CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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Via Videoconference
July 25, 2024
Commencing at 9:32 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

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

COMMISSIONER:

Lisa Lee, Department for Medicaid Services

P R O C E E D I N G S

CHAIR SCHUSTER: Okay. All right. We have quite a long agenda today, so let's go on and call the meeting together. As the stewardess says when you're getting ready to take off, I hope you're on the right flight.

This is the Medicaid Advisory Council meeting of July 25th, and we'll call it order. I'm Sheila Schuster, your erstwhile chair. And Mackenzie Wallace, our secretary, will call the roll.

MS. WALLACE: All right. Elizabeth Partin?

(No response.)

MS. WALLACE: Nina, I know that you're here.

Susan Stewart?

CHAIR SCHUSTER: She had told me she couldn't be here.

MS. WALLACE: Dr. Jerry Roberts?

DR. ROBERTS: I'm here.

CHAIR SCHUSTER: Great.

MS. WALLACE: Heather Smith?

MS. SMITH: Here.

CHAIR SCHUSTER: Good.

MS. WALLACE: Dr. Bobrowski?

DR. BOBROWSKI: Here.

MS. WALLACE: Dr. Steve Compton?

DR. COMPTON: Here.

MS. WALLACE: Dr. John Muller?

(No response.)

MS. WALLACE: Dr. Gupta?

CHAIR SCHUSTER: She's also -- she's traveling.

MS. WALLACE: John Dadds?

(No response.)

MS. WALLACE: I see Heather Smith on here, so I'm going to take a check. She just didn't answer.

Dr. Hanna?

DR. HANNA: Here.

MS. WALLACE: Barry Martin?

MR. MARTIN: Here.

MS. WALLACE: Kent Gilbert?

MR. GILBERT: Here.

MS. WALLACE: Mackenzie Wallace, I am here.

And Ms. Franklin?

CHAIR SCHUSTER: She's also out of town.

MS. WALLACE: Sheila, you are here.

CHAIR SCHUSTER: I am.

MS. WALLACE: Bryan Proctor?

(No response.)

MS. WALLACE: Peggy Roark?

CHAIR SCHUSTER: She was going to be late but, I think, will be joining us in a bit.

MS. WALLACE: Okay.

Eric Wright?

CHAIR SCHUSTER: And he's gone today.

MS. WALLACE: Okay.

And Commissioner Lee?

COMMISSIONER LEE: I am here.

CHAIR SCHUSTER: I count nine.

MS. WALLACE: Five, six, seven, eight, nine. Yes.

CHAIR SCHUSTER: And I think we need ten, don't we, Erin, for a quorum?

MS. BICKERS: I'm trying to recount because I have ten. Give me one second.

CHAIR SCHUSTER: Oh, okay. We'll take your number.

MS. BICKERS: Well, let me run

through real quick. I have Sheila, Nina, Jerry, Heather, Garth, Steve, Catherine, Barry, Kent, Mackenzie; right? Is that not ten?

CHAIR SCHUSTER: Oh, that's ten. Yes. I had not -- I had not --

MS. WALLACE: I must have missed Dr. Bobrowski. My apologies.

CHAIR SCHUSTER: Wonderful.

MS. WALLACE: So that is ten.

COMMISSIONER LEE: Or, Mackenzie, maybe you didn't count yourself.

CHAIR SCHUSTER: Well, I was going to say, I didn't count myself, so that's where it was. And I -- I'm pretty sure that Beth Partin is going to be on because she would have let me know if she was going to miss. So we might look for people who are coming in late. But since we --

MS. WALLACE: That's ten so...

CHAIR SCHUSTER: Yeah. Great. Thank you, Mackenzie.

MS. WALLACE: Yes, ma'am.

CHAIR SCHUSTER: So since we have a quorum, we actually have two sets of minutes

to approve. So let's go back to the minutes of March 28th. Can you all remember back to March 28th, I hope? We did not have a quorum in May, and so we were not able to approve those minutes.

So I would entertain a motion to approve the minutes of March 28th, please.

DR. BOBROWSKI: So moved.

DR. HANNA: Second.

CHAIR SCHUSTER: Thank you. And second is?

DR. HANNA: Cathy Hanna.

CHAIR SCHUSTER: Cathy, thank you very much.

Any additions, corrections, omissions, revisions?

(No response.)

CHAIR SCHUSTER: All right. All those in favor of approving the minutes, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed, like sign?

(No response.)

CHAIR SCHUSTER: Thank you. The

minutes are approved.

So let's go to our more recent meeting, which was May 23rd, which we may remember better. And I'll, again, entertain a motion to approve the minutes of May 23rd.

MR. GILBERT: So moved.

MR. MARTIN: I'll second it. This is Barry.

CHAIR SCHUSTER: Kent and Barry. Thank you very much.

Any additions, corrections, omissions, revisions?

(No response.)

CHAIR SCHUSTER: If not, I'll entertain a motion -- I mean, a vote to approve the minutes of May 23rd. All in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed, like sign?

(No response.)

CHAIR SCHUSTER: Great. Thank you very much.

Commissioner Lee, welcome. Our perennial old business question is: What is

the status of Anthem MCO?

COMMISSIONER LEE: And that is still under litigation, so nothing to report at this time. Nothing new.

CHAIR SCHUSTER: Okay. And we don't have any idea -- I think I keep asking you this every other meeting.

COMMISSIONER LEE: Yeah. I think the next potential date that we may hear something, I want to say, is August 22nd but don't hold me to that. Yeah.

CHAIR SCHUSTER: Okay.

COMMISSIONER LEE: I've heard that was -- yeah, that is correct. August 22nd.

CHAIR SCHUSTER: All right. So it may be that in September, we would have an update from you. Thank you very much.

The next item is something that we've talked about here at the MAC and is of great interest, of course, to the providers. And that is language access.

And I'm sorry that Dr. Gupta had an already-planned family vacation this week. But what do you have to report to us, Commissioner, on language access resources

for providers?

COMMISSIONER LEE: So we have been looking into this, and it's like anything else. The deeper you dig, the more you find. But I think that we -- we are looking at -- you know, currently, we have six MCOs with six different language access lines and, in addition, fee-for-service has one.

So we're looking at having one telephone number that providers can call when they need assistance with language access. And we think that that's going to work, for the most part. We still have a little bit of conversations to have and planning to do.

The one thing that we are thinking about, too -- and I don't know how this would work and maybe, you know, needs some input from our MAC, is, you know, having somebody come into your office for a sick visit is one thing and, you know, calling the language line and having that interpretation.

But, you know, what happens when an individual is actually having, let's say, physical therapy, for example, or speech therapy? How does -- how does that language

access line -- how would that work with actual interaction with that member?

So that's one aspect that we really need to think about. But I think as far as just a member going into an office and the provider needing to call to get some assistance with language, I think that, you know, we'll be able to streamline that to one number but need to kind of continually think about how we improve that service for individuals who are entering offices for, you know, like I said, extended periods of time maybe for -- for additional services.

CHAIR SCHUSTER: Okay.

And let me welcome -- I think Beth has joined us, Mackenzie. She sent me a text. So welcome, Dr. Partin.

So it sounds like your question is if it's a patient who comes in for what would be a fairly short duration visit, you're thinking about it in terms of kind of time-in-the-office question.

COMMISSIONER LEE: Well, yeah. And not so much time in the office as it is what happens if they're -- you know, how does that

work with you have to have actual interaction with that -- with that member providing instructions? And I'm not a clinician, so forgive me for -- but how -- interactions with that member giving instructions on how to actually perform a task.

You know, I just don't under- -- I don't know how that would work but just kind of -- just kind of thinking through that. But I think to get us started, if we have that one number, that that's going to help a little bit.

I think Dr. Partin has her hand up and so does Kent.

CHAIR SCHUSTER: Yeah. I'm sorry. Yeah. Beth, please.

DR. PARTIN: I would say that it's not any different from any other type of visit. If you're coming in for an acute care visit or a chronic visit, if you need an interpreter, you're going to need an interpreter for instructions. Regardless of what you're doing, you're going to need instructions.

For instance, you know, if it's an acute

illness, telling the patient what you're doing. Well, you're doing the exam and then giving them what the diagnosis is and then giving them instructions or education depending on what it is that they need.

So I don't see that any different than any other visit except that probably physical therapy or speech therapy would be a longer visit than, you know, an acute care or chronic 15- or 20-minute visit. But I don't see -- I don't see those any different.

COMMISSIONER LEE: All right. Thank you. Good to know that.

And I think Kent had his hand --

MR. GILBERT: My comments were going to be substantially the same. My wife works with language at UK Hospital, and often there are, you know, lengthy therapy sessions that require, you know, long periods of silence on the part of the interpreter and then instructions and questions and then some silence while that activity takes place. But that's relatively de rigueur.

COMMISSIONER LEE: Very good to know, and we should have an update at the

next -- at the next MAC on that. And if we get anything sooner, we could probably document something in writing and send it out.

CHAIR SCHUSTER: Yeah. That would be great. So it sounds like we're moving toward a single number as opposed to the provider having to kind of sort through and find the number for that particular MCO and so forth. So that -- that sounds fabulous to me.

Any other questions for the commissioner on that?

MS. EISNER: This is Nina. Just a comment. I did turn my computer on and off, and I'm still not getting video.

CHAIR SCHUSTER: Okay.

MS. EISNER: You know, another exception, obviously, is when someone is in a behavioral health facility, and our need to provide language assistance will be eight to ten hours for the entire therapy day. And hospitals do have contracts to ensure that that happens.

Although the one -- you know, the one

number will be helpful during the assessment process, once they're in the hospital, the hospital has other responsibilities. So just a comment.

CHAIR SCHUSTER: Well, that's a really good point. In fact, I was thinking about behavioral health because, you know, the typical therapy session outpatient would be, you know, the traditional 50-minute, hour or so. But my understanding from providers is that they have either an in-person interpreter there, or they have an interpreter on the line during the course of that interaction because, obviously, it's an ongoing interaction.

But you're saying, Nina, that during the eight-hour day that they're in various therapies at the hospital, you all have a contract with providers to cover that.

MS. EISNER: Yes. And it could go up to 12 hours because --

CHAIR SCHUSTER: Yeah.

MS. EISNER: -- meals, for example, are an important time for interaction. So it's really usually more like 10 to 12 hours

depending on the age of the patient.

CHAIR SCHUSTER: Yeah. So the single line might be helpful because I guess you get walk-ins for one thing, don't you?

MS. EISNER: Yes. Yes. And we have arrangements for that in the hospitals as well. But for -- sometimes there's delays, so a single-access line will still be helpful during that walk-in period; for example, the evaluation. But beyond that, the hospital has the responsibility for contracting with others in person typically.

CHAIR SCHUSTER: Yeah. Very helpful.

MS. EISNER: Thank you. Thank you.

CHAIR SCHUSTER: Yeah. Thank you. Anyone else have a comment or an example or a question?

(No response.)

CHAIR SCHUSTER: All right. Well, I will pass along this good news to Dr. Gupta who's the one who's brought this up and kept it alive. And we do appreciate, Commissioner -- Medicaid looking at that and looking at making a single-access line

available. So we'll keep that on the agenda and hopefully have a final answer from you --

DR. ROBERTS: Actually, something just occurred to me.

CHAIR SCHUSTER: Yes.

DR. ROBERTS: What about when a non-English-speaking individual calls in with questions or calls in to make an appointment?

COMMISSIONER LEE: I believe you can still use that --

DR. ROBERTS: There's a three-way --

COMMISSIONER LEE: Yeah.

DR. ROBERTS: We can arrange a three-way call and still utilize that service?

COMMISSIONER LEE: Yes.

DR. ROBERTS: Okay. Thank you.

COMMISSIONER LEE: It's my understanding, but we'll definitely clarify that.

CHAIR SCHUSTER: Yeah. Great question, Jerry. Thank you.

And, Commissioner, if you have something to report to us or something gets settled

before September, you'll let us know, and we'll get the good word out.

COMMISSIONER LEE: Absolutely.

CHAIR SCHUSTER: Yeah. Thank you.

The other old business item was back to the legally responsible individuals in Medicaid waivers, and Eric Wright wanted this to be on just as a kind of update. I don't know -- he was going to send me if he had any specific questions, and he didn't do that. So I don't know if there's any update from our meeting two months ago.

COMMISSIONER LEE: I don't have an update at this time. But we definitely can get -- if we have a specific question, get something and respond in writing.

CHAIR SCHUSTER: Okay. And I'll get back with him. He typically is good about that. I think he just forgot to send me anything.

So under kind of new business, this next item, I think, is going to be the focus of a good deal of work on the part of the MAC and communications with DMS because CMS has finalized their rules and is telling us what

we need to do. We talked about this a little bit at the last meeting. There are changes that have to be made in statute to the way our MAC is set up and then we have to establish the new Beneficiary Advisory Council which, I guess, will be called the BAC.

So I'll hand it over to you, Commissioner, if you're going to make that report for us.

COMMISSIONER LEE: Sure. Thanks, Dr. Schuster. So as Dr. Schuster said, CMS did finalize rules relating to several things. There are three major rules, you know, and it covers -- basically has three prongs. It covers enrollment in coverage, maintenance of coverage, and access to services. Also has some quality parameters. There's some language about -- or some rules related to directed payments.

But as far as the Medical Care Advisory Committee is concerned, CMS proposed several changes to the Medical Care Advisory Committees, or MACs. And they -- which haven't been updated in over 40 years. So

first of all, they propose to require both a Medicaid Advisory Committee, which is a MAC, and they proposed -- or they finalized a new Beneficiary Advisory Group, which is a BAC or BAG. These changes, you know, would be effective 60 days post-publication with a one-year compliance timeline.

So yesterday Erin sent out a whole -- it's a spreadsheet or a listing of all of the changes in these final rules with compliance dates on that. And you'll see that in January of 2025, we have to be compliant with the new rules related to the Medicaid Advisory Committee and that the individuals that we choose for the BAC have to have lived experience.

And so, for example, at least -- going forward, at least 25 percent of those BAC members would also have to serve on our MAC. Now, those compliance dates, I think, are up into '27 with that full compliance of those 25 percent of the BAC members being on the MAC.

It also -- the MAC also has to include state or local advocacy groups, clinical

providers, which, you know, we do have that right now, or administrators.

Managed care plans. That would be a new one. We would have to have someone from managed care plans or plan association on the MAC and some other state agencies serving Medicaid beneficiaries as ex officio members.

We are, in the department, working -- the other thing that it does require, that those members be appointed by the Medicaid director rather than the governor. You know, we do have a statute right now that outlines how MAC members are appointed, and so we would definitely have to withdraw that or make amendments to that statute and create another one. So we are still in the development phase of that.

And as you can see from the document, if you have received it yet, the document that was provided to the MACs and the TACs with all of the criteria, all of the policies that we have to be in compliance with over the next several years. There's a lot going on.

So we have -- we are going to be bringing, you know, someone on board to focus

solely on our final rules and make sure that we're in compliance with implementing those. And that does include our new Beneficiary Advisory Group, or council, and our new MAC format.

So as soon as we get more information -- you know, we're developing some information right now. And as soon as we bring somebody on board and have more, we'll be able to provide information. So I'm thinking this will be an ongoing agenda on the MAC as we go forward.

CHAIR SCHUSTER: Yeah. Erin, do you have -- could you possibly share your screen and just show that document, so people recognize it?

