CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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Via Videoconference
January 25, 2024
Commencing at 9:34 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

**APPEARANCES**

ADVISORY COUNCIL MEMBERS:

Sheila Schuster - Chair
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Dr. Garth Bobrowski - Co-chair
Dr. Steve Compton
Heather Smith (not present)
Dr. John Muller
Dr. Ashima Gupta
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace (not present)
Annissa Franklin
Beth Partin (not present)
Bryan Proctor (not present)
Peggy Roark
Eric Wright

**P R O C E E D I N G S**

CHAIR SCHUSTER: Good morning. Let's call this meeting of the Medicaid Advisory Council, the MAC, to order. I'm Sheila Schuster. I'm the chair of the MAC.

And I don't believe that Mackenzie Wallace, our secretary, is on. So, Erin, if you would, please, call the roll.

MS. BICKERS: Absolutely. Kelli, are you on to count while I call names? I have a hard time doing both.

I know she's had computer issues all week.

(No response.)

MS. BICKERS: Okay. I'll do my best to count and name call at the same time.

Beth?

MS. SHEETS: Erin, I'm here.

MS. BICKERS: Oh. Thank you, Kelli.

MS. SHEETS: You're welcome.

MS. BICKERS: Nina?

MS. EISNER: I'm here.

MS. BICKERS: Susan?

MS. STEWART: I'm here, but my

video is not working. So I'm going to sign on my phone and see if I can get the video to work.

MS. BICKERS: Thank you.

Jerry?

MR. ROBERTS: Here.

MS. BICKERS: Garth?

DR. BOBROWSKI: Here.

MS. BICKERS: Steve?

DR. COMPTON: Here.

MS. BICKERS: John Muller?

DR. MULLER: Muller, yes. Here.

MS. BICKERS: Muller. I'm so sorry. I do that every time.

DR. MULLER: No problem.

MS. BICKERS: Ashima? I saw Dr. Gupta. Did we lose her?

CHAIR SCHUSTER: No.

DR. GUPTA: Can you hear me?

UNIDENTIFIED SPEAKER: You're just muted.

MS. BICKERS: Oh, there she is. Sorry about that.

John Dadds? I think I always say that one wrong as well.

(No response.)

MS. BICKERS: Catherine?

DR. HANNA: Here.

MS. BICKERS: Barry?

(No response.)

MS. BICKERS: Kent?

(No response.)

MS. BICKERS: Mackenzie?

(No response.)

MS. BICKERS: Annissa?

MS. FRANKLIN: Here.

MS. BICKERS: Sheila?

DR. SCHUSTER: Here.

MS. BICKERS: Bryan?

(No response.)

MS. BICKERS: Peggy?

MR. STUART: If that was Brian from Aetna, I'm sorry. I'm here.

MS. BICKERS: No. Bryan Proctor, MAC member. I'm sorry.

MR. STUART: Okay. Thank you.

MS. BICKERS: You're welcome.

Eric?

MR. WRIGHT: Here.

MS. BICKERS: Okay. That is

everyone. Kelli, how many did we have?

MS. SHEETS: I think I counted 11. I am attending on my phone because my laptop is not working. So -- but I think we're at 11.

MS. BICKERS: We should have a quorum.

CHAIR SCHUSTER: Okay. Thank you very much.

The minutes of the November 30th meeting were distributed, and I would entertain a motion for their approval.

MS. EISNER: I'll make that motion. This is Nina Eisner.

DR. WRIGHT: I'll second it.

CHAIR SCHUSTER: That was Nina. And the second was?

DR. WRIGHT: Eric.

CHAIR SCHUSTER: Eric. Thank you very much.

Any additions, corrections, omissions?

(No response.)

CHAIR SCHUSTER: If not, all of those -- I'm sorry. All of those in favor of approving the minutes, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed, like sign, and abstentions?

(No response.)

CHAIR SCHUSTER: Thank you very much. Let me just remind everyone -- we welcome everyone. I think we've got 91 people on the Zoom -- to keep yourself muted, please, during the meeting unless you have a speaking role. And the only people that should be speaking should be voting members of the MAC and then staff from DMS and any other government cabinet. So we appreciate that.

If you have a question and you're not a voting member of the MAC, if you want to put it in the chat, we'll try to respond to it. And this meeting is recorded, and the recording is posted on the DMS website. You can watch and listen. I appreciate that.

Under old business, is Commissioner Lee on?

COMMISSIONER LEE: Yes, Dr. Schuster, I am.

CHAIR SCHUSTER: Oh, great. Good

morning.

COMMISSIONER LEE: Good morning.

CHAIR SCHUSTER: I hope the fog was not too difficult this morning. I was very glad most of us were not having to drive anyplace with the fog this morning.

So let's start with old business, if we could, Commissioner Lee. And we'll ask, as we always do, about the status of the Anthem MCO.

COMMISSIONER LEE: That is still in -- in litigation, so we have no updates at this time.

CHAIR SCHUSTER: Okay. Thank you. We had asked for a description of the 1915C waivers, the 1915(i) SPA, and then the 1115 waivers. There's been a lot of, lot of action, as you well know, on all of these waivers and SPAs. And I don't know who's going to give that description for us.

COMMISSIONER LEE: I believe either Pam or Leslie will update us -- well, give us a description of those waivers specifically, if that's all you'll want, is a description of those; correct?

CHAIR SCHUSTER: Yes.

COMMISSIONER LEE: Okay. Yes. Leslie, Pam.

MS. HOFFMANN: Pam is going to start and then I'll wrap it up.

COMMISSIONER LEE: Fantastic. Thank you.

CHAIR SCHUSTER: Yeah. We had asked for a description because we keep talking about the waivers in our TAC reports and here on the MAC, and there were a number of MAC members that felt like it would be very helpful just to get an overall picture of the various waivers.

So, Pam, whenever you're ready.

COMMISSIONER LEE: Pam, are you on mute, or are you --

MS. BICKERS: I'm -- I'm not sure I see her, Commissioner. I'm scrolling really quick.

COMMISSIONER LEE: Okay. Well, I can give a start.

MS. HOFFMANN: I -- yeah.

COMMISSIONER LEE: Oh. Or, Leslie, if you want to --

MS. HOFFMANN: I was going to say, I can give a start, too. So I think -- sorry. Is it -- you're asking about --

COMMISSIONER LEE: Just a description of the waivers, so the 1915C home and community-based waivers.

MS. HOFFMANN: Okay. So we've got -- yeah. We've got -- oh, wait a minute.

MS. CLARK: I was going to say I couldn't get myself off mute, for whatever reason, but Pam was having some technical difficulties. I think she's trying to come in now. But, Leslie, if you want to go ahead and get started.

MS. HOFFMANN: Yeah. I can go ahead and get started.

MS. CLARK: Okay.

MS. HOFFMANN: So on the -- as far as a description goes, on the 1915C waivers, we have six 1915C waivers. And, Alisha, if I need to speak or change anything different, just let us know. Our oldest is our overarching HCBS waiver, which is for the elderly and disabled services. And we have a SCL waiver, supports for community living,

and we have --

(Brief interruption.)

CHAIR SCHUSTER: Hello. Who is speaking, please?

MS. BICKERS: I'm sorry about that, Dr. Schuster. I got them muted.

CHAIR SCHUSTER: Thank you.

MS. HOFFMANN: Sorry. I'll go back, Dr. Schuster.

So we have our Michelle P waiver, and that's for folks with intellectual and developmental -- and/or developmental disabilities. And that does not include a residential component.

So our waivers that include the residential component were the SCL waiver that I just mentioned earlier and two ABI waivers. So the two ABI waivers are acquired brain injury waivers. One is kind of considered a rehab waiver, and one is considered a long-term care waiver. And both of those have residential components.

We have the Model Waiver II, which is for individuals that are -- and it's a small waiver, lots of children in that program

related to ventilator dependency. And I think the only service in that one is nursing with a case management component where the nurse is actually the -- acts as the case manager as well so --

MS. SMITH: We actually -- they can actually have a respiratory therapist.

MS. HOFFMANN: Thank you, Pam.

MS. SMITH: Sorry. I finally was able to get on. Sorry. Of course, when I'm first, I get -- first, I have technical difficulties and can't get in so -- but you did a good job, Leslie.

CHAIR SCHUSTER: So let's slow down for a minute for those -- so the HCBS is your oldest waiver, and that's for the elderly and disabled. And that's in-home care. That is not --

MS. SMITH: It is in-home care, yes.

CHAIR SCHUSTER: Yeah.

MS. SMITH: And it's our -- it is our largest waiver. It has currently 17,050 slots, and it's also the waiver that we transition the most of our -- using MFP, we

transition the majority of -- the individuals that we transition with MFP come out into that HCB waiver.

CHAIR SCHUSTER: Okay. And then you mentioned supports for community living, which is your intellectual/developmental disabilities folks, and it's very popular because it does have a residential --

MS. SMITH: It does have a residential component, correct. And it has right now 4,900 and -- I don't have the numbers up in front of me, and I swore I would never forget them -- about 4,941 slots.

There were -- we have an additional slot -- 100 slots that'll be coming into that that are in the waiver that's with CMS right now. But we allocate -- for those slots, we allocate only on an emergency basis.

So if someone -- and at any point in time, somebody can request emergency status. So that's usually somebody that either is wanting to transition out of an ICF or a facility or someone that has had, you know, a catastrophic event that has caused them to lose caregivers. So, usually, those

individuals go into a residential setting. We also look at our kids that age out of DCBS that fit into that category, get those emergency slots.

Intermediate care facility, Marcie. Sorry. I forget. Alphabet soup.

COMMISSIONER LEE: And, Dr. Schuster, if it would be helpful, I have sort of a Medicaid 101 presentation, and I have a section in there specifically related to waivers. I can get that and give it to Erin to distribute to the MAC members, if you think that would be helpful, after today's meeting.

MS. SMITH: We also have a waiver 101 that I bet are probably -- they're probably the same kind of components, too, but I would be --

COMMISSIONER LEE: Yeah.

MS. SMITH: -- happy to pass that along as well so...

MS. CLARK: It's on our website. Yeah. I can grab it and put it in the chat, I believe. It's on our website.

COMMISSIONER LEE: Okay. Thank

you.

MS. CLARK: You're welcome.

MS. SMITH: We get excited talking about the waivers. I've done them for a long time, and I know they're awesome programs. And so I get a little excited talking about them.

MS. HOFFMANN: Okay. Do you want me to go ahead, then, or are you going to -- do you want to go over the -- did you go over the 1915(i)? I'm sorry.

MS. SMITH: I can do the (i) really quick.

MS. HOFFMANN: Okay.

MS. SMITH: So the 1915(i) which is -- it's confusing because it is a State Plan Amendment, but it provides home and community-based services. So it's going to be for individuals that have serious mental illness as well as there are some services for individuals with substance use disorder.

It -- the most exciting thing about that right now -- we've been working on it. We just finished town halls at the end of last year. And on Monday, that SPA is going out

for public comment. It will be posted for public comment as well as there will be a companion that goes out that kind of helps with the review of it.

It's -- you know, it's a template. It's something that, you know, they -- CMS -- we have to go into the portal, and it's specific, the way we have to fill it out. So sometimes it can be hard knowing where you want to go if you're looking for something in particular or how to review that.

So we try to release that companion guide that helps know if you're wanting to look for, you know, services in particular or you're wanting to look at something in particular, exactly where to go in the document.

But that is on track and will be posted for public comment on Monday, the 29th. And it -- so it will be our newest of the home and community-based -- our long-term services and supports, but it is a State Plan Amendment.

MS. HOFFMANN: Okay. And I'm going to go over the 1115s that we currently have.

I think I'm just going to start a little bit backwards and just say that the 1915(i) State Plan Amendment is a companion to the recently submitted SMI 1115 waiver, which is -- it's a little bit of a play on waiver.

The waiver on the 1115 side is really allowing for flexibilities of folks in a demonstration period. And so we have -- this is a companion that will include a -- really more of a parity for the additional days' stay in an IMD more than 15 days and then an average stay of 30 in the state of Kentucky as well as a recuperative care piece that allows for a safe place for folks to go if they need treatment or prep before surgery.

Oftentimes, these are folks that are homeless and don't have a clean place to stay during medical procedures before and after. So this is called recuperative care. In the federal world, we often see it called medical respite as well.

So right now, there's no new updates to the SMI 1115 that was submitted. DMS is reviewing currently right now a playbook that's called the *Medical Respite Playbook*

which is a practical guideline for managed care plans, and that was released by the National Institute For Medical Respite. So we're kind of doing a deep dive into that medical respite playbook that came out in fall of 2023.

Going back to our overarching Team Kentucky, which also includes our substance use disorder expansion and extension. Those things we have not heard back from CMS. We meet with them on a regular basis every month.

We were also -- I think, Dr. Schuster, we mentioned at the Behavioral Health TAC that DMS hosted CMS to come here. They asked to come and see what we're doing. We did a very integrative, collaborative meeting and included other partners, other sister agencies.

The Department of Behavioral Health was present and kind of went over all the wonderful things we've got going on here in the state of Kentucky, and they were very impressed with us, according to their emails back, and have also asked DMS to come present

with them at CMS' quality conference in April.

So we'll be -- Angela Sparrow and I will be presenting with CMS at their quality conference, which is a really big deal, and we're very happy that they could see all the good things that are going on here in the state of Kentucky.

We are doing annual monitoring and reporting. Our next monitoring and reporting of our big overarching Team Kentucky 1115 is due to CMS in February. And, again, there's no new updates regarding the extension other than we've been working through any questions they might have, which has been minimal at this time, and trying to figure out -- CMS is trying to figure this out as well -- how we can streamline all these requests that all states have, not just Kentucky, and to get them approved as quickly as we can. They were a little bit backed up after COVID and had 52, I think, to get through before the end of December 31st.

Our other waiver that we've got going on right now is the Reentry 1115. That is

actually an arm off of our Team Kentucky because it will be for more than members who have SUD. So we -- with our submission of the Reentry 1115 December 30th -- we got that out a day early. We were bound and determined to meet our own deadlines. DMS withdrew that old pending incarceration amendment from three years ago because it was not going to be approved as it was, and we've had many states to reach out asking us questions about it.

So in all transparency, for other states, too, that are trying to write waivers, we withdrew the old incarceration and submitted the new reentry, which is the same opportunity. CMS now calls it the reentry application, and that was submitted on 12/30.

Our public comment ran through November through 12 -- December the 9th, and we had about 13 comments that you can find posted on our website. DMS did receive, about 15 days or less after we sent the application to CMS, a letter that says that we meet all the completeness -- they call it a completeness

letter of an 1115 and said that we included all information that was needed and all required fields for the application.

So once it's deemed complete, it is posted to Medicaid.gov for a federal public comment which will run through 12 -- I'm sorry, February the 11th. So we are waiting to see what's going to happen there.

Now, remember, even if CMS approves it, this just starts the implementation plan. So our advisory workgroup will kick off first quarter of the year, so we're very excited to get that started. That will be involved in our implementation plan that will be submitted to CMS as well.

So we've got lots of moving parts for lots of complementary programs to others as well as trying to meet all the needs of individuals that we've got here in Kentucky.

I do want to mention one caveat on the reentry waiver. It is not -- now, it's not only for adults. We are asking for juveniles to be covered as well. So that's a -- that's a very positive.

From incarceration waiver to reentry

waiver now, we had to narrow the eligibility -- or sorry. We expanded the eligibility for folks, and we had to narrow the services. We hope to get this approved -- we already have a list of changes we want to make as soon as we start -- as soon as we get the approval. We want something that we can build upon and to get this through at a very busy time, that CMS has so many other waivers that are out there from states to review.

