before, they were required to take that person to the ER, and only the ER, if they wanted to get reimbursed for that service.

So now they can go to the call, maybe triage and provide some care and not transport somebody, because that is taking care of it and they can get reimbursed.

We have pending, right now, triage and transport. And what that means is we will, after that gets approved, we will actually pay for them to transport to somewhere other than the ER. Also makes sense. Maybe somebody doesn't need to go to the emergency room, but maybe needs to

go to some other setting. It could be to a FQCRHC; it could be, you know, some behavioral health setting. So now once this gets approved, once emergency services responds, if the person needs something beyond what they are able to treat, they can transport it, transport them. So we are waiting for that approval to come through.

During this period of time, we implemented the hospital rate improvement program for inpatient and outpatient, and we also did the University Hospital program and the ambulance provider program. And what that means is, we now are tying quality metrics to reimbursement for those areas, so for additional payment they have to perform and meet certain metrics. This is where Medicaid wants to go to in 2024. You all have heard about the managed-care organization value-based program that started in January, and we are wanting to align the metrics across all of these different programs so that we are all working together towards the same

goal in improving the outcomes of our members, so is still moving that way.

We also started covering nonemergency medical transportation to methadone treatment. Previously, when we implemented our 1115 for substance abuse disorder, it was a carve out to pay for transportation to methadone, but now we have carved that in, so that is covered.

The last thing I wanted to note and that you are all probably very familiar with, is that we enhanced the vision, dental, and hearing benefits for adults. Again, one of those areas that is kind of a no-brainer. Especially if it is a Medicaid member who started coverage with us as a child and then transitioned to adult, why would we cut off those services to them? And oral health is just -- evidence shows that good oral health can also either improve somebody's overall health, or if they have poor oral health, it is an indication of something else going on.

So just again, a long list of a

couple of things that we did during that period of time.

In 2023 alone, we had over 20 state plan amendments approved. I know you all probably don't understand the context of that, but that is enormous. That is a record setting number of state plan amendments. Lots of major changes to our program.

I want to note that Erin Bickers and Kelli Sheets who are our MAC and TAC liaisons are the ones who submit those for us, so not only are they working with you all on your TAC meetings, they were also helping us prepare and submit and get those state plan amendments to approval. We also amended to Kentucky Children's Insurance Program, SPAs, so anything we do in KCHIP has its own state plan amendment that's required, so we did two of those.

Those four directed payments are rate-improvement programs that we talked about, the hospital inpatient, outpatient, university and ambulance. We were, for the first time ever, fully-staffed. It

has never happened. We generally have been about 65 to 70 percent of our vacancies filled. We were able to fully staff and what we are hoping you all will see, is that we are able to be more responsive, we are able to really do the things we should be doing, which is looking at quality, trying to drive better outcomes, assisting providers with understanding, you know, the benefit and reimbursement, working with providers about reimbursement. We just really have not had a lot of extra resources to do that, and so we are really excited about what is on the horizon for all of us.

And then during this period of time, we published our first ever Kentucky Medicaid annual report. It was for the 2020 state fiscal year. We are working on 2021, 2022, in 2023, and we hope to have those released in the near future. This was a major initiative of the Commissioner. She wanted to be able to tell people our story. Who are we covering? What are we paying for? What

does that look like? So more on that in the future.

So other than that, you know, we talk about MCAS, because it was just the other thing that I like to always keep on people's radars is that happening. And you know, the Commissioner just really wants us to continue to focus on quality and population health initiatives. You know, what can we do in Medicaid that we can also do across the state with other insurance coverage or with the Department for Public Health to continue to improve Kentuckians' lives. That's all I've got.

MS. MOORE: Thank you, Veronica. Please give the Commissioner our gratitude as well. I think when you look at that list of accomplishments, primary care touches so many of those things. You know, even in the changes with EMS, you know, really impact how we are passing patients back and forth through different settings of care here in our community, so we appreciate that work and we appreciate that commitment to intervention and to

collaboratively try to solve problems that allow us to take care of patients. So thank you to you and your team.

MS. CECIL: Thank you for those kind words. I certainly will pass that on.

MS. MOORE: We also have the Crisis Stabilization Program on the agenda. I don't know if you are prepared to talk about that.

MS. CECIL: We actually do have -- let me think. Is Leigh Ann on? I think we have somebody on who is working on --

MS. FITZPATRICK: I am on.

MS. CECIL: Yay. Okay, do have a presentation?

MS. FITZPATRICK: Leslie didn't give me one, but I would be glad to talk about it and if there's any questions -- well, I'm sorry.

Currently in Medicaid we have residential crisis stabilization units. That is where someone can go and spend the night if they are in a crisis, but they

don't really meet criteria for a hospital setting, but they need to be somewhere. We have, in one of those SPA improvements that we received from CMS last year, we received the approval to add a service. We call it the Under 23-Hour Crisis Stabilization. So someone can go there and stay 23 hours or less if they are in crisis, and that crisis cannot be stabilized where they are. They just need to be away, out of the physical location, or the situation just can't be resolved. They can go to those locations and stay for the amount of time that is medically necessary. They will receive a medical evaluation, a clinical evaluation, other support services that they may need. Care coordination, so that once they leave the 23 hours, we need to work on a plan so that if you are in this crisis again in the future, what can you do to settle or de-escalate this situation yourself?

These are going to be available to our CMHCs and our residential crisis stabilizations. You can now either do a

23 hour in a residential, or one or the other. Are there any questions? Or did I explain it well? Or any leftover questions?

MS. MOORE: I have, and please don't laugh when I try to show you this.

MS. FITZPATRICK: Oh, no.

MS. MOORE: But this -- it's blurry. Can you tell which one this is?

