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2           CABINET FOR HEALTH AND FAMILY SERVICES  
3           ADVISORY COUNCIL FOR MEDICAL ASSISTANCE  
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12           Via Videoconference  
13           July 25, 2024  
14           Commencing at 9:32 a.m.  
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21           Shana W. Spencer, RPR, CRR  
22           Court Reporter  
23  
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## 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  
Anissa Franklin (not present)  
Beth Partin  
Bryan Proctor (not present)  
Peggy Roark  
Eric Wright (not present)

**COMMISSIONER:**

Lisa Lee, Department for Medicaid Services

## PROCEEDINGS

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 S.

MS. SMITH: Here.

## CHAIR SCHUSTER:

1 MS. WALLACE: Dr. Bobrowski?

2 DR. BOBROWSKI: Here.

3 MS. WALLACE: Dr. Steve Compton?

4 DR. COMPTON: Here.

5 MS. WALLACE: Dr. John Muller?

6 (No response.)

7 MS. WALLACE: Dr. Gupta?

8 CHAIR SCHUSTER: She's also --

9 she's traveling.

10 MS. WALLACE: John Dadds?

11 (No response.)

12 MS. WALLACE: I see Heather Smith

13 on here, so I'm going to take a check. She

14 just didn't answer.

15 Dr. Hanna?

16 DR. HANNA: Here.

17 MS. WALLACE: Barry Martin?

18 MR. MARTIN: Here.

19 MS. WALLACE: Kent Gilbert?

20 MR. GILBERT: Here.

21 MS. WALLACE: Mackenzie Wallace, I

22 am here.

23 And Ms. Franklin?

24 CHAIR SCHUSTER: She's also out of

25 town.

1 MS. WALLACE: Sheila, you are here.  
2 CHAIR SCHUSTER: I am.  
3 MS. WALLACE: Bryan Proctor?  
4 (No response.)  
5 MS. WALLACE: Peggy Roark?  
6 CHAIR SCHUSTER: She was going to  
7 be late but, I think, will be joining us in a  
8 bit.  
9 MS. WALLACE: Okay.  
10 Eric Wright?  
11 CHAIR SCHUSTER: And he's gone  
12 today.  
13 MS. WALLACE: Okay.  
14 And Commissioner Lee?  
15 COMMISSIONER LEE: I am here.  
16 CHAIR SCHUSTER: I count nine.  
17 MS. WALLACE: Five, six, seven,  
18 eight, nine. Yes.  
19 CHAIR SCHUSTER: And I think we  
20 need ten, don't we, Erin, for a quorum?  
21 MS. BICKERS: I'm trying to recount  
22 because I have ten. Give me one second.  
23 CHAIR SCHUSTER: Oh, okay. We'll  
24 take your number.  
25 MS. BICKERS: Well, let me run

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

5                   CHAIR SCHUSTER: Oh, that's ten.

6                   Yes. I had not -- I had not --

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

9                   CHAIR SCHUSTER: Wonderful.

10                  MS. WALLACE: So that is ten.

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

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

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

21                  CHAIR SCHUSTER: Yeah. Great.

22                  Thank you, Mackenzie.

23                  MS. WALLACE: Yes, ma'am.

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

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

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

8                   DR. BOBROWSKI: So moved.

9                   DR. HANNA: Second.

10                  CHAIR SCHUSTER: Thank you. And  
11                  second is?

12                  DR. HANNA: Cathy Hanna.

13                  CHAIR SCHUSTER: Cathy, thank you  
14                  very much.

15                  Any additions, corrections, omissions,  
16                  revisions?

17                  (No response.)

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

21                  (Aye.)

22                  CHAIR SCHUSTER: And opposed, like  
23                  sign?

24                  (No response.)

25                  CHAIR SCHUSTER: Thank you. The

1                   minutes are approved.

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

6                   MR. GILBERT: So moved.

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

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

11                  Any additions, corrections, omissions,  
12                  revisions?

13                  (No response.)

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

18                  (Aye.)

19                  CHAIR SCHUSTER: And opposed, like  
20                  sign?

21                  (No response.)

22                  CHAIR SCHUSTER: Great. Thank you  
23                  very much.

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

1                   the status of Anthem MCO?

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

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

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

12                  CHAIR SCHUSTER: Okay.

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

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

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

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

1 for providers?