And I probably spoke really fast, and I'm sorry, Dr. Schuster.

(Brief interruption.)

CHAIR SCHUSTER: I'm sorry. Does someone have a question?

MS. EISNER: I do. Nina. Will you repeat what you said about the IMD and the 15-day? That was -- I didn't quite grab that.

MS. HOFFMANN: Yeah. So currently right now, in the SUD waiver which we are -- we have embedded with the extension for Team Kentucky, we wanted to do something related to SMI and parity. And that would give us 15

days per stay and then I could also include an average stay of 30 for the state. So it's an average stay.

MS. EISNER: And so that doesn't have anything to do with what happens to provider payments after the 15 days of care if it goes to day 16, 17?

MS. HOFFMANN: So we can cover an average stay of 30. That's why I was -- and I know that's a little confusing. So some might have more, and some might have less. So it's -- we can't go over an average stay of 30 days for Kentucky, and we monitor that.

MS. EISNER: Okay. That's great. Some of the MCOs are clawing back all 15 days if the patient goes to day 16 or beyond.

MS. HOFFMANN: Okay. And so we have made the MCOs aware that we've got this pending with CMS. And, again, it was more -- we wanted to make that happen. It was available under that authority that we were already sending this application for and then it really did seem like parity since we have that availability for SUD already.

MS. EISNER: Perfect. Thank you.

MS. BICKERS: I'm sorry. This is Erin with the Department of Medicaid, if I could step in for just a moment. I'm not sure if it's just on my end, but I'm getting a lot of feedback, static, and noise. So if you're not speaking, if you don't mind to please mute just in case anyone else is also having issues hearing. Thank you.

CHAIR SCHUSTER: Thank you, Erin. I'm not having that problem, but if you are, then we want to be sure that that's taken care of.

Thank you. Leslie, on the reentry, you're going to cover adults and juveniles now. You mentioned it was SUD. Does it also cover people with SMI?

MS. HOFFMANN: Yes. It will cover a dual diagnosis as well. So there's actually some physical health pieces in there. And we've been working also, as a sideline, Dr. Schuster, with the Department of Public Health and others to try to see if we can address increases of Hep C here in Kentucky.

CHAIR SCHUSTER: Good.

MS. HOFFMANN: So we're working to see if we can assist with that, feeling that if we could cover those services during incarceration, they could get at least some of their treatment started before they leave. So that's just a sidebar.

But all the medications that we are going to ensure that they have when they leave with a 30-day supply of medication also includes physical health medications. So it's kind of variety of -- it's really about extensive care coordination, MA -- MAT. I'm trying to think of the other things -- and then a 30-day supply.

And then we're also working through some recovery residential support services for people in a location. If you're familiar with Senate Bill 90, we're trying to assist with some of those pieces as well.

CHAIR SCHUSTER: Well, and you might just mention to people what happens -- what happens now if people are incarcerated and they have Medicaid.

MS. HOFFMANN: So, currently, right now, we are a lucky state in that we suspend.

We don't terminate. So we were progressive doing that in the past. Their leave dates are often fluid. We don't know exactly what date that they're leaving, so we're trying to narrow that down and do a better job in figuring out when folks are leaving.

This is not just something we're doing. DOC and AOC and other folks are -- and DJJ are also, here in Kentucky, involved with us, so the Department of Corrections and Justice. Sorry about the acronyms.

But we want to ensure that they have a warm handoff when they're ready to leave incarceration, or confinement for the juvenile justice, that they've got all their appointments set up and ready to go through intensive care coordination so that they're -- can be successful and have everything set up when they leave, so there's nothing lacking.

We want to ensure that 30-day supply of medication because, oftentimes, crisis happens after they leave when they don't have medication or can't obtain the medication very quickly. So we want to ensure that that

is taken care of.

The MCO of their choice will be involved with them. We are asking for 60 days prior to release and then they will do a post follow -- intensive follow-up for 12 months, is what we're asking for.

CHAIR SCHUSTER: Yeah. So it really changes the entire experience for those that are incarcerated.

MS. HOFFMANN: Very much so.

CHAIR SCHUSTER: They will be able to get Medicaid benefits while they -- those 60 days before they're released and then lots of work to make sure they don't fall off the cliff once they get in.

I'm so glad to hear you're going to address the Hep C because we've heard from the Department for Public Health their concerns about that.

MS. HOFFMANN: Yeah. I'm trying to see -- I think we can figure something out. I don't know if it'll be what everybody wants first round, but we definitely want to try to address that for Kentucky because I -- from what I hear, it is an increasing situation

here in Kentucky. So we want to try to assist with that and see what we can do for prevention.

CHAIR SCHUSTER: Thank you.

And, Garth, you've been very patient. You've had your hand up. Do you have a question?

DR. BOBROWSKI: Just a question. I got a phone call just the other day, and I said I do not know. So I would -- I said, we've got this MAC meeting coming up. I said, the folks that will know will know, and they'll be on this meeting.

But I got a call about -- in the northern Kentucky area about: Are illegal immigrants qualifying through a waiver system or through the MCOs to get orthodontic treatment?

COMMISSIONER LEE: Hi, Dr. Bobrowski. This is Lisa Lee. We do have a citizenship requirement in Medicaid, and only individuals who meet certain criteria related to eligibility can get in the program.

So if an undocumented immigrant is

applying for Medicaid, they most likely will not app- -- will (sic) qualify. We do have an exception for legally residing immigrants who have been in the state for five years for children. So if they are an undocumented immigrant, they would not qualify for Medicaid.

DR. BOBROWSKI: Okay. Well, thank you. I just thought I'd get an answer from this group. Thank you.

MS. BICKERS: There is also a question in the chat from Lori Gordon. It says: How are the MCOs notified of the upcoming DOC release?

CHAIR SCHUSTER: So that's a question, I guess, for Leslie.

COMMISSIONER LEE: We do have -- and I will -- I can chime in and then Leslie can enter.

But we do have a data feed, if you will. I think it's from Appriss, and it comes into our computer when an individual is incarcerated. We get an incarceration status when that individual is released, and that would be removed. There is sometimes a

little bit of a lag. But for the most part, I think this works very well, so we do have those notifications.

We do have some instances, for example, where an individual may be released, let's say, today. They go to the physician today. The physician checks. Everything is okay. But when they file their claim, that claim is denied because the systems haven't talked to each other yet to inform the either -- the MCO that the individual who has been incarcerated has been released.

And we have a process whereby we work through those cases. But we do have data feeds that show incarceration status in our system, and that is passed to the Managed Care Organizations.

Leslie, I'm not sure if you have -- if you want to add anything to that.

MS. HOFFMANN: I was just going to say -- what I was going to talk about was Appriss. And we have -- because we've been involved with Appriss and trying to figure out how we can make things better, we have noticed that the accuracy of Appriss has

definitely gotten a lot better. And it's going to be a good tool for us to utilize.

I will tell -- and folks know that I say this -- I've said this before. If you have a member that's in a situation where they're out and they -- like, right now and they can't get their Medicaid turned back on, I work through a couple of those a month. And we've got wonderful folks in Medicaid that assist with their eligibility. So if you run into one of those situations, I totally don't mind for you to reach out to me, and we'll work through those.

I used to have about six -- probably six or seven a month, and now I probably just get one or two. I haven't had any for January.

CHAIR SCHUSTER: Thank you. And, Commissioner Lee, Dr. Gupta asked if you would review again what you said about the legally residing kids. And do they need to be here for five years before they're eligible for Medicaid? I think that was her question.

COMMISSIONER LEE: Yes. There is a five-year bar. We'll have to -- I can go

back and look specifically at our eligibility policy. But yes, there is a five-year bar on legally residing immigrants. However, for children, we waive that five-year bar.

CHAIR SCHUSTER: Okay.

COMMISSIONER LEE: So legally residing children can enroll in the program but, again, it's legally residing. But, typically, there is a five-year bar. But years and years ago, when we made changes to our CHIP program, we changed that and eliminated that five-year bar for children.

CHAIR SCHUSTER: Thank you.

Then, Leslie, there was a question in the chat about -- could you again review the services that are offered to people in those 60 -- those last 60 days of incarceration before they are released?

MS. HOFFMANN: Yes, ma'am. So here's what we're asking for in that waiver if CMS approves it. We are asking for case management, which it's not just simple case management. We're expecting some pretty intensive case management. And then also, the case management would also continue once

the person leaves for a 12-month follow-up. So that's something extra that we're asking for for support of the member.

MAT coverage, 60 day prior to release. 30-day supply of medications at time of release. And that also includes, remember, the physical and other mental health issues -- coverage, sorry. Medication as well as -- I think there's some durable medical equipment also listed in there.

And then we're also working on recovery, residential support services. If you see RRSS acronym out there in the world, it's Recovery Residence Support Services up to three months post-release. And we're working on that through Senate Bill 90. I always talk about that because I really feel like it's an avenue that is a complement, again, to try to assist these individuals.

And then, also, we're covering confinement of DJJ individuals, the juvenile justice population.

MS. BICKERS: Dr. Schuster, you're muted.

CHAIR SCHUSTER: Thank you, Leslie.

I'm assuming that there also are active treatment programs going on for either the mental illness that's been identified or the substance use disorder besides --

MS. HOFFMANN: Correct. And that's one of the -- we want to ensure that the assessment is completed that can identify any of those needs through care coordination, whether it be mental, physical, the SUD situation, or, like I said, the Hep C. That's another one we want to figure out a way that we can identify and then possibly start treatment while they're there.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: And more to come, Dr. Schuster. Like I said, I've had --

CHAIR SCHUSTER: I know.

MS. HOFFMANN: I've already -- I've gotten multiple comments about: Can we add this? Can we add that? Can you look at this? Can you look at that? And we can.

I -- one of the main things right now is we're trying to get that approval from CMS so that we can -- I don't want to have any questions that delays us getting an approval

right now in the midst of their 52 reviews of other states so...

CHAIR SCHUSTER: Well, and for those of us who have been on this journey with you for, what, the past five years, we are very anxious --

MS. HOFFMANN: Three at least.

CHAIR SCHUSTER: Yeah. Very anxious --

MS. HOFFMANN: I am, too.

CHAIR SCHUSTER: -- for this to get approved. I'm sure you are, too.

MS. HOFFMANN: Yes, yes.

CHAIR SCHUSTER: One quick question because I lost my Internet there for a few minutes while you were talking.

I saw that the notice went out that the 30-day public comment period on the 1915(i) SPA is going to start January 29th.

MS. HOFFMANN: Yes. I think -- Pam, did you -- was it the 29th? Is that correct?

MS. SMITH: Yeah. It's this Monday, so it's -- this upcoming Monday, it starts.

MS. HOFFMANN: Yeah. And it was --

MS. SMITH: And it'll open -- we actually are, because of leap year -- and so I think we're actually leaving it open an extra day or so. I think it closes on the -- I think we left it open through the 29th. So I think it's actually open maybe for a little over 30 days, but it does -- it will start on Monday.

CHAIR SCHUSTER: Great. And the actual SPA will be available for people to review to make their comments on; right, Pam?

MS. SMITH: Yes. So it will be -- so we will send out a -- once it is posted, Kelli will send out the notification of where to find it, the link of where to find it on the website and as well as -- there's the directions on the various ways you can make public comment.

We even -- we have staff that are available that -- if someone, you know, doesn't want to send in written comment either through email or, you know, through regular mail, we have staff that they can call, and they will actually take down the

comment for them and submit --

CHAIR SCHUSTER: That's wonderful. I would -- I can picture some of our consumers and family members using that. That's really great.

MS. SMITH: And so we -- we really wanted to make it be available any way -- you know, every way possible for individuals to be able to comment so -- we didn't want to have any barriers.

CHAIR SCHUSTER: And when you post that, will you be posting a summary of what's in there?

MS. SMITH: Yes. We will have that --

CHAIR SCHUSTER: Because that's a lot of pages --

MS. SMITH: Yes. We will have that --

CHAIR SCHUSTER: That's a lot of pages for people to plow through.

MS. SMITH: It is. It's a lot of pages, and it's not in the -- you know, it's in a format that we have to use. So it's not the most user friendly to read through.

CHAIR SCHUSTER: Right.

MS. SMITH: So there will be a summary that individuals can look at and see. You know, it'll guide them to where -- you know, if there's a specific section or a specific thing that they want to look for, it'll guide them there as well as kind of guide them through the document.

CHAIR SCHUSTER: Wonderful. And will you post your FAQs along with it? Because I think that's a super helpful way for people that are not as familiar with the waiver to look at those --

MS. SMITH: Yes.

CHAIR SCHUSTER: -- questions people have been asking.

MS. SMITH: There is an updated version of those actually that is -- I believe this afternoon, we are going through them one last time and then the updated version of those also will be posted.

CHAIR SCHUSTER: Fantastic. Thank you very much. You're making --

MS. HOFFMANN: Dr. Schuster, I would just mention, like Pam said, the

version, the way it is, it's not real friendly. It's not like your -- it's not going to be your typical C that you're used to looking at; right? It's a 1915C. It's going to look different, and it's complex. And it's complex because we're trying to meet the need of a wide range; right?

CHAIR SCHUSTER: Right.

MS. HOFFMANN: So it's complex. So I would do what Pam says and just suggest to your members to look at the quicker -- like, this section, that section, and the summaries that she's talking about in the upcoming FAQs. Because it is -- it is confusing. It just is because of how complex that we've asked to meet everybody's needs.

CHAIR SCHUSTER: Yeah. Thank you. And I -- I keep calling it, of course, the SMI waiver because that's how it started out, but it actually is for people with severe mental illness as well as people with substance use disorders.

MS. HOFFMANN: Yeah.

CHAIR SCHUSTER: And you all in the town hall meetings did a good job of talking

through which services were available for which of those populations so...

MS. HOFFMANN: Very exciting. It's all kind of coming together now finally. So yeah, we're very excited.

CHAIR SCHUSTER: Great. All right. Any other questions from any of the voting members? I see that a couple of people, Erin, have logged in, Barry Martin and Kent Gilbert. Welcome.

DR. HANNA: Dr. Schuster, I have one question.

CHAIR SCHUSTER: Sure.

DR. HANNA: And it's just to educate myself because, as we all know, substance use disorder when they're being discharged from the -- from jail, you know, from a jail or being incarcerated is so important.

You said that they were just going to be kind of put on hold while they're incarcerated but then their Medicaid number would start as soon as they were discharged. Is that process pretty seamlessly? Because you want to make sure when they hit that door

and need those medications, they're going to be active at the pharmacy level.

MS. HOFFMANN: So, currently, right now -- and this has been a while back, the State actually went to a suspension rather than a termination. So they're not --

DR. HANNA: Okay.

MS. HOFFMANN: -- terminated now. But it has not been an easy process or a timely process, and there's many factors to that. It's not just Medicaid. It's the notification that they've -- you know, they've left and/or what I said earlier.

We have found that their leave is very fluid. Like, you might not think that they're going to leave for 30 days and then the last week, they're combining, you know, all their good time reductions or their time that they've already, you know, served and things like that. And, oftentimes, members might get out earlier than we even expect them to because they haven't calculated. So it's just kind of fluid right now.

DR. HANNA: Okay.

MS. HOFFMANN: So that's what the

Appriss system is working on. But I tell people now, even before this gets started, we occasionally might have a member who leaves and cannot get their Medicaid turned back on. So I've just been telling folks just to reach out.