MS. FITZPATRICK: Yes, I definitely can tell which one that is.

MS. MOORE: You know, one of the things after Secretary Friedlander's presentation, our primary care and behavioral health team feel a little uncertain about the space of primary care, kind of, on this graphic because, oftentimes the CMHCs won't respond to our office, because they think that we have professionals here who can do that evaluation, but we are providing outpatient services. We are not equipped to do crisis stabilization, but we are the places where people show up in crisis.

MS. FITZPATRICK: Right.

MS. MOORE: And, I mean, it is disruptive -- and I don't say that from a space of an annoyance, but more from a place of impeding our ability to care for the other patients that are in our clinic at that time.

MS. FITZPATRICK: Okay.

MS. MOORE: So one of the things that we are really curious is, you know, how DMS sees primary care, sort of, on this graphic and in this metric, and where you feel that we fit in this plan?

MS. FITZPATRICK: That is a very good question. Honestly, we haven't thought about that, so I'm definitely going to take that back to our team and to our ASO and say, where do they fit in? I guess you are having people who present to your office in a behavioral health crisis because sometimes they don't know where else to go and you are primary care and from that point, where do they fit into the crisis continuum?

MS. MOORE: Right.

MS. FITZPATRICK: I will

definitely take that back and get an answer to you for the next TAC.

MS. MOORE: Yeah. We don't want to send them directly to the ER.

MS. FITZPATRICK: Correct.

MS. MOORE: They don't necessarily --

MS. FITZPATRICK: Thank you.

MS. MOORE: -- meet criteria for inpatient admission, and so they are just in this interim space and they are looking to our team for help.

MS. FITZPATRICK: Okay.

MS. MOORE: And it's really difficult. So, yeah.

MS. FITZPATRICK: Something else that you can do, and you probably don't have the staff for this, but if someone is in your room and they can call 988 from your office, and then there will be a call taker on that end that can help with that issue and does that need to be referred on to a clinician or referred on for a mobile crisis dispatch, and that would be an appropriate setting to send the mobile

crisis team to your office to meet with that individual that is having that behavioral health crisis.

MS. MOORE: It has been our experience that they won't respond to our office. So maybe that needs to be part of the communication. And we can continue the conversation off-line, but I just wanted to bring it up.

MS. FITZPATRICK: Absolutely. We can definitely, in part of the training we would get -- the ASO will be responsible for getting the mobile crisis teams contracted under them, but that could definitely be an approved place of service, to a primary care office, because we do not have behavioral health embedded in our behavioral health offices, so thank you for bringing that to our attention and that can just be part of the training that, yes, that is an allowable place to go for mobile crisis dispatch.

MS. MOORE: Okay, thank you.

MS. FITZPATRICK: You're very welcome.

MS. CECIL: Bringing up an excellent point that, you now, in thinking through what is a setting that a mobile crisis team could be dispatched to, like, we are not going to dispatch to a hospital. We are not going to dispatch -- that make sense, but dispatching to a provider office definitely makes sense.

MS. FITZPATRICK: Absolutely.

MS. MOORE: And something we have been intentionally thinking about so it's great that you highlight that so we can loop it in as we implement --

MS. FITZPATRICK: Yes.

MS. MOORE: And even if we have outpatient behavior health integrated in that primary care practice, they are not necessarily connected seamlessly to that next level of care and so the mobile crisis team responding and then us being able to pass off the patient to somebody other than the ER would be fantastic.

MS. FITZPATRICK: Yes.

MS. CECIL: Absolutely. We want to keep them out of the ERs. We want to

keep them out of the jails. Something you noted, just to, kind of, hopefully, maybe address some concerns about current response, is that our administrative services administration, the ASO will be responsible for holding providers accountable to what mobile crisis is, the fidelity of the service. You know, they are going to have to be qualified and contracted to deliver that in accordance to the way we are requiring it. So, you know, we are really, I think the exciting part to that is we cover mobile crisis right now, but not in the way that it should be delivered, so this is really going to change the environment in terms of mobile crisis delivery.

MR. MARTIN: Veronica, this is Barry. Where will these mobile crisis centers be located at in the state?

MS. CECIL: They are across the state. And it is generally the current providers that are available and, Leanne, if I can get you --

MS. FITZPATRICK: Sure.

MS. CECIL: -- since this is your area of expertise. So they are all over the state and there will be providers all over the state. Again, I think the key point, here, is that they are going to be required to be able to meet our definition of mobile crisis; the services that are contained in the mobile crisis; the team, the criteria of the team; so, you know, all of that will be consistent throughout the state.

MR. MARTIN: Is it going to be kind of like our QRT program? Quick response team, to a certain extent, with different personnel?

MS. CECIL: Leanne, is the answer, yes?

MS. FITZPATRICK: Kind of, sort of. Now, in a mobile crisis dispatch if someone calls 911 -- or 988, let's say, a mobile crisis team will get out within two hours of where you are in Kentucky, where the QR team reaches out within 72 hours of the overdose incident; correct? So part of the responsibly of the ASO is to make

sure that there are teams and providers available to reach to someone within two hours of a dispatch.

MR. MARTIN: Okay. Good. And then, are you guys educating the law enforcement in regards to that? Because like, we have, we have a drug tank -- drunk tank withdrawal management at our facility, and a lot of the law enforcement say they don't even know about it and they don't utilize it. So I think educating the law enforcement that this is available is going to be crucial, as well.

MS. FITZPATRICK: Yes. Part of our mobile crisis intervention service implementation that we are doing includes a co-response model that the cabinet has a grant program for co-response, either an EMS in behavior health or law enforcement in behavior health, and we have seven of those around the state, right now, for our first program. And part of the ASO, again, is to educate law enforcement and educate others around the state that this is an available resource and an available

service.

