CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

****

MARCH 28, 2024
9:30 a.m.

Stefanie Sweet, CVR, RCP-M
Court Reporter

A P P E A R A N C E S

Advisory Council Members:

Sheila Schuster - Chair
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Dr. Garth Bobrowski - Co-chair
Dr. Steve Compton
Heather Smith
Dr. John Muller
Dr. Ashima Gupta
John Dadds
Dr. Catherine Hanna
Kent Gilbert
Mackenzie Wallace
Annissa Franklin
Beth Partin
Bryan Proctor
Peggy Roark
Eric Wright

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1 MS. BICKERS: Good morning,
2 everyone. This is Erin from the
3 Department of Medicaid. It's not quite
4 9:30 and the waiting room is still
5 clearing out, so we will give it just a
6 moment before we get started.
7 DR. SCHUSTER: Is everybody in
8 from the waiting room, Erin?
9 MS. BICKERS: I was just trying
10 to unmute myself. We still have a flood
11 of people coming in. So if you'd like to
12 give it just a second.
13 DR. SCHUSTER: Okay.
14 MS. BICKERS: I was searching.
15 You came in with a large group and I
16 didn't see you. You snuck in on me.
17 DR. SCHUSTER: Well, and I had
18 the wrong name. I was traveling incognito
19 with my name. I had to change that and
20 get my video on, so.
21 Yes, Cat, you are right. Just
22 trying to sneak around.
23 MS. BICKERS: The waiting room
24 is officially -- well, we've got one more,
25 but we are pretty much cleared if you

1 would like to go ahead and begin.
2 Okay. Good morning, everyone.
3 Some of us have had late nights watching
4 the action in the General Assembly, so
5 hopefully everybody can join who needs to
6 be with us. We will call the meeting to
7 order. The MAC meeting for March 28th,
8 2024. And Mackenzie Wallace, if you are
9 on, would you call the role, please?
10 MS. WALLACE: Yes, ma'am.
11 Good morning, everyone.
12 Apologies, I think I missed our last
13 meeting. It has been quite a busy
14 session. So --
15 DR. SCHUSTER: Yes, it has been.
16 MS. WALLACE: My apologies.
17 DR. SCHUSTER: No problem.
18 Thank you, Mackenzie.
19 MS. WALLACE: Of course.
20 Elizabeth Parton?
21 DR. SCHUSTER: She is going to
22 be a few minutes -- or an hour late. She
23 texted me, but she's coming.
24 MS. WALLACE: All right.
25 Nina Eisner?

1 MS. EISNER: I'm here.
2 MS. WALLACE: Susan Stewart?
3 MS. STEWART: I'm here.
4 MS. WALLACE: Dr. Roberts?
5 DR. ROBERTS: I'm here.
6 MS. WALLACE: Heather Smith?
7 (No response.)
8 MS. WALLACE: Dr. Bobrowski?
9 DR. BOBROWSKI: Here.
10 MS. WALLACE: Dr. Compton?
11 DR. COMPTON: Here.
12 MS. WALLACE: Dr. Muller?
13 MS. BICKERS: He is on spring
14 break this week.
15 MS. WALLACE: Lucky.
16 Dr. Gupta?
17 (No response.)
18 John Dads?
19 DR. SCHUSTER: I think Ashima is
20 on. I saw her thing. She may be muted.
21 MS. WALLACE: Okay.
22 MS. BICKERS: Heather Smith is
23 currently joining as well. I think you
24 just called her name.
25 MS. WALLACE: Great.

1 Let's try again. John Dads?
2 (No response.)
3 MS. WALLACE: Dr. Hanna?
4 DR. HANNA: Here.
5 MS. WALLACE: Barry Martin?
6 (No response.)
7 Kent Gilbert?
8 MR. GILBERT: I'm here.
9 MS. WALLACE: Mackenzie Wallace?
10 I am here.
11 Anissa Franklin?
12 (No response.)
13 Dr. Schuster, you are here?
14 DR. SCHUSTER: Here.
15 MS. WALLACE: Brian Proctor?
16 (No response.)
17 Peggy Roark?
18 (No response.)
19 Eric Wright?
20 (No response.)
21 And Commissioner Lee?
22 COMM. LEE: I am here.
23 MS. BICKERS: Mackenzie, I see
24 Peggy Roark logged in. She might not have
25 heard you. She just logged in, for the

1 record.

2 MS. WALLACE: All right. Anyone

3 who has just joined that I may have

4 missed? Dr. Gupta, okay. Dr. Gupta is

5 here. She says she cannot hear though.

6 She wonders if she is still in the

7 waiting.

8 MS. BICKERS: I'm sorry, who was

9 that you said can't hear?

10 DR. SCHUSTER: Dr. Gupta.

11 Ashima Gupta.

12 MS. BICKERS: No, we see her.

13 So I'm not sure. She's not -- there's no

14 one in the waiting room currently.

15 DR. SCHUSTER: And we also have

16 that from a pharmacist with Anthem that

17 says they cannot hear. So it must be at

18 there end; right, Erin?

19 MS. BICKERS: That would be my

20 guess. Can everyone hear me? I can hear

21 everyone. So I'm not sure.

22 COMM. LEE: Should we ask them

23 to log out and log back in and see if that

24 corrects it?

25 MS. BICKERS: That might be a

1 good idea, Commissioner, I know Zoom
2 has -- Dr. Schuster knows, we were
3 breaking up a couple of weeks ago during
4 Behavioral Health and Zoom and I have just
5 not been good friends, so.
6 DR. SCHUSTER: I'm not sure how
7 to signal them to log off and log back in.
8 COMM. LEE: I just sent them a
9 message in the chat. I just sent them a
10 message in the chat. Because they are
11 looking at the chat.
12 DR. SCHUSTER: Yeah. All right.
13 Well, let's go on. We have a
14 quorum, Mackenzie? Do we?
15 MS. WALLACE: Yes, ma'am.
16 DR. SCHUSTER: Okay. Let's go
17 on and approve the minutes of the January
18 25th meeting that was sent out by the
19 court reporter. Is there a motion to
20 approve?
21 MS. EISNER: This is Nina
22 Eisner. I will make that motion.
23 DR. SCHUSTER: Thank you.
24 MR. GILBERT: I'll second it.
25 DR. SCHUSTER: Was that Garth?

1 Who seconded, please?
2 MS. EISNER: Kent.
3 DR. SCHUSTER: All right.
4 Any additions, corrections,
5 revisions? All those in favor of
6 approving the minutes, signify by saying,
7 "Aye."
8 MAC MEMBERS: Aye.
9 DR. SCHUSTER: Any opposed? And
10 any abstaining? Thank you.
11 Our perennial question, although
12 there may be a slightly different answer
13 this time, what's the status of Anthem
14 MCO, Commissioner?
15 COMM. LEE: Well, it does still
16 remain the same answer. All legal avenues
17 have not entirely been exhausted, so the
18 legal proceedings are not final as of
19 today. So we may have a different update
20 at the next MAC meeting, but as of right
21 now, no change.
22 DR. SCHUSTER: Although there
23 was a court ruling.
24 COMM. LEE: Yes.
25 DR. SCHUSTER: Between this

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1 meeting and the last meeting that was not
2 in their favor, so the question is whether
3 they appeal and so forth.
4 COMM. LEE: Correct. So nothing
5 final yet.
6 DR. SCHUSTER: Yeah, thank you.
7 We had some questions because
8 the MCOs at our last meeting mentioned a
9 2 percent withhold to meet HEDIS quality
10 measures and we are wondering if that is a
11 change in the MCO Medicaid contract for
12 2024?
13 COMM. LEE: Yes, that was a
14 change in the contract in 2024, and I
15 believe later on in the meeting, Angie
16 Parker is going to give a little bit of an
17 update and explain a little bit about how
18 all that works and some of the parameters
19 around that and the specific quality
20 measures.
21 DR. SCHUSTER: Yes. I think
22 we've got some materials about that, so we
23 look forward to that later in the meeting.
24 Thank you.
25 And then, just going back

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1 because the Telehealth keeps coming up as
2 a question. Do any of the MAC members
3 have any questions on Telehealth? Any
4 differences between the federal and state
5 flexibilities?
6 MS. EISNER: This is Nina.
7 Sorry, have a question, still, about
8 whether or not PHP can be provided via
9 Telehealth.
10 COMM. LEE: Hi, Nina. We have,
11 and someone else has reached out to me
12 with that same question as well. We have
13 been communicating with CMS and I've not
14 heard back from them, but I will follow up
15 after the MAC meeting with CMS related to
16 that question.
17 COMM. LEE: Thank you.
18 DR. SCHUSTER: Thank you,
19 Commissioner. I know that's been a
20 question that hospitals and others
21 providing partial hospitalization. For
22 those who don't know PHP.
23 Any other questions that you
24 had, Nina?
25 MS. EISNER: No. That's all,

1 thank you.

2 DR. SCHUSTER: Okay, Kathy Adams

3 of the Children's Alliance has her hand

4 up. Kathy?

5 (No response.)

6 Ashima, you have your hand up?

7 Dr. Gupta? Now we can't hear you.

8 MR. GILBERT: Kathy says she

9 can't unmute.

10 DR. SCHUSTER: Yeah, do you have

11 the -- Erin, do you have people muted who

12 are not on the MAC?

13 MS. BICKERS: No. They should

14 have the ability to unmute themselves.

15 DR. SCHUSTER: Kathy, if you

16 can't unmute, would you put your question

17 in the chat, please?

18 MS. ADAMS: I just got it. I

19 was just able to unmute. I apologize.

20 This is Kathy Adams with the

21 Children's Alliance and we just received a

22 clarification from Behavioral Health

23 Department of Developmental Disabilities,

24 DBHDID regarding supervision performed via

25 Telehealth for CSAs, TSM, and peer

1 supports. Because their regulation
2 requires it to be in-person and so they
3 are going -- I think its face-to-face, but
4 their definition might be different. So
5 they intend to amend their regulation, but
6 did give us the green light to go ahead
7 and provide supervision for TSA -- CSAs,
8 TCM and peer supports by Telehealth until
9 they can get their regulation amended.
10 And I just wanted to make sure that it
11 wouldn't be a problem with Medicaid. The
12 Medicaid regs refer specifically to the
13 behavioral health regulation number, that
14 they have to follow the requirements of
15 that regulation. Is that on your radar?
16 COMM. LEE: Thanks for bringing
17 that to our attention. I would defer to
18 our behavioral health specialist to see if
19 that is on their radar. If not, what I
20 would recommend, definitely, in the event
21 of a future audit to keep that
22 documentation from DDID on the file, so
23 that you have that documentation from them
24 stating needed they have are amending
25 their records and they have given you the

1 approval to continue those services via
2 Telehealth and I will ask my behavioral
3 health team that is on the phone -- on the
4 call, if they have anything else to add to
5 that, or if there is anything on their
6 radar, or even if Jonathan is on the call
7 related to the regulation.
8 MR. SCOTT: Hello, Commissioner
9 Lee. Jonathan Scott, Chief Legislative
10 and Regulatory Officer, DMS.
11 That's correct. You know, we
12 defer to the licensing boards. So if you
13 have documentation from the licensing
14 boards that it is acceptable, then you
15 just need to keep that documentation and
16 it will be consistent with 3170.
17 DR. SCHUSTER: In this case,
18 Jonathan, it is not a licensure board.
19 It's actually the Department for
20 Behavioral Health. Would that also
21 qualify?
22 COMM. LEE: If our reg, Jonathan
23 referencees, the behavioral health reg?
24 MR. SCOTT: Yeah, but we do also
25 defer to other state and federal law so

1 you could use that justification as well,
2 to use the behavioral health reg, would be
3 my interpretation.
4 DR. SCHUSTER: Okay. In the
5 meantime, before they get their reg
6 changed, what you're suggesting,
7 Commissioner, is the letter would suffice
8 to move to that or be able to do
9 supervision via Telehealth. Not
10 inconsistent with the Medicaid reg and
11 they have the permission and the letter
12 from DBHDID.
13 COMM. LEE: Yes, and again, I
14 make sure to maintain a copy of that
15 letter on file for any future questions or
16 audits that may come up around those
17 services.
18 MS. ADAMS: That would be
19 wonderful. Thank you all so much.
20 MS. ADAMS: Kathy, can you
21 repeat the groups that you are going to be
22 able to do supervision via Tele? You said
23 peer support and who else?
24 MS. ADAMS: Community support
25 associates and targeted case managers.

1 And this is awesome so thank you
2 all so much.
3 DR. SCHUSTER: Thank you for
4 bringing it to our attention. Telehealth
5 is so important and I think we probably
6 just need to keep it on there in case as
7 things come along and until we get the PHP
8 resolved, we will just keep that on there.
9 Dr. Gupta, we are still up in
10 old business, I think you had a question
11 about where we were in the agenda. Did
12 you have a question about Telehealth?
13 (No response.)
14 Was there anything in the chat
15 from her?
16 MS. BICKERS: There is. I'm
17 trying to scroll, sorry.
18 COMM. LEE: She says --
19 MS. BICKERS: She says: In
20 regards -- sorry, Commissioner.
21 COMM. LEE: That's okay, Erin.
22 Yeah, she wanted us to repeat whether the
23 2 percent withhold was a change in the MCO
24 contract and, yes, that was a change in
25 the MCO contract.

1 DR. SCHUSTER: Oh, okay.
2 And, yes, Leslie Hoffman from
3 the behavioral health team says that they
4 will coordinate with DBH --
5 MS. HOFFMAN: Yeah, so it is
6 just hanging out there, Dr. Schuster, we
7 will connect with them.
8 DR. SCHUSTER: Okay, great.
9 You know, it is confusing to us
10 all when one state agency saying one thing
11 and another state agency saying another
12 thing and the providers get caught. We
13 don't want that to happen.
14 And Commissioner, the MCOs are
15 going to have these same HEDIS measures?
16 MS. PARKER: Commissioner, this
17 is Angie Parker. Would you like me to go
18 through a PowerPoint that I have regarding
19 the value-based payment program, or wait?
20 COMM. LEE: It's on down, I
21 mean, Dr. Schuster, it's up to you. We do
22 have on 5D the -- and quality measures, if
23 you would like Angie to go through her
24 presentation right now, we can go back up
25 to some of the others under 5.