And like I said, I used to do probably about six of those a month. I don't think I had any in December. Actually, I don't remember any since Thanksgiving, so it's been a while since I've even worked on one.

DR. HANNA: Okay. I just --

MS. HOFFMANN: It's definitely getting better.

DR. HANNA: Yeah. Well, that's good. I've heard that that was one barrier for many patients and the pharmacies, you know, trying to find out how they're going to take care of those patients, so thank you for that clarification.

MS. HOFFMANN: Exactly. And we've found that that can cause crisis as well --

DR. HANNA: Yes.

MS. HOFFMANN: -- when leaving; right? Very soon thereafter. And that's

something that we are trying to prevent, is crisis and any reason that they may have issues coming out, so thank you.

DR. HANNA: Thank you.

CHAIR SCHUSTER: And you mentioned, Leslie, that they are released with 30 days medication supply?

MS. HOFFMANN: That is correct. And that includes physical health as well, so there's -- anything that's addressed in that care management assessment, we're going to try to see if we can get identified and then leave -- and I think even durable medical equipment and things like that can be covered.

CHAIR SCHUSTER: And one final question in the chat. Who is billed for those in jail -- or in-prison services? Is it the MCO, or is it Medicaid directly?

MS. HOFFMANN: So right now, what's -- I think what's going to be -- what will happen is, is that the jail will be able to bill the Medicaid services and then pharmacy will also be able to bill -- the current pharmacy for DJJ and DOC happens to

already be a Medicaid provider.

So that was not a hard lift at all. I was actually worried about that side, and it was not a hard lift at all to figure out how to make that happen. So they're already currently a Medicaid provider.

CHAIR SCHUSTER: Okay. So it's Medicaid while they're incarcerated and then their handoff to the MCO --

MS. HOFFMANN: That's correct.

CHAIR SCHUSTER: -- starts when they leave the prison?

MS. HOFFMANN: That's correct.

CHAIR SCHUSTER: Okay. Thank you.

All right. Well, that was a lengthy discussion, but these waivers are so incredibly important. We have a big campaign going to address the waiting list for the 1915C waivers because there's over 12,000 people on those.

And the House budget had actually funding for more 1915C waiver slots than we've ever seen before. The funding is in there for 2,550 slots. I think that's maybe ten times -- certainly five times as many

slots as we've ever seen in a budget, so we're excited about that.

Let's go on to the next, which is that several of the MCOs in their presentations mentioned a 2 percent withhold to meet the HEDIS quality measures. And I'm wondering if this is a change in the contract for 2024 between Medicaid and the MCOs.

COMMISSIONER LEE: Yes, Dr. Schuster. This is Lisa Lee. Yes. This is a change in the contract. As many of you may know, Kentucky has one of the lowest rates of uninsured in the country. We're below the national average with a little over 1.5 million enrolled in Medicaid, another 75,000 enrolled in our QHP. And as such, you know, the MCOs cover 90 percent of our Medicaid population.

And we have a priority to not only enroll individuals in the program to make sure -- but to also make sure that their health status is improved. And we do have several quality measures; for example, in our Hospital Reimbursement Improvement Program and our Outpatient Reimbursement Improvement

Program. And hospitals receive supplemental payments if they meet certain quality measures.

We are also doing that in the managed care contracts. We have a value-based payment for those Managed Care Organizations. We do withhold 2 percent of their capitation payment. Once they meet certain quality measures, they can receive those funds back. We also have a bonus pool measure.

So we have about five or six core measures which includes, you know, good control of their A1C, their diabetes -- you know, related to diabetes. We also have child and adolescent well care visits from 3 to 21 years of age, some measures around childhood immunizations and other postpartum care and social needs screening and interventions. Those are some core measures.

We also have a bonus pool measure which includes, you know, metabolic monitoring for children and adolescents on antipsychotic medications and a few other measures that are bonus pools. So if they meet certain measures, they will be able to receive those

bonus funds back.

CHAIR SCHUSTER: Okay. Thank you very much. Could we get a list from you of those quality measures that you just mentioned?

COMMISSIONER LEE: Yes. We will provide that and then, again, they will be spelled out in the 2024 contract. But we will get those measures to you or get them to Erin, and she can send them out to the rest of the MAC and TAC members.

CHAIR SCHUSTER: Yeah. That would be great. Thank you very much.

And the final question -- and this came up a little bit at our last meeting. Changes in telehealth, but I think there were some questions about the federal versus the state flexibilities.

COMMISSIONER LEE: I think Jonathan Scott may be on the line. I'll have him address this. You know, Medicaid -- Kentucky Medicaid has always had pretty flexible telehealth policies, and so I'm not sure -- I think ours actually mirrored the federal regulations or statutes. I don't know if

there's any major discrepancies.

I know that we -- at one point, you know, we could not -- we were waiting on information related to non-HIPAA compliant platforms such as FaceTime and that sort of thing, for the Federal Government to make a decision if we could continue to use those platforms.

But I'll let Jonathan speak to -- to the telehealth.

MR. SCOTT: Good morning, everyone, and good morning, Commissioner. We -- we are not aware of anything that we're doing that is additionally restrictive. If it's within the scope of licensure and scope of practice, the general rule of thumb is that it is allowed. There are a couple of federal restrictions that we're starting to see with -- I think there was some hospital -- partial hospitalization issues that had gone on.

Our hands are pretty tied with a lot of these things where we just have to kind of, you know, either follow the billing code if that's involved or follow the federal

restrictions. We're trying to be as open as possible. That's how our reg is written. That's how we have interpreted these statutes that have passed as well.

CHAIR SCHUSTER: And, Garth, you had a question. Thank you, Jonathan.

DR. BOBROWSKI: Going back on the 4C and under old business, I just had a question on -- Commissioner Lee, you don't have to do it right now. But just if you could get us some information on the bonus system for the MCOs on -- that Medicaid provides to them and what qualifies them to, you know, get a bonus. I'm assuming it would be related to health improvements, but if you can just -- I just need a little information there, please.

COMMISSIONER LEE: You know, it might be helpful at the next meeting to let Angie or someone on her team provide a little bit of a presentation on how that withhold works because it's not really a bonus insomuch as it is part of their already -- a capitation payment that we pay.

We withhold 2 percent of their

capitation payment, so they have to meet certain measures in order to get that funding back. If they don't meet measures, that money that is left over goes into a bonus pool. And then if the other MCOs meet some of the quality measures, they can draw from that bonus pool. But it is not going to exceed the capitation payment that they would have received had this 2 percent withhold not been in place, if that makes sense.

Does that help, Dr. Bobrowski?

CHAIR SCHUSTER: Does that help, Dr. Bobrowski?

DR. BOBROWSKI: Yes. Thank you very much. Yes.

COMMISSIONER LEE: Yes. Okay.

CHAIR SCHUSTER: Yeah. Okay. I think that's a great idea, Commissioner. Thank you. Let's put that on the agenda for March, that we'll have a presentation about the withhold, the contracts, the requirements on the quality measures. I think there are good questions about that.

Nina has her hand up.

MS. EISNER: I do. Jonathan, you

were talking about the telehealth for partial hospitalization programs not being restrictive if in scope of licensure and scope of practice. What about intensive outpatient programs?

COMMISSIONER LEE: Hi, Nina. It's Lisa. I can answer that.

MS. EISNER: Hey, Lisa.

COMMISSIONER LEE: Hey. So we had a conversation. We had a meeting with some representatives from KHA related to the changes in maybe hospital to home, if we want to call it that, where hospitals can deliver services to individuals in their home. There was some flexibilities in the Public Health Emergency, and we are looking to see what those services look like outside of the Public Health Emergency.

So we did have a call with CMS, and they asked what services -- for example, in IOP specifically, how the providers would meet the criteria outlined in the ASAM level of care.

So I have reached out to a representative, I think Rosmond. I reached

out to Rosmond with some questions yesterday, and I'm sorry if I didn't copy you on that email. I'll be more than happy to forward that to you. But we are looking at that IOPP and specifically working with CMS to see -- you know, answer some of their questions and then to see if we can either continue with the IOP as it was in the -- implemented in the public health flexibilities or if we would need to do a waiver or some other change to allow those services to be delivered in that setting.

MS. EISNER: Thank you. That must be why Rosmond scheduled a meeting with me this afternoon.

COMMISSIONER LEE: I believe it is.

MS. DOLEN: That's it.

MS. EISNER: There's Rosmond.

MS. DOLEN: I was going to jump in and say I went ahead and forwarded it to her, so you don't have to worry about it, Commissioner Lee.

COMMISSIONER LEE: Okay.

MS. DOLEN: But thank you very much for --

MS. EISNER: Thank you. Thanks.

CHAIR SCHUSTER: All right. Any other questions on telehealth?

(No response.)

CHAIR SCHUSTER: Thank you very much, Jonathan.

Commissioner Lee, we're ready for updates. I suspect you have some.

COMMISSIONER LEE: I do have some updates. I had quite a few at one point. But I guess what I would really like to go into is, you know, we have an opportunity these next four years to really make a difference in the lives of those we serve. So that's one reason that we talked about the bonus pool. We've talked about the Hospital Reimbursement Improvement Program and the Outpatient Reimbursement Improvement Program.

And so going back and looking at the -- over the past four years at some of the things that we have done in Medicaid, we've looked at some of our accomplishments. And I have to say -- I've been in Medicaid about 23 years, and these past four years, I have seen some of the most exciting changes in our

program.

So, for example -- this is not an all-inclusive list. But we have eliminated all co-pays in the Medicaid program over the past four years. We no longer have co-pays in the program.

We combined our KCHIP benefits or -- if you -- it was totally seamless, and we didn't make a big deal about it. But before these past four years, all KCHIP programs -- we had two separate programs. We had a Medicaid expansion CHIP, and we had a separate CHIP.

And those children in the separate CHIP didn't receive the same benefits that the children in the expansion CHIP received. For example, they did not receive the EPSDT benefit which included some school-based services. They did not include nonemergency medical transportation.

So when we combined those programs into one Medicaid expansion, we did a couple of things. We gave -- every single child now in the Medicaid and CHIP program has absolute access to every single benefit available.

We also shored up a little bit -- you

know, if you're aware, the CHIP program is so embedded in Medicaid that a lot of people don't realize that CHIP is actually a grant that has to be renewed every so often.

In the event we run out of those CHIP funds, we would have to pay for all of those CHIP kids in that separate program at 100 percent state general fund dollars.

So by moving them into that Medicaid expansion, if we run out of CHIP funds now, we can draw down that Medicaid match rate for those CHIP kids. So the main reason that we combined those programs was to give children the exact same access to benefits.

We also, in the last four years, have our single preferred drug list. This means that everybody in the Medicaid program regardless if they are in a Managed Care Organization or in a fee-for-service population have access to the same prescription drugs.

We also implemented a single pharmacy benefit manager. Again, this means that pharmacies no longer had to go through six different pharmacy benefit managers depending

on the MCO in which a member was enrolled. They now have the one single PBM.

We have implemented a Program of All-Inclusive Care for the Elderly. This is a program that is not only accessible to Medicaid members. It's also accessible to individuals in Medicare and individuals who have private insurance.

This is a program -- again, just like Medicaid, this PACE is very similar to a Managed Care Organization in which that PACE organization receives a capitated payment to take care of the individuals in their program. And it is designed to keep individuals in their home and community, much like our 1915C waivers, rather than in a nursing facility.

We also have gotten our mobile crisis SPA approved, and I think you've heard Leslie Hoffmann talk about that mobile crisis SPA, State Plan Amendment, and some of the benefits we hope to see out of that within the next few years.

We have received approval for a treat/no transport State Plan Amendment. So what this

means is prior to that change, ambulance providers had to pick up somebody and take them to a hospital in order to receive payment. Now, an ambulance provider can go to an individual -- if somebody calls 911, for example, that ambulance provider can go. They can provide treatment on site and bill Medicaid for that treatment. They will not get transport, but they will get payment for that treatment on site.

We have also received approval for treat, triage, and transport. So this means that an ambulance provider can pick up an individual and maybe treat them on site and say, well, you probably should go to your doctor. You should go to an urgent care center, or you could go to a behavioral health hospital.

So now that ambulance provider can transport those individuals to the appropriate treatment location rather than having to send them -- or treat them to -- at a hospital, a PACE provider.

We have increased our psychiatric residential treatment facility rates. We

have two levels of psychiatric residential treatment facilities. They now receive -- Level 1 is a 500-dollar reimbursement. Level 6 is 600-dollar reimbursement. And this is aligning with our priorities to ensure that we have a good continuum of behavioral health services for our children.

We know, for example, that we have some high-acuity youth that we're having difficult placements for. I'm sure that you all have heard on the news and read in papers that we have had some children who had to stay in our DCBS offices because there was no treatment place. Some of them may have been staying in hotels. So this is one step in us building out that continuum of care for our youth, to make sure that they all have a place to stay and an appropriate form of treatment.

We've also talked about -- a little bit about our Hospital Reimbursement Improvement Program. Our hospitals have been paying the match for this program. It allows us to pay the hospitals the average commercial rate. They receive this payment -- these payments in supplemental payments at the -- I think

quarterly. But that's bringing more money to our hospitals, and it has been responsible for helping some of our rural hospitals stay open.

We also have started covering nonemergency medical transportation for methadone treatment in the past four years. We had -- for some reason, when the -- our behavioral health program was expanded, that treatment for -- the transportation for NEMT for methadone was not included. We are now covering that.

We have enhanced our vision, dental, and hearing services for adults. We've extended postpartum coverage for pregnant women for 12 months. We've also included pregnant women in our CHIP program now which allows us to enroll women up to 218 percent of the federal poverty level in our program.

We have continuous eligibility for children which means that children who come into our program now will have 12 months of continuous eligibility regardless if there is a change in circumstance. That would have meant they would have been disenrolled

without this approval from CMS.

We are reimbursing for community health workers. We have a home and community-based rate study and pay increases that I think Pam had talked just a little bit about. We are going through unwinding from the Public Health Emergency. We have a children's waiver feasibility study.

And, of course, you all have recently heard about the 1115 reentry and SMI at the beginning of this meeting.

And in our enhanced vision, dental, and hearing, over 1,900 adults have received glasses -- oh, wait. Did I say -- I think over 119,000 individuals. 119,000 adults now have glasses that would not have otherwise had those.

We have -- 66,658 members have received dental services. That's in the form of another cleaning or dentures or a root canal or a crown. We have over 18,000 individuals who have received hearing services.

And, again, this is not an all-inclusive list of everything that we have done in the past four years, but I just wanted to say a

big thank you to the MAC members and the TAC members for everything that they have done to help push all of those changes forward. We could not have done this -- without all of our partners and our advocacy communities, the legislators, and the Secretary of the Cabinet and Governor Beshear, we could not have made all of these significant changes.

And so we're very excited for the next four years and another term with Governor Beshear and how we can move that healthcare needle to actually show that we are improving the health status of our state.

Recently, we have moved from 43rd to 41st in America's health rankings. And I think within the next four years, if we keep on this trajectory, we should be able to see some more movement. I mean, how great would it be in four years if we could be up in the 30s rather than in -- you know, at 41st?

And I know when I first started in Medicaid, I think we were 48th or 49th. And in my tenure, I've seen us move up to 47th and 45th and then 43rd. So we are making those changes to improve the lives of those

we serve. And, again, it's a team effort and -- you know, Team Kentucky. Just really appreciate everybody who has had input and helped us drive those policy changes.

And I think that's a very positive update, and I will be more than happy to take any questions.

CHAIR SCHUSTER: I think we ought to break out some champagne, but it's hard to do that remotely.