MR. MARTIN: Okay. Sounds great.

MS. MOORE: Next on our agenda, utilization trends from 2023.

MS. CECIL: So we saw this agenda item on here. I know that KPCA is working with our quality division to try to come up with some data points to be shared. I think that conversation is ongoing. We don't yet have the data available. So if it's okay, maybe we can park this on the old business and we can provide updates as we are able to pull that information.

MS. MOORE: Sure. That's great.

MS. PARKER: Veronica, this is Angie Parker. I do have some preliminary data. It doesn't include everything that was initially requested, so I was looking to set up some time with those that we first discussed this with, to go over the beginnings of that, this information, so.

MS. CECIL: Okay, great.

MS. PARKER: There is more to

come with this data, but I want to make sure that we touch base with what we've been able to gather thus far, is what is being requested.

MS. CECIL: Okay, great. So maybe by the next meeting we will have something that we can go over.

MS. PARKER: Yes, this is new news.

MS. MOORE: All right. So moving on to the updates from the PCA and CIN.

Molly, are you doing the PCA and Dr. Houghland, the CIN, or tag-teaming?

MS. LEWIS: Yeah. I'll be quick.

Hi everybody, I'm Molly Lewis. I'm with the Kentucky Primary Care Association. Am I able to share? I just wanted to show you all something really quick.

MS. CECIL: Yes, Erin can make you a cohost.

MS. BICKERS: I'm working on it. Give me just a second.

MS. LEWIS: Sorry. I should have asked in advance. But I was just --

MS. BICKERS: You are now a cohost, Molly. And if you don't mind, what you share, email it to me so I can throw it on the website.

MS. LEWIS: Awesome. Okay. No problem. Here we go.

So something I've been thinking about a lot. We just finished with our KPCA strategic planning, and one of the purposes of a PCA nationwide, we are 1 of 53, is to be a point-of-contact or representative of the interest of the providers in our state, and we are pretty unique in that we have very qualified health centers and rural health clinics.

So if you look at this map of Kentucky -- can everybody see what I am looking at? This is where I click just the rural health clinics, the Barry Martins the Dennis Fouches, those are represented here with the red, and then if we add the FQHC's, you see the sites, you know, more of an impact on the state, and

then if you add the school locations, it's right here. And so I think that this makes a lot of sense of why we are here, today, talking about these things and how we can really increase the impact of these conversations. Veronica, all of those accomplishments that you all have that we are so grateful for, if they're going to be successful, we really need to partner on them, I think. And so, thank you for sharing them with us and for, like, running those things by us. Those conversations that we have monthly, if not more, on what is going on and how things are landing, we really appreciate having those to show the impact of the PCA.

So currently, we are at about -- we are at about 100 members, but if you look at this, when we talk about how we are responding to the needs of Kentuckians, nationally, I think the number of patients seen in this type of setting has increased by about 45 percent. It's just -- as a place, what do we need to do in order to be the provider of

choice, the employer of choice, the partner of choice, for Kentucky Health System. So I think that it is really a valuable time for us to spend together and I will send you this, because it is on our website, but it is really helpful because you can break down where everybody is and how they are located. And I think for the school locations especially, you kind of realize the local flavor of having different models that meet the needs of the community and they work together with public health or work together with Medicaid, or work together -- you know, the level of services that are available and how we are taking care of Kentucky's children in the school setting really varies from place to place, and so thank you for keeping us abreast of what is going on and getting our input. We really appreciate it. We consider this part of what we do as advocacy and just having those communications, and we also, and what we are doing for excellence in terms of the level of services and what we are

providing in terms of training and technical assistance in order for our members to be high performers. So, you know, what Angie is working on with the quality initiatives, and Steve can talk about that a little bit more. And the impact. If we can develop some activities -- when we can do things in concert or collectively together, we really can make a big impact on Kentucky and I think the fact that Kentucky's health status has improved, you know, by several numbers over the past couple of years with your team, Veronica, I think that that shows that we can make progress and we are tracking in the right direction.

So that is all I have to say, but we are just grateful for this time together and we look forward to making it as productive as possible.

MS. MOORE: Dr. Houghland, do you want to jump in with a CIN update?

DR. HOUGHLAND: Sure. Thank you. For the record, Steve Houghland, I'm

the Chief Medical Officer for the Kentucky Primary Care Clinically Integrated Network. I'll also be brief.

Maybe you've heard different iterations of this, I don't want to bore everyone in rehashing, but I think it is important to give a little bit of the background.

So the Primary Care Association is one of the organizing members of the new PPC Clinically Integrated Network, which began, officially in service in January of 2024. It is primary clinical arm to drive improvements for many of the members of the association. It's important to note that not every member of the association is a part of the CIN, but the majority are. In order to be a member of the network, you do have to be a member of the association, however. So the new KPC CIN has a 91 unique tax ID number providers as a part of that network. With about 2000 clinicians across the Commonwealth. So many of those dots that Molly showed are within the KPC CIN.

The network currently holds more than ten value-based agreements across all payer sectors, but the majority of them are in Medicaid, and so very important to this group, as it funnels up information to the Medicaid Advisory Committee.

There are about -- there's actually more than 400,000 patients that are served under those value-based agreements and over 300,000 of them are Medicaid members. So again, very important to where this committee provides information up to and recommendations up to the MAC.

An important initiative that has been undertaken, and again, many of you have heard of this, is the network is sponsoring a data aggregation tool that will be used by the majority of its members over time. That's not something that happens immediately, but at this point, and so that will take information combined from the patient management software of the participants in the network, as well as the EHR and receive

information from external sources including the health plans, HIE, et cetera, so that you have a consolidated source of information that we can use to help drive improvements.