1 DR. SCHUSTER: Why don't we have
2 you do that, Angie, since we have been
3 talking about the quality measures and
4 obvious, so it really doesn't matter if we
5 do that under 4B or 5D, if you don't mind
6 doing that, that would be great.
7 MS. PARKER: Not a problem.
8 DR. SCHUSTER: Thank you.
9 MS. PARKER: Now, to find it.
10 I've got too many windows. Here we go.
11 All right. So I had some
12 questions regarding the MCO value-based
13 payment program. And this value-based
14 payment program went into effect, which it
15 started in contract year 2024 and, yes,
16 there were some contract changes
17 specifically that address this. The
18 value-based program is, we worked with our
19 actuary to determine this and what would
20 be the best measures for the state of
21 Kentucky and where we want to incentivize
22 our MCOs for potential payment strategies
23 to achieve positive outcomes.
24 Some of the -- within the
25 program development and the strategy and

1 goals we are to reward the plans that
2 perform well and penalize the plans that
3 perform poorly. We want to use this
4 program to improve Kentucky's national
5 state health ranking. As you may have
6 heard in other meetings with the
7 Commissioner, we're now at 41 percent.
8 So, you know, we are trying to get that
9 under, even better. So that is part of
10 what this program is as well.
11 Includes performance targets
12 that are realistic and achievable;
13 incentivize quality outcomes; be
14 operationally straightforward to oversee
15 and manage; and hopefully ease
16 administrative burdens for our providers
17 to participate.
18 So how was it designed? As you
19 mentioned, we do have a 2 percent
20 capitation withhold for the contract value
21 for MCO. There are six core measures plus
22 a bonus pool for eligible MCOs. They are
23 to achieve at least 3 percent or 4 percent
24 improvement from measurement year '22
25 HEDIS measures to earn this withhold.

1 They must earn withhold on four core
2 measures and maintain performance on all
3 core measures to be eligible for the bonus
4 pool and it is pass/fail.
5 So what are the measures? The
6 core measures include preventive services
7 for children, postpartum care,
8 immunizations, and we are looking at the
9 chronic condition of diabetes.
10 We are also, for social needs
11 screening, it is a report only for 2024
12 because it is a new HEDIS measure. Also,
13 for immunization for adolescents, the IMA
14 Combo 2, we are allowing just IMA Combo 1
15 for 2024 and the HPV reporting only for
16 2024 to allow for more education for
17 providers and members on the importance of
18 getting the HPV vaccination.
19 If the MCOs have to meet at
20 least four of these, 3 percent or
21 4 percent, depending on the percentile of
22 the HEDIS measure in order to be eligible
23 for the bonus pool. And they have to
24 meet -- these are the measures that they
25 would be eligible for to receive

1 additional monies for.

2 So metabolic margin for children

3 and adolescents on antipsychotics;

4 follow-up after emergency department

5 visits for alcohol and drug dependence

6 within seven days of an ED visit; weight

7 assessment and counseling for nutrition

8 and physical activity for children and

9 adolescents; and breast cancer screening.

10 So that is it in a nutshell.

11 Very high level on what the measures are

12 and what the capitation and what we are

13 withholding. And we are administering

14 that in the start of 2024, based on 2022

15 HEDIS measures. So they have to get at

16 least 3 percent or 4 percent improvement

17 in 2024.

18 DR. SCHUSTER: Angie, I have a

19 couple of questions. Would you go back to

20 the core? They have to have four out of

21 those core measures?

22 MS. PARKER: Yes, ma'am.

23 DR. SCHUSTER: But two of them

24 are report-only so they qualify or they

25 meet that core measure if they have that

1 report?

2 MS. PARKER: Well, for the

3 immunization for adolescents, it is

4 actually IMA Combo 1 that they would be

5 graded on. IMA Combo 2 includes HPV.

6 That section is report-only but you have

7 to meet the IMA Combo 1. You have to

8 improve upon that.

9 DR. SCHUSTER: Okay. And then

10 on the social needs which is brand-new --

11 MS. PARKER: Yes, ma'am.

12 DR. SCHUSTER: -- they have to

13 demonstrate that they --

14 MS. PARKER: Right. They will

15 be establishing the baseline for this one

16 in 2024, because there was no one in 2022

17 for this particular.

18 DR. SCHUSTER: Okay. All right.

19 And then, if you'd go to the next one. I

20 cannot tell you how happy I am to see the

21 metabolic monitoring. You know, we have

22 way too many kids, particularly foster

23 kids, who are on antipsychotic

24 medications. I know that U. of L. has

25 reported on that on a number of occasions,

1 so I am thrilled to see that that is one
2 of the things. I actually think it ought
3 to be a core measure, because it really
4 ought to be done for every kid in that age
5 group that's on antipsychotic medication,
6 because as you all know, FDA does not
7 approve medications for kids that young,
8 so I applaud that. Thank you.
9 Are there any other things from
10 any of the MAC members? And you will
11 share these with Erin so she can send them
12 out to us afterwards? The slides?
13 MS. PARKER: Absolutely. Yes,
14 ma'am.
15 DR. SCHUSTER: Thank you.
16 MS. EISNER: I have a question.
17 I am surprised there are no measures for
18 psychiatric hospitals. You know, one of
19 the things they watch very closely is the
20 HEDIS measure for ambulatory follow-up
21 within 7 and 30 days post-acute
22 hospitalization, and that is something
23 that is really important. And sometimes,
24 you know, if there is not sufficient
25 geo-access or you all monitor, of course,

1 missed appointments, so maybe in future
2 years, you all can consider adding that to
3 oneof the measures.
4 MS. PARKER: Yeah, we can look
5 at that. Just so everyone understands how
6 we came up with these measures. We looked
7 at HEDIS from the measurement year 2022,
8 all of the measures, and where the MCOs
9 measures were lacking or less than the 25
10 percentile and knew that there was a lot
11 of room for improvement. I would have to
12 go and look, Nina, at the specific measure
13 you are talking about to see maybe they
14 are performing well on that, but
15 certainly, this will be an ongoing thing,
16 evaluating each year if we need to make
17 any adjustments to this, but thank you.
18 MS. EISNER: Thank you.
19 MS. PARKER: We will certainly
20 look at that. I see Dr. Bobrowski has his
21 hand raised.
22 DR. BOBROWSKI: Yeah, just a
23 question on -- and I don't know a whole
24 lot about all of this except for some of
25 the things that you see in the news, but

1 that metabolic monitoring in children and
2 adults on the antipsychotics, does that
3 monitoring also involve or include the
4 hormone blockers that some of the doctors
5 are using in our teenagers?
6 MS. PARKER: I don't know the
7 answer to that question, Dr. Bobrowski.
8 I'd have to go look and see. I'm thinking
9 maybe not, but I would have to go back to
10 look at what the specifics are underneath
11 that.
12 DR. BOBROWSKI: Okay, thank you.
13 MS. PARKER: And follow up with
14 that.
15 DR. SCHUSTER: Arthur, if you
16 are talking about puberty blockers, they
17 are no longer allowed in Kentucky for
18 children under 18 unless they have a
19 specific metabolic -- in other words, they
20 are not used for gender transition after
21 the passage of Senate Bill 150 last
22 session.
23 DR. BOBROWSKI: That's right. I
24 remember that now, thank you.
25 DR. SCHUSTER: Unfortunately.

1 So those kids are not getting treatment
2 for gender dysphoria here in Kentucky.
3 Just a reminder about that. Any other
4 questions that any MAC members have?
5 (No response.)
6 All right. Hearing none, thank
7 you very much, Angie. That is very
8 helpful. I appreciate your doing that.
9 MS. PARKER: You're welcome.
10 DR. SCHUSTER: Let's move on to
11 updates. We want to start by
12 congratulating Commissioner Lee on being
13 named the board chair of the National
14 Association of Medicaid Directors. That
15 is a big deal and so we are very proud of
16 you, Commissioner Lee, and very proud of
17 Kentucky, for being recognized in the
18 leadership position. I understand that
19 Dr. Stack holds a similar position among
20 the public health commissioners, as well,
21 so congratulations.
22 COMM. LEE: Thank you so much.
23 My tenure, I guess my new role with NAMED
24 will start on April 1st, so I am really
25 excited to be able to work with all of the

1 Medicaid directors across the country and
2 help put forth Medicaid issues, concerns,
3 and priorities and put them forth on a
4 national level and needs on a routine
5 basis with CMS, and while I will be
6 representing the entire country with the
7 Medicaid program, we can always put forth
8 Kentucky's priorities too, so it does give
9 us a little bit of an opportunity. And I
10 am very excited to start that new role.
11 It will not impact my role as Commissioner
12 in the Department of Medicaid Services, I
13 am still going to be here, it is just a
14 little bit more -- I guess a little bit
15 more responsibility that will help us, I
16 think, at the national level. So very
17 excited for that opportunity, and thank
18 you so much, Dr. Schuster.
19 DR. SCHUSTER: Well, and more
20 contact with CMS is always helpful to the
21 state and I know you all work hard to have
22 a good working relationship with CMS, but
23 it puts you in a great position for that,
24 so we are grateful for that and for your
25 leadership.

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1 Let's talk about unwinding
2 Medicaid. Any changes in approach and
3 flexibilities?
4 COMM. LEE: I think we have --
5 DR. SCHUSTER: That's typically
6 Deputy Senior Commissioner, Veronica Judy
7 Cecil.
8 SR. DEP. COMM. CECIL: Hi, good
9 morning, everyone. This is Veronica Judy
10 Cecil, Senior Deputy Commissioner.
11 Dr. Schuster, I wasn't sure if
12 you wanted me to get into any numbers
13 today. I'm prepared to do that if you
14 want, but we just held our stakeholder
15 meeting last Thursday and that
16 presentation, recorded presentation and
17 slides, are up on our website.
18 I did -- the only thing that
19 really has changed other than the numbers,
20 is that we have decided to redistribute
21 about 39,000 individuals into May as a way
22 for us to manage workload. Our March and
23 April numbers are fairly high in the
24 number of renewals. For March, they are
25 116,000 and for April it was 103,000

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1 individuals going through a renewal so we
2 did want to distribute some of our folks
3 into May, which was approved by CMS for us
4 to do that. So you will see, still,
5 individuals going through their first
6 renewal following the public health
7 emergency in May.
8 DR. SCHUSTER: I think it's
9 helpful to see some of those numbers. We
10 have that at the BH TAC, and I think that
11 is the new group that you are going back
12 and doing the lookback on is particularly
13 interesting.
14 Veronica, if you could share
15 your slides, that would be great.
16 SR. DEP. COMM. CECIL: Happy to.
17 DR. SCHUSTER: Okay, great.
18 SR. DEP. COMM. CECIL: Erin, I'm
19 going to kick you off. Thank you all.
20 Okay. All right. Let me just
21 pop -- don't get too sick. One thing I
22 would like to mention, is we did move the
23 flexibilities related to the 1915c home
24 and community-based waivers into amended
25 waivers, and we just got notice a day or

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1 two ago that all of the waivers are now --
2 have been approved by CMS so all of the
3 amendments that we put into those waivers,
4 which are out on our website, are now part
5 of and permanent as part of the approval
6 of those waivers. So I did want to
7 mention that. We do have a really good
8 website related specifically to Appendix K
9 and those waivers --
10 (Audio interruption.)
11 DR. SCHUSTER: If you are not
12 speaking, please mute.
13 I just want to point out to
14 people, Veronica, that the budget that was
15 just passed by the Senate has a
16 significantly increased number of
17 placements or slots -- I hate slots
18 because it sounds like widgets and we know
19 that these are people. But it
20 significantly expanded number of people
21 who can go into the HBC and Michelle P.
22 and SCL waivers so having those approved
23 by CMS and having those flexibilities in
24 Appendix K is really helpful. So thank
25 you for that.

1 SR. DEP. COMM. CECIL: You are
2 so welcome. Our team Medicaid for the
3 waivers, they are amazing. And have done
4 a lot of work on those efforts.
5 So what you are looking at is
6 new to folks who might have seen our
7 presentation in January or the typical
8 presentation that we give. But just to
9 explain what is going on, it may look a
10 little overwhelming, and I'm not going to
11 go through all of these numbers, but what
12 you are seeing, in October of last year,
13 CMS instructed Medicaid state agencies to
14 start recording an updated monthly report
15 that provides information about any
16 pending cases following 90 days after the
17 renewal month that had been processed.
18 So on the left side, here, you
19 see our original monthly CMS report. So
20 these are from May to November, what we
21 reported in that normal CMS monthly
22 report. All of these are still on our
23 website. In that, you see the pending
24 list, we will take May for an example.
25 You see we had 2,698 pending cases when we

1 reported that for our May renewals. A
2 pending case means that the member has
3 responded to a notice or provided us
4 information and the state had not yet
5 taken action on that when the renewal date
6 passed.
7 So on May 31st, we had 2,698
8 cases pending and they got extended as
9 part of that until the state could process
10 those pending cases. So in the middle
11 there, is that 90-day processing period
12 so, again, following the 90 days from each
13 renewal month. In May, we were able to
14 process 2659 of those pending cases.
15 So on the right side, you are
16 going to see our updated numbers as a
17 result of that processing. You will see
18 that our approval numbers and our
19 termination numbers have moved slightly as
20 a result so that we can put someone in the
21 correct column.
22 We do still have some pending.
23 That is not too unusual for Medicaid and
24 the reason for that, generally, sometimes,
25 is that it is a complex case, but these

1 folks should still be covered as that
2 pending case continues.
3 So that is what you are going to
4 see now on our website is the report that
5 is required by CMS, initially, and the
6 updated report for each month showing that
7 90-day period. We do have to wait until
8 the 90-day period exhausts, and the report
9 is due the 15th of the month following
10 that, so that is why we have May through
11 November so far. We will provide this to
12 the MAC members and it will get posted on
13 the MAC website, but this is out right now
14 as a result of the March stakeholder
15 meeting.
16 So just looking at the most
17 current numbers from our last MAC meeting,
18 that would be for January and February.
19 You see, there, the individual number for
20 renewals for that month, the Medicaid
21 approvals for that month, and then the
22 terminations. Still some pending, and the
23 extended are those folks who use the
24 flexibility. They can have an additional
25 up to three months if they're long-term