COMMISSIONER LEE: It is.

CHAIR SCHUSTER: That is a very impressive list, and there's some comments in the chat. Do any of the voting members of the MAC have any specific questions to ask Commissioner Lee?

I think we've asked you before to give us that in writing, Commissioner, because you gave us that rundown at the BH TAC. And you ought to write it up and put it on gold paper or something.

COMMISSIONER LEE: I have it. I have it in a PowerPoint presentation. And I will give it to Erin, and she can send it out to the MAC and TAC.

And, you know, in my presentation -- and I think, you know, at the end, I don't want to say just thank you but a big thank you to everyone who has pushed for these changes. Again, I mean, it has -- these changes have been involved -- you know, we had legislators involved from both sides of the aisle. We had bipartisan support on a lot of these changes. We had our MACs and our TACs pushing for those changes, particularly, you know, our community health workers, our vision, our dental, our hearing.

None of this could have happened if we had not all been -- had that one focus of improving the health status of this state. And I think, you know, it's just -- these past four years have been so, I think, rewarding for me and the Medicaid team to see how everybody has pulled together to be able to get individuals enrolled, keep them enrolled, and make sure that they can continue to access services.

Now, everything has not been perfect. And we are definitely excited about the next four years and what we can improve upon. And

some of the TAC recommendations, for example, that are coming forth, I'm really getting excited about those.

For example, the Consumer Rights TAC has made a recommendation that we create a form to allow people -- Medicaid members to document when they have trouble accessing services. So we've looked at our presumptive eligibility form that we had online during the Public Health Emergency that was very simple. And we're thinking we can kind of follow that format and have that information go into some sort of database so that we can actually start identifying where those access-to-care issues are. And so very excited about some of those recommendations.

And, again, that's what, you know, the MAC and the TAC are for, is to identify areas of concern and see how we can improve our healthcare delivery system and improve all -- you know, just make Kentucky a healthier place. So very excited about some of the things that we see that'll be coming in the future.

CHAIR SCHUSTER: Thank you very

much. One of them that you mentioned at the BH TAC, and I don't know that you mentioned it, was the number of SPAs that were submitted --

COMMISSIONER LEE: Oh.

CHAIR SCHUSTER: -- successfully. And I think that's our very own Erin Bickers and Kelli Sheets who were responsible for that.

COMMISSIONER LEE: Yes, it is.

CHAIR SCHUSTER: So I want to give them a very positive shout-out. Was it 20?

COMMISSIONER LEE: Yeah. Over 20 State Plan Amendments impacting Medicaid. Two KCHIP State Plan Amendments, four directed payments. And all of those were submitted and approved in 2023 and -- I mean, over 20. We haven't done that many in -- I couldn't remember. There's no way that -- that was just a monumental task.

But the one thing that Kelli and Erin did is, you know, they always reached out to CMS when we had a State Plan Amendment. And we had conversations, and CMS was a great partner on this. As everyone knows, that

Medicaid is a public -- it's a partnership between Medicare and Medicaid, the state and the federal agency. And we have had some really good conversations with CMS before we submit our State Plan Amendments, even before we submit our 1115s, so that they're complete. And CMS knows what's coming, and they're easily approved. I mean, we had a couple that were approved in the 30-day time frame.

When we submitted our 1115, there had been so many conversations between Leslie and her team and CMS that it was declared complete when it was submitted. And we're hoping that that means that we'll get something -- approval very soon.

But, again, the work that these individuals have put into the -- I cannot thank the Medicaid team enough for everything that they've done. I think that we have a really good Medicaid team right now. We have individuals who have quite a bit of tenure who can say, oh, we've already tried that, or we need to try this.

And it's just -- you know, it's a great

team right now and, again, very excited for the next four years.

CHAIR SCHUSTER: Thank you. And I think Peggy has her hand up. Hi, Peggy.

MS. ROARK: Yes. Good morning. This is Peggy Roark, a Medicaid recipient. I'm sorry. I'm running late.

I had some questions. Is the MCOs paying for crowns?

COMMISSIONER LEE: Yes. Our enhanced vision, dental, and hearing for adults includes coverage of crowns if that individual meets medical necessity and that crown would be the most appropriate service for that -- for that individual.

MS. ROARK: I also found out -- I didn't know that you can download an app for the MCOs, and I just found that out and also found out -- people is reporting their doctor visits, they're not going to take until March.

COMMISSIONER LEE: So if we can have -- if we can have some of those individuals -- we get some specific examples or those individuals can reach out to us, we

can help them -- we or the MCOs -- we being the Department for Medicaid Services or the Managed Care Organization -- should be able to help them find some services sooner. We will definitely work on that.

MS. ROARK: Thank you, Commissioner Lee. That's all my questions.

COMMISSIONER LEE: Thank you, Peggy.

CHAIR SCHUSTER: Yeah. Thank you for bringing those things up, Peggy.

I do think the enhanced vision, hearing, and dental services, those numbers are just astronomical and in a time when so many of our legislators want people to get back to work. You know, we have to assume that people that have glasses and can actually see now or have -- and don't have dental pain or are hearing better can pursue school and work and enjoy their lives.

So I think, you know, from the mental health standpoint -- and we've testified on this. The mental health benefits of having those things taken care of are just astronomical, I think, so thank you.

Let's move on, then. We're due for our biannual maternal/child update, and that's typically Dr. Theriot.

DR. THERIOT: Hello.

CHAIR SCHUSTER: Hello. How are you?

DR. THERIOT: Great. How are you? I'm going to go ahead and share my screen --

CHAIR SCHUSTER: Great.

DR. THERIOT: -- if I can find it and hope that it works. Can you guys see that?

CHAIR SCHUSTER: Yes.

DR. THERIOT: Wonderful. Well, this won't take much time. I just wanted to give a little bit of an update on some of the things that we've been doing with maternal health.

Basically, I'll talk about two different things. The first is going to be congenital syphilis or syphilis in general. And the second is the Lifeline for Moms which probably some of you have heard about.

Congenital syphilis, I don't know if you guys are aware, has really skyrocketed in the

last ten years. So this is a national -- from the CDC, national data from November of 2023 that showed an increase from 335 patients being born with syphilis to over 3,700, which is huge. 30 years ago in the United States, we thought we were going to eradicate syphilis completely. When we look at Kentucky, we've actually gone up a little bit more than that percentage-wise. We went from 2 babies in 2012 to 35 babies in 2022. And I don't have the number for 2023 yet. I'm afraid it's going to be more. But the increase nationwide was over 1,000 percent. Ours was 1,650 percent, which is crazy.

And when you look at it on a -- you know, what states are having more trouble with this issue, it's the southeastern states. So Louisiana, I believe, is leading the pack with a very large number of babies born every year with syphilis. Kentucky is kind of included in that -- those southeastern states. We're the northernmost of that group, and we actually have the lowest increase of the group. So it's a very big problem.

And the crazy thing is it's preventable. That Vital Signs report from the CDC in November said about 90 percent of newborn syphilis, it could have been prevented with timely testing and treatment. More than half of the moms who tested positive did not get effective treatment.

Now, about 40 percent of those had no prenatal care. So they, you know, walked into the hospital to deliver, they were tested, and they were positive. So they didn't really have to -- they didn't have time for treatment. But effective treatment means if you're pregnant and you test positive for syphilis, if you're treated within 30 days -- 30 days prior to the baby being born, that's effective. That should work.

And so 60 percent of the people were tested in an appropriate amount of time but not treated. And that's -- that's a little scary. So I don't know if people aren't looking at the test, and you don't know how to interpret the test. It's pretty simple. You don't know how to treat it if it's

positive. But there seems to be a lack of training or an opportunity to train and educate providers more on what to do if you get a positive test and the time frame you have to do it in.

So congenital syphilis is syphilis when the newborn is born, so you've already got infected from your mom. Usually, infected mothers, and sometimes the infants as well, don't have any symptoms. So you can't tell by looking at the patient if they have syphilis or not.

So, really, you have to screen, and that screening is done with the -- several times during the pregnancy. You don't screen people you think are going to be positive. You really need to screen everybody to have an effective screening tool.

And so the CDC is suggesting that we screen pregnant persons at three different times during the pregnancy, so that's great. If you screen them, you find them positive. You treat them, and the treatment is easy. And it's actually a penicillin shot. It's very easy.

If you don't treat, you can have stillbirths. A lot of times, if syphilis -- congenital syphilis occurs in the first trimester, the baby will be born dead, so you'll have a stillbirth. You can have premature births. A lot of blindness and deafness occur, developmental delays which could, you know, last lifelong with intellectual disabilities. And there's other things, problems with your teeth, problems with your bones, different things that can happen if it's -- if you're not treated.

And so -- and these things are things we don't see in an adult that catches syphilis because it's, you know, what happens for the developing fetus in utero and the infection that's affecting all of your different body parts. So the crazy thing is, it is preventable if we just screen for it.

We also looked at Kentucky Medicaid paid claims and -- for babies with syphilis. Because if it's going to cause all this trouble, what's the financial impact? And we found that at least in the first year of life, that babies with congenital syphilis

have double the amount of paid claims than all the other babies combined.

And that -- those other babies combined include the congenital heart babies. It also includes the babies with spinal muscular atrophy, which is -- if you don't know, spinal muscular atrophy is the congenital disease that we now -- miracle -- have a treatment for. That treatment is a shot that costs two million dollars. So that's including those babies. And congenital syphilis, you know, outcrossed them all.

So what have we done? I got together with the other Medicaid medical directors in the southeastern states, and we thought we would put out a health alert all on the same day. So we did it on December 15th of last year to kind of alert our states all at the same time and, again, thinking that if all of the southern states are doing it, then maybe, you know, somebody on the national level would notice as well.

But put out a health alert asking docs to screen routinely anybody of childbearing age but certainly of pregnant individuals.

And if they're pregnant, treat -- or screen three different times, at the beginning of the pregnancy, at the first prenatal visit, between 28 and 32 weeks, and then at delivery. And do this regardless of perceived risk because if you perceive a risk, that's subjective. You just have to do it to everybody.

And then we've asked that you do not discharge that baby until you know the results of the test. And I know that sounds crazy, but if that test is positive, you have to start treating right away so you can help prevent some of these long-term consequences. And every day counts, so don't discharge the baby until you know the results of the test.

And then, of course, report the test to the Department of Public Health because they need to do their investigation and try and find out, you know, where, you know -- how it's spreading and how to stop it.

So we partnered with -- we -- Kentucky Medicaid partnered with the Department of Public Health to help put out this health alert, and I think that's just a good example

of how we are partnering with our sister agencies, you know, leaning on each other's strengths to try and address health effects in the state.

So do you guys have any questions about congenital syphilis?

MR. GILBERT: I have a question, Dr. Theriot.

DR. THERIOT: Okay.

MR. GILBERT: Two things. Do you have any understanding of why the southeast states seem to be seeing the greatest, you know, uptick?

And then the second question, again, speculative. It seems to me like some additional testing just in the general population -- is testing expensive and difficult? Is it something that -- you know, folks who are getting other routine tests, could it be included relatively easy in that?

DR. THERIOT: Well, for your first question, I think there's a lot of poverty. There's a lot of access-to-care issues, not necessarily in Kentucky. There is poverty. But in the southeastern states, there's more

difficulty with health insurance, and I think that probably plays into why it's worse in the southeastern states.

For screening, we are looking into -- anybody can screen. I mean, I'm a pediatrician, and I routinely screen my patients if they had, you know, reason to be screened, if they were sexually active.

A lot of doctors will screen for gonorrhea and chlamydia because that's just peeing in a cup, and they wouldn't screen for the rest of the sexually transmitted diseases which require a blood test, basically HIV and syphilis. But they're all sexually transmitted diseases, and so I suspect we're not screening for the -- the other two as much because it's a blood test than you are for chlamydia and gonorrhea.

The -- but we are looking into -- we have syringe exchange programs where they routinely will test for HIV with a rapid test, and we're looking into seeing if we can use a rapid test, because they do exist, for those syringe exchange programs to do HIV as well as syphilis testing.

A lot of times, the hospitals will do batch testing. And so let's say on Thursday morning, they'll run the syphilis test. Well, that's great except if you get your blood drawn on Friday, you have to wait a week, you know, before you get the results.

So maybe utilizing a rapid test, if not for everybody that gets tested in the hospital but certainly on labor and delivery. That will give you an answer right away, would be one -- one thing we can do.

So working with public health, we're looking into different ways to increase screening that won't really increase costs but will reach more people.

MR. GILBERT: I'm really struck by the statistic about the cost involved in treating those children who are adversely affected. You know, I'm just slightly old enough to remember when the Wassermann test was required in various places before you got a marriage license -- right? -- to test for syphilis. And I think, oh, that's why they did it. Ah.

DR. THERIOT: There you go. That's

true.

MR. GILBERT: Thank you. That's very helpful. And it's also, I think, just a good reminder of why some of those rapid tests -- and anytime -- I mean, you know, syphilis is a silent -- it's silent for so long. It can be traumatically problematic to not catch it.

DR. THERIOT: Yes. Very -- I mean, and it's -- this is obviously dramatic for the baby if you don't catch it. But, you know, for me, if I got syphilis and didn't know, I can advance -- well, I could spread it, but I can also advance to neurosyphilis, which is not good. So there's so many reasons to screen. That's why preventive health is so important.

CHAIR SCHUSTER: Dr. Theriot, Leon Lamoreaux from Anthem put in the chat that they would be happy to have this alert and put it in their -- I think he said monthly newsletter that goes out to all of their providers. So I wonder if the alert was sent, you know, specifically to the MCOs.

DR. THERIOT: It was sent out to

providers, but I will send it -- or I will give it to Erin, the actual alert.

CHAIR SCHUSTER: Right.

DR. THERIOT: And she can send it out to the group after the meeting.

CHAIR SCHUSTER: Yeah. I think that would be very helpful.

Thank you, Leon, for that suggestion and offer to spread the word. This sounds like a really important one to spread the word and then to get providers to do the screening, basically, and do it with everyone, to emphasize that.

MR. LAMOREAUX: Repetition --

CHAIR SCHUSTER: Not just people that you kind of -- yes.

MR. LAMOREAUX: Yeah. Repetition builds conviction; right? So if we can just hit them many, many times with the message, I think that we'll all be -- we'll all be better off.

DR. THERIOT: That's true. That's true. And, you know, nine months is a long time. You know, I -- so it's really important to test more than once during the

pregnancy. Anything could happen during that time.

CHAIR SCHUSTER: Right. Right.

DR. THERIOT: But I do remember when we started testing for HIV during pregnancy, it was sort of the same thing. Once people started testing, they would test, you know, at the first prenatal visit and then it would be negative and then they'd say, okay, I don't have to worry about that. And it's like, well, now we test multiple times because yes, you do have to worry about it, and this is exactly the same thing.

All right. Well, moving on to something more -- well, not exciting but more upbeat. I wanted to talk about Lifeline for Moms. This is a service that started in Massachusetts, and it is a perinatal mental healthcare support and counseling service. And it's a little bit of a misnomer because it's really a lifeline for providers.

What it is is perinatal mental health for the frontline providers, like, the OB/GYNs, the family medicine, the pediatricians that are seeing moms during

this time of their lives. So perinatal mental health is from -- during the pregnancy up through 12 months postpartum.

And it really includes mental and behavioral health, and so why is it important? Well, we know that one in eight women will experience postpartum depression, and that's not just, oh, baby blues or, oh, I'm sleep deprived. It's postpartum depression. If you add in other mental health issues as well as substance use, you get up to one in five women, which is, you know, 20 percent of individuals in this category. Maternal suicide causes 20 percent of postpartum deaths among women with depression.