The goal is to have as many of those 91 groups connected as possible. That is the long-term plan. At this point, we have 10 to 12 groups that are in various stages of implementation, and by the end of the calendar year 2024, we anticipate over 30 groups being connected. That is part of our plan and rejection, and that would represent about 60 percent of the attributed patients within the network.

Another important data point, just to throw out, on top of the more than 400,000 patients who are in value-based contracts, or covered under value-based contracts is probably more accurate, the network and the association sees over a million unique Kentuckians per year. That is pretty sizable, obviously. Roughly, one in 20 -- sorry, about 20 percent of

the population of Kentucky seen by the member.

So obviously, an important channel for all of us to think about how we can help improve the health of our communities. So the members of the committee have heard a lot of this, but it's a lot more for the other stakeholders, but happy to entertain any questions that may be out there at this point.

Stephanie, I think you are on mute.

MS. MOORE: I am. Thank you.

So I said, hearing no questions for Dr. Houghland, we will move on to provider updates. So we switched the alphabet. So WellCare is up first this time.

MR. OWEN: Yes. Good morning to you. Thanks for shaking it up with the alphabet. That's nice every time and again to get to go first. We appreciate that.

Stuart Owen with WellCare. I am

not going to be talking. It is Brooke Hall, also with our care management team. I know you all didn't ask for presentations, but to organize thoughts, I know Brooke has a couple of slides, basically about different ways that we steer members to primary care. So Brooke, the floor is yours.

MS. SHEETS: This is Kelli. I'm sorry, Erin is having technical issues and she cannot unshare her screen at this time.

MR. OWEN: No problem.

MS. HALL: This is fine.

MS. SHEETS: You can try to take over, but I don't know if it will let you.

MS. HALL: It is not. I was just trying and it would not let me override that.

MS. SHEETS: I do apologize. I don't know what is going on.

MS. HALL: It's fine. It was just two slides, just an overview and highlights of, kind of, the map and the way that we view our primary care provider

partnerships, and how our initiatives drive members towards that primary care home.

So at WellCare of Kentucky, we have all of our member-facing programs with a process flow documented guide, if you will, that suggests the most important aspect is getting and establishing primary care provider relationships. We believe that primary care is the cornerstone of wellness in our state. We want to see each of our members have the opportunity to have that trusting and engaging relationship with their primary care.

So we have programs, such as transition of care, where we have embedded case managers in hospital facilities that, before the member even leaves the facility, they are discussing where their primary care office is located, can they get there; what are the barriers to that; and making sure that they've got that appointment.

We have health coaches and quality teams that are making hundreds and

hundreds of calls a week to identify members who have missed a primary care appointment in the last 12 months. They haven't had their physical.

We are making a very concerted effort on the well-child, pediatric space. Plugging those kids back into a provider to act as their primary care home.

We have OB who not only works with the OB/GYN involved with our members who are pregnant, but we also have that team that pushes the member also to the primary care location for overall health maintenance and preventative care.

Our population health type chronic condition programs also all drive our members back to their primary care locale. So the way that it works is we are in a constant state of assessment. We are wanting to reach out to our members and then make sure that they are satisfied with their current primary care, also that the primary care assigned in our system is accurate. And then we correct that if they are not accurate. We also work to

find a primary care provider for those that may have a concern or feel like they may want to go to a different clinic or provider.

We have a ED diversion program, which was a pilot in 2023, which has shown phenomenal outcomes. The entire central theme of that program is establishing primary care relationship from those members to take them away from the utilization of the ED, move them to utilization of primary care. We want our members to be able to get to primary care providers, so each of the staff doing those outreach and making these calls to members definitely have a robust resource database, and have a very high-level working knowledge of the resources available in the state from transportation options, to housing, to, you know, making sure they are enrolled in SSI appropriately, making sure they have the resources that they need as far as food. Just your basic SDOH barriers. We remove those to the best of our ability. We have

an entire housing program that looks for housing placement and housing stability for our members. What we have noticed in our ED diversion work and some of our frequent admissions -- the lack of food, lack of heat, the lack of transportation, is driving these members to be admitted or to the ED, and we want to remove those barriers so that they can be better served at the primary care home location that they have available to them.

We work heavily with transportation. What we find is we can get members to a specialist appointment using that non-emergent transportation through Medicaid, but if we have a UTI, strep throat, something like that, that 72-hour required scheduling prior to the transportation is kind of a limiting factor. So while we appreciate and utilize that non-emergent transportation option with a lot of our membership, we also have options that are put in place to get members to the provider for those sick visits.

We have just a phenomenal data and analytics team here. So their role is to constantly evaluate the state of our members. Have they been to the PCP in the last 12 months? If they haven't, there is a revolving algorithm that then farms those members to an outreach program.

We have also data that looks at gaps in care. Data where, like the ED diversion program, discharge and readmission data, that is kind of signaling to us that we may have a gap in that primary care relationship space that we are desiring for our members for their best outcome.

One thing to note, too, is we believe we are good partners with providers. It's our job to be good partners with primary care, through our IPAs, our value-based contract providers, through all of the providers, we have 3,314 individual primary care providers in network for WellCare in the state for Medicaid and we want to partner with those provider offices. We know that there are

gaps that need to be closed and member outreach that needs to be made, and the ask for that to be carried solely on the provider office is a burden that is just too large to overcome. So we use our data and analytics as well as our provider relationship relations team. They're phenomenal at sending us provider panels. Hey, we haven't seen this member in 24 months, and then we go down the rabbit hole and we work hard to find that member and get them scheduled. We check out claims to see maybe they are going somewhere else and we can reassign to the appropriate primary care and remove them from the wrong panel.