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

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

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

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

1 access line -- how would that work with  
2 actual interaction with that member?  
3 So that's one aspect that we really need  
4 to think about. But I think as far as just a  
5 member going into an office and the provider  
6 needing to call to get some assistance with  
7 language, I think that, you know, we'll be  
8 able to streamline that to one number but  
9 need to kind of continually think about how  
10 we improve that service for individuals who  
11 are entering offices for, you know, like I  
12 said, extended periods of time maybe for --  
13 for additional services.

14 CHAIR SCHUSTER: Okay.

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

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

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

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

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

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

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

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

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

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

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

12                  COMMISSIONER LEE: All right.

13                  Thank you. Good to know that.

14                  And I think Kent had his hand --

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

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

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

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

12                  Any other questions for the commissioner  
13                  on that?

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

17                  CHAIR SCHUSTER: Okay.

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

25                  Although the one -- you know, the one

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

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

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

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

22                  CHAIR SCHUSTER: Yeah.

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

1                   depending on the age of the patient.

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

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

13                  CHAIR SCHUSTER: Yeah. Very  
14                  helpful.

15                  MS. EISNER: Thank you. Thank you.

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

19                  (No response.)

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

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

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

5 CHAIR SCHUSTER: Yes.

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

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

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

13 COMMISSIONER LEE: Yeah.

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

17 COMMISSIONER LEE: Yes.

18 DR. ROBERTS: Okay. Thank you.

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

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

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

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

3 COMMISSIONER LEE: Absolutely.

4 CHAIR SCHUSTER: Yeah. Thank you.

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

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

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

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

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

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

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

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

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

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

17                  And so, for example, at least -- going  
18                  forward, at least 25 percent of those BAC  
19                  members would also have to serve on our MAC.  
20                  Now, those compliance dates, I think, are up  
21                  into '27 with that full compliance of those  
22                  25 percent of the BAC members being on the  
23                  MAC.

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

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

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

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

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

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

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

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

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

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

19                  CHAIR SCHUSTER: Thank you very  
20                  much because --

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

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

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

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

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

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

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

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

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

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

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

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

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

15                  CHAIR SCHUSTER: Yeah.

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

20                  CHAIR SCHUSTER: Yeah.

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

1                   reshuffling of membership at that time?

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

5                   MR. GILBERT: Yeah.

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

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

19                  MR. GILBERT: Right.

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

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

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

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

11                  MR. GILBERT: I think that --

12                  CHAIR SCHUSTER: So the final --

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

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

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

20                  CHAIR SCHUSTER: Yeah. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25                  CHAIR SCHUSTER: Yeah. There's

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

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

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

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

1           IDD TAC is another one.

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

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

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

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

1 Dan Tsai. And we talk through some of those.

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

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

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

16 COMMISSIONER LEE: I think we  
17 just --

18 CHAIR SCHUSTER: -- by January 1st?

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

21 CHAIR SCHUSTER: -- or just --

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

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

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

22                   But we will have to have an annual  
23                   report to CMS regarding the activities of the  
24                   MAC and BAC, which, you know, that's not a  
25                   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.

CHAIR SCHUSTER: I like that.

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

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

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

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

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

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

5 CHAIR SCHUSTER: Great. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

1                   We call our navigators connectors.

2                   There are also connectors who are certified  
3                   application counselors. They work in  
4                   hospital settings and some other facilities  
5                   and that kind of thing. We kind of all put  
6                   them under the umbrella of connectors.

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

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

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

1                   assisting that individual or family.

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

11                  And we're planning soon on once -- our  
12                  people in DMS are putting together a Waiver  
13                  101 for internal staff and others, but we're  
14                  going to run that to our monthly all-hands  
15                  connector meeting. We usually have several  
16                  hundreds of them actually meet us with every  
17                  month, and sometimes we have a specialized  
18                  presentation on something just like this.

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

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

3                   I kind of said that all in one breath.

4                   Apologies. Does anyone have any questions or  
5                   suggestions?

6                   CHAIR SCHUSTER: Thank you, David.

7                   I was invited to talk to the Disparity and  
8                   Equity TAC just last week.

9                   MR. VERRY: Oh, good.

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

19                  MR. VERRY: Yeah.

20                  CHAIR SCHUSTER: I'm sorry.

21                  MR. VERRY: Yeah. Absolutely.

22                  That's how it works, especially on the  
23                  electronic application, but also on the  
24                  paper. If -- on the electronic application,  
25                  it's no wrong door. You just start filling

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

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

17                  CHAIR SCHUSTER: Right.

18                  MR. VERRY: So it's -- we're always  
19                  willing to take feedback as to how we can  
20                  improve this process. But it's pretty  
21                  remarkable, and it is indeed unique among the  
22                  50 states plus D.C.