And we do know that mental health and substance use are a leading cause of preventable causes of maternal death. We see that in our own Kentucky data. We've presented to you guys on that.

And the scary thing is 75 percent of women who screen positive -- so these are women you have screened. It's positive for depression. They -- 75 percent don't receive

any treatment. And that's a little crazy for me, almost as crazy as, you know, not treating somebody for syphilis.

Because if you don't know how to treat, you just look it up, and you know. But these are women that have screened positive, probably in their provider's office. It's documented, and they're not treated.

And we've actually done studies on this, and we've seen that -- you know, asked providers, well, why don't you treat. And they -- and a lot of providers say, well, I don't want to screen because I don't know what to do. I don't know how to treat it. I don't have the resources to treat it, and so I don't. I don't treat it, which is really sad and scary.

The other thing providers say, I just don't want -- you know, if I wanted to be a psychiatrist, I would have gone into psychiatry. I don't -- you know, I became a pediatrician, or I became an OB. And I don't want to deal with that mental health stuff. And I know you behavioral health folks on the call understand because people have probably

told you that.

It's scary because, you know, what if -- you know, what if I was walking down the street and I saw somebody lying in the gutter and they have a gunshot wound and they're bleeding. And I say, well, I'm not a trauma surgeon. I can't treat you. And you just walk on by. You know, it's sort of the same thing. If you have a patient with an issue that needs treatment, I think you're morally obligated to treat. So that's what Lifeline for Moms will do.

The other thing, we've talked about disparities for -- in maternal health. And although black women are more likely to have an illness related to their maternal mortality than white women, when you look at perinatal mental health, despite the higher rates of illness, black women are actually less likely than white women to get mental health care.

So Lifeline for Moms or, a.k.a., lifeline for providers is really going to help give the providers a tool to use to treat women and feel confident in helping

women with this issue.

And so the Department of Public Health -- again, we're working with the Department of Public Health on this. They've received a five-year grant that's $750,000 per year. They've just gotten it, so this is the first year.

They're going to be hiring a full-time staff, which is going to be a social worker. They're going to have -- hire two healthcare professionals, usually a psychiatrist. They want a psychiatrist and probably a psychologist. And they're going to start some academic detailing first with OB/GYNs and then expanding to other people that see moms during the perinatal time period, so pediatricians and family medicine.

We're going to use our Medicaid data to see where the highest use of emergency room is for postpartum women and where the higher levels of maternal mortality and mental health issues are a diagnosis. And we're going to start in those areas of the state first.

And, providers, if you screen somebody

that's positive and they're sitting in your office and you don't know what to do, providers will be able to call a 1-800 number, talk to the administrative staff who will contact the behavioral health person on call who will return your call immediately while the patient is in your office. You can chat with that person, exchange the clinical information. And at the end of that call, the provider will have a treatment plan and will be able to direct the patient's care.

So it, you know, could be: Okay. They need to go see this doctor. Here's the appointment. You know, we can get you an appointment in three days. Or it could be: Start this medicine and follow up, you know, in three weeks. Or it could be: Go straight to the emergency department, you know, because she's suicidal.

So it could be anything, but the provider will have that backup who will be able to talk to the expert, come up with a treatment plan, and help the patient right away. It will start 8:00 to 5:00 and hopefully expand to 24/7. In Massachusetts,

it's 24/7. And, obviously, plans are to expand through the rest of the state.

So this is -- this has just started, Lifeline for Moms, really lifeline for providers. I think this is going to be a game changer. I mean, because I've been in the situation where I'm talking to the mom. I don't know what to do.

And, honestly, in our clinic, we now have clinical social workers. We have a list of docs we can call for postpartum depression and get them in right -- who understand the need of getting the patient in right away. And we developed these resources on our own because -- out of need. And that'll -- hopefully this will increase the number of healthcare providers over time that can go ahead and address the needs of these perinatal women.

Because they're going to learn -- the more phone calls they make to the hotline, they're going to learn what to do and then they'll have more tools in their toolbox to address the needs of the patient.

So yes, it's going to help providers.

It's certainly going to help pregnant and postpartum individuals and, ultimately, it may lead to more integration of mental health and physical health into the same care settings which, you know, is what we ultimately need.

So do you guys have any questions about Lifeline for Moms?

CHAIR SCHUSTER: Dr. Theriot, Sheila Schuster here. I'm curious about -- is this a grant to Medicaid or a grant to public health? Who actually got the grant?

DR. THERIOT: Public health, Dr. White. Public health.

CHAIR SCHUSTER: Okay. All right. Dr. White. Good. Because there's been a lot of movement legislatively. You remember that we passed Senate Bill 135 in the 2023 session, and it was directed at the perinatal mood and anxiety disorders which includes, of course, postpartum depression but also all of the others. And I know that Dr. White has pulled together that group of stakeholders and that they're meeting.

And one of the things that's included in

that is representation from some of the Kentucky universities because we really have a shortage. There are very few psychologists, psychiatrists, and social workers who actually have the training specifically in perinatal mood and anxiety disorders.

I also -- are you all in communication with Representative Moser? Because she has House Bill 10, and it's a bipartisan bill she's calling the momnibus bill. And it starts out actually with putting psychiatrists and a psychologist -- it sounds very much like this. I'm a little bit confused about what the overlap might be or duplication.

DR. THERIOT: Well, Dr. White was working with her to put this into legislation, and it is the same thing. But the thought is the HRSA grant is for five years, and it's only $750,000. And, eventually, if it's going to expand to the whole state and be 24/7, it's going to need a lot more money. And it's probably going to need more support from the state.

CHAIR SCHUSTER: Right.

DR. THERIOT: And so I think Dr. White was thinking this is a first step. But you're right. It's the same thing.

CHAIR SCHUSTER: Okay. I thought it sounded very familiar, and I was like -- and it's actually an extension, then, of what we started with Senate Bill 135 --

DR. THERIOT: Yes. Yes, ma'am, it is.

CHAIR SCHUSTER: -- with Dr. White. Okay. All right. That's great.

DR. THERIOT: It just shows that -- how we are working with other, you know, sister agencies to address different needs throughout the state and moving forward for maternal health.

CHAIR SCHUSTER: Well, I think it's very exciting and certainly the -- when you look at the stats on suicide particularly. And you've also presented in previous presentations to the MAC the disparity numbers between white moms and moms of color.

DR. THERIOT: Yes.

CHAIR SCHUSTER: We see that in

mental health for sure.

So any other questions for Dr. Theriot?

DR. BOBROWSKI: This is Garth Bobrowski. I had a quick question. I just -- and I think it was on your slide 13. But if you could help me understand, you know -- and, Dr. Schuster, you just made a comment about the disparities, you know, between groups of folks.

And I was just kind of wondering why the, you know, black women were having, you know, three or four times more problems. And I can't remember the exact slide. But, you know, and it just looks like -- well, is access to care the problem or -- I mean, in this day and time, I mean, a lot of times, transportation is provided. You know, there's MDs. There's, you know, healthcare clinics. There's pastors, counselors, you know, community healthcare workers.

I just wondered: What do you all see in your area as the reason they have this disparity?

DR. THERIOT: It is actually amazing, when you look at maternal deaths --

and this is nationwide as well as Kentucky. The most common reason for a maternal death for white women have to do with mental health and substance use. The most common reason for death for a black woman is, like, hypertension -- like, postpartum hypertension or cardiovascular issues. So it's a medical type issue. But then when you ferret it out, black women are less likely to be treated for depression than white women.

So it's still bad. But it is amazing that when you look at the death by black and white, the black women are dying from medical causes more than white. And so when you want to address maternal mortality, you need to, you know, address both. If you just go headlong into substance use, you're really only going to be affecting white women, and you're still going to have a disparity.

But, you know, most black women in Kentucky, they live in urban areas. They have access to transportation. They have access to tertiary medical centers with all the experts, you know, and the high-risk OBs and all that. And yet they still are dying

at a higher rate than white women of illness.

So it's multifactorial. I think implicit bias has to do a lot with that, you know, because it's the same doctors and same staff and same hospitals. But the white women are getting treated differently than the black women. So there's a lot to look into, and I don't really have a good answer for you. I just know what we see.

DR. BOBROWSKI: Okay. Thank you.

DR. THERIOT: Thanks.

CHAIR SCHUSTER: Thank you, Dr. Theriot.

Any other -- Ramona Johnson just suggested that psychiatric nurse practitioners would also be -- should also be included as providers in this, and I think that's true as well.

Any other questions, then?

(No response.)

CHAIR SCHUSTER: Well, we thank you very much, and we'll see you in six months because I think we have you on a six-month schedule so...

DR. THERIOT: Thank you.

CHAIR SCHUSTER: Thank you very much, Dr. Theriot. We appreciate it.

Next up is our quarterly update on PDS, person directed services, rate increases. And I think Eric Wright wanted us to put this on on a regular basis. That may be Pam Smith who's going to address this.

COMMISSIONER LEE: Yes. That would be Pam.

MS. SMITH: Yes. So there really hasn't been any -- any changes. I mean, the -- the rates for PDS, those base rates went up at the same time that the other rate increases went in. And we've been instructing the -- you know, anytime we've had any issues from anyone receiving -- having a modification done to update that rate, we've addressed those with those particular providers. So I think it's -- I'm not aware of anything that is any different or any other issues that we're having outside of the ones that we're addressing.

And PDS is participant directed services, so it's in the waiver programs where the individuals are able to -- they

actually act as the employer, and they are able to hire their own care staff.

CHAIR SCHUSTER: Yes. So there was a good bit of funding in the budget bill, House Bill 6, for increased reimbursement for providers in the 1915C waivers, Pam. Does that include the PDS? Does that funding --

COMMISSIONER LEE: I think that the --

CHAIR SCHUSTER: -- include the PDS?

COMMISSIONER LEE: Yeah. Well, the budget bills --

CHAIR SCHUSTER: Yes.

COMMISSIONER LEE: -- they are still -- they are preliminary right now, haven't been finalized. And I think that after session and when we see that finalized budget, we'll be able to talk more and answer some of those questions.

CHAIR SCHUSTER: Okay. You want to see what the final budget is before you --

COMMISSIONER LEE: Yeah. Before we --

CHAIR SCHUSTER: -- move forward on

that. That makes sense. Because we know that there's a long road ahead for the budget bill. Hasn't even gotten out of the House yet so...

COMMISSIONER LEE: Yeah.

CHAIR SCHUSTER: Any other questions? Eric, do you have any questions for Pam?

(No response.)

CHAIR SCHUSTER: I think maybe Eric had to step away for a minute. He had a student come in who needed something. I'll let him follow up directly with you, Pam, if he has any other questions.

MS. SMITH: Okay. That sounds good.

CHAIR SCHUSTER: All right. Thank you. And then our regular report on the unwinding. The unwinding continues to go on with flexibilities and so forth.

So who's going to do that for us, Commissioner?

COMMISSIONER LEE: I -- I can do that. Veronica was really busy today. She does a really good job, and she's on top of

all this. I do have a presentation, but I think in the interest of time, I'll just kind of, you know -- rather than going through the numbers and everything, I can tell you one big piece of news is that our eligibility flexibilities -- you know, we were -- our -- we're moving through unwinding, and we will be -- would have been done with unwinding at the end of May.

And we have so many flexibilities that have helped individuals stay in. But CMS has extended those flexibilities, will allow us to extend those flexibilities without taking action until December the 31st of 2024. So that is really good news for all of our eligibility flexibilities that will be extended.

We're currently -- our enrollment is 1.5 million -- actually, 1,560,000 individuals right now. If you remember, at the height of COVID, we were about 1.7. Prior to COVID, we were 1.3 million. So we're still around 200,000 individuals in our enrollment.

With our terminations -- you know, we started again in May with our terminations.

We saw 34,124 terminations in that month. December of 2023, we only saw 1,244. Again, those individuals that we -- we prioritized up front. We knew that many of those may not meet Medicaid eligibility. So we wanted to focus, you know, on all of those individuals who may remain in the program.

But we're starting to see our numbers -- our terminations really decrease. In October, for example, we had 12,613 terminations. Again, in December, 1,244.

We have some demographic information on our December disenrollments, and that is in this PowerPoint. Again, I will give this to Erin, and she will be able to send it out to the MAC members.

As of December, individuals who had -- were procedurally terminated, you know, they have 90 days to respond and come back into the program. If they're determined eligible, they're reinstated. In December, we had 391 reinstatements.

And, again, you know, we just ask that everyone keep -- help us get the message out about the unwinding and how important it is

for individuals to respond to information.

Related to our Qualified Health Plan enrollment window, it closed January 16th of 2024. However, we will have a special enrollment period after January 16, 2024, with a qualifying event. And we will have an unwinding special enrollment from March 31st, 2023, through December 31st of 2024.

So in addition, if a Kentucky resident loses their Medicaid coverage at any time, they can -- they may be eligible to enroll in a Qualified Health Plan with financial assistance. Our Qualified Health Plan open enrollment ended with 75,820 enrollees. That was a significant increase from our 2020 -- from our previous enrollment in 2023.

And, again, you can just stay informed on Facebook, Twitter, and Instagram with all of our unwinding activities. We will have ongoing stakeholder meetings the third Thursday of each month at 11:00, and we will send out links to those.

So I will share this presentation that has a little bit more information with Erin, and she can send that out to the MAC. But I

would be more than happy to answer any questions you may have.

CHAIR SCHUSTER: Thank you, Commissioner. That presentation is always very helpful, to actually see the numbers. And I think you've beefed up the demographics, as I recall, from the presentation --

COMMISSIONER LEE: Yes.

CHAIR SCHUSTER: -- that Veronica did at the BH TAC.

Any questions from any of the TAC members about unwinding? I do think it is all of our responsibility -- whatever role we have here on the MAC and with the TACs, whether you're a provider or you represent Medicaid beneficiaries, the basic message is answer the questions. You know, respond to your mail or to the call or to the texts that you're getting.

I know that DMS is reaching out in every way possible. The MCOs are also reaching out. But it's a lot easier to keep people enrolled than to let them fall off the wagon and then have to get them back on, although

they can reenroll, I think, for those 90 days without any difficulty.

COMMISSIONER LEE: Absolutely. And as far as children -- you know, our children, we have continuous eligibility. But if a child has -- if it's time for their recertification, we were supposed to -- well, we do that recertification to make sure they still meet and then -- for a year.

But we received -- we're one of the only states right now -- several states have reached out to us and asked for our information. We did receive approval from CMS to keep those children enrolled without doing that recertification. We got approval to extend all children up to 12 months during this public health unwinding emergency. Again, one of the only states that has done that, and we are helping other states to keep their children enrolled through that method.

CHAIR SCHUSTER: That's fantastic news, Commissioner Lee. Because we know that it starts with the kids, and we've got to get them healthy.

Any questions on unwinding? We've heard

about unwinding. We all feel a little unwound, I think, but I appreciate that.

(No response.)

CHAIR SCHUSTER: If not, then the last update that we had asked for was on mobile crisis, and that's probably Leslie.

MS. HOFFMANN: That would be me. So as you're aware -- I can actually give you some information today, and this is going to be exciting because we can continue to work towards more and more information, Dr. Schuster.

And then, also, I was going to talk to you about maybe having our contractor to sit in on one of the meetings, so folks can see the face of the Kentucky representative. And he's actually moving here to Kentucky, so that's a really good thing.