MS. BICKERS: Yes, ma'am. Give me just a moment.

CHAIR SCHUSTER: Thank you very much because --

COMMISSIONER LEE: And I think it's very important for the MACs and the TACs to kind of look at that. And this document was created by the National Association of Medicaid Directors to help all of -- all of

the directors across the nation stay in compliance and make plan as they go forward. So I think it's really good for y'all to familiarize yourself with everything that's in that document to see how it may impact your particular area.

For example, there is a lot of home and community based. You can see the HCB there, some of the things that we have to do. Medicaid Advisory Committee and Beneficiary Advisory Council is up at top. So you can see there, yeah, the dates that we have to be in compliance with everything.

There's access to care and service payments rates. Some of our directed payments will be impacted. And it's just the way that we handle those payments. And there's access to care. You know, some of the stuff that we are already doing but we will definitely have to make sure that -- that we stay in compliance with those state -- anything that's in this final rule.

And this is just a real quick snapshot of what's in that rule and what we have to do. Of course, the final rule is over 1,000

pages long, has a lot more detail. But this will keep us on line.

And here, again, some of the quality measures that you can see we'll have to be reporting on. And that's -- the other thing is the final rule requires a lot -- a lot of reporting by the Medicaid agency.

Some -- for example, it related to our fee schedules. We'll have to post -- and all our fee schedules are already currently online, but we will have to have our fee schedule online. And we will also have to have a comparison of our fee schedule with what Medicare pays. We have to update that every two years.

So those are just some of the things that we have to do. But the reporting -- lots and lots of reporting that we have to do. And, of course, it's all in the spirit of transparency.

So I would definitely encourage the MAC members and the TAC members to familiarize yourself with some of those provisions in the final rule and if there's anything that we need to talk about in depth as we go forward.

I'm sure that, you know, as we move forward on the updates, a lot of this will be particularly -- especially when we get someone on board to help us make sure that we're in compliance and to have a project work plan, we'll be definitely reporting out the progress on implementing all of these new rules.

CHAIR SCHUSTER: Yeah. And I think, Erin, that you sent that out just a couple of days ago.

COMMISSIONER LEE: I think it may have been yesterday even, so I know y'all haven't had time to look at it.

CHAIR SCHUSTER: Yeah.

COMMISSIONER LEE: But just want y'all to know that it's out there and something that, you know, definitely familiarize yourself with.

CHAIR SCHUSTER: Yeah.

MR. GILBERT: Commissioner Lee, this is Kent Gilbert. Will this -- when we create the Beneficiary -- the BAC, will they -- will that be members in addition to the current MAC, or will there need to be a

reshuffling of membership at that time?

COMMISSIONER LEE: Well, we're not real sure, but we do think that there will need to be a shuffling of membership.

MR. GILBERT: Yeah.

COMMISSIONER LEE: And there will be term limits as outlined in the new rule. But we definitely are going to be focusing a lot on our Beneficiary Advisory Group because they do have to -- we do have to have individuals with lived experience or individuals who live with them and represent or take care of those individuals.

So that -- that's going to be one of our main focus on how we -- how we get that and how to best tap into some of those individuals who have that lived experience and are very critical --

MR. GILBERT: Right.

COMMISSIONER LEE: -- into making policies as we go forward.

MR. GILBERT: And how will -- one other question. I know that we've had conversation about how best to better create portals to the legislative process in terms

of either a legislator observer or legislative members participating in the MAC. Do you have a sense of how this might affect, either positively or negatively, that process?

COMMISSIONER LEE: I do not at this point. I don't think that the legislation calls for legislators to be on the Medicaid Advisory Committee but definitely something they may be interested in as we move forward.

MR. GILBERT: I think that --

CHAIR SCHUSTER: So the final --

MR. GILBERT: -- there's an opportunity there, yeah.

CHAIR SCHUSTER: Yeah. The final rule does not require legislators to sit on the MAC?

COMMISSIONER LEE: I'd have to double-check, but I don't think it does.

CHAIR SCHUSTER: Yeah. Okay.

MR. GILBERT: No. I know that -- and I'm not sure that that's -- that was the substance of our conversations previously, but we have had conversations about how to get better lived experience into the realm of

the legislative decision-making process, which we think has become somewhat divorced from that. And I think this may present -- if there's some way that we can get a conduit at least established as we reshuffle, I think that's an opportunity that might benefit us all.

CHAIR SCHUSTER: Yeah. Yeah. I think that's why we had talked about it originally.

Garth, you had a question. Thank you, Kent.

DR. BOBROWSKI: Commissioner Lee, good morning. I know, typically, Medicare has never really paid for dental. Of course, you've got these Medicare Advantage Plans, but all that stuff is set up by insurance companies.

But I was just going to -- and I know you probably haven't got a solid answer on this one yet, but just how will the plan be to do those comparison charts on fees when Medicare typically did not even cover dental?

COMMISSIONER LEE: Yeah. In those areas -- and I'll go back and double-check

the final rule. It's been a while since I've read it. I think there are specific areas that we definitely have to compare Medicare. I'm not sure dental is one. And if there's isn't a Medicare fee schedule, we would just have to notate that, that there's not on there.

And, Garth, I'm glad you brought up the Medicare Advantage Plans. You know, there is a rule related to Medicare Advantage Plans, too, and to promote more transparency and make it easier for individuals to choose one of those plans.

I don't have information on that yet, not able to speak intelligently about it because I haven't read that final rule. But that is something that will be coming out, too, just making it easier for individuals to be able to choose a plan and something -- you know, I think that if -- that they need to be more streamlined.

And there will be combining of some -- of some Medicare Advantage Plans. And a carrier, for example, will not be able to offer four, five, or six different plans.

They have to streamline those, and there's criteria around all that.

DR. BOBROWSKI: Okay. I know what we're -- we're coming up on the fact that we're telling patients to "buyer beware." Because like you just said, these different companies are coming up with multiple plans, and they're taking -- the customer is getting shammed. Because they think they're buying some access to dental care, and it may just be a cleaning-only plan.

So I hope some transparency comes for the people that are selling those plans, or maybe there's -- and I don't know the relationship that has to go between the state in developing this and dealing with individual private companies. I don't know the dynamics of that yet, but we'll learn.

DR. ROBERTS: I don't want to get off topic, but there was something in the proposed final rule from last year that -- on the broker side that would standardize commissions for patients signing up for Medicare Advantage Plans.

The -- historically, you know, let's say Plan A would -- they would make a higher commission. Plan B, they would make a lower commission. So they steered them towards a specific plan.

One of the things in the proposed rule last year was to standardize commissions for signing the patient up for Medicare Advantage Plans, and hopefully the function of that is for the brokers to act in the patient's best interests, not theirs.

COMMISSIONER LEE: Yeah. And I think that the whole -- the whole point of some of these new final rules, particularly around access, is to be very transparent. And with the Medicare Advantage Plans, it's the same thing, to promote transparency and also coordination of benefits.

So if Medicaid, for example, in Kentucky covers dental and somebody is also -- if they're dual eligible, then they should know what their Medicaid benefits are when they sign up for a Medicare plan, a Medicare Advantage.

CHAIR SCHUSTER: Yeah. There's

lots and lots of questions there. I do think that Kent raises a good question because there are a number of us, myself included, Kent and others, who are -- Mackenzie, who are appointed to represent various groups of Medicaid beneficiaries and do not necessarily have the lived experience.

So we would not qualify probably to serve on the BAC, and I think we'll have to make a decision about how large the MAC is. Because it sounds like the MAC could get pretty large with adding MCOs and adding -- now, some of us would probably switch over to a different hat if they're looking for representation of advocacy organizations. You know, many of us are in that.

So I think the other thing -- and I think we had a discussion about this, if not at the last MAC meeting, the one before. And I think, Erin, you did a little bit of work. We kind of compiled...

There are some of the TACs that have required membership of people with lived experience. The BH TAC is one. Obviously, the Consumer TAC is another one. I think the

IDD TAC is another one.

It would be helpful, I think, as we look at developing that BAC, Commissioner, to really look at what some of the barriers are to getting people involved. You know, it's a big leap for a lot of people to move from lived experience to serving on a purely pretty bureaucratic, large -- with a lot of focus on it.

And -- everything from transportation to assistive technology for people that might need that to really preparing people to serve on those councils or committees, I think, is really going to be something we need to look at.

You mentioned a January 1st. I'm assuming that we're not out of compliance if we're working on a piece of legislation in the upcoming session; right?

COMMISSIONER LEE: That is correct. We do have -- as you know, I'm part of the executive team at the National Association of Medicaid Directors, and we do have routine calls, at least monthly, sometimes twice monthly, with leadership at CMS including

Dan Tsai. And we talk through some of those.

You know, every state is different. For example, I brought up Medicaid has a statute that covers our Medicaid Advisory Council. Our legislators don't meet until January, so we will have to have time to come into compliance. And they fully understand.

Every state is a little bit different and that, you know, as long as we have that plan and we're showing we're working towards it, that they will be -- we will remain in compliance with their guidelines.

CHAIR SCHUSTER: Yeah. And do you remember what the -- does the BAC need to be up and running --

COMMISSIONER LEE: I think we just --

CHAIR SCHUSTER: -- by January 1st?

COMMISSIONER LEE: No. I don't think --

CHAIR SCHUSTER: -- or just --

COMMISSIONER LEE: No. It doesn't have to be up and running by January 1st. We have to have a plan in place by January 1st to --

CHAIR SCHUSTER: Okay. Because I think the recruitment for membership is going to be really critical.

COMMISSIONER LEE: And we have -- we have discussed that with CMS, too, not only recruitment but, you know, maintaining -- how do we maintain them? What services do we need to provide in order to ensure participation? And the final rule does have a lot of that stuff in there. They have, you know, a lot of criteria, for example.

All of the meetings have to be -- we have to post all of the meetings online. We have to have notes from the meetings. And at the end of the year, we have to have a report to CMS at the end of -- I think it's at the end of 2025, or each year regarding all of the meetings, everything that was said, recommendations that were made, actions that were taken.

But we will have to have an annual report to CMS regarding the activities of the MAC and BAC, which, you know, that's not a bad thing. But, again --

CHAIR SCHUSTER: No. It's not a bad thing but lots of reporting.

COMMISSIONER LEE: All of the reporting, all of the -- and that's, you know, in addition to the other reporting we have to do with the HCBS programs, for example, and the fee schedules.

CHAIR SCHUSTER: Yeah. Any other questions from any of the MAC members about the final rule; the new MAC, the new, improved, expanded, whatever, MAC; and the new BAC?

MR. GILBERT: MAC plus.

COMMISSIONER LEE: We're very excited about it. I mean, it -- you know, very excited. Definitely need to have our members have a platform to tell us exactly what their experience is and what would make accessing services and receiving their health care better as it relates to policies.

DR. BOBROWSKI: I think it should be called the Big MAC.

COMMISSIONER LEE: Let's do that. Let's do that. We'll name it the Big MAC.

CHAIR SCHUSTER: I like that.

All right. Well, thank you very much, Commissioner. And as I indicated to you earlier, we certainly are interested here at the MAC of being of help to you in any way and certainly of whatever help we can be in discussing some of this with legislators and, you know, having it make sense. This is a short session so, you know, it's got to move quickly in a 30-day session. So thank you for that.

An issue that we've been talking about here at the MAC, and a number of the TACs have also been talking about it, is improving communications with potential beneficiaries and possible waiver recipients. And I think, Commissioner, there's a DMS workgroup on this.

COMMISSIONER LEE: I think what I want to do, Dr. Schuster -- I know we have been doing some strategic planning specifically around communications.

And I have -- Senior Deputy Commissioner Veronica Judy-Cecil is going to talk about our strategic planning. And I think David Verry is also on the line, and he's going to

talk a little bit about some of the work that the connectors have been doing.

So I'll turn it over to Veronica and David at this time. Veronica?

CHAIR SCHUSTER: Great. Thank you.

MS. JUDY-CECIL: Hi. Good morning, everyone. Veronica Judy-Cecil, Senior Deputy Commissioner here at Medicaid.

We are embarking on strategic planning. And for those of you who have gone through that, then you can probably sympathize or empathize with us. Those who have not, what that means is we are really looking both internally and externally and trying to develop a plan, sort of our roadmap, on, you know, where -- what we want to focus on and how -- what are our goals, and how do we reach those goals? What are the strategies or, you know, different ways that we're going to try to reach those goals?

And to do that, we are -- and part of this really is also looking at our members, our providers, and just kind of every stakeholder that engages in the Medicaid program from whatever, you know, point they

do that, to try to help us understand a little bit more about that interaction and inform, you know, the development of our goals and strategies.

So we are embarking on strategic planning. Emily Moses is our staffer that is heading this up. Emily has her -- you know, really has a lot to do here.

But one of the first things that we're going to do is a stakeholder survey, and so we just recently released this. We released it back on the 16th of July, and we're going to keep it open through August 16th. And Emily is posting the link to it.

This is open to everybody. This is not just MAC members or TAC members. Really, everybody on this call today in some way, shape, or form interacts with Medicaid, and so we want to hear from you. And so we ask that you fill out the survey. The more people who fill it out, you know, the more informed we are, and so we're really encouraging it.

But, you know -- and we'll keep you guys posted on our progress through strategic

planning. You know, the Department has never done this before, so we're really excited about where this could lead us and, you know, have us all on the same page. And just, you know, a great way for us to communicate and let folks know outside of the department what we're doing, our mission, and our vision. You know, we're really kind of updating all of that.

So want to hear from everybody, and we kind of felt like, you know, this really sort of plays into communication. This is one of our efforts to try to help communicate better with those including our beneficiaries, our members, about what's -- you know, how does Medicaid impact them, and what can we do differently.

Now, more specific to this line item, I am going to turn it over to David because I think he has some updates about the request and what we've been trying to do.

MR. VERRY: Good morning, everybody. David Verry, Director of DMS Health Plan Oversight. In Kentucky, that means Kynect, our state-based marketplace.

We call our navigators connectors. There are also connectors who are certified application counselors. They work in hospital settings and some other facilities and that kind of thing. We kind of all put them under the umbrella of connectors.

And unlike the federal system and really unlike any other state in the union, our connectors carry a pretty heavy load in not only helping people with state-based marketplace, the Qualified Health Plans, the ACH plans, but helping in Medicaid.

And in Kentucky, because we're part of Medicaid, which is also rare but a wonderful partnership that we're actually part of, the department, they help people with all kinds of Medicaid, MAGI and non-MAGI. They can even get that application started for long-term care.

And we have provided kind of some point-the-way help, job aids and that kind of thing, on how they can help people who are seeking a waiver, which is -- which can be very complicated for both the person who is applying for the waiver and the person who is

assisting that individual or family.

Current day, we have some job aids that we have one-pagers that we have distributed to the connectors and to our licensed insurance agents who partner with us as well. That is also -- we're the only state that does that. And there are just these one-pagers that -- the same one-pagers that you would see on the DCBS sites, just a different way to get to them.

And we're planning soon on once -- our people in DMS are putting together a Waiver 101 for internal staff and others, but we're going to run that to our monthly all-hands connector meeting. We usually have several hundreds of them actually meet us with every month, and sometimes we have a specialized presentation on something just like this.