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

25                  MR. VERRY: Yes, ma'am.

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

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

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

23 MR. VERRY: Oh, absolutely.

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

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

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

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

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

1 everyone gets on board.

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

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

6 MR. VERRY: However, if this one  
7 connector says, I don't know anything about  
8 waiver, do you know whose fault that is?

9 Mine. And we'll take that, and we'll take  
10 that back and try to increase our campaign.  
11 These are some of our most vulnerable  
12 residents of the commonwealth. So if we have  
13 to triple our efforts, we will.

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

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

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

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

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

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

15                  CHAIR SCHUSTER: Right.

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

24                  CHAIR SCHUSTER: Right.

25                  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

1 our CHWs.

2 MR. VERRY: Yeah, very similar.

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

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

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

17 CHAIR SCHUSTER: Sure. Thank you.

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

24 CHAIR SCHUSTER: Oh, that's right.  
25 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](mailto: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

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

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

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

1                   health needs of many of his congregants.

2                   So one of the ideas -- and we used to do  
3                   this in the behavioral health community -- is  
4                   to meet with faith leaders and even give them  
5                   a little breakfast early one morning and, you  
6                   know, provide some materials and so forth.

7                   The other thing is to provide materials for  
8                   them to distribute at their church services  
9                   or synagogue or temple services.

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

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

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

1                   the word out with our minority communities.

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

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

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

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

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

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

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

1                   really helpful.

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

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

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

25                  So those were some of the ideas that we

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

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

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

13                  CHAIR SCHUSTER: Right.

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

1 CHAIR SCHUSTER: Right.

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

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

13 MR. GILBERT: Okay.

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

16 MR. GILBERT: Yeah. Right.

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

21 MR. GILBERT: Right.

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

1 MR. GILBERT: Great.

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

4 MR. GILBERT: Perfect. Thank you.

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

7 CHAIR SCHUSTER: Great idea, Kent.  
8 Thank you.

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

11 CHAIR SCHUSTER: Yes, Barry.

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

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

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

4                   MR. MARTIN: Yeah.

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

8                   CHAIR SCHUSTER: Right.

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

11                  CHAIR SCHUSTER: Right.

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

15                  CHAIR SCHUSTER: Yeah.

16                  MR. MARTIN: Yeah.

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

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

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

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

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

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

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

8 (No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 CHAIR SCHUSTER: I assume that that

1                   first is that Chevron ruling.

2                   COMMISSIONER LEE: Yes.

3                   CHAIR SCHUSTER: Yeah.

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

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

12                  COMMISSIONER LEE: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

25                  (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.

1 MS. JONES: Thank you very much.  
2 Let's see. Are you able to see my screen?  
3 CHAIR SCHUSTER: Yes, ma'am.  
4 MS. JONES: Okay. So I'll go ahead  
5 and get started. I'll go through these --  
6 the overview of our project, SHINE Kentucky.  
7 That's an acronym for Strengthening Health  
8 Integration and Education for Kentucky  
9 students. Go over a little bit about the  
10 school-based services history and then our  
11 goals and strategies, our budget, and then  
12 that first-year work plan.  
13 So in January of this year, CMS released  
14 a Notice of Funding opportunity for  
15 two-and-a-half million dollars for a  
16 three-year grant period. And there were  
17 several options. It was for implementation,  
18 expansion, or enhancement of school-based  
19 services.  
20 The implementation for states that  
21 haven't implemented, the expanded access for  
22 school-based services, and then the expansion  
23 is for the ones that haven't  
24 done -- beyond students that have an IEP.  
25 And then enhancement are for those states

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

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

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

17          And then a bit about the history. In  
18          2014, CMS did the free care reversal, which  
19          allows states to implement school-based  
20          services for children that had Medicaid  
21          coverage but did not have an IEP. And so  
22          that would allow school-based services to be  
23          offered to a lot more students, any student  
24          that had Medicaid. And if it was a  
25          Medicaid-covered service in the school

1 setting, it could be covered.