So we work in conjunction and collaboration daily with providers in the primary care space to make sure that we have adequate coverage. We overlay heat maps so as new members come into our plan and members leave our plan, we are constantly updating those heat maps to make sure that we don't have primary care deserts located in areas of our state and

our contract and network teamwork diligently to shore that up in areas where there has been a change in the volume of membership.

So we have just some excellent data and analytics that is constantly churning out ways that we can outreach to our members. Again, all of our programs and workflows and processes to the letter are driving members back to their primary care provider.

We do every 30-day outreach. So if we don't reach you in 30 days the first time, we are going to try you again. We are diligent, we work hard to close those gaps to make sure that our members are receiving the primary care services that we believe and know will be best suited for their overall wellness.

Is there any questions about that or any clarifications on anything I shared? Okay.

MS. MOORE: Thank you, Brooke.

MS. HALL: Sure.

MS. MOORE: Dr. Cantor, I think

I saw you turn your camera on, so go ahead.

DR. CANTOR: Yes. Good morning. And I'm, like Stuart, I appreciate the alphabet getting reversed. Thank you so much. From United Healthcare's perspective and for those who might not know me, I'm the CMO with the plan. We did give a VAB list earlier, so if there are any questions, please let me know.

Our updated for 2024, I t hink there are some things to specifically point out. Car seats that we are able to give moms who complete their 6- to 8-week postpartum appointment. We are so able so happy to be able to offer diapers. So 200 diapers if the mom completes their postpartum visit. We can give age -- or size appropriate diapers to that mom. And we have a doula network, both Telehealth and virtual -- sorry, Telehealth and person-to-person opportunity for our pregnant moms, as well as supplemental transportation where we are offering rides to the grocery store as well as other

medical needs, if they should need that. And that is for unhoused, justice-involved members as well as our pregnant moms again. Those are just a few of the VABs, but I did want to point out that we have a welcome letter that is clear to the members regarding their benefits, so I'm hoping that that becomes easier for them. We are adding on the back of the members card a BH number that's specifically a crisis line phone number. And we've expanded the CP PCPI provider incentive program with KPCA, and I really appreciate Molly and Dr. Houghland's presentation earlier. To share with that, might be an increase in the pay per gap and we are putting more providers in that program as a whole, so really excited to be able to incorporate that into this large network.

We have a Dare to Care Cooking Matters class in Louisville, targeting members with high hemoglobin A1c's and members that have diabetes, we are expanding home-delivered meals programs to them. So that is some of the highlights

that we are doing for member engagement. Any questions?

MS. MOORE: The home-delivered meals is across the state or just in Louisville?

DR. CANTOR: Good question. No. That's across the state, is my understanding, because we are able to do that. It initially started for members who were hospitalized, had a diabetic diagnosis, or COVID when we were under the PAG, so that was state-wide so home-delivered meals is still a statewide program..

MS. MOORE: Thank you.

DR. CANTOR: Yeah. Thank you.

MS. MOORE: Any other questions for UHC? Handing it over to Passport.

MS. COWHERD: Good morning. I'm Yolanda Cowherd with Passport by Molina. Nicole Yates, our AVP of growth and community engagement will be presenting this piece. Thank you.

MS. YATES: Hello, everyone. Thank you for the opportunity to present

for you today.

I just wanted to tell you just some highlights of things we are doing at Passport for our members.

So on the provider engagement side, we are doing e-news communication that is sent to registered providers announcing education programs, and members can benefit from those requests, provider action of helping to push such education and help complete the forms, et cetera. And then there's quarterly provider newsletters -- the quarterly provider newspaper contains articles along with the provider services representation that also pushes education to providers via the monthly JOCs or other avenues of communication.

On the community engagement side, we do a lot of member education sessions virtually and every day of the week and in Spanish. We do lots of advocate sessions, meetings with advocates, CEOs, FBO's, and one-on-ones about our benefits. Along with sharing

information with community partners and at community partner meetings, such as the health councils coalitions. And then KYA, SAP, et cetera, and just across the state we do a lot of that.

Members can come into our one-stop health centers that are located in Covington, Owensboro, Bowling Green, Hazzard, and Lexington, and get some one-on-one and that happens from 9 to 5, Monday through Friday local time, and there is a specialist in there and we also hold educational classes and help with the value-added benefits. We provide health education virtually, in person, and then again, at the one stops with flyers and other things that we share with our CEOs to inform them and the members of our trainings. We use social media platforms as well to educate and inform members of upcoming events.

Our members receive, in communication style, new members receive a welcome kit that contains a member handbook, quick start guide, member ID

card, HRA forms, the PCP selection form, a business-return envelope so they can return those forms, notice of privacy and practices, and then there is a maternity flyer for female members ages 14 to 50. That will be coming soon. And then we have a member newsletter that goes out three times a year to all of the head of households that contains all of our new initiatives.

So that is just a few things that we do at Passport by Molina to engage the members.

Any questions? Okay. Thank you for the opportunity.

MS. ASHER: Hey, Nicole -- I'm sorry, Stephanie, I have a question for Nicole.

MS. MOORE: Go ahead, Sammie.

MS. ASHER: Hey, Nicole it's Sammie Asher with KPCA.

One quick question. At your regional offices, are your staff equipped or knowledgeable about the redetermination with Medicaid? Are you having members

come in and get help with that?

MS. YATES: Oh, yes. They can come in and ask questions about it. We can guide them through any questions that they have. We also make calls every day from the one-stop health centers about redetermination, so we get a list and then we call those folks our WRAP specialists, our community engagement specialists. They make calls and we are doing about 500 calls a week to members to inform them about redetermination.

And then at all of our events we also discuss redetermination, so we are doing it anywhere and everywhere we can.