So that's what's kind of on the horizon. And as we go through our QHP open enrollment, we hold office hours. And that is always kind of, like, open as far as what the topics may be. And if everything else is running smoothly, which we're planning on, we might even be able to carve this education into

part of one of those office hours, our virtual webinars as well.

I kind of said that all in one breath. Apologies. Does anyone have any questions or suggestions?

CHAIR SCHUSTER: Thank you, David. I was invited to talk to the Disparity and Equity TAC just last week.

MR. VERRY: Oh, good.

CHAIR SCHUSTER: And the question came up -- because we were -- the topic was this improved communication. And someone there, it may have been Leslie Hoffmann, was on and said, you know, there are some questions on the overall Medicaid application that would lead one possibly to indicate that there might be eligibility or a need for waiver services and --

MR. VERRY: Yeah.

CHAIR SCHUSTER: I'm sorry.

MR. VERRY: Yeah. Absolutely. That's how it works, especially on the electronic application, but also on the paper. If -- on the electronic application, it's no wrong door. You just start filling

it out, and the fully-integrated system will then figure out where your best needs can be served. If you answer certain questions about your age or a disability, for example, it'll then, all of a sudden, stop populating resource questions because it knows that you are a non-MAGI potentiality.

If you say that you live in a nursing home or something like that, it may, all of a sudden, load and start asking questions that would be appropriate for long-term care. And if you answer questions that show that you might be appropriate for waiver, it at least gets that going. The first step towards a waiver application is a Medicaid application, of course.

CHAIR SCHUSTER: Right.

MR. VERRY: So it's -- we're always willing to take feedback as to how we can improve this process. But it's pretty remarkable, and it is indeed unique among the 50 states plus D.C.

CHAIR SCHUSTER: Well, the question that came up --

MR. VERRY: Yes, ma'am.

CHAIR SCHUSTER: And I'm delighted to hear that if somebody is doing that initial application online, that the software takes over and kind of takes you where you need to go with more questions and so forth.

The discussion we got into was whether the connectors themselves had the education and training to know to follow up. And our impression was that they did not necessarily have that, that they may not have been trained or not reminded in their training about what to do with those initial questions and what the appropriate follow-up questions or direction might be.

And so I think there was some discussion about that, and it sounds like, David, that you're planning some education around that. I just wonder about connectors that have been out there for a while. You know, we always have new ideas, and so new people coming in to assist them always get better training than the people that were at it years ago.

MR. VERRY: Oh, absolutely.

CHAIR SCHUSTER: And so I'm just curious because we actually had a connector

on there who said that they did not get essentially waiver training in their initial education as a connector. So I guess you're the right person for me to be asking this question of.

MR. VERRY: Oh, that's a very honest question. And we're always looking for good feedback, and sometimes good feedback isn't positive. You know what I'm saying. And that is a -- that's definitely a delta and definitely a takeaway.

That's why we're trying to increase awareness of what waiver is and how to apply and kind of a step-by-step. We're really looking forward to this Waiver 101 presentation that we'll get to do. That invitation will go to all connectors existing or newer.

And every Friday at 1:30 sharp, every single connector gets a Friday Fax one-pager from us, from my team and I. And we have sent out, this is what a waiver is and the fact sheets and if you have any questions, to elicit feedback. And we look forward to more formalized settings as well to make sure

everyone gets on board.

Sometimes when you talk to one connector, you've talked to one connector.

CHAIR SCHUSTER: Yeah. I'm sure that's true.

MR. VERRY: However, if this one connector says, I don't know anything about waiver, do you know whose fault that is? Mine. And we'll take that, and we'll take that back and try to increase our campaign. These are some of our most vulnerable residents of the commonwealth. So if we have to triple our efforts, we will.

CHAIR SCHUSTER: Well, I appreciate that, and I don't share that in the spirit of criticism at all.

MR. VERRY: No. It's -- thank you.

CHAIR SCHUSTER: But because this whole communication issue has come up with people not understanding how to get into Medicaid and then not understanding what the waivers are there for, which is what Commissioner Lee and I found in talking to some families, particularly of children and families that might not be eligible for

Medicaid otherwise, so they're not thinking Medicaid necessarily. And then they have a child who's born with significant, significant disabilities, and they're, you know, suddenly in that space.

But I like the idea of your being aware. And, you know, hopefully, the training also, David, would remind connectors that those questions on the application form may indicate that follow-up needs to be done, you know.

MR. VERRY: Oh, yeah. Absolutely, especially the connectors who are not working in a hospital setting.

CHAIR SCHUSTER: Right.

MR. VERRY: They become associated with that person and follow them through the course of whatever is going on with them. We've found that if you have a connector or an insurance agent, you're more likely to stay insured, and you are also more likely to actually go to your primary care physician and make --

CHAIR SCHUSTER: Right.

MR. VERRY: -- other kind of

things. It would be wonderful -- we're not there yet, but it would be wonderful if having a connector would make you more likely to follow through all those steps that you need to do for waiver or even long-term care. They can't make the final decision, of course.

CHAIR SCHUSTER: Right.

MR. VERRY: And there's a lot in the application flow that they cannot do as well. But to be an advocate for that person and to help liaison with us and others so they're getting through that process.

CHAIR SCHUSTER: Well, you know, I think, universally, the connectors are seen in very positive ways. I think it's one of the unique things that Kentucky did early on, and it really -- you know, I'm proud of the fact that we have them and that we're one of the few states that was smart enough to create them early on.

And I do hear from people that go back and check in with their connector when something comes up. I mean, they become that kind of go-to resource person, almost like

our CHWs.

MR. VERRY: Yeah, very similar.

CHAIR SCHUSTER: Or in the behavioral health field, those peer support specialists. You know, it's the person who's knowledgeable that's reached out and made a connection. And when you have a question or you're in crisis or whatever comes up, you tend to go back to those people.

So the connectors are great. I just -- since they're accessible, I just want to be sure that they've got that information about the waiver so...

MR. VERRY: Oh, absolutely. And I appreciate you bringing that to our attention.

CHAIR SCHUSTER: Sure. Thank you.

MR. VERRY: And if anyone else hears anything else that we can do to improve what their capabilities are. They're always looking, too. Only state in the union that we have connectors taking SNAP and childcare application as well now.

CHAIR SCHUSTER: Oh, that's right. Yeah. Yeah.

MR. VERRY: It's getting ridiculous in a good way towards that no wrong door, where you can go to one place and at least get the process started. And so, yeah, thank you. I really appreciate --

CHAIR SCHUSTER: No. Thank you for being on and for --

MR. VERRY: -- inviting me to come here. And if you want to reach out to me, davidverry.ky.gov, for anything else, follow up.

CHAIR SCHUSTER: Well, thank you.

MR. VERRY: I'm always --

CHAIR SCHUSTER: Let me see if any -- I've monopolized your time. So let me see if anybody else on the MAC has any questions for either Deputy Commissioner -- Senior Deputy Commissioner Veronica Judy-Cecil -- that's a long title, Veronica -- or to David Verry.

Any other questions around the DMS strategic planning and connector education?

(No response.)

CHAIR SCHUSTER: All right. I have been gathering some information from MAC

members from TACs and others. And let me just share a couple of things, Commissioner and Veronica, as we kind of think about this. And some of this may be helpful in terms of the strategic planning as well.

So some of the ideas that have come up are the importance of working with schools to get the word out about Medicaid and the waivers. They have a captive audience. And, you know, they create great opportunities, in particularly, of open houses or back-to-school nights for parents and students. It's a great place to get the information out and just to ask some of the questions and, also, to meet with the PTAs because, obviously, the parent involvement there is very important.

Another category of people is to work with the faith community. So often our churches, you know, address some of these social determinants of health or the health-related social needs, and so they're very interested. And they hear, those pastors, ministers, and the people -- Kent would tell you that he probably knows the

health needs of many of his congregants.

So one of the ideas -- and we used to do this in the behavioral health community -- is to meet with faith leaders and even give them a little breakfast early one morning and, you know, provide some materials and so forth. The other thing is to provide materials for them to distribute at their church services or synagogue or temple services.

And many of them have groups that focus on youth or groups that focus on the elderly or parenting groups, that kind of thing. So it's another good way to get the information out.

Obviously, we want to work with our minority communities. And several people have said, you know, the Latino community in particular very often will have health fairs or gatherings. We know in many communities where the hub, if you will, of that community is.

There are Spanish newspapers. There's Spanish radio stations. Even some of the local cable stations are Spanish-speaking, so there are lots of opportunities there to get

the word out with our minority communities.

And I think the same is true of our black communities, particularly through, again, the faith leaders. But, also, as they're gathering about other issues, to be sure that they've got -- and there are a lot of health fairs that are conducted in conjunction with those social service agencies.

Obviously, social media and media. Facebook is still very popular, I'm told, particularly, again, with the Latino community.

The best outreach to rural communities is the radio. They're much more likely to have a radio as their source of news and entertainment than television and perhaps producing some 30-second spots. Articles and ads in local community newspapers, which typically are hungry for information. So sending in an article about a health fair or that kind of thing or a new benefit that Medicaid has can be helpful.

And then, apparently, the Kentucky Broadcaster Association can be helpful in

terms of public service announcements. And I think there's some rules around that and so forth, but radio is certainly cheaper than television, we know. And there are, I think, some requirements for PSAs that some of those channels have.

Reaching out to any number of sister organizations or agencies. So the AD districts, certainly the area agencies on aging. Commission on Children With Special Health Care Needs. Your local United Ways, AARP, and the retired service volunteers.

And then local hospitals. I was interested that one of the people attending one of the TAC meetings -- I think it was the Disparity TAC -- talked about working at a hospital, particularly around pediatric issues, and finding that there were a lot of people that were not familiar with the waivers, for one thing, and didn't have a good source for putting materials out just for people coming through. And we know that a lot of people are in and out of hospitals. I would think around maternal health, would be the other place that hospitals could be

really helpful.

And then we -- there was some discussion about the screening questions on the waivers and the training for the connectors. And I don't know if Peggy Roark is on, but she and I had a long discussion about this. And she felt strongly that getting -- making sure that providers have that information in their offices. And, you know, I think it's an ongoing issue to keep things like that fresh and, you know, easy to read and maybe available in at least English and Spanish.

But I do think people are there for a healthcare need or a health-related or a dental need and just having, you know, a very simple but attractive one-pager that gives a couple of phone numbers, in particular.

I think we have to be very cognizant that we don't have broadband everywhere in Kentucky and that we have a lot of people that don't have Internet access. Because it's easier to do Internet kinds of things and to send out, you know, blast emails and so forth.

So those were some of the ideas that we

had, and I'll -- Commissioner Lee and Veronica, I'll send you that paper just so that you have those. That might be helpful to you.

And I'll ask any of the MAC members -- Kent, you had something in the chat about this.

MR. GILBERT: I just -- something I'll reach out to Mr. Verry for, which is, I think there was -- at one time, you know, a lot of parishes and congregations of faith-based organizations had parish nurses.

CHAIR SCHUSTER: Right.

MR. GILBERT: I'm seeing a need for parish connectors. In other words, if we could develop some way in which parishes who wish to -- congregations, faith communities could have a trusted partner from within that would be trained and fully certified as a connector, I'm wondering if there wouldn't be -- you know, that would be a great program for faith-based communities to engage in so that they'd have a trusted person they could go to as a connector and those local -- local access would be increased.

CHAIR SCHUSTER: Right.

MR. GILBERT: It wouldn't change -- it would just be a question of how we would get those people trained, but I'm sure there's a process. And I'll reach out to Mr. Verry about that and see if I can promote that.

MR. VERRY: Yeah. There is a process. Certified application counselors, they can be from hospitals, many health centers, those kind of things. But they can also be from 501(c) organizations.

MR. GILBERT: Okay.

MR. VERRY: Typically, these are, like, food pantries and that kind of thing.

MR. GILBERT: Yeah. Right.

MR. VERRY: That would be, you know, brilliant. And many of them that are in, like, a food pantry or something are also doing staff applications as well.

MR. GILBERT: Right.

MR. VERRY: Obviously, that has a lot of advantages. So yeah, I'll get with you or send me an email, or I'll send you an email --

MR. GILBERT: Great.

MR. VERRY: -- on how a 501(c) organization can apply for that process.

MR. GILBERT: Perfect. Thank you.

MR. VERRY: That's a great idea. Love it.

CHAIR SCHUSTER: Great idea, Kent. Thank you.

MR. MARTIN: Hey, Sheila, I'd like to say --

CHAIR SCHUSTER: Yes, Barry.

MR. MARTIN: This is Barry from Primary Care Centers. We've had a lot of great luck with our connectors and then they're also -- we're having some connectors in the Kentucky Community College System as well, and they're reaching a lot of people. And it's a great program, so keep up the good work.

CHAIR SCHUSTER: Yeah. That's a great idea. I was thinking schools more of K through 12 but, obviously, the KCTCS and probably at the other campuses as well. It's a little bit harder to quite figure out. But, you know, there are a lot of college

students that are in that in between. They may have just rolled off their parents' coverage and be kind of lost about that.

MR. MARTIN: Yeah.

MR. VERRY: The average age of a community college student is 32, something like that. They're slightly older.

CHAIR SCHUSTER: Right.

MR. VERRY: So they're not with Mom and Dad and --

CHAIR SCHUSTER: Right.

MR. VERRY: -- it's really, really a good example and, many times, need food or childcare assistance.

CHAIR SCHUSTER: Yeah.

MR. MARTIN: Yeah.

MR. VERRY: Sometimes that childcare assistance is the benefit cliff of whether they're going to be able to continue their education or not. So yeah, great.

CHAIR SCHUSTER: Right. David, there's a request in the chat for you to put your email address in, please.

MR. VERRY: Okay. Yep. Someone already did.

CHAIR SCHUSTER: But he just put it in there so...

MR. VERRY: 'Tis I. That's me.

CHAIR SCHUSTER: Yeah. There you go, david.verry, v-e-r-r-y.

Thank you so much. Any other suggestions along those lines?

(No response.)

CHAIR SCHUSTER: All right. Thank you so much, Veronica and David, for being on. That's very, very helpful.

Commissioner Lee, you were going to talk about the recent Supreme Court rulings and some that might have some impact on Medicaid and services.

COMMISSIONER LEE: Yeah. Sure. And thank you. And before I get started, just -- I am not an attorney. I'm just wanting to give you a little overview of what we've been talking about at the national level related to these court cases.

So, basically, over the last several weeks, there have been a number of court decisions that could have an impact on federal agency regulations and overall -- or

challenges to those federal regulations overall, with specific challenges to actions taken by CMS.

There have been recently three Supreme Court cases that have implications for federal agency regulation actions overall. And, basically, these actions shift authority from federal agencies to courts for the purpose of interpreting ambiguous federal law. So that's one that we're keeping an eye on.

Another one extends the statute of limitations for initiating legal challenges of regulations.

And then the third one gives defendants who are subjects to Securities and Exchange Commission civil penalties the right to a jury trial, and so that could have broader implications for civil compliance actions.

So, basically, you know, a common thread among these decisions is an examination of the role the courts play in determining under the federal -- I think it's the Administrative Procedures Act, whether federal agency regulation actions are

permissible in relation to the plain language of a federal law enacted by Congress.

So, basically, what this means is it could be relevant to Medicaid programs because CMS, they often issue regulations or rules that -- such as all the final rules that just came out, that interpret and apply federal Medicaid law.