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

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

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

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

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

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

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

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

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

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

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

23                  Apologies. My mouth was getting awfully  
24 dry.

25                  The outreach and community engagement.

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

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

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

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

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

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

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

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

25                  And there is my contact information if

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

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

8                   MS. JONES: Yes.

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

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

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

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

1                   And the money is specifically designed to do  
2                   what?

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

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

7                   Any other questions from any of the MAC  
8                   members?

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

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

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

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

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

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

20                  DR. BOBROWSKI: Okay. Thank you.

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

23                  (No response.)

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

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

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

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

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

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

8 The other thing I would point out is  
9 that Senate Bill 2 that just passed in this  
10 2024 session builds on the earlier  
11 Senate Bill 1 and Senate Bill 8 in 2019 and  
12 2020 that are the School Safety and  
13 Resiliency Acts that were first started after  
14 the Marshall County High School shootings  
15 where two students were killed in 2018.

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

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

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

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

12 MS. JONES: Yes, we will.

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

18 Any last questions, please?

19 DR. PARTIN: I have a question.

20 CHAIR SCHUSTER: Yeah. Who is  
21 that?

22 DR. PARTIN: This is Beth, Beth  
23 Partin.

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

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

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

12 DR. PARTIN: Okay. Thank you.

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

19 You know, kids get admitted to the  
20 hospital, to the psych hospital, and receive  
21 treatment. And the provider -- you know, the  
22 PCP, the pediatrician, the family  
23 practitioner never gets notified. And I'm  
24 sure it's true at the level of the school  
25 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

1                   dichotomy or difference but --

2                   COMMISSIONER LEE: I was just

3                   wondering if any of that information is

4                   available maybe in KHIE, in the Kentucky

5                   Health Information Exchange, or in, you know,

6                   our KyHealth Net. I mean, I -- it would be,

7                   I guess, to go out and look it up, but I

8                   don't know if it's available there to our

9                   providers.

10                  DR. PARTIN: I don't know.

11                  CHAIR SCHUSTER: You know, it's --

12                  there's such longstanding stigma around

13                  mental health and addiction treatment. And

14                  the addiction information is even more

15                  strongly protected federally in terms of

16                  release.

17                  Nina, what do you all do in terms of

18                  being in touch with or communicating with the

19                  PCP? She may not still be on.

20                  MS. EISNER: It's certainly -- no.

21                  I can hear you. It's certainly desirable,

22                  but it does require the patient consent for

23                  communication.

24                  CHAIR SCHUSTER: Yeah.

25                  MS. EISNER: And sometimes there

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

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

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

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

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

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

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

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

18 DR. PARTIN: Right.

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

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

8                   CHAIR SCHUSTER: Yeah.

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

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

25                  But we don't get any kind of

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

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

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

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

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

1                   they're not always very accurate historians.

2                   DR. PARTIN: Right.

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

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

9                   MS. EISNER: Yeah.

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

14                  MS. EISNER: Yeah.

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

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

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

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

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

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

9                   MS. JONES: Yes. Thank you.

10                  CHAIR SCHUSTER: Thank you.

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

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

19                  CHAIR SCHUSTER: Okay.

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

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

1 to get to another meeting.

2 CHAIR SCHUSTER: Yes.

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

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

11 MS. SPARROW: Yes.

12 CHAIR SCHUSTER: The guru of the  
13 Reentry TAC.

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

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

1                   our flexibilities under our 1115 programs.

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

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

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

25                  So, again, prior to the approval,

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

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

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

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

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

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

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

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

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

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

1                   that is covered under the demonstration.

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

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

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

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

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

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

19                  So, again, individuals with a substance  
20                  use diagnosis that would meet criteria for  
21                  that service would be eligible for --  
22                  Medicaid would be eligible to reimburse that  
23                  60 days' prerelease and then, again, be able  
24                  to carry that forward into the community at  
25                  the time that they are released.

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

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

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

25                  And so the correctional facilities will

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

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

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

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

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

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

9 But by doing that, we'll also look at  
10 what is that -- by building that  
11 infrastructure and that health data exchange  
12 system and that data integration, it then  
13 does not just become about reentry; right?

14 So it also becomes on the entry side.

15 Ensuring, again, that our healthcare systems  
16 are sharing data with our correctional  
17 systems, again, so that it does not just  
18 become about reentry.