MS. ASHER: Okay, so those folks coming into the offices, they, obviously, if they've lost their coverage not Passport specific, but they don't have to be Passport specific members in the past. You're helping everyone who comes in. Perfect, thank you.

MS. YATES: Yeah, if anyone comes into the office -- and sometimes, you know, people come in there and they

don't have insurance and we just direct them to a connector, and then so they can go that way. If they are asking about redetermination, then we can direct them as well. Of course, the goal is to get members, but what we don't want is anyone, no matter what plan they are with, to lapse on their current insurance.

MS. ASHER: Thank you. Good job.

MS. YATES: You're welcome. Thank you.

MS. MOORE: Dr. Houghland?

All right. Moving on. Humana?

MS. MOWDER: Hi, this is Kristin Mowder. I'm the Health Services Director for our Medicaid program.

So today we'll talk about some of our engagement opportunities that we have. First of all, we have our Case Management Population Health program. So we have integrated physical health and behavior health case management. We have a Chronic Condition program. We have a Humana Beginnings, which is the maternity

program where we focus on high-risk maternity members. We have an ER Diversion program. We also have a housing program, a workforce development program and community health workers that focus on SDOH. But what we really want to focus on today is more of our community collaborations as partnerships that we have.

So part of one of those things that we do is try to connect and address the transportation needs of our members. Through our case management and our population health programs, we work with the Kentucky Department of Transportation to connect with those non-emergent transportation needs.

We also have a few pilots that we do. We have a Behavioral Health Transportation Assistant pilot that we are doing with Seven Counties. So what that pilot is, is we provide vouchers for 150 members. And that is for them to go to follow-up appointments, get lab work, and preventative screening. And with that,

one thing that we do do is they have to -- Seven Counties has to fill out the health risk assessment and send that back to us, so that is the mechanism that we use to be able to provide that transportation voucher.

Another pilot that we do is around maternity. It's with a program called Doula Dash. It works similar to an Uber or a Lyft where they have drivers who are trained by prenatal health professionals and doulas and it assists members in Louisville within a 30-mile transportation to their visits and for well-child visits with appointments, prenatal education, and they also provide childcare while the member is at that appointment.

One of the other programs that we have is our workforce development program. And so our program is statewide and we engage members who are 18 or older and we provide three roundtrips per month depending on the transportation available in their geographic area.

And then another part of our rewards is members are able to earn rewards through our 365 Wellness Program, and through that they can purchase gift cards, like Uber gift cards.

Another program that we have is we are doing a collaboration with Humana, Aetna, and Samaritan to help at least 200 Kentuckians address health-related social needs and achieve their health and housing goals. And a subset of that is enrollees with insulin-requiring dependent diabetes. So what Samaritan does is they'll work with case management teams in Louisville to reach that targeted 100 Humana members or Aetna members, and they'll give them a free 12-month membership to Samaritan. So participating Samaritan members share SDOH goals and then set short-term action steps and then meet with their case managers or appropriate staff, like Volunteers of America, Goodwill, St. Vincent de Paul, or other community-based organizations that are already engaged with Samaritan.

The membership is a 12-month

membership that will help them gain financial support so no less than 40 hours a month. The relational support with Samaritan was to meet critical needs such as clothing or bills or medication. And steps toward their goals that they are taking, like talking with the housing specialist, getting their prescriptions filled on time, and attending things like diabetes self-management programs.

And then the last program that we want to talk about is our partnership with Melanated Health. So Melanated Health is a digital company and they also provide medical practice that focuses on healthcare technologies and services. They are empowering and providing Black, indigenous, and people of color, and underserved communities access to quality, cultural, competent healthcare professionals.

So we have provided funding to expand access to Telehealth services. This pilot started in September 2023. We address the gaps to the prenatal care. It

aims to reduce preventable poor pregnancy outcomes, addresses late or insufficient access to care, and also provides Spanish and language services to our Latin population.

So that is, kind of, an overview of some of our community partners that we are working with and programs that we have for members to engage with services in the community.

Any questions?

MS. MOORE: I don't have a question, specifically, Kristan, but a comment.

I appreciate your conversation around transportation. You know, I think, in primary care, it's probably one of the things that comes up most often that we have challenges addressing. I would encourage you to, and all of your MCO colleagues, the transportation situation in rural communities is quite different. We don't -- Uber is not an option. There is not Uber in McKee, Kentucky or Irvine, Kentucky. And so we really struggle.

What ends up happening is, oftentimes, it is end-of-day urgent needs. So what is really most helpful is if there are ways that providers can have gas cards. Sometimes they might have a friend or family member who is willing to get the member to where they need to go, but they don't have gas money. So, you know, if some thought could be given to some creative ways to how we can solve those issues in rural communities, because what happens, it's a running joke at our office. It's like, if you are the last person here Friday at 5:30, you are going to be figuring this out.

It's people who need to go -- non-emergently, but urgently, to the ER, to, you know, behavioral health inpatient facility, situations like that. A lot of times families need to get to specialty appointments, you know, sort of, same-day kinds of things. So Medicaid transport is not a good option and then, you know, there is not another mechanism to get these families. So we've been spending a

lot of energy on that, internally, and that is a great area where partnership could really help us better serve patients.

MS. MOWDER: Okay. I'll definitely take that back to our group where we discuss our value-added benefits and put that forward as one of the options for us to look at. Thank you.

MS. MOORE: Thank you.

I think Anthem is up next.

MS. JUDE: Hi, everyone. My name is Victoria Jude. I'm the Director of Marketing for our Anthem team and lead our community engagement outreach strategies to best support both members and community partners in the field.