Just to give you a little bit of background, you know, over -- gosh -- three years, we've been working on mobile as well. And we started out -- not quite three years but working on a grant that allowed us to take a year to partner with our sister agencies and work on an implementation for an

all-inclusive, one continuum for mobile crisis here in Kentucky.

We did have a lot of programs going on here in Kentucky. A lot of them were small or limited, and some might have been limited in funds. And so what we were trying to do is figure out how to leverage the wonderful work that we have here in Kentucky and leverage that into a system that we could create together.

So we did a -- if you remember, we did a 258-page needs assessment. That wasn't what Medicaid felt like the State needed. That was boots on the ground, hearing from folks, hearing from providers, advocacy groups, CMHCs, CCBHCs, all those acronyms of all the different providers and hear -- EMS, the emergency transport folks, and crisis and first responders like police officers, law enforcement, and things like that.

So we developed that and, from that needs assessment, drove every decision that we've made going forward based on what we heard that Kentucky needed.

So in July of 2023, CMS approved the

Kentucky Department for Medicaid Services state plan to cover a Community-Based Mobile Crisis Intervention Service, which we call MCIS. I know that's a lot of acronyms again.

And DMS has actually just contracted -- and I can say this because we announced it in a meeting on the 18th -- that Carelon was awarded as the oversight administrator for, lack of better words, provider capacity, training, and data gatherer of this multi-faceted system. It's a huge program with lots of moving parts. Again, it had to be complex to meet Kentucky's needs.

So we have developed and gotten approved by CMS as well, things like new service definitions that meet not only that state letter that CMS asks for, all those requirements, like a two-person team, 24/7, and all those things in order for the -- CMS to give -- make a match rate or give us part of that -- those funds to produce.

But we also realized during that needs assessment that although we wanted to minimize law enforcement, that in rural Kentucky, we were going to need to have

another plan. So if you remember, we've also developed a community -- CCCR model, which is a Community Crisis Co-Response Model. And that's where we know that in rural Kentucky where 112 of the 120 counties is deemed rural, that we're going to need to build more available teams out in Kentucky.

So we gave out grants from CHFS with Medicaid looking over the administration of that. We gave out grants to municipalities who wanted to build a team that would have a licensed person available, or maybe some of these were folks who had limited grants that needed to be able to expand maybe 24/7, nights and weekends.

I've gotten lots of calls that just say simply, I need a licensed professional on my team. How can I cover this? And we've been working through that.

So we did our first round, and I can tell you who those awardees were. They were the Lexington Fayette Urban County Government, the Warren County Sheriff's Office, the Perry County Ambulance Authority, the Cynthiana Police Department, Maysville

Police Department, Christian County Fiscal Court, and Boyle County Fiscal Court.

And I don't know if you had an opportunity to watch -- when the governor announced this, we actually had them to make videos. And it was -- when we awarded those six -- the videos are humbling in themselves. But when we awarded those grants, it was so humbling to see a group of folks who just wanted to make their community better and wanted to help those in need.

There was -- it was just a wonderful experience personally for me to be able to hear those folks, for example, in Boyle County saying, "Here we are in Boyle County. We want to expand our services. We love our community, and we just want to figure out how to help folks." It was so empowering just to hear them talking about that.

We will be giving out another round in the fall. I don't have an exact date, but we will be giving out another round. I have told the folks that have been awarded please do not feel like competition. We want to expand this thought process across Kentucky,

so we want to build that.

The -- this administration has given us the ability to enhance and provide services that we've wanted to for many, many years and just didn't quite know how to get there. So it's so exciting to see this opportunity to come about.

I do want to mention that last -- January the 3rd, there was a provider letter. I think it only maybe got out to providers -- to all providers last week. You may have seen that. And it's just describing what I've told you, that CMS approved our services. We've added other services.

We have mobile crisis intervention services, 23-hour crisis observation, and lots of acronyms to go along with that. I'm sorry. And then we have a behavioral health crisis transport.

We were also involved with what Commissioner Lee mentioned earlier about helping with EMS, the treat/not transport, and as well as being able to transport and get paid from other locations than a hospital. So we've been working on those

things as well.

The long and short of things that people usually ask me -- and there is a letter out there -- is, you know, how does this all work. So we -- for one thing, we wanted to ensure -- and I can give the story that I've given many, many times about the warm handoff that -- you know, SAMHSA pretty much has a guideline about how we want this to occur. And it's someone to call, a warm handoff, someone to respond and a place to go.

So that's -- based on that needs assessment, we realized we didn't have a lot of places to go. So that's why we've been developing, like, the 23-hour crisis observation and being able to have a transport that's not necessarily law enforcement involved.

So we -- the one main thing that we want to make sure that we can do is that we want to serve all, anyone, anywhere, anytime. I also have been asked about waiver clients. We can cover waiver clients. We can cover the uninsured and the underinsured.

So, Dr. Schuster, if your insurance

doesn't cover a crisis and you have a crisis, we can cover you. Same for me, same for anybody in my family, anybody that's on this call today. It's very exciting. Our big hope is to divert from emergency rooms, psychiatric hospitals, and definitely incarceration and making sure that -- two things: Appropriate level of care and an appropriate response.

You all have heard me, that I don't -- I don't want the response to a 21-year-old with anxiety and depression to be the same response that we would give to an elderly person who's having a crisis with dementia; right?

So we want to ensure that there's training and access and oversight, technical assistance for those specifics. And I have a whole list of areas that we want additional training, LGBTQ community. All those different -- brain injury.

So it's very, very exciting, and I can continue to tell you all more as it rolls out. But that's currently where we are.

We did have to change where we were with

our contractor, Carelon, when they first came on because the grants were already out there, and we were trying to ensure that they're going to get paid timely for their grant awards. So that'll be one of the first things, pass-through dollars to pay for those seven grant awardees that I told you about.

They are currently working with DMS and our sister agency, DBH, to contact all providers. We will be starting with the safety net CMHC providers and the CCBHC providers first. And they will be starting next week with a collective group and then we're going to meet with them individually after that.

So very exciting. Lots more to come. Do you have any questions for me, Dr. Schuster?

CHAIR SCHUSTER: I wonder if you could send Erin a copy of that provider letter --

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: -- to be distributed. That sounds like a great overview of the services. I think that would

be very, very helpful to see.

And I think the question that has come up -- and we've talked about the 988 crisis and suicide prevention line. Nationally, it's been around since mid-July of 2022. So how does that interface with all of this? How do those call centers interface with this, Leslie?

MS. HOFFMANN: So from the call center, we wanted to leverage the good work that we have here in Kentucky already. So we have embedded our existing 988 and partnered with DBH and the CMHCs that provide that 988 crisis call center. So calls can come from 988 or 911, and depending on that avenue is where that call would go.

But the main -- the most important thing is that warm handoff. And if they need deployment, then the ASO will take over as the deployer based on the 988 call and triage. So we are leveraging everything that DBH -- all the good work that they've done as our beginning phase to this.

So I think one of the most important things, and especially when we were out there

listening to folks, is instead of saying "hang on the line" or "just a minute" or "we'll be right with you" or something like that, the person is going to come and say, you know, "Leslie, I hear your crisis. I've got you. We're going to get somebody out to you," and don't drop the phone line.

We are going to connect them through our air traffic controller technology with our ASO, and that person will come online. And then this person will say, "I have Susie online for you, Leslie. And now Susie is going to take over, and they're on their way to you."

So that -- sorry. I'm sorry. That's been the most important thing for us, is that warm handoff and then a place to go so that they are diverted from any inappropriate care.

I'm sorry. My dog is barking.

CHAIR SCHUSTER: Does your dog want to be a part of the MAC?

MS. HOFFMANN: Yes. Actually, he's got the vacuum cleaner, I think.

CHAIR SCHUSTER: Okay. That's very

helpful.

Any questions from any of the MAC members about the mobile crisis? I think it'll be helpful for us to see that letter and see the articulation of the various services and so forth.

MS. HOFFMANN: Erin, if you're on, can you just ensure that everybody gets that if they haven't already? You may have already sent it out to at least the TACs.

MS. BICKERS: I'm sorry. You caught me taking a drink of water. I just sent out the EMS treat/no transport provider letter. Is that what you're talking about?

MS. HOFFMANN: No.

MS. BICKERS: Oh, my apologies.

MS. HOFFMANN: This one -- it's actually the mobile crisis intervention, MCIS, expansion. So if you don't have that, I'll make sure that you get it and get to the MAC and TACs.

MS. BICKERS: Yes, ma'am. Thank you.

CHAIR SCHUSTER: That would be great, Leslie. And thank you, Erin.

Any questions for Leslie?

(No response.)

CHAIR SCHUSTER: Okay. So we are finished -- thank you very much, Leslie, and thank you, Commissioner Lee.

And we are ready to move on to our TAC reports, and I would like to point out that we --

DR. ROBERTS: Sorry, Sheila.

CHAIR SCHUSTER: I'm sorry, Jerry. Yeah.

DR. ROBERTS: I just wanted to ask. Is there a poster for the crisis center that doctors' offices could put up? Because, I mean, that sounds like a beautiful, you know, program.

MS. HOFFMANN: I have a poster that we just developed recently, like a big one in my office, through communications. But online, you'll be able -- I know you probably can't see. We have a diagram that explains that 988 warm handoff and then going through the process all the way through post-crisis services. So that is on the website, and I'll ensure that Erin gets that and sends it

out as well.

But it's kind of powerful in a way that it shows that we're trying to close every loop that we can. And also not just -- not just mobile itself, but it's the whole sequential intercept for Kentucky. We want to ensure that, with mobile, you know, even as the starting point, that we continue all through our processes to decriminalize and to ensure that we've got diversion all along the way. So I'm working on a draft picture for that one, too.

So I will ensure that you get this draft, though; okay? Thank you.

CHAIR SCHUSTER: Yeah. Great question, Jerry. And that reminds me that Keith put in the chat from the EMS TAC that the provider letter was very informative and very helpful.

I think I would ask the TACs -- if your TAC would deal in any way with crisis situations, if you might include this on your agenda for your next couple of meetings so that you can -- we can get a feel here at the MAC about what you're seeing on the ground.

It would give us a great source of feedback. And I would think, Leslie, it would be helpful to you all to get that feedback, and the TACs may be a great way to do that.

So -- and I'll send out an email to you all just to remind you because I know a couple of people had to get off. So thank you very much.

So for our TAC reports, we're going to start at the back end of the alphabet. We'll start with Therapy Services, and I think that's Dale Lynn.

MR. LYNN: It is. Thank you, Sheila.

CHAIR SCHUSTER: Yeah.

MR. LYNN: We actually don't have anything to report at this time.

CHAIR SCHUSTER: Did you all have a meeting since we last --

MR. LYNN: We did have a meeting.

CHAIR SCHUSTER: Okay. And no recommendations and no report?

MR. LYNN: Correct. There was no recommendations for the MAC. Thank you.

CHAIR SCHUSTER: Okay. Thank you.

Primary Care, I know, had to leave because they're having an event with their legislators over in the annex, and they've moved to a quarterly meeting schedule. So they have not had a meeting, but they will have a meeting in February and will have a report for us in March.

Physician Services. Dr. Thornbury?

DR. GUPTA: This is Dr. Gupta reporting for that. We did not meet.

CHAIR SCHUSTER: Ashima, are you saying something?

DR. GUPTA: Yes. Can you hear me?

CHAIR SCHUSTER: Not very well. Speak up.

DR. GUPTA: We did not meet.

CHAIR SCHUSTER: You did not meet. Okay. All right. Thank you.

CHAIR SCHUSTER: Pharmacy. Ron Poole?

DR. HANNA: Okay. Ron is not here today.

CHAIR SCHUSTER: Okay.

DR. HANNA: I apologize. He couldn't be here, so I'm going to report for

him, on his behalf. They did meet on 12/13, and they did have a quorum. They did not have any recommendations for -- you know, or anything of note from the meeting, but there were a few things that they wanted me to bring to the MAC's attention.

They did discuss a community health worker regulation and reenforced, you know, that many of these functions that are being done within that sector are already being done or could be done in a pharmacy and be offered to patients. And since, you know, pharmacists and their staff are the most successful providers in the community, as such, this could make a positive impact. So there's some discussion around that.

At this time, you know, pharmacists and pharmacy staff and pharmacies are not included as approved providers for community health worker services within Medicaid. But the acting director of Health Care Policy for DMS did explain that this was a new program, and everyone understood that it's been in the works for a long time, two years. And it takes time to work these things out, and they

need to do some more research. So that was positive.

They did say that they would continue to work with the pharmacy stakeholders involved in this process and continue to reach out. So that was good to know, and they wanted to thank everyone for that.

But they did have some questions remaining they kind of wanted to bring up, you know, and I think they'll bring up this in the next meeting. Did they mean that pharmacy would play a supervisory role eventually and be able to order and manage job duties of community health workers? You know, what does the Department see as that role basically in the end?

But, again, they wanted to thank the Department for continued conversations in this area.

Other things of note. The PTAC has had two meetings organizing the statewide, you know, HPV protocol rollout with Dr. Theriot. These are progressing well, which is great. And they wanted to make sure that pharmacists out there knew about the immunization

counseling. There's been a little slow uptake in that, I believe, because of confusion on how to bill for that through the MCOs and wanted to make sure everybody knew to get the word out through the state association to make sure staffs could work through these issues with the MCO representatives because these are very important to get done.

But all -- at the end, to wrap it up, they wanted to thank -- and so did I -- wanted to thank the Department for Medicaid Services for working with the pharmacy stakeholders on this and other issues. These are very important. And I think that -- you know, and they did, too -- that we've had some positive things happen for our patients in all areas. So thank you.

CHAIR SCHUSTER: Great report, Cathy. Thank you very much. That's the kind of detail, I think, that's helpful for the MAC members to hear. It gives you a much better feel for what the issues are that you're looking at.

I see my friend, Steve Shannon, is on to

report from the Persons Returning to Society from Incarceration.

MR. SHANNON: Correct. This is Steve Shannon, and I'll report on behalf of -- we call it the Reentry TAC because it's a little bit easier.

One, you know, we're all eagerly anticipating the implementation of the waiver that Leslie Hoffmann discussed. We think it's a great opportunity. I think it's going to really change people's lives. And, ideally, the goal is to get people connected ASAP to services and supports in the community. And we're excited about that, and we've been partnering with Leslie on this for about 18 months now and looking forward to it.

A significant event -- one, we had no recommendations. We did not have a quorum. But we did have a great discussion led by two pharmacists at the University of Kentucky about Hepatitis C in correctional facilities. This was -- really came out at our previous meeting and then we followed up afterwards and had a more detailed conversation.

And they presented data, and it really is -- I think, was a great opportunity. Great education for me personally. 50, 60 percent of folks in facilities, correctional facilities, test positive for Hepatitis C. It is treatable. It takes about 84 days for the treatment regimen to go through, but that can be accomplished. You know, we had some discussions, and Leslie was there. And Angela Sparrow did a great job at the meeting as well.

You know, does it make sense to start that treatment 90 days before they leave versus 60? And I think it's still open. It wasn't a no, obviously. The CMS guidance is 60 days prerelease, so it's more challenging. The concern is: Do we lose track of people once they are released and that regimen doesn't finish?

UK data is this can save billions of dollars, you know, long term. They've had some conversations themselves with CMS. They asked for their contact information to be sent to Medicaid. I think there's going to be more conversations.

But I really think this was a really great dialogue about what could be done to address a Public Health Emergency that we're not really tracking. Kentucky is No. 1 in the country, I think the data says, in Hepatitis C cases. And this is a great place to look at it. There's also a really great benefit to correctional officers.