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

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

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

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

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

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

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

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

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

1 implementation.

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

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

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

25 But, again, just kind of the reminder.

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

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

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

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

1                   found it on them. Or they were selling it.

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

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

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

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

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

1                   those services based on evidence-based  
2                   practice.

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

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

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

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

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

12                  CHAIR SCHUSTER: Did we lose you,  
13                  Angela?

14                  COMMISSIONER LEE: It looks like  
15                  she might be frozen.

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

18                  CHAIR SCHUSTER: Yes.

19                  COMMISSIONER LEE: Yes.

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

1 provided the way --

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

4 CHAIR SCHUSTER: Yeah.

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

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

18 DR. BOBROWSKI: Right.

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

22 DR. BOBROWSKI: Yeah. Thank you.

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

1                   about local jails probably. And so --

2                   DR. BOBROWSKI: That's right, yeah.

3                   CHAIR SCHUSTER: Yeah. The program  
4                   is not going to be in the local jails yet.

5                   It's going to start in the prisons and with  
6                   DJJ, which are the juveniles.

7                   DR. BOBROWSKI: Okay.

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

12                  But excellent questions. And Steve  
13                  Shannon is on. We'll hear from him in a  
14                  little bit. He chairs the Persons Returning  
15                  to Society from Incarceration TAC, which is  
16                  actually the Reentry TAC, and they meet the  
17                  second Thursday every other month. It's the  
18                  months that the MAC meets, and they meet at  
19                  9:00. And those are open meetings if anybody  
20                  is interested. That's a great way to kind of  
21                  follow along.

22                  I thought it was important for the MAC  
23                  to know that this is going on because  
24                  Kentucky has such a very high incarceration  
25                  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

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

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

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

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

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

25                  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

1 different pieces and parts of the request.

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

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

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

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

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

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

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

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

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

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

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

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

25                  Thank you, Leslie. Do you have some

1 waiver waiting list numbers?

2 MS. BICKERS: Leslie, you're muted.

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

6 Sheila, this is the last numbers I have,  
7 and I can update those again for you all  
8 later. We've got plenty of reporting going  
9 on this month. Our HCB waiting list was  
10 1,932 with my last numbers. Michelle P is  
11 9,244. SCL is 3,550. Last I checked, we had  
12 approximately 186 urgent category, and we had  
13 3,364 in future planning. And then nobody  
14 was in emergency at that time.

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

20 CHAIR SCHUSTER: Right.

21 MS. HOFFMANN: And we do have a  
22 large percentage of the slots that we  
23 allocate of folks not -- either not taking  
24 that slot, unfortunately have passed away,  
25 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

1                   the end of last week.

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

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

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

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

24                  MS. HOFFMANN: Absolutely.

25                  CHAIR SCHUSTER: Thank you very

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

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

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

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

21                  And we're hoping maybe September; right?

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

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

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

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

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

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

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

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

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

15                  CHAIR SCHUSTER: Good.

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

18                  CHAIR SCHUSTER: Great.

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

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

23                  MS. HOLLEN: Sure.

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

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

3 MS. HOLLEN: Thank you.

4 CHAIR SCHUSTER: We are super  
5 excited.

6 MS. HOLLEN: So am I.

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

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

22 MS. HOLLEN: Thank you.

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

1                   flexibilities.

2                   MS. JUDY-CECIL: Hello again.

3                   CHAIR SCHUSTER: Hello again.

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

8                   CHAIR SCHUSTER: Yeah.

9                   MS. JUDY-CECIL: So just a reminder  
10                  to folks that what we're talking about here  
11                  is the Public Health Emergency that ended and  
12                  required the state Medicaid agencies to  
13                  restart annual renewals after March 31st,  
14                  2023. So we have been in what we call  
15                  unwinding which required us to start those  
16                  renewals. And our renewals, we started with  
17                  the month of May in 2023.

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

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

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

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

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

1 tracking.

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

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

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

23 The flexibilities that relate  
24 specifically to the home and community-based  
25 1915C waivers that we've been talking a lot

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

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

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

19                  We are, as I said, unwinding. And so at  
20                  some point, this no longer becomes unwinding  
21                  because we're going to be finishing up those  
22                  first PHE renewals. But they are in the --  
23                  we have our April, May, and then those eight  
24                  in June are part -- are still within that  
25                  90-day reconsideration period.