So, you know, CMS -- when individuals or when states submit 1115s, CMS usually reviews and negotiates that with states, whether to approve or deny their demonstrations. And Kentucky does have a current 1115 that was just recently approved, our reentry waiver.

But, basically, we're just keeping an eye on all of this and some of the actions that have come out that haven't really referenced these cases. For example, both Indiana and Georgia have 1115 waivers that expanded their Medicaid program. But those waivers do have some provisions very akin to work requirements and premiums that are currently being challenged.

In Indiana, depending on how that goes -- of course, Indiana is very concerned

right now that if the challenge is upheld in court, that it could have an impact on their overall Medicaid expansion program.

So the good news for Kentucky is our Medicaid expansion is in a State Plan Amendment. We don't think there will be any challenges but just wanted to alert you all to the fact that there are those court cases and some challenges to some Medicaid agencies already related to those recent decisions. Just putting that out there.

We are keeping an eye on this at the national level and tracking those court cases such as the one in Indiana, Georgia. I think there's another one in Tennessee that is not related to Medicaid expansion, but there's a few more. But we're just kind of monitoring and watching the situation just to see where it may go but just wanted to alert you to that.

Not sure I can answer any questions other than those court cases do have the potential to challenge CMS interpretation of certain laws as we move forward.

CHAIR SCHUSTER: I assume that that

first is that Chevron ruling.

COMMISSIONER LEE: Yes.

CHAIR SCHUSTER: Yeah.

COMMISSIONER LEE: That's what has been referred to as the Chevron, but there were three specific --

CHAIR SCHUSTER: For us non-attorneys, there's been a fair amount of newspaper coverage that has explained that where basically, I guess, the justice has said the Courts will decide, you know.

COMMISSIONER LEE: Yes.

CHAIR SCHUSTER: For those of you who have not worked with regulations, you know, when I do my advocacy training, I talk about you pass the statute. And that's like framing your house, but you can't live in it. And so it's the regulations that put in the wiring and the flooring and the windows and the HVAC and so forth. So it literally is the crossing of the Ts and the dotting of the Is.

And, of course, those decisions are made by the agencies, federal agencies or state agencies, by people that have, in most cases,

longevity and a lot of knowledge about the specific thing that the regulation is written about.

So it's a bit disarming, at least to me, to think about a judge who was trained in the law but was probably not trained in health care, in any sense, looking at a CMS reg and deciding that they know best how it should be interpreted, which I think is basically what Chevron does.

COMMISSIONER LEE: Yeah. We're definitely keeping an eye on things. And, you know, if we see other cases that are coming to bear, then we will let you know. But the Indiana and the Georgia one, a little bit concerning for them because, again, they do have their expansion in an 1115.

And the -- we think that the challenge may be that those 1115s are a little bit more maybe stringent than they should be as it relates to work requirements, or it doesn't really keep with the intent of the Medicaid program to provide access to care.

But definitely, Dr. Schuster, I think that you've hit the nail on the head with the

concerns that Medicaid directors have as to who gets to interpret that ambiguity. And we know that there are several regulations or statutes that are ambiguous just for the sake of being -- having to have some flexibility.

CHAIR SCHUSTER: Yeah. Yeah. That's an interesting point, is it really takes away your flexibility, or you're reluctant to put it in there if you think it's going to be interpreted by a single judge or a group of judges so...

Well, thank you. I think it's helpful for us to have that perspective from Washington, and you certainly are in a great position as chair of that national group of Medicaid directors to, you know, kind of get this firsthand. So keep us posted. Let us know how worried we should be as we go along.

COMMISSIONER LEE: Yeah. Right now, not -- not too worried right now but as it goes along, you know.

CHAIR SCHUSTER: Okay. Any questions from any of the MAC members of the commissioner on that issue?

(No response.)

CHAIR SCHUSTER: I don't know if we've got any attorneys -- probably not -- on the MAC, at least in our current makeup so...

All right. We have exciting news that we have a new school-based services grant. Are you going to talk about that, Commissioner, or somebody else?

COMMISSIONER LEE: I think, you know, we've been -- we have Erica Jones here who --

CHAIR SCHUSTER: Oh, good.

COMMISSIONER LEE: -- has been leading up this initiative and has been working really hard. And I think I'm going to let Erica -- she's on; right? Yeah. There she is. I see her.

I'm going to let Erica give y'all an update because she definitely has more knowledge about this project than I do.

Erica?

CHAIR SCHUSTER: Well, and she was kind enough to come and report to our BH TAC at our last meeting, which we appreciate, so we're looking at having ongoing reports from her as well. Welcome, Erica.

MS. JONES: Thank you very much. Let's see. Are you able to see my screen?

CHAIR SCHUSTER: Yes, ma'am.

MS. JONES: Okay. So I'll go ahead and get started. I'll go through these -- the overview of our project, SHINE Kentucky. That's an acronym for Strengthening Health Integration and Education for Kentucky students. Go over a little bit about the school-based services history and then our goals and strategies, our budget, and then that first-year work plan.

So in January of this year, CMS released a Notice of Funding opportunity for two-and-a-half million dollars for a three-year grant period. And there were several options. It was for implementation, expansion, or enhancement of school-based services.

The implementation for states that haven't implemented, the expanded access for school-based services, and then the expansion is for the ones that haven't done -- beyond students that have an IEP. And then enhancement are for those states

that have already expanded access, and it just allows them to further work on that space.

So it, again, is a three-year project duration and two-and-a-half million dollars. And when we applied for this grant, it was with the assistance of the lieutenant governor's office, Department of Education, and also the Department For Behavioral Health, Developmental and Intellectual Disabilities.

And there were 18 states that were awarded grants. Kentucky is one of three to receive funding for enhancing school-based services along with Massachusetts and Minnesota.

And then a bit about the history. In 2014, CMS did the free care reversal, which allows states to implement school-based services for children that had Medicaid coverage but did not have an IEP. And so that would allow school-based services to be offered to a lot more students, any student that had Medicaid. And if it was a Medicaid-covered service in the school

setting, it could be covered.

CHAIR SCHUSTER: Erica, would you just define an IEP? There may be some people on the MAC that are not familiar with that term.

MS. JONES: Certainly. IEP is an individualized education plan and, oftentimes, there's a committee in each school, an ARC committee with parents, therapists, school administration. And it lays out the services that are needed for a child. So it could be that a child needs speech therapy so many days a week, occupational therapy, that sort of thing.

And so in 2014, again, that free care reversal meant any child that had Medicaid, states could allow for reimbursement for any of the services in that school setting. Kentucky applied for -- or submitted our State Plan Amendment in 2019 to expand the services to include those students that -- regardless of having an IEP.

In 2020, that was implemented but, of course, COVID hit, and so it wasn't as robust an implementation as we had hoped for. And

so with this grant, we'll be able to build upon the foundation that we have already for enhancing our school-based health services.

And these are the goals that we have laid out. The first one is to increase provider capacity by 40 percent within three years. We know that there are issues with the capacity of providers as it is, and so we want school districts to be aware of all the different possibilities or modalities of providing services. And that could include contracting with CMHCs or BHSOs, FQHCs, and other private providers, if necessary.

We also wanted to make sure that we're reducing or eliminating any barriers to billing or administrating the program within the school districts.

And then that second goal is to increase or to improve the infrastructure so that telehealth services can be provided in the school setting. We know, because of that provider shortage, that sometimes it would be more beneficial to have a provider in another area be able to perform those services via telehealth.

The strategies that we have for completing those goals, the targeted clinical and administrative staff recruitment. So that includes, of course, the providers. But, also, we found from our survey that there's a lot of turnover in the administrative staff. And that's one of the issues that schools have had in implementing expanded access.

We are also launching the SHINE Kentucky grant program. This is to award seven school districts $100,000 each to model enhanced behavioral health services within their school district, hopefully with the intention of rolling those out statewide.

The training and capacity building. We plan to do a very comprehensive training for school districts that may not already be using expanded access so that they're more comfortable with what it entails, the covered services, and also getting parental consent and other training as needed.

Apologies. My mouth was getting awfully dry.

The outreach and community engagement.

So we want to make sure that there's a continuity of care. So if a student is receiving services in the school setting and that's not the same provider that they're seeing in the community setting, we want to make sure that we are engaging those community providers as well and also that there's increased parental involvement so that they, again, are aware of the services that are available to their children in that school setting.

And then going back to the telehealth, making sure that there is the necessary infrastructure and -- the physical and technological infrastructure for -- to be able to provide the telehealth services.

And then the project budget for the three-year period. Of course, the majority of the money is going to be spent on the second year, and that's when we will be seeing that -- more of a rollout of all of the different initiatives we plan to incorporate with the grant funding.

And so this is just showing the first year of what our plan is. The first thing,

of course, is to figure out who we need to have on our core team and then we're going to complete a final needs and infrastructure needs assessment.

And this is the same information. It's just laid out by the months, again, showing the first task that we have ahead of us, and that is to form that -- the core team and then the needs and infrastructure assessment.

And so doing that, we want to identify the stakeholders, engage them, develop a survey that will be able to capture all of the data that we need. But we also know that there have been a lot of other surveys that have gone out, including DMS. The school-based health alliance has sent one.

So several other different agencies have sent out surveys regarding school-based services. So we want to also synthesize those findings as well to make sure that we have a true picture of the landscape of school-based health services so that we can actually know what we need to -- what those final needs and infrastructure needs are.

And there is my contact information if

there is anyone that wants more information about this grant or any of the school-based services that Medicaid covers. And I will open it up to questions.

CHAIR SCHUSTER: Thank you very much, Erica. Will you send your PowerPoint to Erin Bickers?

MS. JONES: Yes.

CHAIR SCHUSTER: So she can send it out. That would be very helpful. Thank you.

I have a question. Then we'll see if there are other questions. What's the time frame for grants to the seven school districts, and what's that process?

MS. JONES: So the core team that will be working on that project, the first six to nine months is that time frame of identifying those school districts. So that will be, let's see, six -- around January, I believe, we'll start our process of determining which school districts, how they will apply, and then determining which ones will be awarded those funds.

CHAIR SCHUSTER: Okay. Because I would think there would be a lot of interest.

And the money is specifically designed to do what?

MS. JONES: To enhance behavioral health services within that school district.

CHAIR SCHUSTER: So it's pretty broad. Great.

Any other questions from any of the MAC members?

DR. BOBROWSKI: This is Garth. I may have a -- I don't know if this is a question or just a comment. But I was looking in the University of *Kentucky Humanities* magazine a month or so ago, and they had an article in there, you know, about a one- or two-pager, on, you know, working with schools on behavioral issues and bullying and how folks can get involved and help with that a little bit. But it wasn't an in-depth thing.

But is -- Erica, is this something that, you know, communities can get involved with to -- and with their schools to look at behavioral health and health issues like that to decrease bullying, you know, other societal issues that really can have

long-ranging effects on people? I just happened to see that article.

And, Kent, I thought, well, that might be something, you know, our church could even, you know, help get involved with, but it's just an awful thing.

I was little in school and still a little person. But I guess I was mean enough that I just didn't let anybody pick on me too much. But I was just wondering about that. I remember reading that article from the *Kentucky Humanities* magazine.

MS. JONES: Certainly. We work a lot with the Kentucky Department of Education on different initiatives for school-based services including some of those, like, school trainings, the whole child, whole community aspect as well. So, certainly, that would be helpful.

DR. BOBROWSKI: Okay. Thank you.

CHAIR SCHUSTER: Any other questions from any of the MAC members?

(No response.)

CHAIR SCHUSTER: I will say that Erica presented at the BH TAC meeting a

couple of weeks ago, and I think we were all -- I don't know if disappointed is the word. But the Medicaid billings for behavioral health for both the kids with IEPs, who are typically kids with an identified disability, and the kids without who are Medicaid eligible was really miniscule.

And part of that problem, I think, is being addressed in this grant, as I understand it, Erica, and that is that the schools are either not knowledgeable about or are reluctant to get into the business of billing Medicaid for services. So that's one piece of this.

And the other that I think this grant is also going to address is that some of those services are provided by outside providers such as the CMHCs or one of the -- we call them BHSOs, Behavioral Health Service Organizations. Or, Barry, one of the FQHCs, Federally Qualified Health Centers, that have behavioral health providers.

So I think we talked at some length at the BH TAC meeting about how to get a much

more comprehensive and more accurate picture of what's really happening in the schools, the stuff that's being billed by the schools and then the services that are being billed by outside providers. So that's an ongoing discussion that we will have at the BH TAC meeting.

The other thing I would point out is that Senate Bill 2 that just passed in this 2024 session builds on the earlier Senate Bill 1 and Senate Bill 8 in 2019 and 2020 that are the School Safety and Resiliency Acts that were first started after the Marshall County High School shootings where two students were killed in 2018.

And it fine-tunes that and makes the Kentucky Department of Education responsible, among other things, for reporting annually what the Medicaid billings for behavioral health have been. So this close-working relationship between KDE and our DMS certainly makes sense.

The other thing that's in there is the goal of having school employees who are either school counselors, school social

workers, or school psychologists in a ratio of 1 to 250 students. And when they started this back in 2019, it was, I think, 1 to 430 students. And we've gotten better. We're up to about -- or down, I guess, 1 to about 313 students.

So that's an ongoing kind of push that, I think, Erica, is also consistent with what you all are going to be doing in the grant. Because you'll be working with those school employees as well, won't you?

MS. JONES: Yes, we will.

CHAIR SCHUSTER: Yeah. Great. So very exciting that you're getting some money to do this work, and it's work that we need to be doing but nice to have some funding and some direction.

Any last questions, please?

DR. PARTIN: I have a question.

CHAIR SCHUSTER: Yeah. Who is that?

DR. PARTIN: This is Beth, Beth Partin.

CHAIR SCHUSTER: Oh, Beth. Hi. I don't have my --

DR. PARTIN: For the kids that are getting school-based services, would there be a way for feedback to get back to the primary care providers on the services that the kids provide? Because right now, at least I don't receive any feedback when the kids are seen.

MS. JONES: That's something we're wanting to work on, for that continuity-of-care part. So now it may vary by the different providers, but that is a piece of what the grant will be working on.

DR. PARTIN: Okay. Thank you.

CHAIR SCHUSTER: That's an excellent point, Beth. I attend a regular meeting of pediatricians and mental health people in Louisville that UofL sponsors, and there's that constant question from the medical providers.

You know, kids get admitted to the hospital, to the psych hospital, and receive treatment. And the provider -- you know, the PCP, the pediatrician, the family practitioner never gets notified. And I'm sure it's true at the level of the school services as well.

So excellent point. Thank you for bringing that up.

DR. PARTIN: Yeah. You know, along that same line with behavioral health, we never receive any reports or consultations or feedback from behavioral health providers regarding diagnoses or treatment of patients, any patients, kids or adults. So it would be great to get some kind of feedback.

In the past, I was told that that information was confidential, and so it wasn't shared. But I think it's important for primary care providers to know what the diagnosis is and what medications or treatment people are receiving in the behavioral health arena.

CHAIR SCHUSTER: Well, we're not going to have integrated care until that starts happening on a regular basis; right?

DR. PARTIN: Right.