1 care or 1915(c) waiver members and they've
2 not yet returned that notice, we can
3 extend them up to three months past their
4 renewal date. That's not the same thing
5 as the 90-day reinstatement, which I'll
6 talk about, but this is actually us being
7 able to keep the person covered for an
8 additional up to three months if they've
9 not returned that packet, so we cannot
10 procedurally terminate them.
11 And then for everyone else, they
12 get a month. So if somebody hasn't
13 responded by the end of February, then we
14 can give them an additional month to
15 return that information. We do conduct a
16 lot of additional outreach during that
17 time, both the state and managed-care
18 organizations, outreach to those members
19 to try to get them to respond to that
20 notice.
21 The reinstatement on the far
22 right, there, is if somebody, after they
23 terminate, and within 90 days following
24 that, they provide the information we
25 needed because they didn't respond, and

1 then we can determine them eligible based
2 on that information, and we can reinstate
3 them back to their renewal date 90 days as
4 if there was no gap in their coverage. So
5 we still try to outreach to folks, and to
6 providers, or anyone who comes across a
7 Medicaid member who was terminated for not
8 responding, that they can still, within
9 these 90 days, still try to work through
10 their renewal. Those are the numbers.
11 Happy to take any questions.
12 DR. SCHUSTER: Thank you so
13 much, Veronica. Are there any questions
14 from any of the MAC members?
15 Just a reminder to all of you,
16 particularly those who represent
17 providers, that we really do have an
18 obligation to keep reminding people to
19 respond to these requests for information.
20 And I know, Veronica, that you
21 got on your website, some easily
22 downloadable flyers or poster kinds of
23 things that people can post in their
24 offices and clinics and they are available
25 in both English and Spanish, as I

1 remember.
2 SR. DEP. COMM. CECIL: That's
3 correct. I think the other thing,
4 Dr. Schuster is, though we really
5 increased our outreach as a result of the
6 public health emergency unwinding, we are
7 looking at keeping the nudges and the
8 outreach as we move into the new normal of
9 enrollment and eligibility processing.
10 And so we hope that all of our
11 stakeholders, all of those folks out there
12 supporting our members, the families, the
13 advocates, the providers, that we stay,
14 you know, I think, vigil in reminding
15 folks about the fact that they have to go
16 through an annual renewal. So we hope
17 that all of those communications, you
18 know, continue to be used following the
19 public health emergency unwinding.
20 DR. SCHUSTER: That's a great
21 point. And I see that Beth Fisher has
22 just put a link in the chat for anyone who
23 needs those materials. Obviously not just
24 the MAC members, but the people who are
25 attending this meeting. It's just so

1 important that we keep people enrolled who
2 are eligible, and we checked their
3 eligibility, so we appreciate it. And I
4 know this has been your baby from the
5 beginning, Veronica, so we appreciate the
6 updated numbers as well.
7 SR. DEP. COMM. CECIL: You're
8 welcome.
9 DR. SCHUSTER: Commissioner, I'm
10 sorry, we congratulated you and then
11 immediately went to specific reports.
12 Let's go back and see if you have some
13 general comments or updates that you want
14 to give from the department.
15 COMM. LEE: Yeah, I think I'd
16 like to take this opportunity,
17 Dr. Schuster, coming on the heels of the
18 quality update that we just heard.
19 I'd like to take this
20 opportunity, if I could, to talk about
21 America's health rankings. In 2014,
22 Kentucky was ranked 47th. and we have
23 moved up in the rankings to 41st as Angie
24 has pointed out in her presentation. I
25 think it's a wonderful, wonderful thing,

1 but let me see if I can share my screen.
2 I would like to -- let's see if I can
3 figure out how --
4 MS. BICKERS: One second,
5 Commissioner. I need to make you a
6 cohost.
7 COMM. LEE: Thanks, Erin.
8 MS. BICKERS: You should be good
9 to go now.
10 COMM. LEE: Let's see. Can you
11 all see my screen now with the America's
12 health --
13 DR. SCHUSTER: It just says you
14 started screen sharing, yeah.
15 COMM. LEE: Yeah, you can see
16 that?
17 Okay, this is Kentucky. This is
18 America's health rankings and they have
19 every single state listed and where they
20 rank. As you can see, Kentucky is the
21 41st. We can see that our strengths are
22 definitely a low prevalence of excessive
23 drinking, which we think is really good.
24 We have a high prevalence of colorectal
25 cancer screenings, and we have a high

1 supply of primary care providers, which
2 was just a little bit surprising to me,
3 but that is another strength.
4 Challenges, of course, are
5 prevalence of multiple chronic conditions,
6 high occupational fatality rate. I don't
7 know that this group can do anything about
8 that. And high prevalence of insufficient
9 sleep.
10 We've moved from -- we've had an
11 increase in homicides, we've also had an
12 increase in diabetes and we've had a
13 decrease in physical inactivity. These
14 health rankings are for the entire state.
15 They are not just for Medicaid. However,
16 we think that the 1.5 million members that
17 we serve, if Medicaid can be a leader in
18 improving the healthcare status of those
19 individuals, then we can also improve the
20 health status of this state overall. So
21 we think that Medicaid has a really good
22 position to, kind of, make a difference in
23 health policy and be a leader.
24 And I've highlighted some of the
25 areas that we could concentrate, for

1 example, our adverse childhood
2 experiences, we rank 46. So all of these
3 areas that I've just highlighted a few, I
4 think, you know, definitely room for
5 improvement.
6 I think Dr. Bobrowski will
7 agree, you know, dental providers number
8 per 100,000 we rank 32nd in the nation.
9 You know, how can we get more dental
10 providers to focus on oral health.
11 Preventative clinical services, again, we
12 rank 42nd on the number of adults who have
13 visited a dentist.
14 The HPC vaccine, you know, we
15 saw that in our quality measures that we
16 have put in place for the managed-care
17 organizations. We are hoping to make a
18 difference there. Preventable hospital
19 discharges, exercise, physical activity,
20 teen -- smoking. Here is a really big one
21 is, smoking and the percentage of adults.
22 And just recently, this month, the Center
23 for Medicare and Medicaid Services
24 released a guidance related to what states
25 can do, specifically Medicaid agencies, in

1 order to reduce smoking in the state. So
2 what I want to do is, I want to send a
3 link to Erin, and I will give that to her
4 to send out to the TAC, and what I would
5 like for you to do and request your
6 assistance is, looking at this America's
7 health rankings, looking at something that
8 we think we could make a difference in.
9 So let's look at the policies, the
10 Medicaid policies around those certain
11 measures, and what sort of information do
12 we need to see, where, what data do we
13 need to see from our claims information
14 that we can start looking at to make a
15 difference in some of these measures.
16 I mean, drug deaths we are 47th.
17 We know that we've got pretty extensive
18 behavioral health delivery system, but
19 what else can we do in order to bring that
20 number into an alignment with, at least on
21 the national level, or increase it for our
22 members, premature deaths, again, physical
23 health, we know frequent physical
24 distress, low birthweight babies, how can
25 we improve that? And it's not just us and

1 it's not just the MAC, it's any of our
2 partners across the state. And
3 particularly, our sister agencies, the
4 Department for Public Health, Department
5 for Committee-based Services, Behavioral
6 Health, and our Department for Aging and
7 Independent Living, happy to form any kind
8 of workgroup to work on any of these
9 measures.
10 Obesity, you see that we are
11 37th. What can Medicaid do? What
12 policies can we look at? Are there
13 educational materials that we can develop
14 specifically for our members and, if so,
15 what does that look like? So just again,
16 I would like the MAC to look at all of
17 these measures, look at the report, and,
18 kind of, help Medicaid figure out, like,
19 you know, what we can do. Because the
20 report itself basically states that this
21 is sort of a roadmap. That they urge
22 policy makers and leaders to use this
23 report as a snapshot of the post-pandemic
24 health landscape and improving health
25 outcomes for all needs to remain at the

1 forefront of our nation's priorities, and
2 I could not agree more with that. And I
3 think that we have an opportunity with,
4 given air quality measures, not only with
5 our MCOs but with our hospitals and our
6 directed payments. We have an opportunity
7 to further increase Kentucky's health
8 rankings, and I would just ask for your
9 future collaboration, and would be remiss
10 if I didn't thank you for everything that
11 you have done on the MAC and the TACs to
12 help us get to 41st, because we did not do
13 that on our own. This was a collaboration
14 and just want to make sure that we are
15 using this information in a way that
16 guides us on a road map in improving the
17 health status of all those that we serve.
18 DR. SCHUSTER: Thank you so
19 much. I think this is an excellent
20 project for the MAC and I hope that the
21 link will link us to your version of this
22 where you have highlighted some of the
23 ones --
24 COMM. LEE: Yes.
25 DR. SCHUSTER: -- that stick out

1 to you. That would be great. And Erin
2 can share that and then I'll get with the
3 MAC members and see and the TAC chairs,
4 actually, and see what kind of
5 recommendations we can come up with, or
6 projects to look at some of these things.
7 COMM. LEE: And again, we are
8 happy to pull in other partners and form
9 little workgroups if you think that is
10 necessary.
11 DR. SCHUSTER: Yeah. Yeah.
12 That is great.
13 Are there any questions from any
14 of the MAC members about the health
15 rankings or the Commissioner's thoughts
16 about this?
17 MR. GILBERT: I would just like
18 to underscore the importance of this and I
19 would like to thank the Commissioner for
20 raising this. I think that, you know,
21 those who are in my circles know that I am
22 on a constant drumbeat that Kentucky
23 doesn't have to be in the lower ten of
24 every ranking. We have shown some
25 dramatic ability to improve, and I think

1 some of the next steps that might be --
2 Sheila, maybe you or Commissioner Lee,
3 maybe help us to identify where can we
4 have the greatest impact with limited
5 resources. As we know, some of these
6 things will be vastly improved with
7 improved budgeting, which we are at great
8 pains to get but at limited access to.
9 If there are ways that we can
10 target specific things that are within the
11 departments, the MAC's ability to
12 influence, I think that it would be a
13 great -- it would be a great project for
14 us to, sort of, be able to target
15 something and see those needles move, and
16 to then, God willing, use that to say,
17 look, this is the reason we need more
18 funding and here is how we can apply that
19 effectively.
20 I want to thank you so much for
21 raising this issue, because I think I am
22 unsatisfied deeply that we are 41st.
23 Not -- thrilled that we went from 47th,
24 but I don't think we should rest on any
25 laurels. I'm really glad that we got

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1 better, but we ain't there, and anything
2 we can do to get better, particularly in
3 outcomes for children and preventative
4 care, all of the things that you
5 highlighted are very, very important.
6 COMM. LEE: I couldn't agree
7 more.
8 DR. SCHUSTER: Yeah, any
9 other -- Garth, did you have your hand up?
10 DR. BOBROWSKI: Yes, please.
11 Just wanted to thank Commissioner Lee for
12 bringing these up, and I know you
13 mentioned one of them was the drug use and
14 it was -- I was watching a news channel
15 the other day, and they had the President
16 of Mexico on there, and in a way, he made
17 a stunning remark that the United States
18 drug problem was not his problem. And in
19 a way, I guess, I hate to admit it, but in
20 a way, he's correct. But it's like, why
21 do Americans seek these drugs, and you all
22 know once you get on one, you want to
23 get -- your body becomes immune to it, and
24 you need more or a stronger dose. And I
25 know a few years back I did almost, like,

1 a term paper for the Kentucky Dental
2 Association on narcotics, opioids, and
3 prescription writing and all of that. But
4 it's kind of like, those are things that
5 Commissioner Lee says that we need to look
6 at even how other states, or brainstorming
7 within this group, how to decrease the
8 demand in Kentucky. I know there used to
9 be a DARE program through the school
10 systems that they had, I think, was maybe
11 fifth or sixth graders, but to be honest,
12 I don't know the final results or even if
13 there is a way to test the results of
14 those programs, but you are right. I
15 mean, knowledge is what we got to get out
16 there, but when so many children are
17 raised in a drug-using home or
18 environment, that is all they know.
19 But I just wanted to emphasize
20 what Commissioner Lee was saying on drug
21 use, and I agree with Kent on some of the
22 things that he was saying. So thank you,
23 just a comment.
24 DR. SCHUSTER: Thank you, Garth.
25 And we are going to talk, later, about

1 expanding healthcare access in schools,
2 both on the behavioral health side, and
3 the physical health side, and I think that
4 we've got to concentrate our efforts on
5 prevention and education there. I think
6 you are right. Unfortunately, I don't
7 think the DARE program yielded the results
8 that we hoped that it was going to and the
9 Just Say No part of that was easy to say,
10 but I think we can come up with some
11 things and there are some things in the
12 works, I think.
13 Any other -- Dr. Gupta is
14 saying: This is good information,
15 Commissioner.
16 Any other questions or comments
17 from any of the MAC members?
18 Okay. Well, thank you. I think
19 that is very stimulating and certainly
20 gives us some excellent guidance,
21 Commissioner, and something to work from,
22 which is really helpful.
23 I think, Leslie, you are
24 probably up on the Mobile Crisis
25 developments since our last report,

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1 please.
2 MS. HOFFMAN: Yes, and I would
3 just say, we're busy both internally and
4 externally right now, with our
5 stakeholders and providers. Lots of work
6 is going on and we probably have anywhere
7 from 7 to 10 meetings a week in various
8 different areas, so I think I've told you
9 before, that we met with the CMHCs, we
10 started with the CMHCs and the CCBHCs as
11 the CMHCs are the safety net. We started
12 there. We have also started to reach out
13 to the RSUs and BHSOs.
14 We, actually, have meetings
15 today with additional providers. We've
16 reached out to four possible behavioral
17 health transport providers as well, and
18 trying to build capacity there, and will
19 be reaching out to more BHSOs in the near
20 future, and also any interested to
21 providers that can meet the criteria to be
22 Mobile Crisis providers, meet that
23 fidelity.
24 We did complete some policy
25 guidance. We sent it out related to the

1 Mobile Crisis services, and what the ASO
2 will be responsible for, and I think those
3 went out to all folks who were interested
4 in possible contracts, at the time, so
5 those will continue. We have ongoing,
6 regular weekly meetings with the MCOs and
7 continue to work on the contract.
8 Our CCR grant option, which is
9 our community co-response. I know you all
10 that every time I'm on here, that is going
11 so well. We have been so pleased with the
12 folks who have stepped up to the plate and
13 several of them have even met, like they
14 had to meet milestones within their grant
15 opportunities and several of those have
16 already exceeded their expectations on
17 their milestones. And we did a
18 in-person -- if you saw that on social
19 media just recently -- it was hybrid, but
20 we had a lot of folks there. Very
21 exciting times and we also met with each
22 one of those individually. So that is
23 pretty much my conversation about Mobile
24 right now. More to come very soon.
25 Dr. Schuster?