So I do want to start off with highlighting a few of the VABs, just calling them out for 2024, and some of our various programs that we do have to best support our members, and then I'll go into some new member engagement and then kind of end off with a few helpful tools and resources we have for members through the

new and redetermination process.

So starting off with the VABs, I do want to start off with our transportation assistance because we do provide gas cards, Uber cards, and bus passes as options for our transportation benefits. It's $100 worth of supports for members who have completed their health risk assessment for the year.

And then we also have (audio went out) year for anyone with a diagnosis of obesity. Asthma resources for members under the age of 18 with a diagnosis of asthma, that provides various relief solutions from inhaler vaporizing kits to travel nebulizers, hypoallergenic bedding, air filters, pillow covers, mattress covers, things like that to help with the management piece of that.

We also, this year, have our air fryers for individuals with a diagnosis of diabetes, and we have a healthy cooking class for those individuals, as well, to help provide that wraparound support for those individuals seeking diabetic

friendly meals, and they'll actually get from those cooking classes, the ingredients to create and replicate those meals at home to take home with them as well.

And then we also have various programs such as our Lark and Livongo programs that help with individuals experiencing prediabetes or a diagnosis of diabetes to provide that preventative and long-term care support.

And then in the field we have a team of community relation coordinators and a team of member empowerment engagement navigators located across the entire state of Kentucky that are all CHW certified, both working with the members, working with the community partners, to provide that one-on-one support for our members that may be having limited access to health resources or may be experiencing social determinants of health barriers.

So our member empowerment program, we work very closely with, and they are able to work directly with our

members to aid in any type of housing assistance for individuals who experiencing homelessness or who are at risk of homelessness or transition of housing. And food assistance for members experiencing any food insecurities, along with any type of education and employment supports, and even the record expungement process, working with our local legal aid offices.

And then for our community relation coordinators, we actually have education hubs across the state of Kentucky with local community-based organizations. We have areas that, at these education hubs, we also have diaper pantries and health and hygiene closets. And then, at the end of last year, we launched six food pantries in schools in partnership with Feeding America and we have both community relation coordinators and member empowerment navigators that have ongoing schedules at those locations to aid members to provide that wraparound support.

And so for individuals moving on to those that are new members, we do have welcome packets that go out to our members that have both resources around provider directories, completing the health-risk assessments, so we can tier our care plans and meet the needs of our members early on and provide that wraparound support for any case management and getting them connected to programming.

Some of our -- in that welcome packet we also have resources around language lines, interpreter services. And we -- within that time, they receive that packet within five days of enrollment. So following that packet they also get a welcome call from us to make sure that they are aware of the resources that they received, if they have any questions or feedback getting that direct one-on-one support, if needed.

And then we also offer member orientations. And they can access this through a variety of avenues from, we post them on our website. We post them on our

Facebook. We also have a blog where we have the entire year schedule available, and we offer those in both English and Spanish throughout the year, where we will actually talk through any terms that they are not familiar with, their card on the -- the member ID card that they receive in the mail; and talking to them about what does PCP mean; what does -- we have the primary care dentist on there as well; talking to them about how to navigate those resources and taking those steps to get involved and utilizing their value-added benefits, but also getting connected and referred to specific programs that they may be interested in as well.

I do want to say, as part of those efforts continue to try and gather feedback and resources to better support our members, so we have taken the approach this here with what many referred to as the QMAC, our Anthem Health Collaborative is we provide that virtually and in the field. Our first one is going to be on

March 25th in Paducah, where we will have an opportunity for our community partners and our members to come together and discuss feedback around dental access and different services that we provide to better gauge how to support our members in Western Kentucky, and getting them connected to our dental home program out there.

And then for redeterminations. We host throughout the year on a monthly basis, health and resource days at our local education hubs so we can best support individuals. Our community relation coordinators are able to guide and assist through the renewal application process and we also have a call center for Anthem, as well, to directly work with those individuals as they are reaching out to Anthem and providing those supports.

So far, through the redetermination process, we have been able to deploy over 55,000 member communication campaigns, so.

MS. MOORE: Thank you, Victoria.

MS. JUDE: Thank you.

MS. MOORE: And last, but usually first, Aetna.

MS. SAGE: This is Tabitha Sage. I and the Quality Practice Liaison for Aetna.

Similar to all of the other MCOs, rate do have a lot of really great programs, as well. We have a great community outreach team that works with a lot of local community events such as back-to-school bashes. We work with food banks and do a lot of great outreach there. We have a great SDOH program, we have community health workers, our SKY team is for our Kentucky youth. We have a great program there, a great member services team as well, and a lot of care managers that work with our SKY members.

As far as our incentives, we do have a great Maternity Matters program. We help outreach those pregnant moms, getting them to their prenatal visits. We offer a $25 gift card for getting that initial visit and then have a $25

subsequent gift cards for every visit after that, and then we have a gift card for our postpartum visit, as well. So we make sure that they are following up after the delivery.

We do also offer up to $90 for those new moms to get either a car seat or a portable crib. So we have that available for new moms as well.

We do have programs for some of the chronic diseases such as slow-cooking classes, home-delivered meals, as well as the others. We also do want to point out that this year we've added some great incentives for our members that are geared around some of those priority measures that I know all of the MCOs are focusing on this year.

A couple of the big barriers I know everyone has probably faced is around flu vaccines and HPV vaccines. So we did add incentives this year for the members to receive a gift card for completing two flu vaccines by their second birthday and an HPV series by their 13th birthday. So

doing a lot of outreach there to help with those barriers that we see, as well.

And I just want to say to providers, we do send our value-added benefits out with our providers. I, myself, work very closely with our value-based program providers on gaps in care, making sure that they are hitting their targets, and we do provide these value-added benefits and mention them with every visit, and we do have a lot of providers letting the members know about these incentives, which is great.