And, initially, they were talking adult facilities, you know, Department of Corrections. But, clearly, Leslie Hoffmann and Angela Sparrow said, you know, juvenile detention centers are included as well. Let's figure out how to move forward and address that.

So that was really a great dialogue we had, and we're looking for further partnerships to move that forward if we can. And, for sure, that's part of the 60-day prerelease plan as well so -- and we had no recommendations again.

CHAIR SCHUSTER: Thank you, Steve. And, again, really, really helpful and a nice reenforcement from Leslie's presentation to hear about the concerns around Hep C. So if

you think about both the financial health and the physical health of Medicaid in Kentuckians and so forth, if we could get a handle on that while people are in incarceration, it sounds like, to get those 84 days of treatment in, that would be great.

So, so glad you had that presentation and had the relevant DMS people there, too. Thank you.

Optometric Care. Matthew Burchett?

DR. COMPTON: I'm Steve Compton from the Optometric --

CHAIR SCHUSTER: Oh, Steve. Okay. Sure.

DR. COMPTON: We have not met since the last MAC meeting. We meet again in February, and we'll probably have a report and some recommendations for the MAC at that time.

CHAIR SCHUSTER: All right. Thank you very much, Steve.

DR. COMPTON: All right.

CHAIR SCHUSTER: There was a message from Lisa Lockhart, the Nursing Services, that she could not be here. And I

can't remember now, Leslie, whether she said they had met or not met.

MS. BICKERS: They -- excuse me. They did meet, Sheila, and their next meeting, I believe, is at the beginning of February.

CHAIR SCHUSTER: Okay.

MS. BICKERS: And they also moved to quarterly meetings as well.

CHAIR SCHUSTER: All right. Thank you. So they didn't have any recommendations or a report from the meeting they did have?

MS. BICKERS: No, ma'am.

CHAIR SCHUSTER: Okay. Thank you. Nursing Homes?

DR. MULLER: Greetings. It's John Muller. We -- our TAC did --

CHAIR SCHUSTER: Hi, John.

DR. MULLER: Hi, there. Our TAC did not meet so nothing to report this time.

CHAIR SCHUSTER: Okay.

DR. MULLER: Thank you.

CHAIR SCHUSTER: Thank you very much.

I see my friend Rick Christman is on all

ready to report on the IDD, or Intellectual and Developmental Disabilities TAC. Rick?

MR. CHRISTMAN: Yes, Dr. Schuster. Thank you.

Yes. We met on the 5th of December. We had a quorum. Among the items we discussed, we're still working with Pam Smith to gather information about what happens to people who are being served and their providers have concluded that they don't have the resources to properly serve those individuals. So we're looking, again, at what happens to that. How long does it take for them to find an alternative provider?

On waiver redesign, you've heard this -- our population really works with two waivers, the SCL which has a residential component, and Michelle P, which is more in-home support. You know, they have some services that are common. However, the definitions differ and the rates differ. And hopefully under this waiver design, we'll have a lot more consistency which will be great for providers because it is kind of complicated.

Wait list. Michelle P has about 6,000,

I recall. Two-thirds of those are children. I think I mentioned last time we are -- there is a feasibility study for a children's waiver being considered right now for children with developmental disabilities and behavioral health issues.

Of the 3,370 people on the SCL waiting list -- again, that's the residential component -- 79 are in urgent status and zero on emergency. And that's basically been the case for a long, long time. I think the Department is doing a really good job of making sure that people whose living situations have collapsed, that they do get those SCL services.

We mentioned HB 6 already. It might contain as -- I think, like, nearly a billion dollars for all waiver services increase. That includes slots for residential and -- 250 for residential, 1,000 for Michelle P. Also money perhaps to fulfill some of the items that are contained in the rate study to enhance rates even more.

I just want to say I really enjoy working with both Pam and Erin. Pam does a

great job of dealing with a very complicated issue here with these two waivers. And I attend these conferences, and I'm really glad I'm from Kentucky because we are really doing a pretty darn good job compared to other states.

And we had no recommendations, and that's my report.

CHAIR SCHUSTER: Thank you. That's an excellent report, Chris -- I mean, I'm sorry, Rick. You know, there was money put in the second year of the biennium in the budget bill to do further study on that children's waiver. I don't know if you saw that or not. But many of us have been involved in the study group for that. It does --

MR. CHRISTMAN: Yes.

CHAIR SCHUSTER: It does raise some questions that I sent actually to Leslie and Pam about -- because people are already wondering. You know, we have so many kids that are on the waiting list, as you mentioned, for Michelle P and if this new waiver -- if and when -- and we're probably

talking two or three years down the road. Then we're going to have to really have a program for deciding who gets those slots, and are they the kids that have been on waiting lists for, say, Michelle P for umpteen years or not.

I think it's going to raise -- I don't want it to be a source of anxiety for parents, but I'm already getting those questions. And you may be getting them as well.

MR. CHRISTMAN: Yeah. I think that's going to be a tricky process. I think it may -- but over time, over time, we'll see many fewer people on that Medicaid -- I mean, the Michelle P waiting list who are children. And hopefully, then, they'll be on this alternative waiver. So it will get better, but I suspect it will take some time because it needs to be done carefully.

CHAIR SCHUSTER: Yeah. Absolutely. All right. Thank you very much.

Russ, I saw you were on. Hospital Care, please?

MR. RANALLO: Yes, ma'am. The

Hospital TAC met December 5th. We had a quorum. We had a presentation on Medicaid open enrollment and Medicaid redeterminations. We talked about and set a workgroup to discuss the Sepsis 3 change that is scheduled for January of 2025. We've had one meeting since then, and we've got our questions and issues logged to work through.

And we asked to have a presentation on the 2022 quality -- HRIP quality results.

We had no recommendations, and our next meeting will be on February 27th of this year.

CHAIR SCHUSTER: Okay. Thank you very much.

MR. RANALLO: Thank you.

CHAIR SCHUSTER: Home Health Care, and I think I see Evan is on.

MR. REINHARDT: Thanks, Dr. Schuster. The Home Health TAC met December 19th, and we did not have any recommendations.

But we discussed EVV, electronic visit verification, which launched January 1st, the updates to the DME fee schedule, and the KOG

site delays in authorizations. And we continue to monitor the electronic visit verification program to make sure it doesn't have any impact on access or provider ability to serve patients. So more to come on that.

CHAIR SCHUSTER: Okay. I'm glad you all are looking at that because I hear a lot about EVV and its glitches and its -- you know, sometimes it's working and sometimes not. So appreciate you keeping an eye on that. We would welcome more discussion about that if you have some as you go along.

MR. REINHARDT: Sure. It's a big change. Absolutely. We'd be happy to provide more information.

CHAIR SCHUSTER: Yeah. I think that's something that we may need to have a more general discussion about. Thank you.

Health Disparities. Dr. Burke?

DR. BURKE: Yeah. We met on January 17th. We did not have a quorum at that meeting. We had a presentation regarding Kynect services and how those are able to help pair people with organizations and get referrals a little smoother to

hopefully help connect people with what they need and find what they need in their area.

We did not have any recommendations at this time.

One of the main things we discussed or brought up again was language access, and it sounds like DMS has a few different things that they're working on and meeting with people to try to hone in on that area.

CHAIR SCHUSTER: I think we may ask for a presentation on that at our next meeting, Dr. Burke, so I'm glad that you all are talking about it. That language access has come up. And if you remember, at our last MAC meeting, you know, some of the MCOs weighed in and said they were doing some things.

I think we really need to look at an overall picture of what's out there because I know that providers -- I remember Dr. Gupta had specifically asked, you know, if I'm in my office and somebody comes in and, you know, I need language access right then, which is often what happens to providers, who do I turn to? And it's expensive. Some of

the services, I think, are expensive.

DR. BURKE: Yeah.

CHAIR SCHUSTER: So will you be meeting again before the March MAC meeting?

DR. BURKE: No. Our next meeting is on April 17th.

CHAIR SCHUSTER: Ah. Okay. All right. So we may look at language access either for March or our next meeting after that because I'd really like to get input from you all. I think that's --

DR. BURKE: Yeah. They've provided us -- sorry. Go ahead.

CHAIR SCHUSTER: I just started to say I think it's a huge issue, obviously, for people for whom English is not their first language and so forth.

DR. BURKE: Yeah. The MCOs have previous -- in previous meetings have sent us some resources or, like, presentations regarding what current things they do offer regarding language access, and so that may be something that they could go ahead and send to you to look at beforehand. But it is something we've talked about

frequently.

CHAIR SCHUSTER: Yeah. All right. Thank you very much.

DR. BURKE: Thank you.

MS. BICKERS: Dr. --

CHAIR SCHUSTER: And EMS? I'm sorry.

MS. BICKERS: I was just going to say, Dr. Schuster -- this is Erin. If the MAC is interested in seeing that information, I can go ahead and gather that up and send it out to you.

CHAIR SCHUSTER: That would be great, Erin, if you would do that because, then, I think we could decide what other information or what specific questions we want answered in a presentation on that. I think that would be very helpful. Thank you.

EMS, and I think Keith Smith is on.

MR. SMITH: Yes, ma'am. Thank you, Dr. Schuster.

The EMS TAC did meet. We've had an ongoing project happening with the MCOs along with DMS about changing the prior authorization system that we had for EMS. It

was creating some serious financial hardships for our EMS providers because those prior authorizations would needed to have been turned in before the transport would take place. However, in many cases, our EMS providers may have 30 minutes' notification that a transport needs to take place, which means they didn't have an opportunity to get the PAN.

Working with the MCOs through DMS, we've been able to change that system, and we've basically adopted the Medicare system of using the Physician Certification Statement form that EMS is very familiar with. All of the MCOs agreed to use that, and we had set January 1st as the go-live date.

A few of the MCOs weren't able to get everything in order. However, they have agreed to retro back to January 1st so that if we have any EMS providers that have a claim that far back, that they would still get covered.

So the TAC wanted to make sure to recognize the MCOs, DMS, especially Erin and Kelli, for all the work they've done to

support us. It has been a tremendous improvement for EMS, for us to be able to get this change, and we couldn't have asked for better partners in getting this done.

The one thing that I would like to pass on to get on everybody's radar -- this is not in the form of a recommendation or anything. This is mainly just informational, is -- and I hate using this word because it sounds dire, but it's -- we're getting to this point. We are starting to see some collapse of EMS in Kentucky. We have got multiple counties now that have no paramedics that are on duty in the counties.

We've been contacted by several county agencies at the Kentucky Board of EMS notifying us that they intend to drop from advanced life support to basic life support only because they are not able to find paramedics to hire, or they're not able to pay paramedics enough to be able to keep them in their region to be able to work.

The Board of EMS is working as carefully as possible with the legislature along with the Kentucky Ambulance Providers Association

along with a few other organizations to see what we can do.

We have recommended legislation to go before the State in order to get more educational opportunities available for students to become paramedics. But one of the biggest issues that we've got is compensation for paramedics.

A lot of people don't understand this or realize it. But to become a paramedic in the state of Kentucky, you go through as much education as what a registered nurse goes through except pay in Kentucky can be anywhere from $16 an hour to 35 to $40 an hour depending on what part of the state you're in and what the agency can afford to pay.

So we've really got a deck that is stacked against us in some of these smaller communities. So, again, wanted to make sure we put this on everybody's radar to let you know that we are in a very trying time in EMS, and we do support and appreciate all of the work that DMS has done with us and for us with the TAC.

And the only other thing to report is that we are switching from a bimonthly meeting to a quarterly meeting as well. So going forward, we'll be meeting on a quarterly basis unless we need to call a special meeting in between. But that's the end of my report.

CHAIR SCHUSTER: Thank you very much, Keith. Please keep us posted, and I'm sure you will continue to talk about the -- what you're calling the collapse of the system. But, certainly, if the paramedics are not available, those services are not going to be available. So I'm sure you will keep that, but we really need to stay on top of that.

And I'd be -- what's the bill? Do you have a bill number on the --

MR. SMITH: We've got several. We've got House Bill 57, which is one that we really need to have go through. We've also been working with the Kentucky Hospital Association. They have a "super speeder" bill that they are trying to find a sponsor for that would provide funding for EMS

education.

And we have a workforce development bill that we have written -- actually, we had one of the House members allow their bill writer to work with us. We're still looking for a sponsor, and it looks like we're going to get a sponsor this week. I don't have a number for that particular bill yet.

CHAIR SCHUSTER: Okay.

MR. SMITH: I could email it to you once we know what it is, but if we could get any assistance through the legislature in getting these bills. We have got to get more places performing paramedic education. And to that point, we're even having a hard time finding EMTs anymore.

So it is a -- it's not a good time to be in EMS, quite honestly, with the challenges that we have. So anytime that we get a victory like we just had with the Prior Certification Statement change --

CHAIR SCHUSTER: Right. The prior authorization, yeah.

MR. SMITH: Yes, ma'am.

CHAIR SCHUSTER: If you will send

me those bills, I'd be interested in tracking those and letting people know. You know, I've been involved with EMS at work because of the issues we ran into with transporting behavioral health patients and so forth, so I'm very interested. And I think we all are certainly concerned that we don't want that system to fall apart, so we appreciate that. Thank you very much.

MR. SMITH: Thank you.

CHAIR SCHUSTER: Garth, you're up.

DR. BOBROWSKI: Okay. Thank you very much. The Dental TAC did not meet yet. We are meeting the first part of February, so we don't have any report. We don't have any recommendations right now other than I just did want to thank Commissioner Lee and her -- the staff for all the help that they have given dental on the -- you know, our day-to-day operations and appreciate their willingness to take phone calls and emails and pigeon flights, too, so...

But I do have a couple of recommendations, but I'm going to move that down to No. 8 as possible topics for future

meetings. So I won't include that in my dental report just yet. Thank you.

CHAIR SCHUSTER: All right. Thank you.

I see my friend Emily Beauregard is on. Consumer Rights and Patient Needs?

MS. BEAUREGARD: Hi. Good afternoon, everyone. Excuse me.

The Consumer TAC met on December 14th. We met remotely, and we had a quorum present.

And I just want to reiterate that we are really pleased with Medicaid's response to a previous recommendation that we made related to network adequacy -- Commissioner Lee mentioned it earlier -- to create a process for beneficiaries to report when they're unable to access an in-network provider within time and distance standards.

We think this will make a really big difference in how we understand the adequacy of our provider network and where there are gaps and where we need to really focus attention on making sure that there are providers that are able and willing to see Medicaid members. And we are really looking

forward to seeing what that report looks like.

Just for context, the current process is that an individual can call their MCO, but no information is then, you know, passed along to DMS. So DMS hasn't really been able to measure this, and this will give us new data that we can work with.

I also want to recognize Kelli Sheets for her work on an orientation packet for new MAC and TAC members. That was another recommendation that we had made last year, and I think this is going to be incredibly helpful education, not just for new members honestly, but any current members as well who just need a little bit more context and -- to better understand how the Medicaid program operates, some of the policies that we aren't all aware of when we're not doing this work on a daily basis.

And we're reviewing a draft of that now. We're going to provide some feedback at our February meeting, but hopefully there will be something to share soon. And I believe that this is going to be an orientation packet

that every TAC and MAC -- and the entire MAC can take advantage of.

During our December meeting, we checked in on the status of Medicaid renewals and updates related to the 1915C waivers. We discussed a number of other issues that we typically do, including language access, so I'm glad that that came up again.

Dr. Schuster, I think that your idea for having a presentation at one of the upcoming MAC meetings is a good one. We're looking at language access not only in terms of, you know, other languages spoken but also the needs of people with intellectual and developmental disabilities. And so we're going to have a number of recommendations, I believe, that we'll be making in February.