1 DR. SCHUSTER: And what is the
2 target implementation or go-live date?
3 MS. HOFFMAN: So our tentative
4 target was June and that may change based
5 on -- and just waiting to see what's going
6 on with the budget, and I won't speak much
7 more to that right now.
8 DR. SCHUSTER: Okay. I did look
9 at the budget, House bill 6, was passed by
10 the Senate, 36 to 1, I guess, last night
11 and there was no restoration of the Mobile
12 Crisis funds that had been taken out, so
13 continuing concern that we have there.
14 You had mentioned at the BH TAC,
15 Leslie, the policy guidelines. Could you
16 send me a copy of those, please?
17 MS. HOFFMAN: Yes. Sorry. I
18 didn't mean to cut you off. I thought --
19 they sent those -- I thought they were
20 going out individually, but they actually
21 send those out with the contract, so I
22 will get a copy of that for you,
23 Dr. Schuster.
24 DR. SCHUSTER: Yes, I would like
25 to share that with the BH TAC --

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1 MS. HOFFMAN: Absolutely.
2 DR. SCHUSTER: Obviously, with
3 anyone on the MAC that is particularly
4 interested, this is a major overhaul of
5 Mobile Crisis around behavioral health
6 issues to try and get treatment, not just
7 the 988 Call Line, but actual
8 transportation to treatment if necessary
9 at the time of crisis.
10 So any questions from anybody on
11 the MAC?
12 MS. EISNER: This is Nina. I
13 just have a question from our partners
14 with Medicaid. Is there any update on the
15 BHSOAODE rate increases? The last one was
16 April 1st of last year, and I think you
17 all were working on them. I didn't know
18 if anything had been finalized.
19 MS. HOFFMAN: Lisa, or
20 Commissioner Lee, correct me if I am
21 wrong, is that something that Victoria was
22 working on and she will bring back to the
23 Behavioral Health TAC in May?
24 COMM. LEE: Yes, we will follow
25 up on that, Nina.

1 MS. EISNER: Thanks.
2 DR. SCHUSTER: And we will keep
3 this item on the MAC agenda, Leslie,
4 because, obviously, there will be some
5 updates.
6 MS. HOFFMAN: Dr. Schuster,
7 would you mind if I mentioned the rate
8 situation where I called you the other
9 day?
10 DR. SCHUSTER: Yes.
11 MS. HOFFMAN: I'm sure folks
12 have questions about that. So on the
13 behavior health fee schedule that got
14 posted and sent to the MCOs, we did find
15 an error. It was a human error. It was
16 on the H0002. I think that rate was about
17 52.57, maybe. It will have an MEI which
18 is the Medicare Economic Index added,
19 which, I think, this year was around 4.6
20 and the new rate will be 65.45. So the
21 MCOs have already been notified of that,
22 and I've already requested for it to be
23 reposted with the correction on the
24 website. So there was not supposed to be
25 any decreases. There were 46 or more

1 increases. So no decreases. We will get
2 that one corrected if anybody is asking
3 about that one, Dr. Schuster.
4 DR. SCHUSTER: Yes, thank you.
5 And I proactively reached out to the CMHCs
6 and some of our big providers to let them
7 know that, so I appreciate that, and
8 appreciate the fact that there were no
9 decreases in any of the behavioral health.
10 I think you mentioned that some
11 of the Medicare rates had actually gone
12 down, but the Medicaid rates had not gone
13 down.
14 MS. HOFFMAN: A couple, I think,
15 went down and we ended up keeping the '23
16 rate. So there was no decrease for this
17 time.
18 DR. SCHUSTER: Yeah. That's
19 really good news. We appreciate that.
20 And Angie, you are back on
21 again, please. You had sent out some
22 materials on hospital and university
23 quality measures that we had or. We're
24 interested in learning more about.
25 MS. PARKER: Yes, I believe --

1 yes, Angie Parker, Director of Quality and
2 Population Health.
3 I believe Erin sent what the
4 preprint looked like, as far as what the
5 quality measures were for 2024. We are
6 actually working on 2025 and getting ready
7 to submit those. As you may or may not
8 know, this is an annual thing. We review
9 and update measures annually, and have to
10 submit it to CMS for their review and
11 approval.
12 I do have another little
13 PowerPoint --
14 DR. SCHUSTER: Good.
15 MS. PARKER: -- that shows this
16 information, you know, and as we continue
17 to discuss about the quality healthcare
18 and what Commissioner Lee just provided,
19 it's very exciting to me to hear
20 everybody's excitement on how to work
21 together to improve the quality of
22 healthcare, not just within our Medicaid,
23 but within the state, so I will pull this
24 up again, or another one.
25 MS. SHEETS: Give me just a

1 second, Angie. I had to step away for a
2 second, and I'm trying to stop her share,
3 so.
4 MS. PARKER: Can you see mine?
5 DR. SCHUSTER: Yes.
6 MS. PARKER: Okay. So what I'm
7 going to be showing you is what the
8 UK/UofL directed payment measures are;
9 what the Hospital Rate Improvement Program
10 measures are, and also the Value-Based
11 Payment Program with the MCOs, and all in
12 one little spot.
13 And, as you know, we are trying
14 to work to align all of these measures so
15 that we can all be working towards the
16 same goals. As you can see with UK/UofL
17 there are, you know, the well-child visits
18 which were on the Value-Based Purchasing
19 Program, what the Commissioner talked
20 about, how obesity is, we are very high on
21 the health index so postpartum depression
22 screening, SDOH, you know, chronic
23 conditions, tobacco use, all of these
24 measures that UK/UofL, and with their
25 Directed Payment Program are focusing on.

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1 And then the Hospital Rate
2 Improvement Program, it's more directed
3 for inpatient hospital with the
4 catheter-assisted UTIs, C diff, sepsis
5 screening, all cause readmissions
6 concurrent or e-prescribing, opioid
7 education, admission screening, hours of
8 restraint, hours of seclusion, and rehab
9 discharge and also social determinants of
10 health, which are not on this list, but
11 they were developing programs for 2023,
12 which they will be measured on in 2024.
13 And then, we just went over the
14 value-based purchasing measures, and how
15 UK/UofL and the Hospital Rate Improvement
16 overlap. They go through the 30 day all
17 cause and then the opioids.
18 Because UK/UofL has the clinic,
19 you know, outpatient clinic, that is where
20 a lot of their focus is and that does
21 correspond with our Value-Based Purchasing
22 Program. A lot of the same measures,
23 which you will see.
24 And that is all I have on this
25 little presentation.

1 DR. SCHUSTER: Okay. Can you go
2 back to the very first slide that had
3 UK/UofL?
4 MS. PARKER: Yes, ma'am.
5 DR. SCHUSTER: I'm really glad
6 to see the emphasis on screenings for
7 depression in different age groups,
8 postpartum, but also ages 12 to 17,
9 because we know that that is a time of
10 great angst for our preadolescents and
11 adolescents. And then it looks like, from
12 Angie, that that fourth one is for adults
13 screening for clinical depression, if it
14 doesn't have an H in the plan, that would
15 be for all adults patients; is that right?
16 MS. PARKER: Yes, ma'am.
17 DR. SCHUSTER: Okay. Good.
18 Glad to see that.
19 Are there any questions or
20 comments from any of the MAC members?
21 This makes more sense than what I was
22 trying to work my way through these
23 tables, at least preprints that came out,
24 and I was like, what is this?
25 MS. PARKER: This is very high

1 level, again, it doesn't go into the
2 detail of preprints, but I thought this
3 might be simpler. We are working to align
4 our quality measures within all of our
5 programs, you know, and Dr. Gilbert
6 improving at 41, we don't want to stop at
7 41. We want to move that needle.
8 We are, within the Division of
9 Quality and Population Health, we are
10 looking at those health rankings and how
11 we compare to the other states, and seeing
12 what they are doing. We just recently
13 completed a comparison to the number 1 and
14 2. Of course, it's going to be a
15 challenge to get down to that, but we are
16 also going to be looking at surrounding
17 states. Number 1 was Massachusetts, I
18 believe, or maybe they were second, and
19 New Hampshire. So, you know, those are
20 the northeast, but they are not on the
21 west side, so we are looking to see what
22 programs other states are doing, and
23 potentially how we can also initiate that
24 here.
25 DR. SCHUSTER: This maybe a

1 question more for the Commissioner, but as
2 you look at those health rankings,
3 Commissioner, if you look at southern
4 states, where is Kentucky? Because
5 southern states are always poorer in
6 general health and in funding, as Kent
7 pointed out.
8 COMM. LEE: Yeah, the least
9 healthy states are Alabama, Oklahoma,
10 Arkansas, Mississippi, and Louisiana. So
11 all of those southern states, you know, we
12 rank 41st. So we are a little bit better
13 than some of our neighbors, but the bottom
14 five are definitely those southern states.
15 DR. SCHUSTER: Well, we've
16 always said, and it's probably not very
17 nice, but we've always said, thank God for
18 Mississippi in most comparisons. But so
19 it is, I think that's interesting, Angie,
20 that you all are reaching out to look at
21 what other states and, obviously, 1 and 2
22 seem way ahead of us, but there may be
23 some lessons to be learned, but that
24 middle tier, the ones that are around 25th
25 to 35th, or something like that, it would

1 be nice to get into that tier next in our
2 rankings. Any other questions for Angie?
3 And again, you will share that PowerPoint
4 with Erin, correct? Please.
5 MS. PARKER: Yes, absolutely.
6 DR. SCHUSTER: Yeah, thank you.
7 Thank you very much.
8 And then, something that is near
9 and dear to my heart is expanding
10 healthcare access in schools. And I'm not
11 sure, Commissioner, who is reporting on
12 that.
13 COMM. LEE: I think Erica is on.
14 DR. SCHUSTER: Erica is on?
15 Good.
16 COMM. LEE: And if Erica is not
17 prepared, I can talk about it. I'm not
18 sure if Erica is still on, but I can start
19 out talking about it.
20 As you all know, early in 2020,
21 or maybe 2018 or 2019, Kentucky did a
22 state plan, we completed a state plan
23 amendment that allowed us to provide
24 school-based services, expanded access in
25 care, it was under the Free Care Rule. We

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1 don't like to call it the Free Care Rule,
2 but basically, before this rule came out,
3 CMS said state Medicaid agencies could not
4 pay for services in schools if that school
5 provided the service free for the
6 population, and they could not just bill
7 Medicaid for the service.
8 Well, then they reversed that
9 and said yes, they can bill, they can bill
10 Medicaid, so we had to get a state plan in
11 place, and we did. We got a state plan
12 improvement with CMS that allows us to
13 provide services outside of the
14 Individualized Education Plan. So prior
15 to this change, Medicaid could only pay
16 for services that were developed and in a
17 child's Individualized Education Plan.
18 So now, Medicaid can expand
19 services to any service that a school has
20 personnel able to bill. So a school, for
21 example, could bill for a well-child
22 check, or for speech therapy for a child
23 who is not -- does not have a developed
24 IEP.
25 So there is a huge work group

1 that was created and then COVID hit. And
2 so COVID took precedence over all of our
3 expanding health access in schools. So we
4 have taken this project back up. We did a
5 survey, because the first thing that we
6 want to do is get a lay of the landscape,
7 if you will, in our schools. We have some
8 schools that are not billing services
9 through the expanded care and, however,
10 they do have a relationship with some of
11 their community clinics to provide
12 services or to set up schools in the
13 clinic, so we are trying to get a lay of
14 the land to see what Medicaid can do to
15 help facilitate those services in schools,
16 because we do believe that that is
17 definitely a location where children are,
18 and we can focus on primary and preventive
19 care. And so, we have also embarked upon
20 some workgroups, for example, we have,
21 through the Annie Casey Foundation, there
22 is a children's behavioral health lab and
23 Medicaid is participating in that for the
24 Department of Behavioral Health, in
25 addition to the Department for Juvenile

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1 Justice. We also have a National
2 Governors Association of Behavioral Health
3 learning group which we are in
4 collaboration with Kentucky Department of
5 Education and the Governor's office is
6 heavily involved with that.
7 As well as, we have just
8 submitted a CMS grant application for
9 school-based services. If awarded, we
10 would be able to use funding to further
11 expand care in schools to children and
12 help schools come up to speed, for
13 example, on billing and that sort of
14 stuff.
15 So this healthcare access in
16 schools is a primary focus of ours. Erica
17 Jones is leading up those initiatives and
18 we are very excited about some of the
19 opportunities that we have to move
20 forward.
21 And if Erica, if she is on the
22 phone, if she would like to add anything
23 to that.
24 MS. JONES: This is Erica.
25 Commissioner Lee, I think you covered

1 everything.
2 Just wanted to add that we know
3 of the 171 school districts, we have 166
4 that are participating in billing
5 school-based services. Not all of those
6 are using the expanded access, so that is
7 what we are really pushing for is to get
8 more of those school districts to offer
9 services to all of our Medicaid eligible
10 students. And so that is our push now, as
11 well as offering more mental health
12 services. And when we did do that survey,
13 we found that all models of delivery of
14 school-based services are being used in
15 Kentucky. We see that some school
16 districts are being the billers of the
17 services themselves, and others are
18 contracting with some outside providers,
19 and allowing those outside providers to
20 bill, and others are contracting with
21 outside providers to do the services, but
22 the school districts are the ones that are
23 doing the billing for those as well. So
24 we have several different models of
25 delivery of services in the school

1 setting.