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

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

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

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

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

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

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

7                   So what you're seeing in that middle  
8 column that says 90-day processing period,  
9 it's just going back and reporting what  
10 happened with those pending cases within that  
11 90-day period. And then on the right-hand  
12 side is where those individuals ended up as  
13 an updated monthly report to show CMS.

14                  So, for example, I'm just going to walk  
15 through February. February, we had 93,004  
16 individuals that went through renewal. We  
17 had 64,789 originally approved. We had  
18 10,128 that were terminated, and the majority  
19 of those are for not responding. It's called  
20 a procedural termination. We sent them a  
21 notice, and they did not respond back.

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

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

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

10                  The most recent is June. We had 58,959  
11                  individuals. Keep in mind that now we're  
12                  reporting both PHE and non-PHE renewals. So  
13                  we're talking about in this number, really,  
14                  there's only eight renewals that are tied to  
15                  the PHE. Of those, 41,336 were approved.  
16                  13,187 were terminated, and we had one case  
17                  pending on June 30th.

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

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

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

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

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

19                  CHAIR SCHUSTER: Okay.

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

22                  CHAIR SCHUSTER: Terminated. Okay.

23                  MS. JUDY-CECIL: Yeah.

24                  CHAIR SCHUSTER: Okay.

25                  MS. JUDY-CECIL: And they are

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

3                   CHAIR SCHUSTER: Right. Right.

4                   Okay.

5                   Any questions from any of the MAC  
6                   members of Veronica?

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

15                  MS. JUDY-CECIL: I know  
16                  percentages.

17                  CHAIR SCHUSTER: That's fine.

18                  Yeah.

19                  MS. JUDY-CECIL: Yep, yep.

20                  CHAIR SCHUSTER: Percentages, yeah.

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

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

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

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

11                  CHAIR SCHUSTER: That's all right.

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

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

15                  MS. JUDY-CECIL: It is, yes.

16                  CHAIR SCHUSTER: It's really --

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

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

1 CHAIR SCHUSTER: Yes.

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

5 MS. JUDY-CECIL: Yeah.

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

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

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

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

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

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

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

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

1 just going into regular renewals.

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

8 CHAIR SCHUSTER: Yeah. That's  
9 great.

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

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

17 CHAIR SCHUSTER: Yeah.

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

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

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

10                  So thank you for that plug.

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

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

21                  CHAIR SCHUSTER: Yeah.

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

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

3 MS. JUDY-CECIL: That's correct.

4 CHAIR SCHUSTER: Yeah. Great.

5 Any other questions for Veronica?

6 (No response.)

7 CHAIR SCHUSTER: All right.

8 Thank you so much. And you'll share your  
9 PowerPoint with Erin, please?

10 MS. JUDY-CECIL: Absolutely.

11 CHAIR SCHUSTER: Yeah. Thank you.

12 MS. JUDY-CECIL: Thank you all.

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

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

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

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

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

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

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

1                   she incorporated our questions in the  
2                   presentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

1                   months. And we have a -- our new TAC member  
2                   had a conflict, so our meetings will be from  
3                   2:00 to 4:00 going forward.

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

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

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

13                  CHAIR SCHUSTER: Okay.

14                  The Consumer Rights and Client Needs.  
15                  And Emily Beauregard, their chair, is out of  
16                  town. They did meet and had a quorum on July  
17                  7th, and they have three recommendations.

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

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

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

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

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

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

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

23                  CHAIR SCHUSTER: Oh.

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

1                   on -- they have to be a TAC member.

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

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

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

14                  CHAIR SCHUSTER: Yes.

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

17                  CHAIR SCHUSTER: All right.  
18                  Thank you.

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

1                   stuff, too.

2                   MS. JUDY-CECIL: I agree with that.

3                   I think that gives us a good opportunity.

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

9                   The Dental TAC, please.

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

18                  CHAIR SCHUSTER: Okay. Thank you,  
19                  Garth.

20                  The Disparity and Equity TAC?

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

1 CHAIR SCHUSTER: Yeah. Okay.

2 Thank you. Yeah. They met last week, and we

3 had that robust discussion about

4 communication and so forth.

5 How about Emergency Medical Services?

6 MS. BICKERS: Keith is out of town

7 and apologized he cannot be here. They did

8 meet, had a wonderful conversation. No

9 recommendations, per his words.