CHAIR SCHUSTER: The whole idea of integrated care is that there's no wrong door for people, whether they have a behavioral health need or a physical health need, if you will, which is sometimes not a very clear

dichotomy or difference but --

COMMISSIONER LEE: I was just wondering if any of that information is available maybe in KHIE, in the Kentucky Health Information Exchange, or in, you know, our KyHealth Net. I mean, I -- it would be, I guess, to go out and look it up, but I don't know if it's available there to our providers.

DR. PARTIN: I don't know.

CHAIR SCHUSTER: You know, it's -- there's such longstanding stigma around mental health and addiction treatment. And the addiction information is even more strongly protected federally in terms of release.

Nina, what do you all do in terms of being in touch with or communicating with the PCP? She may not still be on.

MS. EISNER: It's certainly -- no. I can hear you. It's certainly desirable, but it does require the patient consent for communication.

CHAIR SCHUSTER: Yeah.

MS. EISNER: And sometimes there

might be a reluctance. I think it's easier probably with the pediatric patients and with the psychiatric patients than it is with the addiction patients.

As you've said, the federal law that protects communication about addictions, treatment services is pretty strong and supersedes state law. So we have to have that consent from patients to communicate.

I agree with you all wholeheartedly. You can't really have a really integrated care system until such time as you have that communication back to PCPs.

I know in an ideal world, I would hope that with patient consent, the physician would call another practitioner or, you know, APRN or therapist or whatever, so there's that direct communication, not just a release of paper information. But I know it's a dilemma. Patients don't always want to give that consent.

CHAIR SCHUSTER: Well, I certainly agree with you. I wonder how much it just is not thought about. You know, most of my practice, when I was in practice, was

evaluations. A lot of the referrals I got were from pediatricians or family care providers. And, of course, I said to the parent, you know, I'm going to have you sign a release because I want to get the information back to Dr. So-and-so, Dr. Partin, you know, so-and-so.

On the evaluation side, it's a little bit more straightforward. I think it's tougher on the therapy side to do it on a regular basis or to know, you know, what information needs to be...

But what you're asking, in part, Beth, is a very straightforward -- you know, what's an initial diagnosis, and are they getting medication that I should know about? And is there a treatment plan kind of thing?

DR. PARTIN: Right.

MS. EISNER: Well, and another thing that, you know, I know we have always said at the front door is if there's a professional refer, they need to understand that the hospital is going to try to secure communication or permission to communicate back.

And a very simple message is if you don't hear from us, that indicates that there might be a problem. And then that primary care provider or professional refer can reach out to the patient directly and say, you know, would you allow me to communicate with your care providers?

CHAIR SCHUSTER: Yeah.

DR. PARTIN: That's -- that would be ideal, but the thing is that we don't even know. So, one, you don't know to ask the question because you don't know that that type of care took place.

And then secondly, we get -- automatically, we get reports from hospitals and from specialists when we send patients for consultations or when our patients are admitted. The hospitals are really good about sending a notice. You know, this patient was admitted and then sending us information that they were discharged. And then once we get that notification, then we can send a request for the discharge summary from the hospital.

But we don't get any kind of

notification about behavioral health. So we don't know to ask the question in the first place.

CHAIR SCHUSTER: So if you're not the referring agent, is what you're saying, Beth, you have no way of knowing unless the patient tells you.

DR. PARTIN: Right. Or even if we are, we don't get any information. We don't get a consult letter. You know, if I refer somebody to pulmonology or oncology or cardiology, I get a consult letter back. But if I refer somebody to behavioral health, I never get anything.

MS. EISNER: That might be something, Sheila, that would be important to take back in terms of: What are strategies to enhance communication with other care providers within the regulations and the laws? But, Beth, I think you're absolutely right. I think there is not always great communication back to the team of providers.

And sometimes, you know, hospitals, for example, may not know who all the patients -- who all the patient is involved with because

they're not always very accurate historians.

DR. PARTIN: Right.

MS. EISNER: But, Sheila, I think that would be very good to take back to the BH TAC for further discussion.

CHAIR SCHUSTER: Yeah. I think we will add that to our already long list of issues.

MS. EISNER: Yeah.

CHAIR SCHUSTER: I may have to go to the second page of my BH TAC agenda. But it is -- I think it is critical, and we've talked so much about --

MS. EISNER: Yeah.

CHAIR SCHUSTER: -- integrative care. And if there's no communication, there is no integration, basically.

MS. EISNER: Yeah. I think Beth brought up a really good point.

CHAIR SCHUSTER: Yeah. So thank you, Erica, for stimulating this very good discussion.

And the schools are a piece of that. If you're dealing with kids, you've got to be communicating with schools. That's where

they spend a lot of hours of their awake time, or hopefully awake time. And, you know, the other piece obviously are -- the parents are so critical if you're dealing with kids.

So thank you very much, Erica. We look forward to hearing periodically how the grant is going, if you would.

MS. JONES: Yes. Thank you.

CHAIR SCHUSTER: Thank you.

We have good news. The reentry waiver was approved by CMS. This is huge, folks, and we're going to have a summary of that. And, Lisa, I'm not sure who's doing that.

COMMISSIONER LEE: The Deputy Commissioner, Leslie Hoffmann, will be. She's been leading this project up for several years.

CHAIR SCHUSTER: Okay.

COMMISSIONER LEE: So we're going to turn it over to her.

MS. HOFFMANN: This is Leslie, and I would like just to ask -- I cleared it with Veronica -- if I could do E and G and then Veronica is going to take over F. I've got

to get to another meeting.

CHAIR SCHUSTER: Yes.

MS. HOFFMANN: Actually, I've asked Angela Sparrow to give you a short little presentation, if that's okay. She is on her -- a behavioral health supervisor and has been fabulous on this project. So, Angela, take over.

CHAIR SCHUSTER: Thank you very much. Yes, Angela.

MS. SPARROW: Yes.

CHAIR SCHUSTER: The guru of the Reentry TAC.

MS. SPARROW: Good morning. Good morning. I am going to go ahead and share just a couple of slides, again, that we had presented last week at the Medicaid stakeholder forum. Let me go ahead and pull those up.

Okay. All right. So, again, yes, great news. Kentucky did receive our approval for our Section 1115 Reentry Demonstration. Again, it will fall under our broader Team Kentucky 1115 Demonstration, so lots of great things happening across the state in terms of

our flexibilities under our 1115 programs.

So we did receive approval from CMS along with some of the other states, again, in that first cohort of states where they are piloting, again, and had a proposed implementation of a fast-track approval for some of the demonstrations that historically, again, may take months and even years, if we're all familiar with the original incarceration amendment submitted to CMS a few years ago.

So, again, with the approval, we are moving forward. Just wanted to provide hopefully an overview if you're not as familiar with -- with the demonstration and the opportunity.

But it does allow Medicaid, again, the authority to be able to reimburse for a selected services benefit package, if you will, for individuals that are designated in public institutions, justice-involved individuals that are designated in public institutions that would otherwise be eligible for Medicaid benefits.

So, again, prior to the approval,

Medicaid was not able to reimburse for services while an individual is incarcerated. And I think, again, we're probably all familiar with many of those barriers and challenges that that creates for, again, all of our systems.

And so under this opportunity, again, we did receive authority. It does allow the states to begin to provide select services to individuals that are covered under the demonstration, in the facilities that are covered under the demonstration prerelease.

And really, again, to begin facilitating those linkages to both, again, medical, behavioral health, addressing our health-related social needs of that individual. Really, again, pulling together our correctional facilities and systems, our healthcare systems, our community-based systems to wrap around and support that individual as they begin their time reentering into the community.

And so under the demonstration, initially, what is approved is for adults and juveniles. So, again, we did receive

approval to begin providing services, the select services that we'll talk about 60 days prerelease. And that, again, is for our adults in our state prisons right now and for our youth that are in our youth development centers, our Department for Juvenile Justice youth development centers. And so, again, those are the youth that are adjudicated, again, that are -- I believe there are nine of those centers across the state.

With that being said, again, we are encouraged and, under the demonstration, all individ- -- all the youth entering those facilities, again, or adults entering the state prisons would be screened and would, again, apply for Medicaid, if eligible, at the time that they are incarcerated.

We will continue to move forward with suspending eligibility, not terminating eligibility, during that time period. And then again, at the time, 60 days' prerelease, when they're eligible for the selected benefit package, their eligibility would be reinstated. Or, again, they would go through that redetermination process.

And so the goal is that really those -- the coverage is reinstated prerelease and that, again, we're starting to identify those needs or, again, working with our correctional facilities who are already providing services to those individuals and identifying those needs, to be able to come together to, again, really wrap around that individual in terms of what those needs are and supports as they transition back into our communities.

So the benefit package does currently include case management services. It really is intended to be an enhanced case management. All of the adult individuals in the state prisons and then, again, our juveniles in the youth development centers are eligible for that case management service.

And so, again, it's a little bit different than what we think of targeted case management, which, again, is more targeted towards individuals with chronic health conditions and, again, behavioral health needs. So this, again, would be for anyone

that is covered under the demonstration.

But through that case management service, again, the -- we would begin to do a complete, a comprehensive assessment and screening of needs, identify what those medical, behavioral health, and health-related social needs such as housing, employment, food, transportation, et cetera, for that individual is and then developing what that plan is going to be to help them transition back into the community.

Ensure, again, that there's those linkages to primary care providers, to -- if there is behavioral health needs. If there are, again, chronic conditions, et cetera, that we are making, again, those referrals, those linkages, scheduling those appointments, working with our correctional partners to do that as well.

And then again, really working with our community providers to ensure that those needs can be met at transition and that there really is that plan for that individual to support them, again, as they initially transition back into the community but really

looking at what is that long-term support for them as well.

So individuals would be eligible for that case management service up to 12 months post-release, if needed. And then again, under the demonstration, medication-assisted treatment is defined as the medication plus the accompanied therapies. And so Medicaid would be able to reimburse for that.

We know, again, that there are some programs already occurring within our correctional facilities. And so this, again, is an opportunity to be able to expand that to additional correctional facilities, different -- excuse me, additional forms of medication and be able to work with our correctional partners to build that service as well and support that.

So, again, individuals with a substance use diagnosis that would meet criteria for that service would be eligible for -- Medicaid would be eligible to reimburse that 60 days' prerelease and then, again, be able to carry that forward into the community at the time that they are released.

And then our correctional facilities in terms of our state prisons and our youth development centers are already doing this. But, again, it's an opportunity that Medicaid can support but ensure that there are no disruptions for that individual when they're leaving the correctional facility, going to the community again, trying to get their medications.

But, again, part of the service package is reimbursement and covering and ensuring that there is a 30-day supply of all medications, over-the-counter or prescription, including durable medical equipment, at the time that that individual is released.

So that is -- again, we know that there are often barriers for obtaining some of those medications in terms of also, again, having the appointments to follow up and being able to continue those into the community. And so that is also, again, a part of the service package that would be included.

And so the correctional facilities will

be considered the provider at this time. So, again, they would actually work and would be providing the services, would be reimbursed for the services. The correctional facilities, again, can still contract with our community providers to be able to provide those services if they choose to do that.

But, again, the focus and emphasis really under the demonstration is bringing together our correctional facilities, our healthcare systems, and our community providers, really, again, looking at which --

The conversation before this, again, Beth, I think, brought up some great points. That's really what -- the demonstration and the infrastructure that we want to build and CMS wants to see our states build across our systems, is that health data exchange and information exchange. So ensuring that we really -- that our healthcare providers, our community-based providers have access to that, to those records that are accessible; right?

And so what is the system that we are going to use to support that? Is that KHIE?

Again, really getting that buy-in. Are there other systems in place?

But that is really going to be key in supporting this demonstration and then being able to grow the demonstration in terms of additional services and settings that are going to be covered as well. So that really is what we want to look at, again.

But by doing that, we'll also look at what is that -- by building that infrastructure and that health data exchange system and that data integration, it then does not just become about reentry; right? So it also becomes on the entry side. Ensuring, again, that our healthcare systems are sharing data with our correctional systems, again, so that it does not just become about reentry.

But when that individual does actually enter into the correctional facility, our correctional facilities are also able to access the healthcare information that they need to be able to provide services upon reentry. So really, again, that's a key component to the implementation.

And so, again, there are several milestones and goals, again, that the State has developed and required to meet under the demonstration. We are required to submit an implementation plan to CMS by the end of October.

So even with the approval, again, just to be transparent, that does not mean that we are able to begin providing these services today or that the individuals have access to the services today. We do have to submit our implementation plan to say how we are going to meet and -- demonstrate the services and meet the requirements.

And so to do that, again, we have kicked off kind of our project oversight and governance structure. There, again, is an advisory committee who will really see kind of that high-level oversight and strategic direction of the project.

And that, again, is made up of state partners, community partners, individuals with lived experience. We really do want a very broad array of folks to be a part of that committee.

It did kick off a couple of months ago. And, again, we're looking to reschedule and get kind of a re-jump start, if you will, since, again, with the fast-tracked approach and submission of CMS, we really had to meet those asks.

And with that being said, our implementation timeline to submit our plan back to CMS was shortened just a bit. So we are looking at how we again are going to move forward. So we will be pulling that committee back together.

But we also have a core project team made up of, again, our state partners and agencies. So they really will be kind of the boots on the ground, if you will, in that direct oversight of the workgroups and work streams that will be completing some of the implementation details and planning.

And so, again, hopefully -- I know many of you are involved in that. Hopefully, you're aware of that but really, again, how we will move forward in terms of implementation planning and then what that timeline looks for at -- before the actual

implementation.

So, again, it is slated to be possibly summer of next year in terms of implementation approval, system changes, meeting all the requirements, readiness assessments, et cetera, before the go live so do want to be transparent about that.

Again, continue to say this really is the building block. We already are leveraging the work that's already being done across the state. It is not just Medicaid by any means. So, again, it's a true partnership across our cabinets and our systems and, again, our communities as well to be able to implement this. And if we -- we'll continue to build upon it, but really ensuring that we have that infrastructure to build and grow upon is going to be key.

So, again, just -- we are working to get some FAQs and some information up to the website and get it updated post the approval. So, hopefully, that can be up for you very soon, and we'll certainly share that when it gets posted.

But, again, just kind of the reminder.

It is not the full state plan benefit package prerelease but, really, there is a selected benefit services at this time. Really wanting to be able to support across all systems, really that integration and support for that individual as they transition back into the community. And then again, at that time, they would have access to their full Medicaid benefits that they're eligible for at that time.

So I'll pause and see if there's any questions. I know that's a lot of information to throw at you, but it's great information so...

DR. BOBROWSKI: This is Garth Bobrowski. I've got a couple of questions, Angela, and I don't know if I should direct this to you or Steve or both of you.

But living out here in the country, a lot of times, we get -- on our local radios, they'll -- they did it again this morning. They had a -- they report publicly the list of, I guess, public offenders, who's going to jail and -- but so many times, we hear part of the report is repeated drug use, or they

found it on them. Or they were selling it.

But anyway, part of that is -- is there a way to see or evaluate the effectiveness, you know, long term or follow up on patient improvements? And who evaluates the SUD or the improvements that are being made? And then how -- how does it or does it even tie in with a patient's contract?

A lot of these pain clinics have contracts with the patient that they're not supposed to seek or obtain any other drugs without the pain clinics' notice. Because I noticed you had a -- I can't remember if it was 30- or 60-day where -- that the Medicaid program would help supply, you know, some medication in helping people get reentry.