2 DR. SCHUSTER: And Erica, that

3 is both physical health and behavior

4 health; right? That you are tracking?

5 MS. JONES: That's correct.

6 DR. SCHUSTER: Great. Great.

7 And I think you are scheduled to present

8 that data to the BH TAC in July at our

9 meeting, so that is something that we want

10 to be sure the Children's Health TAC is

11 aware of and, perhaps, that data can also

12 be shared with them.

13 MS. JONES: Yes, ma'am.

14 DR. SCHUSTER: And I think,

15 Commissioner, I think you mentioned that

16 the Nursing TAC asked for some of that

17 information; is that right?

18 COMM. LEE: Yeah, I believe that

19 is correct. And Erica did the original

20 request for the school-based services,

21 come from the Nursing TAC?

22 MS. JONES: I believe it did,

23 yes. So we can present all of that

24 information to all of the interested TACs.

25 DR. SCHUSTER: Yes. I would

1 like to see the TACs coordinate more with
2 each other. There is obviously overlap.
3 The Primary Care TAC would be interested
4 in that information too, so that would be
5 May the 1st. We moved that meeting to
6 1 o'clock on May the 1st, but we will let
7 people know so that they can join in and
8 get that report as well.
9 I think this is really exciting.
10 I think this also fits in with the
11 presentation that the Commissioner made on
12 our health rankings, because I think we
13 have to concentrate, at least
14 preventively, on school kids. They are
15 captive audiences in many ways, and we've
16 got a better shot at heading off
17 something, then waiting until they are
18 adults and then having to treat something
19 that has developed.
20 Any questions?
21 Kent, you had a question in the
22 chat. Were you asking about the Annie
23 Casey grant and how much it was for?
24 MR. GILBERT: I was looking at
25 that Shine grant, actually, to see how

1 much funding we were hoping to get for
2 that.
3 MS. HOFFMAN: Erica, I just put
4 in the title. We are calling it Kentucky
5 Shine here in Kentucky. So that's what I
6 put in the chat. So do you have that
7 information? Is it 2.5?
8 MS. JONES: Yes, ma'am, it's
9 2.5 million.
10 MR. GILBERT: That would be
11 great. That would be a great support.
12 And just to underscore, Sheila, I think
13 all of the data, keep showing, that the
14 more that we can prevent the cost dollars
15 that it saves Medicaid down the road is
16 huge, so, and of course, outcomes for
17 quality of life for those kiddos.
18 DR. SCHUSTER: Right, right.
19 All right. Any other questions
20 or comments from any of the MAC members?
21 All right. Well, let me thank
22 all of the DMS folks who have presented
23 and contributed to the discussion. It's
24 so important to have the data, obviously
25 and for us to be coordinating our efforts.

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1 So we appreciate that.
2 Let me turn to the TAC reports.
3 And just -- Dr. Gupta, oh, you are talking
4 about a program with vaping. And vaping
5 is a huge issue, Garth, that gets back to
6 is that a gateway to drug use. And I hear
7 from school counselors and school
8 psychologists and school social workers
9 about their concerns around increases in
10 vaping and even with very young kids. So
11 that they be something we may want to
12 particularly look at as we think about
13 some ways to move forward on improving
14 health status. Thank you for sharing
15 that.
16 Want to encourage, again, the
17 TACs to work with other TACs and to let us
18 know what data you are requesting from
19 Medicaid, so that we can share that data
20 with other TACs that would be interested
21 in it. So let's keep that in mind. And
22 also to hear your recommendations.
23 So we are starting at the front
24 part of the alphabet, Behavioral Health
25 TAC met on March 14th, six of our seven

1 voting members were present. And very
2 sadly, we announced that Mike Barry, a
3 voting number of the TACs since its very
4 beginning, had recently passed away, and
5 we had a moment of silence in his honor.
6 He was a great advocate for people with
7 substance abuse disorders and a
8 replacement will be sought from that
9 organization, people advocating recovery.
10 We had representatives from DMS, from
11 DBHDID, all six MCOs were present, and a
12 number of members from the behavioral
13 health community.
14 We had updates on the 1915(i)
15 SPA, which is the one that would provide
16 respite for families and supported housing
17 medication management for people with
18 severe mental illness, and also a range of
19 services for people with SUD. We had an
20 update on the reentry TAC, or I'm sorry,
21 reentry waiver. We had inticipated that
22 we would have a report from the Office of
23 Data Analysis on behavioral health rates
24 including their multistate comparison
25 study, but it was not quite ready, so we

1 will have that at our May meeting.
2 We quite a lengthy discussion
3 about behavioral health associates. These
4 are Bachelor-level folks who would be
5 allowed to do some clinical services as
6 long as they are enrolled in a program
7 working on their advanced degree in a
8 behavioral health field, and Jonathan
9 Scott was his usual helpful self. There
10 was a lot of discussion about BHAs and
11 also the MHA, mental health associates,
12 who had been utilized by the CMHCs for
13 nearly 30 years, and they are going to be
14 apparently displaced by the BHAs and there
15 is certainly some concern about that.
16 Jonathan announced that there will be a
17 meeting with the CMHCs following the BH
18 TAC meeting, and also a meeting with the
19 licensure boards and other interested
20 stakeholders.
21 Justin Dearinger was not able to
22 be at the meeting, and so we are delaying
23 the report on the no-show dashboard.
24 Alicia Clark stood in for Pam Smith, we
25 always have an update on the 1915(c)

1 waiver waiting list which, of course,
2 continue to grow and are a source of
3 concern.
4 I am pleased that the General
5 Assembly has decided to look at this
6 problem seriously and has funded many more
7 placements in those waivers then we have
8 ever had in a single budget session.
9 Leslie gave a report on the
10 Mobile Crisis services model, and
11 deputy -- Senior Deputy Commissioner
12 Veronica Judy Cecil gave a Medicaid
13 unwinding report.
14 Erica Jones was on talking about
15 the billing for student services, and I
16 had intended to reach out to the
17 Children's TAC to be sure they would hear
18 that report in July, but we will also
19 reach out to the Primary Care TAC and the
20 Nursing TAC and just, generally, let all
21 of the TACs know when that report is going
22 to be given.
23 We had a brief report from
24 myself and Steve Shannon about what was
25 going on in the legislature, and I see

1 that Karen Lentz has shared with us that
2 there have been a number of bills related
3 to vaping that are making their way
4 through the legislature so there may be
5 some hope there from the legislature.
6 We have no new recommendations
7 to the MAC at this time.
8 We then had a very active
9 discussion initiated by Kathy Adams under
10 new business about a significant number of
11 prepayment audits being conducted by the
12 MCOs and causing great concern among
13 providers. And it was a far ranging
14 discussion. Veronica Cecil gave us a
15 history that some of us were not aware of
16 of the audits, and CMS's position and
17 DMS's position, and so forth. And a
18 number of other people at the meeting, and
19 a number of other agencies weighed in
20 about a concern about this increased
21 number of audits. So in our May meeting,
22 will have a presentation from DMS
23 preparing a list for some questions that
24 we have that we would like to center the
25 discussion around to better understand how

1 these audits, and what the purpose is, and
2 what the guardrails are, both the MCOs and
3 the providers. In the meantime, it was
4 suggested that providers use the provider
5 complaint process to submit issues to DMS,
6 if they feel like the MCOs are acting in
7 ways that are not appropriate.
8 Our next meeting will be on
9 Wednesday, May 2nd, I guess that is, from
10 1 to 3, and again we had no
11 recommendations. So that is the report
12 from the Behavioral Health TAC.
13 Next on the list is the
14 Children's Health TAC. Is there a report
15 or anybody there?
16 (No response.)
17 All right. Consumer Rights and
18 Client Needs, please.
19 MS. BEAUREGARD: Hi, good
20 morning, everyone. I'm coming to you from
21 the Capitol. I hope I have a good enough
22 signal, and I apologize to the MAC members
23 that I didn't submit a written report in
24 advance as I normally do, but I will put
25 that together for you and give you a

1 verbal report today.
2 Our Consumer TAC last met on
3 February 20th. We met remotely using Zoom
4 and we had a quorum present. We discussed
5 a number of things that we typically
6 monitor, but we had a rather long
7 discussion about language access and other
8 accessibility issues.
9 For the past two or three
10 meetings, we have been talking about a
11 decision tree that would help to guide
12 people when they are needing language
13 access services. And we are thinking
14 about it for four different populations:
15 People who speak different languages,
16 people who are deaf or hard of hearing,
17 people with speech impairment, and people
18 who are nonverbal.
19 So the plan is we are working
20 with DMS on this decision tree, but we
21 will also be making some more
22 recommendations around these four
23 populations at the upcoming meeting. And
24 then, another part of our discussion
25 focused on the Access to Services Form,

1 which was something in development for the
2 past few months. DMS has been working on
3 a form that Medicaid members could
4 essentially use to report when they are
5 unable to access a particular service, and
6 that will help us to identify some of our
7 network adequacy issues. So that is still
8 in development, but I hope that is
9 something that can be used soon.
10 And then, we had a discussion
11 around the Medicaid membership survey.
12 That may have already been discussed this
13 morning. We are excited that DMS is
14 surveying members. This is the first
15 time, in my memory, that members have been
16 asked to share their input or their
17 feedback on Medicaid services, and their
18 experiences as an enrollee, and we think
19 that this can be really beneficial for a
20 number of reasons. In terms of how the
21 program is operating, you know, future
22 policy decisions, and we are excited to
23 work with the cabinet on disseminating
24 that, getting that out to as many people
25 as possible and encouraging people to

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1 complete the survey.
2 We also discussed a number of
3 other things, but again, I wasn't -- I
4 didn't have the time, because the
5 legislative session to put together a full
6 report.
7 We have made two recommendations
8 and I will just jump to those. The first
9 recommendation is that DMS engage the
10 Consumer TAC on the development,
11 dissemination, and evaluation of a
12 Medicaid membership survey.
13 And the second recommendation is
14 that DMS create more video explainers and
15 standardize the use of screen readers,
16 closed captioning, and subtitles.
17 And again, we'll come back with
18 some more recommendations around language
19 access after our next meeting, I suspect.
20 We have an upcoming meeting
21 scheduled for April 16th at 1:30 p.m.
22 eastern time, and that will be on Zoom.
23 And I'm happy to answer any questions.
24 I did want to bring up one more
25 thing. And Dr. Schuster, you may have

1 mentioned this to the folks on the call
2 today, but we are concerned about funding
3 hole for the Medicaid budget over the
4 biennium. It is $62 million that is
5 currently cut from base funding and, I
6 think, now is the time for legislators to
7 be hearing from Medicaid providers and
8 other stakeholders that we need to fully
9 fund Medicaid. We think there may be a
10 path through House Bill 1 to make sure
11 that that money is included in the budget,
12 but we just need to make sure that that
13 happens before the end of this session.
14 DR. SCHUSTER: Thank you, Emily.
15 I had not mentioned that hole, which is
16 significant, and it is in the base, so if
17 people could reach out to their
18 legislators and make sure that there is
19 still -- House Bill 6 has already passed
20 the Senate, but House Bill 1 has funding
21 for a weird assortment of things, I can't
22 even describe it, so anyway. But there is
23 another budget bill that is out there, so
24 it could get fixed and we definitely need
25 for it to get fixed.

1 I appreciate your work, Emily,
2 on language access because that is
3 something that I have on the agenda for
4 the MAC to look at. So we will be working
5 with you on that. Thank you very much.
6 And two recommendations we will come back
7 to.
8 The Dental TAC, please?
9 DR. BOBROWSKI: Yes, thank you,
10 Dr. Schuster. And the Dental TAC met in
11 the middle of February. We did have a
12 quorum, and the next meeting is the middle
13 of May. We had some discussions and some
14 of these will include the issues that we
15 have on our MAC that we bring up. I will
16 take them back to the TAC meetings that we
17 have. One of the things I will bring to
18 your attention, these are a new
19 development that could affect each of us,
20 individually. When you go to the dentist
21 or in the groups that you represent, the
22 medical physicists, the American Dental
23 Association, the FDA, the Academy of Oral
24 and Maxillofacial Radiologists have come
25 out with new recommendations, with the

1 advances in x-ray technology and digital
2 x-rays, the use of lead aprons is not
3 needed now. So when you go to the dentist
4 next time, and they don't put that lead
5 apron on you for your x-ray, that is the
6 new technology of the machinery and stuff,
7 hardly no radiation is exposed to the rest
8 of your body.
9 So the other thing we talked
10 about is a dental loss ratio. Like some
11 of you all, you are on your local boards
12 of health, and I am the chairman of our
13 board of health, and one of the things
14 that was brought up, and Angie brought it
15 up in her presentation this morning, about
16 how diabetes is affecting Kentucky and
17 some of the information was very important
18 and the rate of diabetes in Kentucky has
19 doubled since 2000 to 2021. Kentucky is
20 13th highest in mortality rate in the
21 nation.
22 Diabetes treatment costs
23 Kentucky $5.16 billion per year, so we do
24 need to put all of our heads together and
25 look at these situations and see what we

1 can do.
2 The other thing that we talked
3 about was our community health workers
4 and, at the time, we did not have any
5 recommendations from the Dental TAC to the
6 MAC, and I apologize again to you all,
7 that I didn't get this sent out to you to
8 have this earlier on the reports because
9 sometimes life happens. So thank you.
10 DR. SCHUSTER: Thank you, Garth,
11 and I appreciate the heads up about the
12 lead aprons, because I would have asked
13 for sure. Also, the emphasis on diabetes.
14 So you have no recommendations from the
15 Dental TAC at this point; is that right?
16 DR. BOBROWSKI: That's right,
17 yes.
18 DR. SCHUSTER: All right.
19 EMS, please?
20 (No response.)
21 No one there from EMS? They may
22 be moving, Erin, to quarterly meetings?
23 MS. SHEETS: Dr. Schuster, yes,
24 this is Kelli. Erin had to step away for
25 a minute. Yes, they are moving to