10 CHAIR SCHUSTER: Okay. All right.

11 Home Health?

12 MS. BICKERS: They meet at the

13 beginning of August. Evan was unable to be

14 here as well as Susan. He emailed me this

15 morning.

16 CHAIR SCHUSTER: Okay.

17 Hospital Care?

18 MR. RANALLO: This is Russ Ranallo.

19 We did not have a meeting. Our next meeting

20 is in August.

21 CHAIR SCHUSTER: Okay. So it

22 sounds like we need to be prepared at the

23 September meeting for a whole bunch of TAC

24 reports. Thank you, Russ.

25 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?

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

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

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

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

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

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

21 DR. COMPTON: Okay.

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

25 DR. COMPTON: That's a good point.

1 CHAIR SCHUSTER: Yeah.

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

3 list.

4 CHAIR SCHUSTER: All right.

5 Thank you.

6 DR. COMPTON: All right.

7 Thank you.

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

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

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

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

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

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

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

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

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

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

6                   CHAIR SCHUSTER: Yeah.

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

10                  CHAIR SCHUSTER: All right.

11                  Thank you, Steve.

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

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

22                  CHAIR SCHUSTER: Oh, okay.

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

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

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

11                  MR. SHANNON: Correct.

12                  CHAIR SCHUSTER: Almost every  
13                  family across the state. Thank you, Steve.  
14                  Pharmacy?

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

19                  CHAIR SCHUSTER: Thank you.  
20                  Physician's?

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

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

1 report or somebody else?

2 MS. BICKERS: Yes, ma'am, she does.

3 And I believe it was October. My math is  
4 wrong there. Apologies.

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

7 Primary Care?

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

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

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

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

1                    obviously involve primary care providers as  
2                    well.

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

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

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

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

1                   Our next meeting will be October 24th.

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

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

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

16                  DR. MOORE: That would be very --

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

20                  DR. MOORE: Sure.

21                  MS. BICKERS: Thank you.

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

25                  DR. MOORE: To update the sports

1 physical forms.

2 CHAIR SCHUSTER: Okay. Great.

3 Thank you. Thank you for the report.

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

6 MR. LYNN: Thank you, Dr. Schuster.

7 The Therapy TAC met on July 9th, and I -- we  
8 had a light agenda and really have nothing to  
9 report to the MAC. And we meet again on  
10 September 10th.

11 CHAIR SCHUSTER: Okay. And no  
12 recommendations, then?

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

15 CHAIR SCHUSTER: Thank you.

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

20 MR. GILBERT: So moved.

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

23 CHAIR SCHUSTER: Nina.

24 MR. GILBERT: And I'll second.

25 DR. BOBROWSKI: Second. Okay.

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

3 MR. GILBERT: I did.

4 CHAIR SCHUSTER: Okay. Thank you.

5 MR. GILBERT: There was a contest.

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

9 MR. GILBERT: I may have thirded.

10 Instead of seconding, I may have thirded.  
11 I'm not sure.

12 CHAIR SCHUSTER: All right.  
13 Thank you.

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

17 (Aye.)

18 CHAIR SCHUSTER: And any opposed?  
19 (No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1                   different benefits for going to the doctor's  
2                   office and having a survey of reaching out.

3                   And let's not forget about the folks that  
4                   can't speak English.

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

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

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

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

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

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

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

7                   MS. ROARK: Yes. 250.

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

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

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

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

1           will email to you all -- I don't have a link  
2           right now. You can go on the Legislative  
3           Research Commission, [www.legislature.ky.gov](http://www.legislature.ky.gov),  
4           and look under committees, special  
5           committees. And it will have the meeting  
6           dates and times of that housing task force.  
7           They've met once, and they will meet again, I  
8           think, next month in August.

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

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

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

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

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

6                   MS. ROARK: Thank you.

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

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

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

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

1 MS. ROARK: I greatly appreciate  
2 your time.

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

9 MS. ROARK: Thank you. Appreciate  
10 you.

11 CHAIR SCHUSTER: Thank you.

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

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

25 MR. MARTIN: Thank you all.

1 CHAIR SCHUSTER: Yes. Bye-bye.

2 (Meeting concluded at 12:34 p.m.)

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2 C E R T I F I C A T E

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

9

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

14

15 Dated this 5th day of August, 2024.

16

17

18 /s/ Shana W. Spencer

19 Shana Spencer, RPR, CRR

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