And I just want to mention that if you do have members that reach out to you saying, I was supposed to get a gift card and I haven't done so, please refer them to Member Services so that you all are not having to deal with getting that for them. That puts it back on us and we will get our Member Services involved to help the members make sure they are getting those gift cards for their incentives.

Are there any questions?

MS. MOORE: Thank you.

MS. SAGE: Thank you.

MS. MOORE: I think one of the challenges at the care delivery level, you know, there have been six presentations with slightly different benefits so it's really difficult for the care teams when they're eyeball-to-eyeball with the patient, what the benefits are within that particular MCO, so I know we are still working on trying to figure out how to increase that engagement and help make people aware, but it is certainly a challenge.

MS. JUDE: Stephanie?

MS. MOORE: Yes.

MS. JUDE: I do want to let you know for Anthem, that we have a provider pamphlet that has member incentives both the value-added incentives and the healthy reward incentives available along with, like, a provider training to help support that as well, because I know that while time is of the essence and very limited to be able to refer back to those trainings,

those virtual trainings, we do want to make that a little more accessible and available as the provider is working directly with the patient for any Anthem members.

MS. MOORE: Okay, thank you.

MS. CECIL: I also think -- and maybe someone on Team Medicaid can confirm, but I do believe we have, hopefully, maybe, it's helpful, a snapshot of every MCOs value-added benefits so at least at a high level you can see, and you can quickly just pull that out and see what the value-added benefits are, it is all encompassed on one page. Anybody from Medicaid, do we still do that?

MS. PARKER: Yes. We have a value-added benefits, what we call a side-by-side. It is on our DMS website, but we can also have Erin or Kelli send that to the TAC members as well.

MS. MOORE: I think that --

MS. BICKERS: Can you hear me?

MR. MARTIN: It's very well done.

MS. BICKERS: This is Erin on Kelli's computer. Sorry about that. I'm having issues.

The value-added benefits for 2024 was emailed out to all of the MAC and TAC members, I want to say several weeks ago, but I'm happy to pull that and resend it to you guys after the meeting.

MS. MOORE: Didn't you send -- is that what you sent, maybe, last week, Erin?

MS. BICKERS: I have sent it twice. I received one and then I received also an updated one, and sometimes all of those email blasts tend to run together. I know it was fairly recently that the revised one went out, but I will pull that and send it in your all's updated meeting.

And again, I apologize for all of the Zoom problems.

MS. CECIL: That's okay. I don't know if anybody can quickly go out to our website and pull the link to add to the chat for everybody on the call today, I think would be helpful.

MS. PARKER: I can do that.

MS. CECIL: Try to do that, Erin.

MR. MARTIN: We talked about this years ago, and you guys did pull together the sheet, so we really appreciate it. It is helpful.

MS. MOORE: One of the things that I'm thinking about just in looking at it is, you know, trying to almost put on the other axis, the common barriers that we see in the clinics. You know, creating a sheet that says, "transportation," and here, if you've got member who has a transportation problem, here is what their particular MCO is able to offer to support that.

You know, one of the other things that we see pretty frequently -- Barry, I don't know, Dennis, if you see this as well, but when you are referring patients to specialists, particularly specialists not affiliated with a large system, they oftentimes aren't offering translation services, and they are putting

back to the primary care provider to send a translator with the patient that we are referring. So having that at the quick and ready is probably helpful as well.

MR. MARTIN: We don't have much of that problem in Eastern Kentucky, but I know farther west it does become a problem.

MS. MOORE: Maybe you're just good people out there, Barry.

MR. MARTIN: I think we have less of a population.

MS. MOORE: All right. So other business from committee members to bring forward today?

MR. HOUGHLAND: Stephanie, I'm not a committee member, but if I could chime in really quick. I don't want to make the day longer for everyone.

But with all of the communication issues that are going around, with AT&T and other cellular, there have been some emails going back and forth. But for those that aren't familiar with FirstNet as providers, I mean there

are some logistic things, and Stephanie and I have been sharing some emails around that about whether it's personal devices or if it's company-owned, et cetera, but I think the rules around FirstNet have broadened at the national level allowing more access to people working in healthcare fields, so just something to maybe think about. That system does allow for outages to shift to other carriers a lot easier than it does just switching cell phone towers. It also prioritizes email and other communications coming off of those devices so that you get less slowdown even, kind of, in normal time. I'm not necessarily making a sales pitch for AT&T and FirstNet on this, necessarily, but it does seem to make a difference in being able to have consistent access for those who are involved in the healthcare fields. Initially, it was just first responders and licensed individuals. It is now much more expanded.

For those who are part of the

association, think we've had think some communications going out around that, but just making a broader pitch as well. If it is a service that we can be available to those that are touching the service of, you know, peoples and communities, that is something that we should really explore.

MS. MOORE: Yes, thank you. We have already been impacted by that multiple times today.

It's amazing how much you rely on things and don't recognize that.

Other business to discuss today?

Are there specific recommendations that need to be made to the MAC?

MR. MARTIN: I don't think out of today's meeting we had any; did we?

MS. MOORE: I don't think so either.

MR. MARTIN: Just keep up the good work.

MS. MOORE: All right. Our next meeting is June 27th. So barring any other business, is there a motion to

adjourn the meeting?

MR. MARTIN: I'll make a motion to adjourn.

MS. MOORE: I'll motion.

MS. MOORE: Thank you, Barry.

MR. FOUCH: I'll second.

MS. MOORE: Thank you, Dennis.

Meeting adjourned. Thank you for your time today, everyone.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 6th of March, 2024

__/s/ Stefanie Sweet_____

Stefanie Sweet, CVR, RCP-M