1 quarterly meetings and they are not able
2 to join the meeting today.
3 DR. SCHUSTER: Okay. Thank you,
4 Kelli. I appreciate it.
5 Health Disparities, please?
6 DR. BURKE: Hi, this is Jordan
7 Burke with the Health Disparities TAC.
8 Yeah, we have not met since the last MAC
9 meeting. Our next meeting is scheduled
10 for April 17th, so we wouldn't have any
11 updates or new recommendations at this
12 time.
13 DR. SCHUSTER: All right. Thank
14 you very much, Dr. Burke.
15 Home Healthcare, please?
16 MR. REINHARDT: Hi everyone,
17 this is Evan Reinhardt from the Home
18 Health TAC.
19 We did meet on February 13th.
20 We discussed electronic visit
21 verification, some supplies issues, and
22 other issues with MCEs. We received some
23 updates from the MCOs and DMS, and we did
24 not have any recommendations.
25 DR. SCHUSTER: All right. Thank

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1 you very much, Evan.
2 Hospital Care?
3 MR. RANALLO: Hello, this is
4 Russ Ranallo from the Hospital TAC.
5 We met on February 27th, we had
6 a quorum. We went through numerous items
7 and it's in our report. Many of those
8 were DMS requested examples where they can
9 go through it and respond. We did have a
10 discussion, in depth, about change
11 healthcare and some of the impacts that we
12 have on the MCOs where they will come over
13 to the hospitals and DMS followed up with
14 a pretty good Q&A on outstanding
15 questions.
16 We had no recommendations, and
17 our next meeting is April 23rd.
18 DR. SCHUSTER: Thank you very
19 much, Russ, we appreciate that.
20 The IDD TAC?
21 MR. CHRISTMAN: Good morning.
22 This is Rick Christman.
23 The TAC met on February the 6th.
24 We had a quorum. We did a little bit of
25 housekeeping discussion on filling up some

1 of our vacancies. We also discussed an
2 issue in terms of people, particularly in
3 residential services who have been
4 involuntarily terminated, checking on
5 their status and how difficult it is for
6 them to find alternative providers, and so
7 we are still gathering information on
8 that. We spent some time talking about
9 the waiting lists. I know Dr. Schuster,
10 that is a issue, a concern of yours. And
11 Pam Smith and her group has put together
12 an analysis of that. That shows -- there
13 are some of these individuals who are on
14 the list that are also getting some
15 services from other waivers, so put that
16 into perspective.
17 And of course, we are all
18 anxious to see with the General Assembly
19 coming to a closure and its budget, we
20 know that there are monies in that budget
21 proposal to expand waiver service and so
22 we are excited about that. Other than
23 that, we had no recommendations.
24 DR. SCHUSTER: Thank you, Chris.
25 I was glad to see that the budget that

1 passed the Senate is now over in the House
2 now has significant funding, $94 million
3 over the biennium to increase salaries for
4 those personal service care deliverers.
5 MR. CHRISTMAN: Yes.
6 DR. SCHUSTER: Which is huge.
7 The increased number of people coming into
8 the waivers, having more people to provide
9 the services is going to be very, very
10 significant.
11 I'd like to talk to you off-line
12 about the involuntary terminations from
13 services, because I've had a discussion
14 with Pam Smith who is willing to look into
15 that if we have more data, and that issue
16 had been brought to me by someone else as
17 well and I didn't have the data, so I will
18 get with you separately, Chris.
19 MR. CHRISTMAN: Yes, I'm going
20 to have to sign off, but we can get
21 together later and that's among our
22 discussion is how we are going to gather
23 that data, so we are working on that.
24 It's an important issue.
25 DR. SCHUSTER: Yeah, thank you

1 very much.
2 Nursing Homes?
3 (No response.)
4 No one there?
5 How about Nursing Services?
6 MS. LOCKHART: Yes, this is Lisa
7 Lockhart. I'm the chair for the Nursing
8 Services TAC.
9 We do have a report and I'd like
10 to introduce Dr. Dee Polito, please.
11 DR. POLITO: Thanks, Lisa. And
12 thanks, Dr. Schuster.
13 I just will summarize the
14 Nursing TAC recommendation. Our last
15 meeting was February, and just a
16 background about our recommendation, is
17 that in January of 2023, DMS responded to
18 a MAC recommendation that essentially DMS
19 was not going to prioritize adding CPMs as
20 eligible providers for reimbursement for
21 Medicaid services, and documented that, it
22 felt that it would create additional need
23 for EMS transports if more home births
24 were adopted in Kentucky.
25 Anjd just to summarize the

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1 Nursing TAC's stance on that statement,
2 that we found no evidence that DMS is
3 concerned that reimbursement for CPM
4 services would strain the EMS system, so
5 therefore, we would like to bring forward
6 to the MAC again, our strong
7 recommendation that CPMs, Certified
8 Professional Midwives be recognized as
9 providers that will be eligible for
10 reimbursement Medicaid services, given
11 that their licensure and regulation is
12 from the Kentucky Board of Nursing. So in
13 summary, we would put forth that
14 recommendation again to the MAC.
15 DR. SCHUSTER: All right. Thank
16 you very much, Dee, and helpful to have
17 that background, as well, so we will put
18 that in as a recommendation that we will
19 come back to vote on shortly. Thank you
20 very much.
21 Optometric Care?
22 MR. COMPTON: Yes, this is Steve
23 Compton, a member of the Optometric TAC.
24 We met on February 1st. We had
25 quorum. We had various discussions

1 generally around billing and coverage, and
2 we generally get those worked out with the
3 MCOs and subcontractors on those meetings.
4 We have no recommendations at this time,
5 and we meet again on May the 2nd.
6 DR. SCHUSTER: All right. Thank
7 you very much, Steve. Appreciate it.
8 MR. COMPTON: Thank you.
9 DR. SCHUSTER: Steve Shannon,
10 Persons Returning to Society From
11 Incarceration, the longest name of any
12 TAC.
13 MR. SHANNON: Correct. This is
14 Steve Shannon.
15 We did meet. We met on March
16 14th and will meet again on May 9th.
17 Obviously, people are more than welcome to
18 join us. We got an update on the Reentry
19 1115 Waiver, maybe now we can call
20 ourselves the Reentry TAC. It has been
21 submitted to CMS, questions
22 back-and-forth, there is a set of standard
23 initial questions and clarification stuff,
24 we do not anticipate any concerns yet. No
25 timeline when it will be approved, we have

1 been waiting on this since we have started
2 meeting, a real step forward. We
3 appreciate the update, a good
4 conversation, again, trying to figure out
5 how to cover Hepatitis C for the full
6 length of the dose, which, I think, is 84
7 days, and it's a 60-day pre-release, so
8 try to figure that one out. But people
9 are talking and meeting on that to really
10 address that issue.
11 A good update from Medicaid.
12 Thank you to Angela Sparrow, for doing
13 that.
14 The MCOs gave us updates. They
15 kind of have the same dilemma we have.
16 It's hard to provide an update on a
17 service that doesn't really exist yet, but
18 they are doing a lot of work now as they
19 can, on reentry. Not many referrals yet,
20 but hopefully that changes. A lot of work
21 on expungement, which is an important
22 piece for individuals accessing jobs and
23 some supportive housing in trying to get
24 those things expunged.
25 We had a round robin update. A

1 reentry lab for some folks, it's an
2 experience of reentry, what people go
3 through. It usually takes about two or
4 three hours, and you're given a list of
5 factors and things you have to do. Then
6 you find out you can't get those things
7 accomplished, and maybe your parole is
8 based on that, and the experience is it's
9 very hard for people coming back in not
10 having sufficient support, and hopefully
11 that will be addressed as well. And we
12 had no recommendations.
13 DR. SCHUSTER: All right. Thank
14 you, Steve. And I know you all have been
15 waiting, waiting, waiting. And hopefully
16 that approval from CMS for the reentry
17 waiver will come soon and then you all
18 will be very busy. Appreciated.
19 MR. SHANNON: We look forward to
20 it.
21 DR. SCHUSTER: Pharmacy TAC,
22 please?
23 DR. HANNA: Yes, the Pharmacy
24 TAC did not have a report. And they will
25 be meeting on April the 3rd.

1 DR. SCHUSTER: All right. Thank
2 you very much.
3 Physicians Services?
4 Oh, Ashima says: We did not
5 meet, but we are curious on the progress
6 of the physicians. I can't read it all.
7 Physician fee schedule. Is there anybody
8 on from Medicaid that can respond to that
9 question?
10 COMM. LEE: Yes, we do have that
11 report ready and we hope to get that out
12 to them at the first of next week, but we
13 do have all of the information, we're
14 preparing it to be submitted to the TAC.
15 So we do have it, it is ready, we will be
16 getting it to them within the next few
17 days.
18 DR. SCHUSTER: Wonderful. There
19 is your answer, Dr. Gupta.
20 Thank you very much,
21 Commissioner.
22 All right, Primary Care?
23 MS. MOORE: Good morning, I'm
24 Stephanie Moore. I'm representing the
25 Primary Care TAC.

1 We met on February 22nd, and had
2 several updates from Senior Deputy
3 Commissioner Cecil covering topics such as
4 redetermination, the quality measures,
5 also the Wrap reconciliation continues to
6 be an evolving process for primary care
7 providers and the states, we had some
8 discussion there. And specifically, some
9 of the system updates in development.
10 We also talked about the Mobile
11 Crisis model and some potential gaps for
12 primary care providers that have
13 integrated outpatient behavioral health,
14 and making sure that there is a response
15 when patients in our clinics need an
16 additional level of service.
17 We did not have any
18 recommendations for the MAC, and we meet
19 again on June 27th.
20 DR. SCHUSTER: All right. Thank
21 you very much, Stephanie.
22 And last but not least, Therapy
23 Services?
24 MR. LYNN: Yes, thank you.
25 This is Dale Lynn. And the

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1 Therapy TAC met on March 12th. And we
2 didn't have a quorum. We didn't have
3 anything to report to the MAC, other than
4 I wanted to report that we are very happy
5 that Medicaid has written a policy update
6 that will not require the physician's
7 signature on a Plan of Care to get an
8 authorization, which is a big relief to
9 the therapy group plus physicians. And we
10 meet again on May 14th. Thank you.
11 DR. SCHUSTER: All right. Thank
12 you very much, Dale.
13 So I need a motion to accept the
14 TAC recommendations. I believe there were
15 two recommendations from Consumer Rights
16 and Client Needs and one recommendation
17 from the Nursing Services TAC. And could
18 I have a motion from a member?
19 MR. GILBERT: So moved.
20 DR. SCHUSTER: And who is that,
21 please?
22 MR. GILBERT: Kent Gilbert.
23 DR. SCHUSTER: Kent, thank you
24 very much. And a second?
25 MS. ROARK: This is Peggy Roark,

1 I'll second it.
2 DR. SCHUSTER: I'm sorry. Who
3 was it?
4 MS. ROARK: Peggy Roark.
5 DR. SCHUSTER: Peggy, thank you
6 very much.
7 So the motion has been made and
8 seconded to accept those TAC
9 recommendations and send them on to DMS.
10 All in favor signify by saying,
11 "Aye."
12 MAC MEMBERS: Aye.
13 DR. SCHUSTER: And any opposed?
14 Like sign, and any abstaining?
15 (No response.)
16 Thank you very much, and thank
17 you to those who are present, and we
18 appreciate, obviously, the work of the
19 TACs. Very important to all work from our
20 various vantage points to improve health
21 here in Kentucky.
22 Next up is Cheryl Hannah. And
23 I've forgotten what MCAFS stands for, I
24 apologize.
25 MR. FLAGLER: Well, good

1 morning, Dr. Schuster. This is Richard
2 Flagler. And I see that Cheryl was on the
3 agenda, but I am IS lead for the Medicaid
4 Claims Administration and Financial
5 Solution project for the department.
6 DR. SCHUSTER: Okay. So it's
7 Medicaid -- say that again -- claims?
8 MR. FLAGLER: Medicaid Claims
9 Administration --
10 DR. SCHUSTER: Medicaid claims
11 administration --
12 MR. FLAGLER: -- and Financial
13 Solution. And I do have a presentation
14 that we did on the 14th of March for the
15 Wrap, that we would like to present here
16 as well, if that's okay.
17 DR. SCHUSTER: That would be
18 great. Thank you very much. Can he share
19 his screen? Yeah, okay.
20 MR. FLAGLER: Okay. Can
21 everyone see my screen?
22 DR. SCHUSTER: Yes. Thank you.
23 MR. FLAGLER: Okay, once again,
24 good morning, everyone. Really appreciate
25 the time with you this morning.

1 This is a presentation that we
2 did a couple of weeks ago for the MCAFS
3 project. You are going to be hearing a
4 lot about this, and that is the Medicaid
5 Claims Administration and Financial
6 Solution.
7 A fact sheet that I would like
8 to, you know, just touch base with you on
9 is the cabinet or the department is
10 replacing it's Medicaid Management
11 Information System. It's been around
12 since 2007. It was known as the
13 Interchange System. Gainwell was the
14 vendor who was maintaining that system
15 since 2007, and interestingly, Gainwell is
16 the vendor that will be maintaining the
17 MCAFS system. It is a very large system,
18 the MCAFS project is going to interface
19 with over 17 Medicaid related modules.
20 There is information that I can provide.
21 I won't go into all of those there, but
22 I'm sure you can imagine.
23 It is a change for the
24 Commonwealth. We are leveraging a
25 software as a service, or commonly known

1 as a SAS solution, and what that really
2 means is it lives in the cloud. We are
3 accessing it online, whereas the other
4 solution, the legacy which we are calling
5 Interchange, that exists today was a
6 custom-designed solution that didn't exist
7 in the Cloud.
8 This is also a commercial, off
9 the shelf, what is known as COTS. Sorry
10 about all of the acronyms. But it is a
11 COTS-based solution. And this is
12 important, once again, this solution from
13 Gainwell has been marketed, stood up in
14 several other states: Ohio, West Virginia,
15 they had just gotten a contract to stand
16 it up in Washington DC, and obviously,
17 Kentucky is one of the states as well.
18 The solution is Medicaid Information
19 Technology, what we call MITA,
20 architecture compliant. We are complying
21 with federal CMS standards to make it
22 little bit easier, and currently, right
23 now, we are in the design phase.
24 Basically, the solution, since it is a
25 COTS off-the-shelf solution will be

1 configured to make it more
2 Kentucky-oriented as we approach the
3 business of Medicaid, and so the design
4 sessions are supporting that
5 preconfiguration effort.
6 Prior to this phase, we were in
7 a requirements validation phase. The
8 contract, as you can imagine, had well
9 over 5,000 requirements in it, so we spent
10 many months at the end of last summer,
11 going all the way up until the end of last
12 year in 2023, validating requirements and
13 now, basically, what we are doing is
14 making sure that we have the design or
15 communication in place to help configure
16 the product.
17 Our go-live date is scheduled
18 for early 2025. We will be on a quarter
19 pure due to financials. I wish I could
20 give you an exact date. There are some
21 impacts, potentially, to the go-live date,
22 the existing legacy system has been
23 experiencing many changes throughout as a
24 custom-designed solution, and so we are
25 currently targeting early 2025.