So these are just stuff I'm not familiar with but just wanting to learn.

MS. SPARROW: Yeah. Thank you, Garth. Good questions.

And so, again, there -- as we're implementing the project in providing the services, again, really part of those requirements in our practices -- right? -- is to ensure that we're providing

those services based on evidence-based practice.

So we really want to ensure that we're also providing the services that are individualized to each member; really, again, identifying what that individual member's needs are and ensuring that we have that individualized plan. And so we do want to ensure that we're not, again, providing services that are more of the scripted, if you will, certain amount of time and days.

But, again, that's really where we want to work towards building that health data integration; right? So that we know if there's services that they were already receiving, that we're coordinating what those medications are. What was the services that they're getting already? And ensure that we're really coordinating that at the time that they're released.

Especially in, we know, our local jails, the time frame could be very short that an individual would be incarcerated and then returning back into the community. And so we really do want to look at: How do we ensure

that we're not duplicating and restarting the wheel as they are entering the facility and then back into the community?

And so those -- you know, those things are all part of the implementation planning process. And in terms of the medication assisted treatment, yes, there -- when the correctional facilities -- and, again, they have programs. Many of them already have programs in place which, again, I think Kentucky is ahead of --

CHAIR SCHUSTER: Did we lose you, Angela?

COMMISSIONER LEE: It looks like she might be frozen.

MS. SPARROW: Sorry. Can you hear me now?

CHAIR SCHUSTER: Yes.

COMMISSIONER LEE: Yes.

MS. SPARROW: So, again, we -- within those programs, we want to ensure, again, Garth, that they're provided by the appropriate practitioners, again, to be able to screen those individuals for the appropriate criteria and that they're

provided the way --

COMMISSIONER LEE: We've lost her again. I don't know if maybe we can --

CHAIR SCHUSTER: Yeah.

COMMISSIONER LEE: So Leslie is available, Dr. Bobrowski. If you have a question, you can ask Leslie.

MS. HOFFMANN: This is Leslie. You can reach out to us. If you want to send an email, Dr. Bobrowski, that would be fine. Or if there was something that -- I think she was just saying that we're very much making sure that each individual's needs are being assessed and addressed and then that the correct practitioner for those needs are being met. So I think that's what she was getting at before she dropped off.

DR. BOBROWSKI: Right.

MS. HOFFMANN: It's not just one population anymore. We're looking at multiple populations with the reentry.

DR. BOBROWSKI: Yeah. Thank you.

CHAIR SCHUSTER: Well, and it's starting, Garth, in the prisons. So you're getting -- your local people are talking

about local jails probably. And so --

DR. BOBROWSKI: That's right, yeah.

CHAIR SCHUSTER: Yeah. The program is not going to be in the local jails yet. It's going to start in the prisons and with DJJ, which are the juveniles.

DR. BOBROWSKI: Okay.

CHAIR SCHUSTER: And we're hoping -- because we know that there a lot of even state prisoners that are in the jails so...

But excellent questions. And Steve Shannon is on. We'll hear from him in a little bit. He chairs the Persons Returning to Society from Incarceration TAC, which is actually the Reentry TAC, and they meet the second Thursday every other month. It's the months that the MAC meets, and they meet at 9:00. And those are open meetings if anybody is interested. That's a great way to kind of follow along.

I thought it was important for the MAC to know that this is going on because Kentucky has such a very high incarceration rate. We unfortunately have one of the

highest state rates across the country. And as a child psychologist, I have to point out that we have more kids in Kentucky who have had a parent or both parents who have been incarcerated. And it has devastating, devastating effects on kids. It's one of the ACEs, the Adverse Childhood Experiences, that we look at for kids.

So I just think that this is -- this is really where our attention needs to be right now, is to try to help those people that are incarcerated who have a behavioral health issue. So it's not just the substance use or addiction disorders, but it's also the mental health care.

And we do know that people get into trouble because they have those disorders, not that having a disorder makes you a criminal. But they are drug-seeking, or they're, you know, exercising poor judgment or whatever the reasons are. And so they get themselves into trouble so --

DR. BOBROWSKI: Well, that was -- Sheila, that was kind of why -- and I just happened to run across and stumble across

that article in that one magazine about, you know, basically, behavioral health and how to help, you know, through possible school-based systems and the younger children.

CHAIR SCHUSTER: Right. Well, and there certainly is a school-to-prison pipeline that has been talked about and researched and so forth. So we really do have to do those school-based services and start -- the younger we can start, the better off we are.

And it really takes -- you know, the proverbial it takes the village to raise the child. It really does take a village, you know, the parents and the support systems there but the schools and the health providers. So, again, that communication is so important.

But this is great work, and we're just so excited. Leslie gets the longevity award for hanging in there with this. What is this? Five years or so, Leslie?

MS. HOFFMANN: It's been a long time, yeah.

CHAIR SCHUSTER: We've been on this

journey. So to get it approved and one of the earlier states to get it approved, I think, is just fantastic. So we will have regular updates from you.

Are there any other -- great questions, Garth. Thank you. Any other questions from any of the TAC members or comments?

(No response.)

CHAIR SCHUSTER: All right. Thank you.

And, Leslie, you're going to go on and talk about the HCBS. Those are the home and community-based waiver waiting lists and the report that's due.

MS. HOFFMANN: Yeah. I was going to mention just the information I have right now about the report that's due to the general assembly, I believe, by 10/1.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: So just to give you an update, we have been meeting regularly. We're diligently working on the house bill report, request for the report. We've started initiating, or we have already initiated a drafting process and working on

different pieces and parts of the request.

We've started gathering data that is necessary to complete the report. And we're trying to strategize on how best to address that acuity-related information they're wanting in House Bill 6.

Today's waiting list management, if you're -- of course, most of you are probably aware it does not collect all of the exact acuity data that we need to meet that request. So we're currently figuring out how we can leverage other resources that we currently have for Medicaid data on wait lists and who is Medicaid enrolled and any acuity factors that we might have and researching other possibilities that we might can gather some quick information from the community that might assist us in making those determinations.

And I would just mention, too -- and I feel like you all would probably agree with me. When folks send in their original information, sometimes they need assistance. Like, they don't know what they exactly need. And even if you tell them, for example, in

brain injury, that you need a document that says you've got a documented brain injury, they still have difficulty sometimes.

And that's where kind of the case manager comes in, or whoever the provider is that's been identified, can help with those things. So it's not always necessarily on those waiting lists.

So as of today, that's currently where we are, that we're trying to figure out how we can address meeting that need, whether that be a survey, a request, you know, those kinds of things, and/or leveraging other Medicaid data that we already have.

We have a whole team working on this, and I've asked Jonathan Scott to also help our team with assisting with this task to ensure that we meet all necessary guidelines and requests.

Our internal target date is to have this completed by the end -- the end of the third week, which -- so we would have it, like, we're hoping, maybe Monday of that last week of August. And we feel like DMS is on track to have the report delivered to the Interim

Joint Committees and Appropriation and Revenue and Health Services by October 1st as outlined in House Bill 6.

So they might have questions, but we feel like that we're on target to meet that request, Dr. Schuster.

CHAIR SCHUSTER: That's great. And just for background, you all may remember that the legislature funded more slots or placements in these home and community-based waivers than we've ever had in one fell swoop. So over the two years, they have funded 1,925 new slots, which are new placements, which is fantastic.

But they also put into House Bill 6, which was the budget bill, that the report was due from the cabinet about how that would be managed. You can't just dump 1,925 people into the system when you don't have the providers, and you have to be sure that people qualify and have the acuity and have -- are lined up with the right waiver to meet their needs. So that's why this is so important.

Thank you, Leslie. Do you have some

waiver waiting list numbers?

MS. BICKERS: Leslie, you're muted.

MS. HOFFMANN: And my eyes are bad, too, so I'm so sorry. I couldn't, like, hit the mute button there.

Sheila, this is the last numbers I have, and I can update those again for you all later. We've got plenty of reporting going on this month. Our HCB waiting list was 1,932 with my last numbers. Michelle P is 9,244. SCL is 3,550. Last I checked, we had approximately 186 urgent category, and we had 3,364 in future planning. And then nobody was in emergency at that time.

I'm trying to think if there's anything else you might want to know. You know that a large amount of those folks that are on the waiting list do have current access to state plan services. You already know that.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: And we do have a large percentage of the slots that we allocate of folks not -- either not taking that slot, unfortunately have passed away, are in another waiver, and/or maybe have

moved out of state.

So we have this constant rotation, so I get asked a lot -- and I'm just going to share this. I get asked a lot why we never, like, are at full capacity of what the waiver allows, and it's because we have that constant rotation. And it takes -- we've been close before.

I checked -- Kathy Litters and I were discussing this. We've come close before to being at full capacity. But when you send out 100 slots, maybe 40 won't -- decide not to take the slot. Or it's not appropriate for their level -- you know, not an appropriate level of care or, for whatever reason, they don't take those. And so the next month, then we reallocate the next round plus the ones that are left over from the month before. So it's so very, very fluid.

CHAIR SCHUSTER: What was the date of those numbers, Leslie?

MS. HOFFMANN: I think it was the end of last week.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: I think I did it at

the end of last week.

CHAIR SCHUSTER: And were there any waiting for ABI? I know there typically are not.

MS. HOFFMANN: We do not have any on ABI at this time.

CHAIR SCHUSTER: All right. So just to put this in perspective, folks. So we're so excited to get 1,925 slots funded starting July 1st. But if you add up quickly those numbers, that's over 14,000 people that are on waiting lists for waivers, so it gives you some perspective.

I was interviewed recently. And I said, you know, it's wonderful that we got 1,925 new placements, but we probably had that many or more joining the waiting lists. So we never -- in fact, we seem to be falling further behind in terms of the waiting list numbers growing. But we've got those slots, and you're going to be able to start putting people in as you get them qualified and so forth so --

MS. HOFFMANN: Absolutely.

CHAIR SCHUSTER: Thank you very

much. And just to remind people, the HCB waivers cover our elderly population. They cover kids. They cover people with developmental and intellectual disabilities and physical disabilities primarily.

Of course, the ABI waiver is the acquired brain injury waiver, so that's specific to the -- to that population. And then there is a tiny little waiver for people that are mentally or -- dependent.

So we haven't yet begun to roll out, say, the reentry waiver which will not have slots but will be funded as needed.

And then the other one that we're waiting on final approval is our waiver -- actually, it's not a waiver. It's a State Plan Amendment for people with severe mental illness, and that's the one that Steve and I have been working on for 20 years. So that may take the prize for the longest work time.

And we're hoping maybe September; right?

MS. HOFFMANN: Yes. And so I did want to -- I just wanted to mention on the call today that DBH is going to be administering that 19 -- it's actually

called, Sheila -- the title in the budget is HCBS, SMI, and SUD because we had the housing, homelessness, and the social determinants of health component that we embedded into that.

So there's lots of eligibility criteria related to that, but I wanted just to share that that -- if you see that, folks ask me is that the same one, and that is the 1915(i).

So DBH is going to take over administering that program before we have completed a finalizing, approval, and implementation for that. So I just wanted to let you know all you'll be hearing from -- Ann Hollen is going to be the lead in the Department of Behavioral Health to oversee that so -- and I don't know if Ann is on. If you'd like to say anything, Ann.

MS. HOLLEN: I am. Give me a second. I'm trying to get my video on. I apologize.

CHAIR SCHUSTER: That's all right. Ann. We've known Ann over at DMS for a long time, so now you have a whole number of new initials after your name, Ann. We're

delighted -- Ann has a behavioral health background, which is very helpful as a social worker. And so you're going to be -- you're at DBH now.

MS. HOLLEN: I am, and I am the point of contact for the 1915(i) state plan services. I just wanted to say that these HCBS state plan services will represent advancement in our system of care, and we're committed to ensuring that it effectively reaches the individuals we are all committed to serving.

My email address is exactly the same as it's been for the last 16 years.

CHAIR SCHUSTER: Good.

MS. HOLLEN: So it did not change. I did ask to keep that so...

CHAIR SCHUSTER: Great.

MS. HOLLEN: So ann.hollen@ky.gov.

CHAIR SCHUSTER: Yeah. Thank you. And I think from time to time, then, we'll have you --

MS. HOLLEN: Sure.

CHAIR SCHUSTER: -- come and talk to us at the MAC. You're used to having your

DMS hat on and been doing that. So thank you very much for being on, Ann.

MS. HOLLEN: Thank you.

CHAIR SCHUSTER: We are super excited.

MS. HOLLEN: So am I.

CHAIR SCHUSTER: I think the MAC members who have been around for a while know how often I've talked about the need for what we call supported housing for people with severe mental illness. So that typically is supervised residential placement to help people not only have a roof over their head but, more importantly, have the supports that they need to stay on their medications and get to their treatment and really get engaged with the recovery program.

So that's our hope. That's the hope of every family who has a loved one with a severe mental illness. So thank you very much, Ann.

MS. HOLLEN: Thank you.

CHAIR SCHUSTER: And I'll go back up to Veronica Judy-Cecil to talk about unwinding, unwinding that Medicaid and those

flexibilities.

MS. JUDY-CECIL: Hello again.

CHAIR SCHUSTER: Hello again.

MS. JUDY-CECIL: I do have a couple of slides just because I know it's sometimes easier to understand the information that way, so I -- hopefully can see those.

CHAIR SCHUSTER: Yeah.

MS. JUDY-CECIL: So just a reminder to folks that what we're talking about here is the Public Health Emergency that ended and required the state Medicaid agencies to restart annual renewals after March 31st, 2023. So we have been in what we call unwinding which required us to start those renewals. And our renewals, we started with the month of May in 2023.

And so here we are finally through those first -- what we call the first post-PHE renewal, so folks who have gone through a renewal for the first time since the end of the Public Health Emergency.

I wanted to note a couple of things. First of all, May of 2024 was sort of our final month, although we had a couple of

individuals, about eight individuals that trickled into June renewal just as we're wrapping up and identifying that first PHE renewal population. We did have a couple move into June. But, really, May of 2024 was sort of our final big push of renewals.

We are talking primarily adults because, just to remind folks, that we did a flexibility around children to automatically renew them 12 months. So they did not have to go through that renewal. We just granted that extension to them. We did that starting in September last year. So it is primarily adults we are talking about.

Another thing to remind folks is there -- so now, as of May of 2024, there are people who came in to Medicaid for the first time last year going through their renewal. So just to really confuse things, we've got folks going through a first renewal that are new to Medicaid last year and then folks going through a second renewal that had May last year as their renewal month and were considered part of the PHE. So we have PHE renewals and non-PHE renewals that we're

tracking.

Also wanted to note, we implemented a lot of flexibilities -- I've talked about them a lot here -- as well as our monthly stakeholder meeting about, you know, things such as being able to extend members for a month if they didn't respond to a notice that allowed us to conduct additional outreach.

Those flexibilities get to continue through June of 2025. We're thrilled by that and mostly because some of those flexibilities have worked very well in helping us maintain coverage for folks going through renewal. And we are wanting to consider implementing some permanently.

There are some that are being permanently implemented through the CMS final rules, and so we look forward to incorporating those on a permanent basis going forward. But it does definitely give us additional time to help folks as they are coming out of unwinding.

The flexibilities that relate specifically to the home and community-based 1915C waivers that we've been talking a lot

about, those flexibilities, some of them -- not all, but some were incorporated into amended waivers. And those became effective May 1st.