We also discussed the need for housing supports and opportunities for more stakeholder input related to measuring access and quality, just on a kind of ongoing basis. There are so many great initiatives that the Cabinet or, you know, Medicaid specifically has going on right now related to quality and really looking at social determinants of

health, looking at, you know, just where we can really make an impact on health outcomes. And it would be, I think, really helpful if we had more of a standard process in place for us to be aware of what those initiatives are but also to have input on a regular basis.

One high priority issue that we discussed was related to Medicaid renewals for people who are being processed ex parte, which essentially means it's passive. There's no action required on the Medicaid member's part. That's what the "ex parte" term means and, you know, looking at how we're determining whether someone is ineligible based on information that the State has access to through the federal hub and other sources.

So the ex parte process is supposed to be used when the State has sufficient information to make a determination, and the State is able to determine that someone is eligible and can, you know, stay enrolled in Medicaid through ex parte with no action taken on the member's part.

But on the flip side, it can't only use the ex parte process if they determine that someone is no longer Medicaid eligible and then, you know, would go on to terminate their coverage. In that scenario, the individual should be receiving something like -- we call it either a full packet or a request for information, an RFI, to verify that the data that the State is using is accurate, is up to date, and is complete.

And so we have heard some cases that, you know, people didn't receive an RFI or that packet to complete in order to verify their information, and they were automatically transitioned to a Qualified Health Plan.

Now, of course, that's not a seamless transition. You're only told you may be eligible. You can apply for a Qualified Health Plan. So, technically, you are just losing Medicaid and becoming uninsured in that scenario.

But they receive a notice in the mail that says: We think you're eligible for a Qualified Health Plan. If you think this is

a mistake, then you can appeal that decision. But what we really want is to ensure that anyone who has been determined in this ex parte process to likely be ineligible to be getting that request for information or that packet so that they can complete it.

And that's something that we made a recommendation about at our last meeting. And that recommendation is that DMS ensure that anyone going through the ex parte renewal process is not passively terminated without first receiving a request for information or a renewal packet to confirm that all data being used by DMS to determine their eligibility is up to date and accurate.

So that was the only recommendation that we made at our last meeting. In addition to that, I just want to also mention that there is a regulation that's open right now on nonemergency medical transportation services, and this regulation will be open for public comment until the end of this month.

And, you know, there are some really relatively minor but also very helpful and important changes made in the regulation to

hopefully provide more access to nonemergency medical transportation to Kentuckians.

We've heard the commissioner present in past meetings that transportation is the No. 1 barrier reported whenever people no-show for an appointment. We know there is national data that suggests that, you know, 60 percent of Medicaid members have a transportation barrier. And so it's an area where I think we can make a lot of improvements and really help individuals get to the appointments that they need and remove that barrier for them if we can take better advantage of that program.

So we always -- like, I'm just offering that in case you weren't aware and want to make a comment on how this regulation -- the changes, you know, will be useful, but we can also always use these opportunities to talk about other improvements.

So with that, I'll wrap up. Our next meeting is set for February 20th at 1:30 p.m. Eastern Time, and it will be remote on Zoom.

CHAIR SCHUSTER: Thank you very much, Emily. So we have that recommendation

that we'll take action on in just a minute. Thank you very much.

And I'm glad to hear that the language access -- I know you've mentioned that in other reports, really important.

Children's Health. Donna?

MS. BICKERS: I don't think Donna was going to be able to be with us today. They did have a meeting in January.

CHAIR SCHUSTER: Okay.

MS. BICKERS: And they also decided to go quarterly.

CHAIR SCHUSTER: Okay. So no report and no recommendations?

MS. BICKERS: No, ma'am. They meet again in April, I believe.

CHAIR SCHUSTER: Okay. Thank you.

And Behavioral Health, and I'm here.

So we met on January 11th, and all seven of our voting members were present. We had Commissioner Lee there, and we -- from DMS, and we had Commissioner Marks from the Department for Behavioral Health, Developmental and Intellectual Disabilities, and the MCOs as well as a good number of

people from the behavioral health community.

We spent a lot of time getting reports in detail about all of the waivers that we've been following because so many of our people are affected, particularly by these new waivers that are being rolled out, the 1915(i), the 1115s, the reentry, and so forth. And so we were pleased with the progress, and you all heard a lot of that earlier today.

We had an ongoing -- excuse me -- discussion about rates, and Victoria Smith with the Office of Data Analytics came and talked to us about how these studies are conducted, that they actually take every one of the billing codes listed in the behavioral health fee schedule and do a comparison with other states about their rates and any regulations about how they are to be billed. And we're going to have a complete -- a report from her and her staff at our March meeting about the results of that study, so we are excited about that.

Justin Dearinger is the one that has reported on the no-show portal. And, again,

I would really urge you all to -- who represent providers to urge your providers to report no-shows into that portal. And Justin is going to give us a report in March about how much it's being used by behavioral health providers.

Leslie gave us an update on the mobile crisis. One of the things she pointed out was interesting, I thought. 112 of our 120 counties are designated, I guess, federally as rural. So think about that, folks, 112 of 120 counties. And that's why they're doing these grants that she described for the co-response in the more rural areas and so forth.

We got the PowerPoint on Medicaid unwinding, which is always of interest.

We have been pursuing getting a better handle on Medicaid billing for students who are in school. And, you know, there's been a huge emphasis on -- ever since the Marshall County shooting in 2018 -- and I think the anniversary for that was either yesterday or the day before. So we lost two students, and several were injured.

And out of that came a workgroup and then Senate Bill 1 in 2019 and Senate Bill 8 in 2020. And the emphasis was not only on kind of what they call the hardening of the schools, you know, better security, doors being closed and all the outside doors being locked and a central entrance and so forth and the SROs, the security officers, and so forth.

But a lot of emphasis on what we call the heart, and that is the behavioral health part. And one of the things is that we know that if any student has at least one adult in the school that they feel comfortable with -- and it could be a teacher. It could be a school nurse. It could be a lunchroom person. It could be the bus driver. If they hear something, they will say something. And that's really what we want. That's what really circumvents some of these threats and some of the safety issues.

So we've been very focused now on Medicaid billing for school-based mental health services, and Justin Dearinger has reported on that. Deputy -- Senior Deputy

Commissioner Judy -- Veronica Judy-Cecil has emphasized that Medicaid really wants to see billing happening in the schools. And it can happen from the employees who are mental health professionals, but it also can happen from contracted community employees. So we are following up on that and hoping to have a report about what that billing looks like.

We had no new recommendations to the MAC. Erin distributed to us an update to the MCO Provider Complaint form, and we made that available to the BH TAC.

Erin, we might want to send that out -- did you send that out to all the MAC people as well?

MS. BICKERS: I apologize. I was reading an email. Which report?

CHAIR SCHUSTER: Yeah. I was just asking about the updated MCO Provider Complaint form.

MS. BICKERS: I did. I sent that out in an email blast to all MAC and TAC members.

CHAIR SCHUSTER: Okay.

MS. BICKERS: But I'm happy to

re-send it if someone did not receive it.

CHAIR SCHUSTER: Do you all remember seeing it? You know, you get a million -- a million emails.

MS. BICKERS: I'll make note to re-send it.

CHAIR SCHUSTER: Yeah. Let's re-send it. Now that we've talked about it, people might look for it.

And we also have an ongoing issue with our targeted case management reg and the way that it's being possibly misinterpreted by an MCO who's trying to recoup lots of money from a provider. And DMS has been very helpful in trying to address that.

So we had no recommendations, and our next meeting will be on March 14th.

So I believe we had one recommendation, so I would entertain a motion to accept that TAC recommendation and send it along to DMS.

DR. BOBROWSKI: So moved.

MR. GILBERT: Second.

CHAIR SCHUSTER: All right. Garth and Kent. Thank you very much.

Any questions? That was the one from

the Consumer TAC about ex parte unwinding practices.

(No response.)

CHAIR SCHUSTER: All those in favor of sending that recommendation forward to DMS, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed?

(No response.)

CHAIR SCHUSTER: And abstaining?

(No response.)

CHAIR SCHUSTER: Great. Thank you very much.

Did any of our MAC members have any follow-up questions for Humana, Passport, or United? If you remember, we had all three of them give a -- give their presentations in the November meeting, and I just want to be sure if there were any questions because we did not have time for any questions at that time.

Anybody have any follow-up question for them?

(No response.)

CHAIR SCHUSTER: Seeing none, I

sent out an email to the MAC members, and I had tried to list some of the things that I had been hearing at that last meeting and in other meetings as possible topics for future MAC meetings. And we had language access, network adequacy, the DMS rate setting for providers, a general thing on patients' rights. And then I think there was an issue that was raised about Medicare Advantage Plans.

Garth, you said that you had perhaps something you wanted to add in that category?

DR. BOBROWSKI: Yes. One -- well, No. 1, the -- I know different boards do have different criteria for licensureship, and I didn't know if the MAC gave out any certificates to the MAC members for participation in these meetings. I know, like I said, some boards do for this type of meeting. It is very informational and, I mean, very related to the public health of Kentucky.

The second thing -- and I briefly talked with Commissioner Lee about this. It's just an idea. I mentioned to her one day about,

well, maybe we ought to add a TAC -- and nobody likes to add work to ourselves but -- my thought was on nutritional health, and that affects most of our jobs. The -- or even have the MCOs, with their networks already established, work on that.

As you all know, there's a huge increase in obesity and diabetes and other health issues, even in our field of dental. And I know the -- you know, the soft drink industries and some of these food industries don't want to hear us talk about it. But, you know, sometimes our food choice decisions are really hurting us in the long run.

A new one that has become knowledge to me was -- of course, as a dentist, I know the candy and the sugar is not good, especially for our children and some of our adults with dry mouth problems.

But the candies are always -- or not always. They're in primary colors, kind of geared towards our children and grandchildren. And some of these colors, these dyes are loaded, like, with Red 40, Red Lake 40, yellows, blues, greens.

And they're finding that a lot of these are causing young children to be labeled as ADHD or ADD. Once they get labeled, then they are given medicine for those situations. But so many of them -- and our pediatric physician that I've been talking to with this, just so I'm getting more knowledge myself, notices these things. And once they get them off these red and blue candies and Gatorades, boy, their ADHD symptoms calm down or almost go away.

So I just -- I didn't know if this was something that we need to even look for or look forward to. I know, you know, even though we're in Medicaid, all these funds come from, you know, our taxpayers. And I feel like we have a responsibility to use these funds to our benefit, and I think the ultimate goal is to improve the health of our Kentuckians at any age.

And I know Commissioner Lee said, well, when she started, I think Kentucky's overall health was in the 49th category. It's down to 43, and it is now 41. And she said, well, that she'd like to see us get into the 30s

over the next four years, so I think that's a lofty goal.

And nutritional issues are -- I'm sorry. Just, you know, my wife fixes stuff the way her mama fixed stuff, you know. Her mama fixed stuff the way her mama fixed stuff. And I'll tell you a story one other day about, well, great grandma fixed it because -- that way because that's the only pan she had. So I'll tell you the rest of that story on another day.

But anyway, I just thought I'd bring that -- the nutritional aspect up. And if there's any way that we can incorporate that as a MAC project, that's fine. Or if you want to let it go, that's fine, too. I just wanted to bring it to awareness. Thank you.

CHAIR SCHUSTER: Thank you very much, Garth. On your first issue, you're talking about getting continuing education credit for participating in these meetings. Is that what you're asking?

DR. BOBROWSKI: Yeah. I didn't -- yes. And I didn't know if we just -- if those that can get CE credit, if all they

would have to do is show the agenda or if they might need a -- like a printed certificate from DMS to just show that we were on the call today. Just an idea for some credit hours.

CHAIR SCHUSTER: Okay. Let's think about that. You know, the boards vary greatly in terms of what they will accept for CE, and I don't want to put a lot of work on our DMS folks. Typically, CEs, to be approved, have to state objectives for the learning experience.

So we'd have to really think about what the objectives are in terms of furthering the education of a provider, whether it's a dental provider or optometric or pharmacy or physician or, in my case, a psychology provider.

So let's -- maybe we can talk about that offline, Garth, and see what we want to do about that; okay?

DR. BOBROWSKI: Okay. Yeah. Thank you.

CHAIR SCHUSTER: Yeah. You know, on the TAC -- and Dr. Gupta put, you know, a

positive comment about: Yes. Nutrition is so much the basis of some of our poor health.

I'm thinking that one of the themes for this year for the MAC might be to think about -- you know, our makeup and the makeup of the TACs are all driven by legislation, so we're not going to do anything this legislative session. But I would really like to see us set as a goal to be ready for the 2025 legislative session, if we want any changes in the makeup of the MAC or if we want to add or modify any of the TACs.

Some of the TACs have mentioned to me that they would like to see their -- makeup of their voting members be handled differently. For instance, maybe they need to add more members, or they need to take some members off. Or it's difficult to get a quorum, some of those issues.

And, actually, one of the things that Commissioner Lee and I had talked about, because she said it was raised at one of her national meetings, is that the MACs in most states have a legislative representation on it so that you would put into statute that a

legislator -- and suggest perhaps it be the chair of the House and the chair of the Senate Health Services Committee, for instance. And I think it's something that we ought to explore.

I know that she was asked at a reg review committee meeting by the legislators on that committee: Well, what is the MAC? You know, you talk about the MAC. We don't know anything about it. What do they do?

And I think there's probably a big disconnect because we're kind of over here in the Medicaid world and then the legislators are over there in the general assembly world. And they ask for testimony certainly from the Cabinet and DMS, but in terms of all of us being involved in this process and vetting things and making recommendations, it really is a disconnect. So that's one of the things we might think about.

We, you know, might think about: Are all of the Medicaid recipients and all the categories of Medicaid recipients well represented? And are there other provider groups?

And I guess one could be nutritionists and dietitians, actually, Garth, along your suggestion about nutrition. Obviously, we can also schedule a presentation on, you know, some general nutritional topics. So I think it's well worth thinking about, and I appreciate your thinking about that.

Are there any other suggestions for our list from any of the MAC members?

(No response.)

CHAIR SCHUSTER: I think I'm leaning toward the language access because it's come up so often. So let's see what Erin can pull together from some of those presentations and see whether we might be ready to have something in March. And we will share all of that with you and then I'll send an email out to the MAC members.

I do hope that the TACs will keep in mind the mobile crisis. Obviously, EMS and some of the TACs are a natural to -- but if the other TACs have any experiences to report, I think it would be helpful for DMS to have that information as well.

Are there any items of new business from

any of the MAC members?

(No response.)

CHAIR SCHUSTER: All right. Well, if we adjourn real fast, we can finish four minutes early, which has hardly not happened in a long time. So I appreciate you all getting on early. We obviously needed the three hours, but at least the TAC members, I think, had a little bit more time to do their reports and so forth.

And if there are no further items of business, I'll entertain a motion to adjourn.

MR. GILBERT: I so move.

CHAIR SCHUSTER: Kent.

DR. HANNA: Second.

CHAIR SCHUSTER: And Cathy. Thank you very much.

I'm going to assume that we're adopting that motion by acclimation. So thank you all for your -- for your participation, and we'll see you in two months.

Our next meeting is March 28th, 9:30 to 12:30 Eastern Time.

Stay warm and healthy and thank you very much. Appreciate it. Bye-bye.

(Meeting concluded at 12:27 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 12th day of February, 2024.

*/s/ Shana W. Spencer*

Shana Spencer, RPR, CRR