1 The second to the last bullet
2 from the bottom, very excited that, just
3 yesterday, we stood up our MCAFS website,
4 which is a page, part of the department
5 existing website external for public
6 facing, and we do have our own page where
7 we will post communications for the public
8 and inform our providers, members, and
9 trading partners, et cetera. So that is
10 one tool that we are using. It certainly
11 is not the only tool that we are using.
12 We do have an internal SharePoint site,
13 we've got minute newsletters that are
14 coming out, so there are multiple tools,
15 but we are very excited about this
16 external facing website to get everyone
17 used to what is coming in 2025.
18 We also have an email that you
19 can contact. It is being manned and Q and
20 A answers, anything that you need to ask
21 related to MCAFS. How is it going to
22 impact me or my committee, et cetera?
23 Please feel free to use that
24 CHFSMCAFSProject@ky.gov site.
25 For those that have an internal

1 KY.gov access, there is also a master
2 project calendar for formal meetings
3 posted there that can be dragged and
4 dropped into your calendar as well.
5 So we are really excited about
6 that website as well as the email address.
7 Once again, it is tools to just facilitate
8 communication with all of our trading
9 partners and stakeholders.
10 There are several enhancements
11 for the MCAFS solution that would like to
12 point out. We've got automation of our
13 work flow of existing manual processes for
14 contract management, et cetera. There is
15 going to be the ability for members and
16 providers to view claims and/or encounters
17 online, which is a step in the right
18 direction. There is document management
19 enterprise; content management solution;
20 there is going to be an MCO portal;
21 program integrity case tracking;
22 consumption of clinical data; management;
23 population health; TPL services for
24 fee-for-service as well as managed-care
25 members, and that's just a few of the

1 enhancements that will be forthcoming with
2 the new MCAFS system.
3 I've got a diagram here that I
4 wanted to present to you all to show you
5 the components. It is a very, you know,
6 complex system. The heart that you are
7 seeing here in the center, highlighted in
8 blue is the VUE360 user experience. And
9 what can be done there, it's basically the
10 central user integration area that you
11 would interact with and see all of the
12 different screens or panels and interact
13 with the system and its capabilities.
14 There's many more modules that I
15 won't go into here. Most certainly, we
16 will share this PowerPoint presentation, I
17 believe it is with Erin that we will do
18 so. But there are TPL, fraud capture,
19 there are many things that the system has
20 capabilities for: Letters, portals as I
21 previously mentioned, call-center. So
22 this is a great diagram that you can take
23 a look at and see, possibly, where
24 different services or capabilities or
25 functionality will live and what we are

1 calling the MCAFS solution.
2 I know there are probably a lot
3 of questions coming out. We are
4 increasing our communication mechanisms,
5 trying to get more information out, we
6 have work groups internally stood up. We
7 also have organizational change
8 management, change champions, different
9 communication mechanisms, as I previously
10 mentioned, to try to get the word out,
11 because obviously, with a change in
12 solution such as this, you know, everybody
13 wants to know how is it going to impact
14 me? Or maybe there may have been some
15 memories of the last change of the MMIS
16 system in 2007. I do want to assure
17 everyone, you know, we are taking a look
18 at our testing of the solution. We are in
19 test planning right now, which will, come
20 after the configuration phase or the
21 design of the system, and I want to make
22 sure we have got the scenarios, business
23 rules, edits, audits, tested
24 appropriately, so that there is no
25 interruption of claims payment, that there

1 is no impact to providers and their
2 enrollment. So there is a lot of news,
3 exciting things to come, and once again,
4 we do have that email address that you are
5 free to ask any questions, give us some
6 suggestions on how we can improve
7 communications, getting the word out, and
8 I want to thank you again for your time.
9 DR. SCHUSTER: Thank you so
10 much, Mr. Flagler. My first question is
11 how does this affect -- and then you start
12 MCOs, providers, members, and we look
13 forward to getting the PowerPoint so we
14 can look through this a little bit more.
15 Kent Gilbert is asking: When
16 will your new website go live?
17 MR. FLAGLER: The external
18 facing website went live yesterday.
19 DR. SCHUSTER: Oh, okay.
20 MR. FLAGLER: So it is currently
21 live. I did, before I presented this
22 morning, tested it myself and can verify
23 that you can get there.
24 DR. SCHUSTER: And one gets
25 there how? Through the DMS website?

1 MR. GILBERT: Can you put the
2 link in the -- if you put the link -- the
3 link that was on the screen is not
4 currently working, but maybe there is a
5 typo.
6 MR. FLAGLER: Mercy. Okay.
7 Well, I will definitely have that fixed
8 and I thought that we had added it. I
9 believe that you can get their through
10 DMS, the CHFS. Are you able to get there?
11 MR. GILBERT: I am able to get
12 to DMS, but I haven't been able to find
13 it. I'm on the Medical Claims
14 Administration and Financial Solution's
15 current page. There is no obvious link to
16 the new pages.
17 MR. FLAGLER: Well, I believe
18 that is the link that you are looking at.
19 The MCAFS.
20 MR. GILBERT: Yup.
21 MR. FLAGLER: That' it.
22 MR. GILBERT: Okay.
23 MR. FLAGLER: It was just
24 launched yesterday. It will be built out
25 much further. So good.

1 MR. GILBERT: Good. Thank you.
2 DR. SCHUSTER: Listen, after the
3 blowup of Zoom links two weeks ago, you
4 know, I don't trust any of these links.
5 So that is very helpful.
6 I'm wondering if it would make
7 some sense to have you back to talk to the
8 MAC in November, you know, as you are
9 much, much closer to actually going live,
10 and we can be in touch about this. You
11 know, we meet every other month so
12 September or November, it would be helpful
13 to have an update from you at that point
14 before you go live again.
15 MR. FLAGLER: Absolutely. We
16 will support the committee in any way we
17 can.
18 DR. SCHUSTER: Okay. Thank you
19 very much. Let me see if there any other
20 questions from the MAC members.
21 You've introduced us to a whole
22 new alphabet soup here, Mr. Flagler. So
23 we are going to have to -- we know MMIS,
24 so this will be different.
25 Any other questions from MAC

1 members?
2 DR. BOBROWSKI: This is Garth
3 Bobrowski. I've got one. Of course, as
4 you talk about billing for claims and
5 things, it's just like one of the things
6 that's happening recently is, I think,
7 it's with change health, what is it,
8 Ransomeware? What security measures are
9 you implementing to -- or concerning links
10 and stuff to help us be safe with our
11 claims and a lot of offices getting paid
12 in a timely manner?
13 MR. FLAGLER: Well, security is
14 a big concern of ours. You know, of those
15 5,000 requirements, you know, there are
16 numerous security requirements that are
17 mandated for the vendor and, you know, one
18 of them, I mean the minimal acceptable
19 risk standards for exchanges, I can go
20 through many of the MMIS, you know,
21 standards, those are all part of this.
22 Third-party security assessment is going
23 to be required. Regular penetration
24 testing, vulnerability scans are required.
25 Those are all ingrained in the contract,

1 and is something that we are very
2 sensitive to, and, in fact, I'm glad you
3 brought that up. I personally, of all of
4 the 60-plus meetings each week on this
5 project, make certain that I attend the
6 regular weekly security meeting. And so I
7 am very involved in that component, have
8 done several MARS-E security assessment
9 reports for numerous states and that is
10 near and dear to my heart.
11 DR. BOBROWSKI: Thank you. I
12 appreciate it.
13 DR. SCHUSTER: Excellent
14 question, Garth. Because that Ransomware
15 attack, has really disrupted billing for
16 lots of providers, obviously not just in
17 Medicaid, but outside of that.
18 Any other questions from MAC
19 members?
20 All right. Well, thank you so
21 much, Mr. Flagler, and we look forward to
22 hearing an update. Appreciate you sharing
23 all of that information with us.
24 MR. FLAGLER: Thank you, Doctor.
25 DR. WRIGHT: Dr. Schuster?

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1 DR. SCHUSTER: Yeah?
2 DR. WRIGHT: Hi, this is
3 Dr. Wright. I had a question prior to
4 Richard's presentation that was related to
5 the TAC reports. I apologize, I didn't
6 get a chance to ask the question sooner.
7 I was meeting with someone here that is a
8 new diagnoses of a child with Angelman
9 Syndrome in the northern Kentucky area.
10 I am wanting to ask the team the
11 process by which a child that has a
12 critical chronic kind of disability would
13 start the process of applying for Medicaid
14 benefits in northern Kentucky, starting
15 with home and community then also adding
16 themselves to waiting lists, just to see
17 if there is actually a flowchart or any
18 part of infographic related to the
19 application process, how that starts. I,
20 kind of, gave them what I've known from
21 the past, but I want to make sure that I'm
22 giving them something helpful moving
23 forward, so I will wait to hear that
24 answer, but I just wanted to ask that
25 question.

1 DR. SCHUSTER: Well, it's so
2 interesting that you are asking that
3 question, Eric, because Commissioner Lee
4 and I had just had a conversation on
5 Monday, as she heard from several parents
6 with exactly those same questions. How do
7 we negotiate this? We have a child who is
8 diagnosed with whatever it is, autism
9 spectrum disorder, actually traumatic
10 brain injury, and felt like they were on
11 their own trying to navigate the system,
12 so I'm so glad that you brought that up.
13 We talked, actually, and we can
14 certainly pull you into that discussion,
15 about how best to both educate these
16 parents, but also get input from the
17 parents, and whether it should start at
18 the TAC level, it could start in
19 Behavioral Health, it could start in
20 Children's Health, it could start in the
21 Consumer TAC, it could start in the IDD
22 TAC for that matter, and what is the best
23 way to get this input from the members who
24 are really struggling, and then, you know,
25 what should our response be?

1 So we are just at the beginning
2 stages of this and your very notion about
3 a flowchart I think is something that one
4 of the moms had suggested to Commissioner
5 Lee, and I'm supposed to talk to that mom
6 sometime this week to get more of a feel
7 for the story and what she has been
8 through. But we absolutely need to be
9 providing clearer guidelines and more
10 usable information for people who need to
11 get first the Medicaid coverage and
12 negotiate the various waivers and the
13 waiting lists.
14 And then with the possibility of
15 a new children's health -- new children's
16 waiver in the second year of the biennium
17 there is funding to continue that study
18 and development for kids with autism
19 spectrum or severe emotional disturbance
20 or chronic health conditions, so certainly
21 the youngster that you spoke about would
22 be covered in that as well. So we don't
23 have an immediate answer for you, but I
24 will tell you that it's on the table and
25 we are happy to include you in those

1 discussions as we try to figure out the
2 best way to get information from those
3 families, and then get information, the
4 best information back to those families.
5 Commissioner, do you want to add
6 anything to that?
7 COMM. LEE: I think Pam has her
8 hand up, we'll see. And I think she
9 probably has something to add. So Pam?
10 MS. SMITH: We actually do have
11 a flow, kind of a flowchart, a couple
12 little guides. Actually, Alicia and I
13 just met with some case managers with a
14 group with the US Army that handles
15 military families that have children or
16 other family members with complex needs,
17 and we handed a bunch of them out
18 yesterday. So I will get the link and
19 have Kelli or Erin to send out to the TAC
20 members. It is on the website, but we do
21 have a couple of resources and a
22 who-to-call list, a couple of flowcharts
23 of, this is where you start, this is the
24 next step, this is what to expect next.
25 DR. SCHUSTER: Right.

1 MS. SMITH: And I think there is
2 one other. There are two or three things
3 that I think may be helpful, so I will get
4 those out to you, Kelli or Erin, so you
5 can get them sent out.
6 DR. SCHUSTER: Thank you. You
7 are fading out a little bit, Pam, but I
8 think you said you would get those links
9 to --
10 MS. SMITH: Yes.
11 DR. WRIGHT: Yes.
12 DR. SCHUSTER: -- to Kelli and
13 Erin to get out. That would be very
14 helpful and, certainly, in this immediate
15 situation, or with these moms that I am
16 going to be talking to, I will get that
17 out to them.
18 MS. SMITH: And also, too, I
19 would like to add that, when you get to
20 the point of, you know, that the waiver
21 application is entered, it is a no wrong
22 door application so we look at -- so every
23 application that comes in, we look at
24 every waiver, we look at all of the needs
25 presented on the application, and they --

1 we can forward them to, for example, if
2 they would meet the criteria for both the
3 Michelle P. and the SCL, we can forward
4 them to both of those, all within the same
5 application.
6 DR. WRIGHT: That was going to
7 be another question that I was getting
8 ready to ask. I guess, Pam, in northern
9 Kentucky, is it NorthKey or --
10 MS. SMITH: You have both. You
11 see there a couple of -- the point helps
12 NorthKey helps and then the northern
13 Kentucky add can help do those application
14 so there's several areas and several
15 groups in that area that are able to
16 facilitate that application to get that
17 entered. And we also have the guide, you
18 know, for individuals, if they want to --
19 they can, you know, create their own
20 account on Connect and they can actually
21 do their own application, too. Some
22 people find it a little bit more
23 complicated or more difficult, so it's
24 easier to go through one of those
25 entities, and it's helpful to have them

1 answer questions, but we do have that
2 resource that our eligibility team was so
3 nice to share with us that we take and
4 hand out when we do those, too, so we will
5 make sure that that is also part of that
6 link so we will make sure that they have
7 multiple resources there that they can
8 reference.
9 DR. WRIGHT: Thank you very
10 much.
11 MS. SMITH: You're welcome.
12 COMM. LEE: And I'm just like
13 that, Dr. Schuster. I think your
14 recommendation or your suggestion that,
15 you know, we let some of the other TACs
16 look at that flowchart, because if it
17 is -- or that diagram -- if it is on their
18 website, maybe it's not easy for some
19 individuals to access, so how can we make
20 it more accessible and is it
21 user-friendly. So I think letting the
22 TACs look at that would help us maybe
23 ensure that it's an easy-to-follow diagram
24 and points people in the right direction.
25 DR. SCHUSTER: And easy-to-find,

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1 to begin with, is the other -- the other
2 issue, you know, if people don't know
3 where to go and find it so, yeah, I think
4 that's a great place for us to start.
5 So appreciate your bringing up
6 that issue, Eric, and it really fits in
7 with some discussions that we are having
8 now, so we are happy to loop you into
9 those discussions as we move forward.
10 Thank you.
11 DR. WRIGHT: Thank you,
12 Dr. Schuster.
13 DR. SCHUSTER: Sure.
14 Last item on our agenda is the
15 language access issues. What questions do
16 we have? What data do we need from the
17 MCOs? We want to have a presentation in
18 May on this very specific, not a broad,
19 you know, here is what the MCO is doing,
20 so what are some of the questions? And I
21 want to get with Emily Beauregard from the
22 Consumer Rights TAC because, you know,
23 obviously they have been delving into this
24 and talking about different populations,
25 so.