We've done a lot of communication with both the members and their families, providers. We've got information out on our website, lots of webinars, frequently asked questions. We've been transitioning those folks really on an individual level because everybody is affected differently.

So that transition is happening and just hope, folks, if you have questions about that, try to go out and look at that information. But we do have out there and available the email address and phone number for specific case questions. Happy to help folks on that.

We are, as I said, unwinding. And so at some point, this no longer becomes unwinding because we're going to be finishing up those first PHE renewals. But they are in the -- we have our April, May, and then those eight in June are part -- are still within that 90-day reconsideration period.

Just to remind folks, that means if that individual comes back in and provides the information after they were terminated within that 90 days following termination, we can reinstate them automatically. And they don't have to ask for that. It just happens automatically, so we are in that reconsideration period for those months. So we're continuing to track them, and I'll show you that in just a moment.

And CMS, Centers for Medicare and Medicaid Services, had asked states to continue reporting. Even though we're coming out of unwinding and those PHE renewals, they've asked states just to continue reporting regular renewals. So we'll still be providing those reports on our website, our unwinding website.

We're looking to kind of shift to a new website to start providing information as we come out of unwinding, and we'll keep folks updated about that. For example, our stakeholder meeting last week had other agenda items on it other than unwinding as we come out of that period.

So I'm going to show a really confusing -- for those who haven't seen this before, I'm just going to give a high-level overview of what you're seeing. This is out on our website. This presentation will be sent around to the MAC members as well as posted on the MAC website. But these are -- all this information is out on our unwinding website.

And what you're seeing here on the left-hand side is that original CMS monthly report that we had to do from the very beginning of unwinding. It's to report the renewals that were processed in that month. That was due to CMS on the 8th of the following month. All of those original reports are out there.

And then CMS came and asked the states to report on a 90-day period following the renewal month for any activities that happen with pending cases. A pending case is one in which we crossed over that end date, that renewal date. And there was state action that was still required to determine somebody eligible.

So if that happened, we put them in a pending status. We granted them continued eligibility until we could act on the renewal and then took the action. Whether they were put in the approval bucket or the termination bucket, CMS wanted states to report that.

So what you're seeing in that middle column that says 90-day processing period, it's just going back and reporting what happened with those pending cases within that 90-day period. And then on the right-hand side is where those individuals ended up as an updated monthly report to show CMS.

So, for example, I'm just going to walk through February. February, we had 93,004 individuals that went through renewal. We had 64,789 originally approved. We had 10,128 that were terminated, and the majority of those are for not responding. It's called a procedural termination. We sent them a notice, and they did not respond back.

Then we had only one case pending at the time, so we processed that one case within that 90-day period. And so our updated monthly report showed that that individual

was actually approved and put into the approval bucket. So that's what you're going to see when you go out and check our website.

Looking at the most current past three months of renewals -- and, again, I mentioned that we're looking at them and separate them out because we're tracking that 90-day reinstatement period a little differently for them.

The most recent is June. We had 58,959 individuals. Keep in mind that now we're reporting both PHE and non-PHE renewals. So we're talking about in this number, really, there's only eight renewals that are tied to the PHE. Of those, 41,336 were approved. 13,187 were terminated, and we had one case pending on June 30th.

The extended bucket, I didn't talk about that. But the extended bucket is that flexibility of the one month or up to three months for long-term care or 1915C waiver members. So if they did not respond by their due date, we could extend them for an additional either one month or up to three months. That's what that extended column is.

And then you see on the far right, we're tracking the reinstatements for each month. So already for June, we've had 213 people come back in. They realized they were terminated. They came back in, provided the information, and we determined them eligible. So all this information is as of July 15th.

So I tried to keep this short in the interest of time but happy to take any questions that folks might have.

CHAIR SCHUSTER: That's very helpful, Veronica, as always. So on that very last slide, for the people that got reinstated, what bucket did they come from, or did they come from a number of those different categories?

MS. JUDY-CECIL: That's just for the June renewals. So the 213 --

CHAIR SCHUSTER: Okay.

MS. JUDY-CECIL: -- is just people who were terminated at the end of June.

CHAIR SCHUSTER: Terminated. Okay.

MS. JUDY-CECIL: Yeah.

CHAIR SCHUSTER: Okay.

MS. JUDY-CECIL: And they are

likely all related to not responding to the notice by June 30th.

CHAIR SCHUSTER: Right. Right. Okay.

Any questions from any of the MAC members of Veronica?

You have an overall -- and it seems like I've heard this from you. And if you don't -- basically, within a ballpark, what percentage of our folks are -- who started out through this renewal, unwinding renewal process are still on Medicaid? Or, conversely, how many of them have we lost off --

MS. JUDY-CECIL: I know percentages.

CHAIR SCHUSTER: That's fine. Yeah.

MS. JUDY-CECIL: Yep, yep.

CHAIR SCHUSTER: Percentages, yeah.

MS. JUDY-CECIL: Through unwinding. So even up and including June, those eight folks, we've had 73 percent approved, so they've maintained their eligibility. And then for the population that was terminated,

you know, over 50 percent of those -- it's closer to 60 percent of those are for procedural reasons, for not responding to a notice.

CHAIR SCHUSTER: Okay. And then I think at the BH TAC meeting, you had some stats about how many have gone on to a Qualified Health Plan.

MS. JUDY-CECIL: Yes. And I don't have that with me, Dr. Schuster.

CHAIR SCHUSTER: That's all right.

MS. JUDY-CECIL: Sorry. We do --

CHAIR SCHUSTER: It always makes me feel good that they're covered; right?

MS. JUDY-CECIL: It is, yes.

CHAIR SCHUSTER: It's really --

MS. JUDY-CECIL: Yeah. Go ahead, David.

MR. VERRY: A relatively modest amount, around 6,000. So the unknown -- the great unknown unknown is how many people do not qualify for Medicaid; however, they qualify for employer-sponsored insurance or were on employer-sponsored insurance all along.

CHAIR SCHUSTER: Yes.

MR. VERRY: So about -- you know, we're at about a 10 percent recovery rate of those who didn't renew and all that --

MS. JUDY-CECIL: Yeah.

MR. VERRY: -- which puts us kind of on par with the national average. We don't stick out as the greatest, but we're definitely not the worst.

You know, the Federal Government did a terrible job on their healthcare.gov because they don't integrate at all. So our folks, you know, are doing better, but it's really kind of unknown how many of them could have come to us and didn't.

MS. JUDY-CECIL: We were tracking each month how many had commercial insurance when they terminated, and there was about 40 percent that -- it kind of -- it kind of doddled between 30 and 40 percent of individuals being terminated that showed have commercial insurance, you know.

So we don't know a lot more information about that but -- and we only tracked comprehensive commercial. So if they just

had a dental plan, you know, we didn't count that. It's if it was -- it was comprehensive.

CHAIR SCHUSTER: Yeah. Well, you all have really done yeoman's work here over these many months to try to reach out to people. And hopefully providers -- we've talked about this on the MAC, and I know TACs have talked about the importance of providers reminding people if you get some letter or you get some notification, you know, respond to it kind of thing. I know that the connectors and the CHWs and all of us are out there, you know, pitching that so --

MS. JUDY-CECIL: We do -- yeah. We do appreciate all of the stakeholders who came on board and teamed up with us. We call them our partners, all of you all. I think we have strengthened our partnership around this, around supporting the member as they navigate renewal and application.

And we plan to keep -- you know, right now, we're reviewing what's worked, what hasn't. And we plan to keep the things that are really working in place as we come out of

just going into regular renewals.

And, you know, our outreach efforts, the flyers and bulletins and all of the information that's on the unwinding website that providers or anyone -- advocates, families -- can pull down and utilize, you know, we're going to continue those efforts.

CHAIR SCHUSTER: Yeah. That's great.

Put in a plug, Veronica, for your monthly stakeholder meeting because I think if people had thought that it was only about unwinding, you all are doing a whole lot more than that now.

MS. JUDY-CECIL: Absolutely. Thank you for the opportunity.

CHAIR SCHUSTER: Yeah.

MS. JUDY-CECIL: And we are promoting this on our social media, and we do -- I think we've created the landing page for -- as we go forward. But we have -- the third Thursday at 11:00 is when we're holding the stakeholder meetings. And as Dr. Schuster mentioned, it was primarily focused on unwinding, but we've switched and

are adding some other -- what we think are really important Medicaid updates.

The final rules. We'll be providing updates on the final rule implementation as we move forward. And it's really an opportunity -- also, we're asking for feedback on what do you all want to hear in those stakeholder meetings that we can bring on a regular basis.

So thank you for that plug.

CHAIR SCHUSTER: Yeah. Yeah. You had -- I think you talked about the school-based grant at the last one and a number of things we touch on here. So it's, you know, I think, a really good thing. And those are recorded, and you put the recordings, I think, on your website as well, Veronica.

MS. JUDY-CECIL: That's correct. And our PowerPoints.

CHAIR SCHUSTER: Yeah.

MS. JUDY-CECIL: And I think I saw somebody -- maybe Beth put the link to the registration for the stakeholder meetings, so please distribute that widely.

CHAIR SCHUSTER: Yeah. And that's every -- every month on the third Thursday.

MS. JUDY-CECIL: That's correct.

CHAIR SCHUSTER: Yeah. Great.

Any other questions for Veronica?

(No response.)

CHAIR SCHUSTER: All right. Thank you so much. And you'll share your PowerPoint with Erin, please?

MS. JUDY-CECIL: Absolutely.

CHAIR SCHUSTER: Yeah. Thank you.

MS. JUDY-CECIL: Thank you all.

CHAIR SCHUSTER: All right. So we'll turn to the TAC reports. And the first one is -- and this is not just the prerogative of the chair, but I'm alphabetically the first, is behavioral health.

So we met on July 11th. We had a new member, voting member, join us, Misty Agne, from the Brain Injury Alliance of Kentucky. We had a quorum. We had our minutes approved of our May meeting.

We had not yet received a response from Medicaid to our May recommendation to the

MAC, so we've since received that. But we had not received it at the time of the meeting.

We had an absolutely fascinating presentation by Victoria Smith with the Office of Data Analytics, and ODA had undertaken a comparative study of behavioral health rates across a multi-state population. So they compared Kentucky's behavioral health rates for the 30 top services that were billed and compared them with the 8 states that are in the southeast CMS region and then they added Indiana and Ohio as contiguous states.

So there were, you know, just a ton of comparisons. We had comparable rates. Kentucky's rates were comparable in three of the states but below the rates that were being paid in eight other states. So I think there's lots of follow-up that might be happening there.

We had some specific questions -- actually, Ms. Smith was delightful. She sent us the report ahead of time, so we had a chance to study it and ask questions and then

she incorporated our questions in the presentation.

And so we're looking now at moving on to kind of a Phase 2 study that will look at some additional services being added, and she's looking to the BH TAC for those recommendations.

Also, some other provider levels. They tried to do comparable -- in other words, if it was a physician rate in Kentucky, they were comparing it with the physician rate in other states. If it was a master's level, independently-practicing behavioral health provider, they tried to do that. You know, it's really hard to get comparable licensure categories, so we're looking at some improvement maybe on some of that.

They didn't realize -- she said she didn't look at the map and didn't realize that Missouri and Illinois are also contiguous states, so they're going to go back and include them in the comparison. And then there were questions about some specifics around populations, age and diagnosis and so forth.

So this will be an ongoing issue, but you can imagine the interest. I think we had over 100 people on our Zoom call for that Behavioral Health TAC meeting because rates are, of course, incredibly important to providers.

We also had Erica Jones give a verbal report of the school-based mental health services, and I won't go into a lot of detail about that since you heard some of that earlier.

We've had an ongoing issue in the behavioral health community with an increasing number of audits by the MCOs. And Jennifer Dudinskie has presented on several occasions to the TAC and has been just very responsive to our questions.

So most of these are audits around targeted case management, and it's because there was a corrective plan put in place by CMS and we, after the meeting, got some information about how that started and so forth.

But -- so more recently, she provided information to us about what the slope or the

scope looked like of the number of audits that the MCOs were requesting. We asked starting in 2019. They only had data starting in 2021, and it's actually been very consistent.

What we're not sure is captured in that is whether there are multiple audits of the same providers by an MCO. So some of those numbers may reflect an audit, but it really may be multiple audits.

We had updates about the 1915(i). That's the SMI state plan amendment. The reentry waiver, current waiting lists, mobile crisis, which was not funded by the legislature, and so is not going to be expanding in the Medicaid unwinding.

And we had no recommendations for the MAC. For those of you who are interested in the BH TAC, we meet on the third Thursday, and we are changing our meeting time to permanently be from 2:00 to 4:00 in the afternoon.

We used to meet 2:00 to 4:00 when the legislature was in session and then we would meet from 1:00 to 3:00 the rest of the

months. And we have a -- our new TAC member had a conflict, so our meetings will be from 2:00 to 4:00 going forward.

So that's our report and, again, no recommendations. Thank you.

How about the Children's Health TAC? Do we have a report? Do you know if they met, Erin?

MS. BICKERS: They met. I do not see anyone on, and they did not have any recommendations. They've also moved to a quarterly meeting as well.

CHAIR SCHUSTER: Okay.

The Consumer Rights and Client Needs. And Emily Beauregard, their chair, is out of town. They did meet and had a quorum on July 7th, and they have three recommendations.

No. 1, that DMS work with DCBS, Department for Community Based Services, and the Office for Vital Statistics to clarify that Kentucky birth certificates should be acquired internally and not require action on the part of the household or the individual.

Secondly, that DMS update their, quote, bad address, unquote, policy to move

individuals or households that are nonresponsive to requests for information for up to six months or until an updated address is received -- I'm sorry, not request for information, fee-for-service.

And thirdly, that DMS send a letter to providers clarifying their responsibility to offer, coordinate, and provide language access services via a qualified medical interpreter and that providers should communicate the availability of language services to their patients in plain language.

And, Erin, you have a copy of those in writing as well from Emily?

MS. BICKERS: I do. I want to clarify just to make sure, Veronica. Please correct me if I'm wrong. I believe someone from that TAC has to present them to the MAC to be voted on. Veronica, if that's incorrect, please correct me.

MS. JUDY-CECIL: That is what the bylaws call for, Dr. Schuster.

CHAIR SCHUSTER: Oh.

MS. JUDY-CECIL: Is there somebody from the TAC that is on that could do it

on -- they have to be a TAC member.

CHAIR SCHUSTER: Yeah. Unless there's somebody from that TAC that happens to be monitoring the MAC meeting, there probably is not. And when Emily emailed us, which was last night, I didn't realize that was the rule, I guess.

So that being said, we would have to wait for two months for those recommendations to come to the MAC?

MS. JUDY-CECIL: Let us take that back. You've already read -- you've read all three in; right?

CHAIR SCHUSTER: Yes.

MS. JUDY-CECIL: Okay. Let us take that back.

CHAIR SCHUSTER: All right. Thank you.

You know, it might be a good idea for us to pull out those bylaws and kind of relook at those since we're doing a lot of -- I guess I have a -- I'll get with Erin and you, Veronica, to make sure we've got the -- since we're overhauling the MAC and creating the BAC, we probably ought to look at the TAC

stuff, too.

MS. JUDY-CECIL: I agree with that. I think that gives us a good opportunity.