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1 And I see, Dr. Gupta, that you
2 are putting some questions in the chat,
3 which is very helpful.
4 What questions do other MAC
5 members have about language access? And
6 how much of a problem is it, I guess, is
7 the other thing? It's always been an
8 issue in behavioral health.
9 MS. ROARK: This is Peggy Roark,
10 can you hear me?
11 DR. SCHUSTER: Yes, Peggy.
12 MS. ROARK: I'm sorry I was at
13 the meeting. My phone has been having
14 some problems, so I recently have had
15 problems getting access to answers, so I
16 can understand everybody's frustrations.
17 With getting on the cell phone to look at
18 Healthy Rewards, and going on a website is
19 two different things, and I'm getting
20 mixed messages about the Healthy Rewards.
21 They are not giving out the gift cards to
22 Walmart and now they have these points
23 where you go on the website to look at.
24 Also, signing up for Weight
25 Watchers, having problems getting signed

1 up for that, the doctors, kind of like a
2 merry-go-round. Once says this, one says
3 that. So as a Medicaid recipient, and
4 other people, and I have some computer
5 skills, so I could imagine how everyone
6 else is having a hard time to access when
7 it comes to behavioral health, or physical
8 health, or anything.
9 DR. SCHUSTER: Yeah, so it
10 sounds, Peggy, that you are sharing with
11 us some concerns or frustrations that you
12 have as a Medicaid member about accessing
13 some of the services like the Healthy
14 Rewards, or following through, for
15 instance, on signing up for Weight
16 Watchers. And is part of the problem not
17 knowing where to get an answer to that, or
18 to get any help with that?
19 MS. ROARK: I'm having -- like,
20 when I call in, I'm getting different
21 answers, and it's like nobody knows, so I
22 feel like everybody needs to be trained
23 properly and everybody needs to be on the
24 same page, and not just saying one thing
25 and doing another. And then you are left

1 in limbo, so I can understand people in
2 rural areas, and they are trying to get
3 help, because I'm having problems myself.
4 DR. SCHUSTER: Well, that's very
5 helpful information to have and it sounds
6 like when you call you get one set of
7 responses, and when you go online, the
8 information is somewhat different. Did I
9 hear you say that?
10 MS. ROARK: Yes, and also if you
11 call back you get a different person to
12 speak to.
13 DR. SCHUSTER: You get a
14 different response?
15 MS. ROARK: Yes.
16 DR. SCHUSTER: Commissioner, I
17 don't know if there is regular training
18 for the call center people.
19 COMM. LEE: Yes, yes, there is.
20 And Angie Parker, I think, has something
21 to contribute to this. Angie?
22 MS. PARKER: I was going to
23 comment regarding language access.
24 DR. SCHUSTER: Oh.
25 MS. PARKER: Because we are

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1 working on information to share and
2 provide to providers. This has been a
3 request from the Disparity TAC and the
4 Consumers TAC, and we have to have
5 something for that in the middle of May to
6 share for review.
7 But as far as what Peggy is
8 talking about, I'm not sure which MCOs she
9 is working with. Are you calling your
10 MCOs, specifically?
11 MS. ROARK: Yes. Yes.
12 MS. PARKER: And you're getting
13 different answers in the member services
14 line, is that what I'm hearing?
15 MS. ROARK: Yes.
16 MS. BICKERS: Peggy, this is
17 Erin Bickers.
18 Are you continuing to still have
19 issues after our most recent outreach?
20 MS. ROARK: Yes, I am.
21 MS. BICKERS: Okay, if you would
22 like to email me off-line --
23 MS. ROARK: Okay.
24 MS. BICKERS: I can send that
25 back off to their last response and we can

1 work on that for you.
2 MS. ROARK: Okay. I appreciate
3 that.
4 DR. SCHUSTER: That's great
5 Erin, but I guess I'm wondering if --
6 Peggy happens to be on the MAC and sohas
7 the advantage of having your assistance,
8 but I just want to make sure that we are
9 looking at that issue at a broader level,
10 which is leading me to the question about
11 training and, I guess, I was thinking more
12 of the call center, but it really is more
13 of the customer service reach of the MCOs.
14 COMM. LEE: We can definitely
15 reach out to the MCOs. Well, first of
16 all, I guess we can get online, just as
17 Peggy did, and see if we had issues on
18 this, and see what we can find related to
19 issues trying to access those services,
20 but definitely we will discuss with the
21 managed-care organizations to make sure
22 that all of those value-added benefits are
23 easily accessible and their members know
24 how to access those value-added, and if
25 they have to go online to get it, as Peggy

1 mentioned, there may be some issues in
2 individuals who don't have access to go
3 online, so how are they informing their
4 members they can access those benefits?
5 DR. SCHUSTER: Exactly. That
6 would be really helpful, Commissioner, and
7 I may put that as a follow-up in May.
8 COMM. LEE: Okay.
9 DR. SCHUSTER: For you to -- or
10 Angie or somebody from DMS to let us know
11 some kind of a response. Because I do
12 worry about the number of people who don't
13 either have Internet access or access to a
14 computer, or don't have those skills, so
15 if they are relying on their phone, it is
16 so important that the people answering the
17 phone have the same information to give
18 them.
19 COMM. LEE: And if we don't have
20 a report, maybe let's get a report from
21 the MCOs telling us how many individuals
22 are accessing those value-added benefits.
23 DR. SCHUSTER: That would be
24 great.
25 COMM. LEE: I'm all about the

1 data.

2 DR. SCHUSTER: I know you are.

3 That's a good question. Let's put that

4 issue on our May meeting as well.

5 Thank you very much, Peggy, for

6 bringing those issues up, and I think

7 that's really important, and that is why

8 we have consumers such as yourself on the

9 MAC. So really, really appreciate that.

10 Angie, I want to talk come back

11 to this report that you are talking about

12 that, I guess, was requested by the

13 Disparity TAC as well as the Consumer TAC.

14 MS. PARKER: Right. We have the

15 information from each of the MCOs. We had

16 gathered that a couple of months ago on

17 what they do regarding language access.

18 And so we are working with our internal,

19 Medicaid internal communications team, to

20 develop a member access communications

21 piece. Obviously, we will have the TACs

22 look at that to determine whether or not

23 it meets their expectation or it will be

24 helpful, but that is in the works.

25 DR. SCHUSTER: Okay. Could I

1 ask you to look at the questions that
2 Dr. Gupta has put in the chat specific to
3 that, to see whether those items would
4 also be included in your report?
5 COMM. LEE: (Reading) Easy to
6 access; can providers use it readily in
7 the exam room with the patient, or is
8 there a long wait?
9 We will certainly take those
10 questions back to see whether or not what
11 we are working on addresses those specific
12 questions.
13 DR. SCHUSTER: That would be
14 great. Would you all, then, be prepared
15 to share that same information at our May
16 MAC meeting, which will be at the end of
17 May?
18 COMM. LEE: If -- possibly. We
19 are looking at mid-May to have it ready
20 for review. Hopefully, it will be and if
21 it is by then, we will certainly share it.
22 DR. SCHUSTER: Okay. All right.
23 Let me do this, then, and ask any of the
24 other MAC members if you have some other
25 questions as you kind of think about this,

1 or if you think about your discussions, if
2 your TAC has talked about this, and I will
3 send this out to the TAC chairs as well,
4 to send those additional questions to me,
5 so I can get them to Angie. That would be
6 very, very helpful. Thank you very much,
7 Angie.
8 Are there any items of new
9 business to come before the MAC?
10 DR. BOBROWSKI: Dr. Schuster,
11 this is Garth. I want to go back one
12 step, if you don't mind.
13 DR. SCHUSTER: Uh-huh.
14 DR. BOBROWSKI: I had a
15 question -- because we were having a staff
16 meeting yesterday afternoon and the topic
17 came up, then, of even our seniors in our
18 rural towns and accessing services or
19 value-added benefits, either one, you
20 know, a lot of our seniors just do not
21 have very good computer skills. Mine are
22 even lacking, but I try to learn on all of
23 this, but the seniors with limited
24 computer skills, and I think that's partly
25 where the Commissioner is working on our

1 community health workers. I know
2 sometimes our local libraries will have
3 computers set up for free access, and I
4 know sometimes our local health
5 departments, but sometimes I just worry
6 about these folks sitting at home. It's
7 like, I don't have anybody to help me and
8 I think that is maybe something to look
9 at. Because some folks are just totally
10 lost in the computer world, and I know
11 that in about 10 to 15 years, that will
12 fix itself, but I just worry about the
13 folks now that have issues getting access
14 or getting information.
15 DR. SCHUSTER: It's an excellent
16 point, Garth, and it's an interesting way
17 to think about language access, because if
18 you can't use the modality, so to speak.
19 DR. BOBROWSKI: Right.
20 DR. SCHUSTER: Dr. Gupta had
21 some questions about people who are
22 hearing-impaired as well as having a
23 language issue, or visually-impaired, but
24 in some ways, not having those computer
25 skills is almost like speaking in a

1 foreign-language. And I wonder if that is
2 an appropriate way to use CHWs. I know
3 the peer support people will often be
4 helpful for those with behavioral health
5 issues, because it is a way to access
6 services, as well as benefits and so
7 forth.
8 So something else that we ought
9 to keep in mind, but I appreciate you
10 bringing that up. Navigators, connectors,
11 sometimes, have become an ongoing resource
12 for people, because they have a connection
13 to Medicaid and they become, kind of, a
14 reliable source for help as well, but
15 navigators as well. So something for us
16 to keep in mind for sure, appreciate that.
17 Are there other items of new
18 business?
19 MS. SHEETS: Dr. Schuster,
20 Justin Dearinger has his hand raised.
21 DR. SCHUSTER: I'm sorry. I
22 didn't hear that.
23 MS. SHEETS: Justin Dearinger
24 has his hand raised.
25 DR. SCHUSTER: Oh, okay. Thank

1 you.

2 Justin?

3 MR. DEARINGER: Yes, I just

4 wanted to say that community health

5 workers are able to provide those types of

6 services, those one-on-one services to

7 individuals to help them gain access to

8 care, to coordinate their care better,

9 that's part of their job to work with each

10 individual person, to also be able to

11 reach out to different interpreter

12 services that Medicaid contracts with.

13 Also I want to remind everybody

14 that the Department for Community-Based

15 Services also has, still has in-person

16 services available during certain hours in

17 most communities, so people can always go

18 to their office and meet with someone

19 one-on-one, and they also have access to

20 different interpreter services at their

21 office.

22 DR. SCHUSTER: Excellent. Thank

23 you very much. I did wonder about the

24 CHWs and that makes a lot of sense. But I

25 had not remembered about DCBS and since

1 they are open for business in, at least,
2 some limited hours each day, people can go
3 in without an appointment, even, and get
4 some help there as well.
5 So maybe part of our finding
6 your way into the system, which is what we
7 talked about with Dr. Wright's case and
8 Pam's response, but let's be sure that our
9 helpers, that we have some kind of
10 available list of helpful agencies or
11 classes of people that are helpful so that
12 people have -- are reminded of that. And
13 for providers to be reminded as well, but
14 thank you, Justin. That's very helpful.
15 Any other comments on that or
16 any other items for new business?
17 (No response.)
18 Seeing none, I'm giving you all
19 back almost 40 minutes of your day. This
20 is an all-time quick MAC meeting, although
21 I think we had some excellent discussion
22 and lots of materials that we will follow
23 up on. But if there is no further
24 business to come before the MAC, we will
25 just adjourn by acclamation, as they say.

1 (Audio interruption.)
2 I'm sorry, was that a comment
3 for all of us? All right.
4 We will adjourn the meeting by
5 acclamation. I assume there are no
6 objections to that. And have a vote by
7 leave-taking. Yes.
8 And for those of you who
9 celebrate Easter, a very happy -- or as I
10 say to my grandkids -- a very hoppy,
11 H-O-P-P-Y, Easter to you all, and a
12 reminder from Marcy Timmerman that Mental
13 Health Month is May, and we will be
14 talking about that at our MAC meeting as
15 well. Thank you all very much for your
16 input. Appreciate it, and I hope you all
17 have a great day. Bye-bye.
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2 C E R T I F I C A T E

3

4 I, STEFANIE SWEET, Certified Verbatim

5 Reporter and Registered CART Provider - Master,

6 hereby certify that the foregoing record

7 represents the original record of the Technical

8 Advisory Committee meeting; the record is an

9 accurate and complete recording of the

10 proceeding; and a transcript of this record has

11 been produced and delivered to the Department

12 of Medicaid Services.

13 Dated this 5th of April, 2024

14

15 /s/ Stefanie Sweet

16 Stefanie Sweet, CVR, RCP-M

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