CHAIR SCHUSTER: Yes. It's been quite a while, as I recall. Beth knows because it happened during her tenure with the MAC that those bylaws were created. So yeah. Thank you for that.

The Dental TAC, please.

DR. BOBROWSKI: Yes. This is Dr. Bobrowski. We meet quarterly. We have our next meeting August the 9th, so that's just right around the corner. And we will probably have some motions to come out of that meeting. But as of today, there's no motions to bring forward to the MAC. Thank you. That's my report.

CHAIR SCHUSTER: Okay. Thank you, Garth.

The Disparity and Equity TAC?

MS. BICKERS: I do not see anyone on from there as well. They did meet. They have a new chair. And you were with -- there, so you know they didn't have any recommendations this meeting.

CHAIR SCHUSTER: Yeah. Okay. Thank you. Yeah. They met last week, and we had that robust discussion about communication and so forth.

How about Emergency Medical Services?

MS. BICKERS: Keith is out of town and apologized he cannot be here. They did meet, had a wonderful conversation. No recommendations, per his words.

CHAIR SCHUSTER: Okay. All right.

Home Health?

MS. BICKERS: They meet at the beginning of August. Evan was unable to be here as well as Susan. He emailed me this morning.

CHAIR SCHUSTER: Okay.

Hospital Care?

MR. RANALLO: This is Russ Ranallo. We did not have a meeting. Our next meeting is in August.

CHAIR SCHUSTER: Okay. So it sounds like we need to be prepared at the September meeting for a whole bunch of TAC reports. Thank you, Russ.

MR. RANALLO: You're welcome.

CHAIR SCHUSTER: IDD, Intellectual and Developmental Disabilities?

MS. BICKERS: I am not sure if someone is on for that. We will be voting for a new chair. They also meet at the beginning of August.

CHAIR SCHUSTER: Okay. And that's been Rick Christman, but they're going to have a new chair?

MS. BICKERS: Yes, ma'am. He is retiring.

CHAIR SCHUSTER: Oh.

MS. BICKERS: And so we should vote for a new chair in the next meeting.

CHAIR SCHUSTER: Okay. Thank you.

Nursing Home Care?

MS. BICKERS: They have not had a meeting.

CHAIR SCHUSTER: Okay.

Nursing Services?

MS. BICKERS: I don't see anyone on. They have a meeting coming up in August. They have a draft agenda floating about.

CHAIR SCHUSTER: Okay.

Optometry?

DR. COMPTON: Steve Compton from the Optometric TAC. We have not met since the last MAC meeting, and we've cancelled our meeting for August. So it will be November before we meet again.

CHAIR SCHUSTER: Is that because you didn't have any pressing issues, Steve? Just curious.

DR. COMPTON: Not many. We didn't have a very big agenda so -- but that's a good thing, I suppose.

CHAIR SCHUSTER: I was going to say, that means that things are going smoothly for you all. That's -- we'll take that interpretation; right?

DR. COMPTON: Well, okay. Yeah. We'll look a little harder for problems, then.

CHAIR SCHUSTER: Well, I'm not trying to dig up problems.

DR. COMPTON: Okay.

CHAIR SCHUSTER: I guess my other thing would be to -- you know, if you're in a good place, how can you make things better?

DR. COMPTON: That's a good point.

CHAIR SCHUSTER: Yeah.

DR. COMPTON: We'll put that on the list.

CHAIR SCHUSTER: All right. Thank you.

DR. COMPTON: All right. Thank you.

CHAIR SCHUSTER: And Steve Shannon who has been chairing this TAC for reentry for years now and finally has something to talk about. So, Steve?

MR. SHANNON: All right. So yeah, we met. We got the very similar update from Angela Sparrow. We met on July 11th. We meet every other month two weeks before -- as Sheila said, typically two weeks before the MAC. But we got the same update.

We're all very excited about the progress being made and now to kind of get operational. It was -- previous to this, it was almost a philosophical discussion. What would happen? What could happen? Now we have some direction.

We always appreciate the reports we get from Medicaid at each meeting. We always get

MCO updates. They've started looking at -- you know, the folks that are on call for the MCOs, to how can they partner and interact with folks who are leaving. And they're looking at both jails and correctional facilities. They're talking about DJJ now as well.

So I think we're seeing a lot more information about this reentry issue, and I think we'll see a lot of action moving forward.

It was reported by one member that four additional Recovery Ready Communities are being identified, and that number continues to grow. And they really look at the community, and this Recovery Ready is really focusing and receptive of people in recovery from substance use disorders.

And it's really -- and we discussed this in some detail at our meeting -- a pretty significant change over the last five, seven, ten years where this wasn't even talked about. Now we have communities coming forward and saying, I want to be identified as a community that wants to support people

in recovery through vocation or through housing, through access to services.

So I think that's worth noting for everyone to understand, that it's clearly a sea change over the last decade.

CHAIR SCHUSTER: Yeah.

MR. SHANNON: We had no recommendations, and we meet again on September 12th. Thank you.

CHAIR SCHUSTER: All right. Thank you, Steve.

And I do think that those -- Garth, you brought up the issue about: What could communities do? Well, here's a program where a community can be certified. I think it's through the Office of Drug Control Policy. Isn't it Van Ingram's --

MR. SHANNON: They oversee it and actually done by folks -- I think it's VOA in Louisville, Volunteers of America in Louisville.

CHAIR SCHUSTER: Oh, okay.

MR. SHANNON: They actually do the survey of the community. And if you're interested, Dr. Bobrowski, we can probably

get you connected with Van Ingram or VOA, Volunteers of America, to figure out if your local community -- where they're at in the process and if they're interested in moving forward. Volunteering, no requirement, but they're up to maybe 16 or so statewide.

CHAIR SCHUSTER: Yeah. I think that's a really neat thing to be doing. And, certainly, the addiction curse, plague has affected every community.

MR. SHANNON: Correct.

CHAIR SCHUSTER: Almost every family across the state. Thank you, Steve.

Pharmacy?

DR. HANNA: Yes. Good morning. The Pharmacy TAC did not meet, and their next meeting will be on August the 7th at 1:00. Thank you.

CHAIR SCHUSTER: Thank you.

Physician's?

MS. BICKERS: They did not meet in July. Their next meeting, I believe, is September.

CHAIR SCHUSTER: Okay. And does Ashima -- does Dr. Gupta usually make that

report or somebody else?

MS. BICKERS: Yes, ma'am, she does. And I believe it was October. My math is wrong there. Apologies.

CHAIR SCHUSTER: Okay. So they're going to meet in October. All right.

Primary Care?

DR. MOORE: Good afternoon. The Primary Care TAC met on June 27th. We received a number of updates on similar topics as we've already discussed today.

One topic of note that wasn't discussed, we did receive and have conversation about pharmacy reconciliation for 340B pharmacies and came to some agreements with DMS there.

We also had representation from DBHDID and had requested representation from DPH as a number of the problems we're working to solve cross over between, you know, healthcare delivery and also public health. So we appreciate that representation.

We spent a good portion of our meeting talking specifically about well-child rates and immunization rates as they are key measures for the MCOs and, you know,

obviously involve primary care providers as well.

We discussed some of the challenges related to parents, social determinant challenges that prevent people from accessing these services for their children and also, you know, some of the challenges and differences that you receive when you access that service in a retail setting versus in a primary care provider office.

We also discussed some of the challenges for providers and also, you know, regulatory limitations so that we could try to work together to solve those.

We had two recommendations: One, that in the next contract, the State require that well-child visits be on a calendar year benefit rather than a rolling 12. There's some uncertainty and differences between various MCOs about that coverage limit.

And that also, you know, we begin to work with the athletic association about changing some of their forms, you know, immunizations being updated as part of that process as well.

Our next meeting will be October 24th.

MS. BICKERS: Hi, Stephanie. This is Erin with the Department of Medicaid. Do you mind to email me those recommendations? My notes show that there were none voted on at the last meeting.

DR. MOORE: Okay. That -- Erin, I honestly couldn't read my own notes as well. Like, I remember that we discussed those, but we felt like neither of this would come to play until the next contract period. So we may have just decided to wait on those.

MS. BICKERS: Okay. I can go back and review the minutes if you'd like, just to confirm.

DR. MOORE: That would be very --

MS. BICKERS: But if you don't mind to send them in writing so that I have them, that would be wonderful.

DR. MOORE: Sure.

MS. BICKERS: Thank you.

CHAIR SCHUSTER: So the second one was about working with the athletic association -- I'm sorry, about --

DR. MOORE: To update the sports

physical forms.

CHAIR SCHUSTER: Okay. Great. Thank you. Thank you for the report.

And last, but not least, certainly the Therapy TAC.

MR. LYNN: Thank you, Dr. Schuster. The Therapy TAC met on July 9th, and I -- we had a light agenda and really have nothing to report to the MAC. And we meet again on September 10th.

CHAIR SCHUSTER: Okay. And no recommendations, then?

MR. LYNN: Yes, ma'am. No recommendations.

CHAIR SCHUSTER: Thank you.

All right. I would entertain a motion from a voting member of the TAC to accept the TAC recommendations and to forward them on to Department for Medicaid Services.

MR. GILBERT: So moved.

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

CHAIR SCHUSTER: Nina.

MR. GILBERT: And I'll second.

DR. BOBROWSKI: Second. Okay.

CHAIR SCHUSTER: Second -- is that you, Kent?

MR. GILBERT: I did.

CHAIR SCHUSTER: Okay. Thank you.

MR. GILBERT: There was a contest.

CHAIR SCHUSTER: There was a contest. Yes. I was -- because I can't see you all so --

MR. GILBERT: I may have thirded. Instead of seconding, I may have thirded. I'm not sure.

CHAIR SCHUSTER: All right. Thank you.

All those in favor of accepting the recommendations and forwarding them to DMS, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And any opposed?

(No response.)

CHAIR SCHUSTER: Thank you. We will forward those recommendations and appreciate it.

Erin, maybe you and I can -- I need to get kind of a calendar, particularly as people are moving to quarterly meetings.

There might be a better way to not go through this litany if we know that people haven't met or something like that.

MS. BICKERS: Yes, ma'am. We can work that out via email. If you want to have a quick meeting, I can look at my calendar. I am out of office next week, but any time after that, I'm happy to fit you in.

CHAIR SCHUSTER: Yeah. Thank you. That would just -- you know, then people don't have to sit through this roll call of -- so very good. Thank you.

Are there any items of new business that anyone would like to bring forward at this time?

MS. ROARK: Yes. This is Peggy Roark. Can you hear me?

CHAIR SCHUSTER: Yes, Peggy. I know you were late getting here, but we're glad that you're here.

MS. ROARK: Yes. I'm sorry. I missed a lot, it sounds like. But I just wanted to bring it to everyone's attention about this House Bill 5, about being homeless. And I encourage people to look and

read. I don't know what we can do, but I think a lot of people is, like, one paycheck of being homeless.

But I was reading through there, and it's a whole lot -- like, you know, if they were homeless and they get a fine, then if they can afford a fine, they wouldn't be homeless.

And so in the meantime, when they go to jail, I think I read it was, like, 40-some dollars a day. In the meantime, they lose employment. They lose their housing. They lose their children. It's a pretty scary thing. It's $44.97 per day.

Also, I had spoke to Sheila in the past about how we can reach our population in the doctors' offices. We have some seniors, some older people or mental health or whatever who don't have access to know what their benefits is for Medicaid. Some people don't know how to do emails, texts, or use phones.

So I was discussing with Sheila. In eastern Kentucky, I reached out to some people that maybe a local radio station or TV station could explain to some people about

different benefits for going to the doctor's office and having a survey of reaching out. And let's not forget about the folks that can't speak English.

So I just wanted to bring it to your attention to see what your thoughts or what we could do to make this better.

CHAIR SCHUSTER: Thank you. I appreciate that, and I did report -- we had an earlier item about improving communication, and I did report to the MAC that you and I had had an excellent conversation about that.

And you had been reaching out to people, and we did talk about doctors' offices. We also talked about radio and TV and reaching out to minority communities where English is not the first language.

So I will send you the list that I kind of went over, but I had incorporated your recommendations in that list. So I appreciate that very much.

The House Bill 5 -- those of you may know it as the Keep Kentucky Safe Act -- was passed. Great controversy around it because

it does criminalize homelessness. It does not allow anyone to sleep even in their own vehicle on public property.

And the first offense is, as Peggy said, is punishable by 125-dollar fine, which I -- or maybe it's 250. I've forgotten.

MS. ROARK: Yes. 250.

CHAIR SCHUSTER: 250. And I'm like, you know what? If they had $250, they wouldn't be sleeping in their car when it was five below zero. I mean, let's be real, folks.

The second fine could end up in incarceration, which just adds to the fines and, as Peggy so rightly pointed out, keeps them from jobs and, you know, just adds expense and so forth.

There are a lot of people looking at what to do about our homeless population. I don't think this is it. We also know that there's a fair number of people that are homeless that have behavioral health disorders.

There is a housing task force that's going on during the interim session, and I

will email to you all -- I don't have a link right now. You can go on the Legislative Research Commission, www.legislature.ky.gov, and look under committees, special committees. And it will have the meeting dates and times of that housing task force. They've met once, and they will meet again, I think, next month in August.

But it's an opportunity to communicate with those legislators about your ideas to address homelessness and the housing shortage that we have here in Kentucky.

And, Peggy, we'll talk some more about whether there's a particular item to put on a future MAC agenda on that in particular. There certainly -- housing is certainly one of those social determinants of health or health-related social needs that probably is at the top of the list.

I think a lot of our providers on here or a lot of the representatives would say that not having stable housing is a huge problem for the people that they're seeing, whether it's for -- in Garth's office for dental services or whether it's in Beth's

office for primary care or over in Nina's hospital in terms of behavioral health.

So I really appreciate your bringing those things up, Peggy, and we will continue that discussion; okay?

MS. ROARK: Thank you.

There's one more thing. There's -- parents or guardians with children in juvenile court proceedings require at least one parent to attend court. If they fail to do so, they are subject to fine, $500 or 40 hours of community service.

CHAIR SCHUSTER: Was that passed recently? Was that in the last year?

MS. ROARK: That house bill creates new penalties for parents or guardians with children in juvenile court proceedings. It requires at least one parent or guardian to attend court with the child. If they fail to do so, become subject to a fine of $500 or 40 hours of community service. That's pretty sad.

CHAIR SCHUSTER: Yeah. Well, we'll add that to our list for our next discussion; okay?

MS. ROARK: I greatly appreciate your time.

CHAIR SCHUSTER: Well, we appreciate your input and your reaching out to people and looking at these from a -- you know, at the ground level perspective. I think it's very valuable, Peggy, and we appreciate it.

MS. ROARK: Thank you. Appreciate you.

CHAIR SCHUSTER: Thank you.

Our next meeting will be Thursday, September 26th, 9:30 to 12:30. And I've kept you a few minutes over, but I think we've had some excellent discussion. And I appreciate you all being here, the MAC members and the many, many people -- I think at one point, we had 140 people in the participant numbers.

So we're obviously talking about things that are of importance to people so appreciate your service very much and hope that you have a good day and a good weekend coming up. And we will see you in September. Thank you.

MR. MARTIN: Thank you all.

CHAIR SCHUSTER: Yes. Bye-bye.

(Meeting concluded at 12:34 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 5th day of August, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR