DEPARTMENT OF MEDICAID SERVICES
CONSUMER RIGHTS TECHNICAL ADVISORY COMMITTEE

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1:30 p.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Emily Beauregard, Chair
Miranda Brown
Melanie Tyner-Wilson
Arthur Campbell
Brenda Mannino
Christy Hardin

MS. BICKERS: Good afternoon, everyone. This is Erin with the Department of Medicaid. It is not quite 1:30 and were still clearing out the waiting room, so we'll give it just a moment before we get started.

MS. BEAUREGARD: That sounds great. Thank you, Erin. And as you see TAC members coming in, if you could just let me know.

MS. BICKERS: I have you, Melanie, and Arthur as of now. I'll make sure he didn't drop now that I say that. It looks like he may have dropped. I will keep an eye out.

MS. BEAUREGARD: I do see him. His camera is off and his mute is on.

MS. BICKERS: Oh, there he is. Sometimes I get so many pages when I try and scroll. It takes me a moment.

MS. BEAUREGARD: Hi, Arthur. I think you are on mute, Arthur, if you are talking.

MR. CAMPBELL: Hi.

MS. BEAUREGARD: There you are.

Now I can hear you. Good to see you.

MR. CAMPBELL: Yeah.

MS. BEAUREGARD: We are going to give it another minute or two to see if some of our other TAC members are able to hop on.

MS. BICKERS: Miranda is logging in.

MS. BEAUREGARD: Perfect. Hi, Miranda.

MS. BROWN: Hello.

MS. BEAUREGARD: Nice to see you.

MS. BROWN: You too.

MS. BEAUREGARD: We are going to give it just another minute to let some other people join. I do think we have a quorum now so that is good.

Arthur, I don't think you are talking to us now. I do hear something, maybe your machine every once in a while. You might want to mute unless you are trying to talk.

MR. CAMPBELL: Okay.

MS. BICKERS: The waiting room

is clear, Emily, if you like I can keep an eye on for our other two TAC members if they join.

MS. BEAUREGARD: That would be great. Thank you. I do think one may be traveling, so it may just be the four of us, but is good to know that we have a quorum.

Thank you all for being here today. I will go ahead and get the meeting started. Let's just go ahead and do brief introductions.

I'm Emily Beauregard. I am the chair of the Consumer TAC and I'm also the director of Kentucky Voices for Health. And I will ask Melanie, Arthur, and Miranda to introduce yourselves.

MS. TYNER-WILSON: I'm Melanie Tyner Wilson. I'm here as a representative of the Arc of Kentucky, Ark of Central Kentucky and the Autism Society of the Bluegrass.

INTERPRETER: Arthur has something to say. He says, he is Arthur Campbell, Jr. He is a representative of

PNA.

MR. CAMPBELL: Thank you.

INTERPRETER: He says thank you.

MS. BROWN: I'm Miranda Brown with Kentucky Equal Justice Center and I'm a connector. Thank you.

MS. BEAUREGARD: All right. Thank you all for joining us today, and we have already established a quorum, so let's go on to approving the minutes from our last meeting, which I hope everybody received and had a chance to look over. Any questions or discussions before I ask for a motion to approve the minutes?

I will ask for a motion.

MR. CAMPBELL: I'll make a motion.

MS. BROWN: I'll second.

MS. BEAUREGARD: Thank you. All in favor say, "aye."

TAC MEMBERS: Aye.

MS. BEAUREGARD: Any opposed? Minutes are approved. Thank you all.

And then we can move on to old business. We have our usual standing data

request.

MS. GRIFFIN: This is Jiordan from Eligibility and Enrollment with DMS. So for our presumptive eligibility members, currently we have 1,466 members enrolled in presumptive eligibility; we have 285 enrolled in emergency time-limited Medicaid; overall, our traditional Medicaid enrollees are sitting at about 147,000; and then MCO, we have 1,318,128, for a current total enrollment of 1,465,388. And I will put these figures in the chat just so you all can see them.

MS. BEAUREGARD: Great. Thank you. Any questions about enrollment? All right.

Jiordan, are you going to provide the 1915(c) waiver enrollment, or is that going to be somebody else from the cabinet?

MS. HOFFMAN: Emily, this is Leslie. I'm on. How are you today?

MS. BEAUREGARD: Good. How are you?

MS. HOFFMAN: I will be trying to answer the long-term questions today. So for our active members. And these are fluid -- I kind of get tickled -- these are from last night to this morning. They are constantly fluid. So our active members, right now, are around 30,825; and our waitlist is around 14,649. That includes SCL with zero emergencies and 3,529; HCBS has 1,987; and Michelle P. is 9,134.

MS. BEAUREGARD: All right. Thank you.

MS. HOFFMAN: Yes, ma'am.

MS. BEAUREGARD: I know that there are some new waiver slots that are starting to open up. Can you give us -- I don't think that I put that on.

MS. HOFFMAN: I thought that you might ask.

MS. BEAUREGARD: Or it might be later on in the agenda.

MS. HOFFMAN: That's fine.

MS. BEAUREGARD: If you have any update.

MS. HOFFMAN: I can. I thought you might ask so I included that information. House Bill 6 for fiscal year '25 allowed for quite a few slots, so I can give you an update on that. We released communication on 7/31 that we would be releasing the slots and they would be staggered. On ABL LTC, we went ahead and released those on 7/30 and the rest we released on 8/1. When I say staggered, I wanted to let you know that in order to prevent a bottleneck effect or to over implode the provider capacity, we did try decide to stagger those out like the SCL in the Michelle P, so I just wanted to let you know that we did try to stagger those out. We have, pretty much, a three-month plan and I can kind of give you that.

What causes some additional bottlenecking, Emily, is we have those slots that rotate around every month already, so not only do you have those that rotate if somebody didn't take a slot and they rotate till the next month and we

also have the new slots. So I think what we ended up doing -- just a second I've got it. Twenty-five additional slots for ABL LTC and we released those already. Then we had for HCB, Michelle P., and SCL, we did a three-month allocation plan for the 250 slots for HCB. Month 1 and 2, we will release 100 slots per month, and whatever the normal rollover is from each month and then month 3, we will allocate the remaining 50 slots and then whatever needs to roll over each month. I know that's hard for everybody to understand, but there are slots that are taken and they are always in process.

So for the Michelle P. waiver, we are doing 85 new slots for months 1 and 2, and 80 slots for month 3; and then we will also have those rollovers every month, which, I think, are around 75, I don't want to quote that for sure, but it's around 75.

And for the SCL slots, was 125 new slots. We do not have anybody on the emergency waiting list and we will start

working through the urgent, so I just wanted to let you know that.

We tried to be diligent. I had left for a little while in previous years and came back when we were allocating those arguments for Michelle P. and it didn't just so slow us down, it stopped us dead in our tracks, and I didn't what that to happen again, so our sister agencies we all met together and decided on this plan together, so it wasn't just a Medicaid decision either.

MS. BEAUREGARD: That is helpful. Staggering slots makes sense --

MS. HOFFMAN: Yes.

MS. BEAUREGARD: -- when you are trying to deal with capacity. I don't recall the exact number that was approved in the budget, in the state budget, but I feel it is more than what you just said.

MS. HOFFMAN: So for the fiscal year '25, it's 25 slots for ABI LTC, 250 slots for HCB; 250 slots for Michelle P. waiver; and 125 slots for SCL. And that's just fiscal year '25, so that is all we

have been working on. If you want for fiscal year '26, we have to do a current evaluation of the waiting list prior to being able to release those, and of course, we have to ask CMS to be able to release those as well.

MS. BEAUREGARD: Okay. That makes sense. Thank you.

MS. HOFFMAN: Yes, ma'am.

MS. BEAUREGARD: Any questions about the new waiver slots? It looks like Arthur may have one.

Arthur, you are on mute right now. Maybe you were talking to your assistant?

Okay. Well, Arthur, if you do have a question, either unmute or put it in the chat. I wasn't 100 percent sure and if there aren't any questions.

INTERPRETER: He says he has a question, but he's waiting until you guys get to the question of C, the HBS waivers.

MS. BEAUREGARD: Okay. That makes sense.

All right. So thank you for

that update, Leslie, and I think we may be going back to Jiordan for an update on the unwinding renewal process.

MS. GRIFFIN: I'm sorry. Which one are we on? How many adults have completed the unwinding renewal process?

MS. BEAUREGARD: That's right.

MS. GRIFFIN: So, for our finalized July numbers, because obviously we are not done with August just yet, but, so the total number of individuals that have a renewal date of July 31st, we had 40,719 individuals. Of those individuals, 36,035 were approved, and 48 of those individuals were approved after termination. So they were terminated for probably non-response, and then they came back and were reinstated.

Of the individuals terminated, 907 of those were determined ineligible; 53 of those were no response or they failed to return their renewal form; the number of individuals that we have pending processing for July is zero, so that is great. That means we have processed all

of their documents and completed their determinations. Then we had some members that were extended to August based on some of the flexibilities that we have, that are continuing until June of 2025 and we have 3,496 of those individuals.

MS. BEAUREGARD: Okay great. Thank you.

MS. CECIL: Emily, this is Veronica Judy Cecil with Kentucky Medicaid.

I just want to note -- so we are now as we come out of the formal unwinding, you know, there aren't really very many cases that we would consider a public health emergency unwinding case, and we've kind of collapsed everything because we are now going through the second round of renewals for individuals that had a first, and then we're going through first renewals for people that enrolled a year ago from today.

In terms of just the unwinding bucket, we had 1.1 million individuals go through renewal due to unwinding. And

then about 83 percent were approved, which I think is fantastic. And then for those who were terminated, a majority of those -- I'm sorry -- over half, about 60 percent, were for that non-response procedural reason, so keep in mind that really May was, sort of, our last large number of PHE unwinding renewals. We had just a handful in June. So almost all of the PHE renewals have been completed.

MS. BEAUREGARD: That's great. Yeah. I knew it was winding down for adults -- no pun intended. Of course, not starting yet for children, but it is good to know that the overall success of renewals was 83 percent. And I know that you all have been allowing as much time for people to get those documents in as soon as possible so we appreciate that.

I think maybe as we move on with our next agenda, we can look at it not so much from an unwinding perspective, but just renewal from year to year.

Thank you for those updates. Any questions about the renewal process or

these numbers?

All right. So then the next section is really just focused on child renewals. I know you may not have an answer to this question yet, but perhaps since last time we talked, do you have a start date yet for child renewals or any response from CMS?

MS. CECIL: No. The question to CMS is still pending and we maintain flexibility until we hear otherwise, so we have been automatically extending children, and of course, we have a lot of children going through first renewal that renewed this time last year, so even though -- there were some child renewals in September last year -- not very many -- they may have been part of another case and so we took the case together, but we have extended children. If a child is being terminated, it's really for those three reasons of, they turned 19 and they weren't enrolled or they may get enrolled in a different type of assistance; they moved out of state; or their termination

was requested.

MS. BEAUREGARD: So just because I think it can be confusing, the timeline which continuous eligibility applies, or that pandemic era eligibility, but if a child was enrolled when the pandemic began essentially, whenever Congress passed that part of the law, or until what date last year, at some point, was when some children if they first enrolled, they weren't covered by this protection.

MS. CECIL: We included the extension for any child renewal from September '23 on, but we moved most of the child cases to beyond that date so we could cover all children with that flexibility. Does that make sense?

MS. BEAUREGARD: I think it does. As I understood what you were saying, I thought you were saying that a child renewed some point last year -- if they enrolled in coverage last year, they would be renewing this year and it could happen before child renewals begin.

MS. CECIL: No. So now, because

we apply the flexibility at the time of their renewal. If they enrolled in August of last year, we applied the flexibility to them for their first renewal, so they are automatically extended.

MS. BEAUREGARD: They will also automatically be extended.

MS. CECIL: Yes.

MS. BEAUREGARD: That's very helpful. I wasn't being very clear in how I asked the question, but I think we got the answer.

MS. CECIL: Okay, good.

MS. BEAUREGARD: So we don't have a timeline there. But they are being extended month-to-month.

The other question here that had come up on a previous call is about the Kentucky birth certificates. Do you have any more information you can share there?

MS. CECIL: Jiordan, do you have an answer to that question?

MS. GRIFFIN: Yeah. When looking at an individual's citizenship, normally the databases that we use, or the

data sources that we use, is able to capture that information automatically, and then our eligibility staff also has a manual lookup access to what is called the KVETS system, which is the Kentucky Vital Statistics data warehouse where they hold all of the birth information for births that take place in Kentucky. They don't have it for other states. So any time a birth certificate would be requested it would be after we've checked all of those data sources, and no information was returned or we weren't able to find that information. It's very rare that we see an RFI going out requesting a birth certificate unless we were just completely unable to verify citizenship. Sometimes we see this with newborns. Their information may not have entered into the data sources yet, but I think we had requested, maybe, specific examples that we could look at to see what the exact situation was around those requests, and we are happy to look at those if they can be provided, but it shouldn't be something

that happens often.

MS. BEAUREGARD: Well, I am glad to hear it. We have absolutely seen them from time to time and children born in Kentucky so sometimes that is some error in what notice may get sent out, but I will follow up with Priscilla to see if she sent them or can send more.

And then Miranda, I wanted to ask you if you had any examples that you wanted to share?

MS. BROWN: I do not. And it's possible there are other connectors, Soraya may, she is not on the meeting at the moment, but I will check with her.

MS. BEAUREGARD: Just knowing that there should be a process in place is good just to have that confirmed.

MS. GRIFFIN: There is. Best practice for us when doing eligibility is always to check our data sources before ask for birth certificates. So, yeah, if you don't mind to send me some examples in email or however you want to get them to me I would be happy to look into them and

see exactly why they were requested.

MS. BEAUREGARD: Okay. Thank you. Any other questions about Medicaid renewals before we move on? So next we have the HCBS waivers, state plan amendment, and rate study. And I know that Arthur had some questions about that in the chat. Let me pull this up.

So regarding the rate increase corrective action plan, Leslie, if you could give us from there and then answer the question.

MS. HOFFMAN: And I think I can answer question one.

MS. BEAUREGARD: I think we need to read them out loud for them to be in the transcript.

MS. HOFFMAN: So I'm just going to, kind of, give you a summary and then we can go back to his questions, if that's okay.

MS. BEAUREGARD: Yes.

MS. HOFFMAN: So giving a summary of the HCBS waivers, state plan amendments, and the rate study. So DMS

updated the six 1915(c) waivers to reflect the new rate methodology that was based on the rate study completed in 2023. DMS had no plans to decrease the rates for any services with the implementation of the methodology.

DMS released those amendments, Emily, for all six waivers and the rate study on August 14th, and I can put that in the chat to solicit for public comment for proposed changes.

Let me see if I can put this in here for you really quick. It says it's too long. I will email it. How about that? I will email it to you, Erin, and get it out to you.

And then, the public comment will go into September the 13th of 2024, and then at that point we will pull those public comments down, we will do a question and answer, and post those back on to the website for review, and then I can also send -- let's see if I can send this -- for more information about posting public comments and then we will be happy

for you to comment and take these back. Let me get this here. And then, the anticipated time frame for that would be public comment ends on the 13th, a Q&A would be posted. Now our Q&A answers back are being posted on the website is really based on the volume. If we get 2,000, that's different than 200, and 20 unique ones versus 200 unique ones are always different, but we plan on getting that turned around really quick. And then at that point we would submit the revised application based on the public comment, back to CMS for review, DMS anticipates approval and implementation by early 2025. So, you know, they've got clocks -- what we call our clocks -- so as long as we can keep negotiating really early on with questions back-and-forth, that is good. Once we go on o'clock -- if we do go on the clock with them -- then that can be up to a 90-day period back-and-forth.

So as far as the proposed rates for PDS, as has historically been the case, rates or services offered through

traditional and participant-directed service delivery are equivalent PDS employers or the participants can pay their PDS employees up to the rates listed in the fee schedule.

And I would mention too, Emily, I will email you the links for this, but because those applications are so long and they are hard to read through and they are not provider friendly or member friendly, we did summaries, so we've got these summaries for each one of the waivers that you can go to as well.

As far as a corrective action plan goes, we do not have anything in formal writing yet like that is a formal cap. We are meeting with CMS and we did include our sister agencies on the last call with them, and we will have another call coming up in September, I believe, so DMS, of course, is willing to provided that to you once we have that official cap.

MS. BEAUREGARD: Okay.

MS. HOFFMAN: I think our next

call with them is September the 30th, I believe.

MS. BEAUREGARD: Okay. Good to know. We have another TAC meeting in October.

MS. HOFFMAN: Okay. And let's see -- next would be the 1915(i), and I will speak on that today as the representative is not available.

So the 1915(i) is what we call and HCB, SMI, and SUD state plan amendment. I know it is confusing, but that's what they call the opportunity through the federal government, so it is a state plan amendment. Our 1915(i) is currently under the administration of the Department of Behavioral Health and Ann Holland, who used to be with our department is now administering that program through the Department of Behavioral Health and they have already started work as administering rather than wait for implementation, and I am going to put her information in the chat. And then Medicaid will remain the authority, the

CMS oversight and the compliance, and we are currently working with CMS off the clock for our second round of requests for information, questions. And we plan to have those submitted back to CMS around the 30th of this month, so about ten days from now. We are looking at a hopeful start date of July of 2025. It's a little fluid right now, because as I mentioned before, we want to make sure that we have a lot of time to do a lot of collaboration, lots of communication, and also we've got a companion SMI 1115 that's coming out that's kind of, are companions to one another, and we don't think that one will be approved until around September, so I just wanted to let you know that we will have to work through all those procedures on the 1115 side that takes a little bit longer than any of the HCB projects.

So the companion SMI 1115 was submitted to CMS in May, if you remember, and that gives us the authority to reimburse beyond 15 days for inpatient

psychiatric stays, and it also allows us to assist with a recuperative care pilot project, which we are very excited about, and this will give folks who may be homeless and in need of care, maybe before or after hospitalization or surgery, this will give them time to recuperate in a safe environment, and a clean environment, maybe if they have to do prep prior to surgeries or things like that.

I was just going to mention too, on the health and housing collaborative, of course, BBH, now with Ann Holland, will be partnering with us in that endeavor, but we continue to partner with our Kentucky Housing Corporation on many initiatives. If you remember, we had previously partnered with them and had written letters of support for another NOFO opportunity that they were applying for and DBH sent support as well. The collaborative has mostly been focused on the housing support under the 1915(i) state plan amendment. And right now, our upcoming discussions will be about system

alignment between CMS and the homeless management system. And we do have, for the first time in history, a HMIS user, that's the data where we can connect our data with the homeless population. And so that is very exciting, and I believe Ann Holland also is going to become an HMIS user as well.

So as far as Arthur's questions, I was just going to mention we have not made any final decisions, at this time, about an RFP. We are in conversations, but we have made no final decisions and, of course, that would be CHFS leadership and the secretary to make the final decisions for that.

Arthur, number 2 and number 3, if it would be okay, I would like for staff to be able to take that back because I don't want to quote anything that would be incorrect to you on this call. If that's okay, we'll reach out directly to you on email, if that is okay.

MR. CAMPBELL: All right.

MS. HOFFMAN: Okay, thank you.

Yes, I will have --

MR. CAMPBELL: Can you please email it to me?

MS. HOFFMAN: Yes. That is what we plan to do. I answered the question 1. We will be reaching out to you for question 2 and 3 by email.

MR. CAMPBELL: They haven't decided when RFP is issued?

MS. HOFFMAN: That's correct. There is no final decision made on whether we are going to follow an RFP process right now. We are still in conversations.

MR. CAMPBELL: What about -- is there anyone in the cabinet in the MDS that can tell me whether or not Medicaid will pay for jelly injection for severe knee pain?

MS. HOFFMAN: That's what I'm going to have to follow up on, unless there somebody on the call that can answer that question, that's one that we will follow up on.

MR. CAMPBELL: I will appreciate it. I have four people who want to have

that done and they call Medicaid.

MS. HOFFMAN: I will need to follow up on that. Jelly injections are not my forte. But I will follow up for you.

MR. CAMPBELL: Okay. Thank you.

MS. HOFFMAN: Okay. Let's see.

Emily, am I next for end of Appendix K flexibility?

MS. BEAUREGARD: Yes. That's right.

MS. HOFFMAN: I'm sure you've heard all of this information already. I have a timeline here, probably because I haven't spoken to about this before, but of course, federal government ended the COVID-19 public health emergency on May the 11th of 2023, and the Medicaid flexibilities approved through Appendix K remained in place through November of 2023.

DMS's response to the public health emergency ending was: In fall of 2023, DMS amended the six 1915(c) emergency waivers to make some of the

Appendix K flexibilities permanent; CMS approved those changes, and they became effective in May of 2024.

We did stakeholder engagement, webinars, in September and in March. And describe the changes that would be permanent and which ones would be expiring, so I have the links for those if anybody is interested. We do have resources and FAQ and a one-pager on the website, which I thought that I could put in the chat for you again.

MS. BEAUREGARD: Leslie, I'm assuming that all of the flexibilities that you been able to maintain permanently, those are in place now. There wasn't, like, a disruption?

MS. HOFFMAN: Not that I am aware of. No.

MS. BEAUREGARD: And there's nothing else changing moving forward.

MS. HOFFMAN: Not that I'm aware of, Emily.

MS. BEAUREGARD: The ones that ended are done, and the ones that are

permanent are in place.

MS. HOFFMAN: Yes.

MS. BEAUREGARD: So we can probably take this off of our agenda all together.

MS. HOFFMAN: And I put the one-pager and the FAQ --

MS. BEAUREGARD: Okay, great. Thank you.

And then, you already spoke to the health and housing collaborative between DMS and the Kentucky Housing Corporation, but I did want to see if Melanie had any questions there.

MS. HOFFMAN: Okay.

MS. TYNER-WILSON: There was something posted that, today, on a source called, Disability Swoop, and they talked about that state agencies will be receiving federal dollars for individuals with disabilities, and Kentucky is on the list to be a recipient, and it looks like they are going to housing agencies, and it will be anywhere from $4 million to $8 million.

MS. HOFFMAN: Melanie, I don't know for sure if this the same opportunity, but we, just recently, like I said, sent support letters in for a NOFO that Kentucky Housing was applying for. I don't know if that's the particular one.

MS. TYNER-WILSON: Oh, okay.

MS. HOFFMAN: It wasn't us that applied for it, though.

MS. TYNER-WILSON: I think it was Kentucky Housing Association, is what I am guessing, and the funding will allow states to develop strategies for individuals, the housing options and provide them rental assistance. Does that sound familiar?

MS. HOFFMAN: Yeah. You will hear us talk about tendency reports in some of our programs. That we are partnering with them. I don't want to speak particular to what you are speaking about today, because I have not read it, but we have partnered with them on several initiatives so far, so we are excited and so honored to have them as partners here

in Kentucky to make sure we can provide a continuum of care, because we are all working together, so that is a very positive thing.

MS. TYNER-WILSON: Yeah. I can send it on to you, if that would be of help.

MS. HOFFMAN: Yes, ma'am. I have a meeting with them on maybe the 9th. I can double check with them.

MS. TYNER-WILSON: That would be great.

MS. HOFFMAN: Absolutely.

MS. BEAUREGARD: Well, thank you, Leslie. And when you mentioned the companion SMI 1115 waiver that was submitted in May, I'm assuming you are in the -- DMS right now is just wait for response from CMS?

MS. HOFFMAN: Yeah. That one is actually tied -- and I know this all gets confusing -- but it was actually tied to our umbrella, which is called Team Kentucky, so it's one of the requests that will be under Team Kentucky, and Team

Kentucky was up -- it was time for us to extend that demonstration period, so it is tied to the whole demonstration getting approved. So there are multiple -- let's see, we've got the SMI, I'm trying to think -- reentry -- went ahead and approved reentry; issue D is under there; we have several ARMS related to formal foster care; some related to -- or was -- related to employee entrance -- there are a lot of things that are under that umbrella.

MS. BEAUREGARD: So are you waiting to submit other components of that, or are you just waiting for CMS to respond?

MS. HOFFMAN: We are waiting for a response. The only thing that we submitted that was, kind of, outside, was the reentry, and then they decided for the reentry, to fast-track six states in a cohort that were very similar to the state Medicaid director letter, and they fast tracked us with some other states to get that done.

MS. BEAUREGARD: So your implementation plan also has to be done sooner.

MS. HOFFMAN: That is correct. There will also be an implementation plan. The 1115's are a lot harder than people realize. The reentry requires an implementation plan, a reinvestment plan that we have never done before, it's specific to reentry opportunity; monitoring and what we call our -- it's like our metrics that we have to get approved -- and some of them will be state specific and some of them will be -- I'm missing my acronym -- we will have state ones and then the ones that are required for STCs -- I'm sorry, standard of terms and conditions. Then we have the federal required ones. So all of that has to be approved. Some of that can work simultaneously, some of it takes 120 days, so of it takes 150 days, it is kind of crazy. So even on the companion 1115 that I told you about that we are waiting for approval, even when I get approval, it's

not ready to go, I have to write an implementation plan. So we are already working on implementation plans even before we get approvals, so we can streamline that quicker.

MS. BEAUREGARD: Yeah. Okay. That make sense. Thanks. That's all good information to have.

Does anybody have any questions?

All right. I think we can move ahead to the School Medicaid Grant implementation.

MS. JONES: Erin, did you want me to share my screen, or were you going to share it?

MS. BICKERS: I made you a cohost, so you should be able to share. Sorry.

MS. JONES: It is taking me a second. I am trying to get my mind around Zoom instead of Teams.

MS. BEAUREGARD: We can see your screen now.

MS. JONES: Okay, good. And I'm trying to see where I can do slideshow.

Okay, good.

Good afternoon, and thank you for allowing me to discuss the SHINE Kentucky grant. SHINE Kentucky, of course, an acronym for Strengthening Health Integration in Education for Kentucky Students. We are really, really excited about this. So what I will do is a little bit of an overview of the project, and then the goals and strategies, and then that first year, our work plan and timeline.

So in, I think it was in January of this year, CMS released a notice of funding opportunity for $2.5 million for up to 20 states to receive the grants for either implementing, expanding, or enhancing school-based services. It is a three-year grant. Kentucky went with the option to enhance our school-based services, because we have already implemented school-based services and also expanded them. Expanding, meaning that we will reimburse for Medicaid covered-services for students who have

Medicaid or CHIP, and that is regardless of whether or not that student has an individualized education plan. So Kentucky was one of three states to receive the grant for enhancing school-based services. There were a total of 18 states that were rewarded, but, again, we were one of only three that were able to get the reward for enhancing services.

So there were two overarching goals for this project. The first to increase school-based services, provider and staff capacity by at least 40 percent within three years. Doing that through eliminating provider billing barriers, increasing overall capacity of our behavioral health providers in the school setting, and also increasing the availability of reimbursement opportunities to expand healthcare opportunities across the continuum.

The second goal is to strengthen school-based services infrastructure through availability of Telehealth by

25 percent within that three-year grant period, through developing and implementing a Telehealth program to support access to behavioral health services and provider education. Both of those goals were based in part, because we have identified that there is a behavioral health provider shortage, especially in that school setting.

So there are six enhancement strategies that we will use. I'm going to try to make these a little bit easier to understand if you are not actually involved in the project. So the first we want to seek to build the staff, capacity and competencies, so we know that there is a need, not just for behavioral health providers in the school setting, but also administrative staff that can understand how to bill for Medicaid, because that is a lot to put on a school district to become Medicaid providers as well, so we want to ease any administrative burdens that there are as well.

Outreach and community

engagement. So that is, of course, outreach to our students to make sure that they know that these services are available, but also parents, so that they know that their children can receive some of these services of school.

And also community providers. We need them to be engaged that if students are receiving services in the school, that there is follow-up in the community, if necessary. Also have these community providers with the school district to partner or contract with the school to provide those services.

Let's see. I can go through each one of these. I'm not sure if that would be helpful or not -- each of these enhancements. But one of the highlights is our SHINE Kentucky grant program. We are going to reward $100,000 to seven different school districts, in order for them to pilot different models of how they are increasing school-based behavioral health services with the expectation that the lessons learned through those piloting

projects that we can have rolled out throughout the state, of any of those successful models.

So there are 11 key tasks for the first year of the grant, and this breaks them down a little bit. We are in the part now where we are gathering who are advisory groups and stakeholders will be and also completing our final-needs assessment. So we have gone through several different -- we have done a survey from DMS on what the needs are for school-based services. We know that there have been other agencies that have also done different needs assessments, so we want to synthesize all those different surveys, and then if there are any other remaining issues that need to be addressed we want to collect all of that information, and we are going to have a final needs assessment by the end of this calendar year.

So, again, the immediate next steps, right now, we are working on: Identifying who the stakeholders need to

be; developing that stakeholder engagement plan; thinking about the different survey and interview tools that we are going to need to get all of the information that we need for our needs assessment; and then present that, again, by the end of the calendar year.

And I didn't know if we wanted to open it up to questions now, or if that is something that would be done through TACs.

MS. BEAUREGARD: I think now is great and thank you very much for this presentation. It's good to see it on paper, and it's really helpful to see the difference on focus areas that you have.

I wanted to ask about any, sort of, overarching goals. I know mental health is a big priority of the administration right now. Of course, we have had a campaign for years to have a nurse in every school. Just wondering if you are, with the grant, or any of your technical assistance, and especially your focus on workforce improvement, are you

looking at targeting a particular sort of type of provider or service?

MS. JONES: We are. Specifically looking at behavioral health services. So that is our goal, of course, is to expand behavioral health services, but we know expanding access to healthcare services in the school setting, that would also include the physical health services as well. But our main priority right now, is the behavioral health services.

MS. BEAUREGARD: Okay. That's good. That's helpful.

Any other questions?

MS. TYNER-WILSON: This is Melanie. I had a question. When you were talking about behavioral health, are you talking about it from the lens of a medical model in terms of having a psychologist or a LCSWs? Help me. I'm just trying to frame what behaviors are you looking to provide supports for?

MS. JONES: So we have a broad range of services that are covered in the school setting, as well as a large variety

of providers that are qualified to provide those services. We have a technical assistance guide for school-based services that list all of those, and I will put a link to that in the chat. But that will tell you all of the services that are covered, so let's see, there are -- different assessments would be covered, psychotherapy is covered; there's substance-use disorder treatments that are covered; family therapy; so it really is a large variety of services that could be provided in the school setting that we do cover. And then, also to your point about psychologists, so it again, psychiatrists, it could be licensed clinical social workers, there is a number of providers that we consider qualified for the school setting.

MS. TYNER-WILSON: And the age range, would it be kids as young as preschool to children that are in high school?

MS. JONES: School-based services covers children ages 3 to 21.

Just depending on our final-needs assessment, I can't say for sure if we would target a preschool age or not, because it is behavioral health focused, and most likely would be middle school and high school. But again, if our needs assessment says that we are seeing a lot of third through fifth grade struggling, then we would adjust our priorities there.

MS. TYNER-WILSON: Sarah Vanover who is with Kentucky Youth Advocates, has written a nice book on mental health issues in the very young child. I don't know if that is something, that's why it's something that popped into my mind, because she saw that there is such a great need for support beginning at that really young age, so just an FYI.

MS. JONES: That is helpful and maybe that is someone we can reach out to as a stakeholder. If you don't mind to drop that information in the chat.

And of course, all that information that is available on adverse childhood events, maybe there's something

that we start looking at the early childhood events too.

MS. TYNER-WILSON: Okay. I am on my phone so I don't know if I can -- I'll try to put it in the chat, but, yeah, I would be happy to do that.

MS. BICKERS: Melanie, this is Erin. If you want to email it to me later. I can get that to Erica.

MS. TYNER-WILSON: Thank you, Erin. You are always saving me. I appreciate that.

MS. BEAUREGARD: Erin is fantastic.

Erica, I wanted to just follow up on that question about more early childhood. I'm assuming that you're talking about programs like a preschool program that might be located within a school, a K-12 school, or could school Medicaid actually, like, the Medicaid-free care rule, kind of, that was reversed and that allows for schools to bill Medicaid and also get that administrative rate. Could that be happening in preschools that

are outside of our K-12 system?

MS. JONES: Our local education agencies, which are the school districts, are the Medicaid providers. They are the ones who enroll. So it would need to be --

MS. BEAUREGARD: Through the LEAs.

MS. JONES: Yes.

MS. BEAUREGARD: Okay. That's helpful.

And of course, Melanie, this is probably information that you know, but even if it wasn't, school Medicaid as we talk about it now, you know, as kind of this program that schools can bill for Medicaid services outside of IEPs, other programs that may serve young children could potentially have Medicaid services as well. It may be a little bit separate and how it is administered, but there wouldn't necessarily be a reason that they couldn't provide those services.

Any other questions about school Medicaid? Okay. Well, we are very

excited to see this getting started and look forward to getting some more information as you all get some pieces in place. I understand the grant is underway; right? You had an automatic implementation date. You're just in the planning phase right now?

MS. JONES: Yes. We were funded beginning July 1, and we were notified of our funding, I think --

MS. BEAUREGARD: Like the week before?

MS. JONES: The week before.

MS. BEAUREGARD: All right. Thank you, Erica. We appreciate it.

MS. JONES: Thanks, Emily.

MS. BEAUREGARD: The next item here is the DMS surveys of Medicaid members and stakeholders. I think both surveys have ended, so just wondering if you all have any data that you can share with us yet.

MS. CECIL: We do not yet. Because we did extend it a little into last month, so we are still kind of

culminating the responses, so I would guess by the next meeting in October, I should be able to present some information.

MS. BEAUREGARD: Okay, great. I will keep it on the agenda for October then. Thank you.

So the next item here is the access to services form that Angie has been helping us with.

MS. PARKER: Yes. And you gave me feedback in July. I don't have any problems with that. I don't know if you want me to pull it up for one last look and we can get it rolling.

MS. BEAUREGARD: That would be great.

MS. PARKER: I'm going to take myself off camera while I do that.

MS. BEAUREGARD: If we can finalize that and look at that while we get started, that would be fantastic.

MS. PARKER: I have the same issue as Erica, because I am used to Teams, but Erin, if you would give me

access.

MS. BICKERS: I did.

MS. PARKER: Thank you. Okay.

So this is what was provided in July, and we determined that, yes, in-network would be here, and the word, "and" was included, as well as, "if available." The date you first requested an appointment, and if there were any offered on the date if accepted, if one was provided, and then given these choices, anything else you needed to know, looks good to me.

MS. BEAUREGARD: Okay. Thank you for just going over it again. I am assuming this is going to be a fillable PDF. I think we talked about that. And then, eventually, it will be a form that people can fill out online.

MS. PARKER: Yes. The expectation is to put it online and then they would be able to fill it out that way and somehow get it to our inbox.

MS. BEAUREGARD: Yeah. Okay.

MS. PARKER: So that could take

a little bit, but we will get on it if everybody is good with how this looks now.

MS. BEAUREGARD: Any other feedback that TAC members want to provide?

I feel like this is a good start. Oh, I think there is a typo on the provider name, but I'm sure you can all take care of those things. And, you know, as we see it being used, we may have to make some adjustments, but I really appreciate you all working on this, and I'm looking forward to seeing how people are able to report and if that can give you all information so that you can really look into where there might be gaps in the network. I guess one question that I have, not so much about the form, but any follow-up that people can expect: Do you anticipate being able to actually respond to someone who has offer to help them find to find a provider or maybe alert the MCO.

MS. PARKER: The expectation would be that if we have the MCO information, then we would forward that to them. There should be a closed loop

process to this.

MS. BEAUREGARD: Okay. If the MCO hasn't necessarily been helpful up until that point, is that when DMS would, kind of, step in?

MS. PARKER: We would send it to them and say: We have gotten this. Could you reach out?

MS. BEAUREGARD: And pay more attention in this particular case?

MS. PARKER: It all depends on what some of the feedback is that we get.

MS. BEAUREGARD: Okay. All right. Any other questions about it?

Angie, would you be able to let us know when it is live?

MS. PARKER: Sure.

MS. BEAUREGARD: And where it is going to be housed on the website so we can share it?

MS. PARKER: Absolutely.

MS. BEAUREGARD: Thank you. This would be a really good topic to have on one of your monthly stakeholder calls. I know that you have now expanded the

topics for the stakeholder calls that originally were started around the Medicaid renewal process and unwinding, but just to --

MS. PARKER: Probably once we get it up and online, that is something that we could certainly add.

MS. BEAUREGARD: Okay, great.

DR. THERIOT: One thing that just popped into my head is doing the same thing for an EMT, because the transportation cabinet does have a survey and it's always glowing, and I'm sorry, I don't want to create anything, but it was just a thought.

MS. BEAUREGARD: I like how you think.

MS. PARKER: You're thought, you get to take it and run with it.

MS. BEAUREGARD: I like how you think. Well, you know, it is a Medicaid service and we've been talking in terms of providers and if -- you know, if this was an online form, and it could be a medical service or a transportation service that

you need, it could all, I think, be integrated pretty easily. But I do think that transportation is a Medicaid service, and we should know whether or not somebody has had trouble getting access to transportation. I wonder if there is a way to just add brokers to that.

MS. PARKER: Thanks, Dr. Theriot. No. I will look at it. I will see if there are any adjustments to this particular form and look at something different.

MS. BEAUREGARD: I have to agree that the data that is collected through the Department of Transportation doesn't seem to really reflect the experience that people have, and I just think that that is probably a matter of that they can provide feedback or where to provide that feedback. And it's also, I'm curious to see how many people will have access to transportation because of the new regulation. Of course, that still depends on whether or not they are familiar with those changes and how to as far as

administering that. I'm glad you brought it up. Thank you.

MS. PARKER: It might take a little bit longer. I will see what we can add to it or if we need to look --

MS. BEAUREGARD: Just to do something similar.

MS. PARKER: -- or a different avenue.

MS. BEAUREGARD: Yeah. I think either could potentially work.

The next item here is a presentation on the 2022 A trip, which is a Hospital Rate Improvement Program and the alignment of the quality initiatives. We've kept this on the agenda because I think the expectation was that later this year you would be able to provide more information. Do you have that --

MS. PARKER: Actually the presentation that I have is something that I presented to the Hospital TAC in February. So I just changed the name to the Consumer TAC and added the date for today, so I can go through this. It's

regarding the program results from 2022 for the HRIP program. And I'm going to take myself off camera. Are you still seeing the form or are you seeing the presentation?

MS. BEAUREGARD: I can see your presentation.

MS. HOFFMAN: Presentation.

MS. PARKER: Okay, great.

So as I mentioned, this is the Hospital Rate Improvement Program, 2022 results, but in order to get to that, I wanted to give just a short overview of what the Hospital Rate Improvement Program is for those who may not be familiar, but it's basically, a directed-payment program that allows us, DMS Medicaid, to provide enhanced payments through the managed-care organizations to advance goals of the Medicaid program to the hospitals. It is based on utilization delivery of services; it is supposed to advance at least one goal of our Kentucky Medicaid's quality strategy; we evaluate it at the end of each program year to measure progress; it

is submitted to CMS annually for approval. Any changes -- we have to do this every year -- any changes to the directed-payment program, also known as a preprint, we have to update, and it also gives us an opportunity to potentially add measures. It is funded through a hospital assessment part of this 205.206 and programs are designed to achieve two main objectives, to maintain outcomes and improve access to services.

2022 HRIP program, we worked collaboratively with the Kentucky Hospital Association. In 2022, 84 percent of the hospitals achieved at least four of the five hospital-specific goals, and 50 percent of the hospitals achieved all fives hospital-specific goals.

Here are the data metrics that are specific for 2022. There are asterisks assigned to some of these that let you know that they are applicable to certain hospitals, or not applicable to certain areas.

CAUTI is the catheter-assisted

urinary tract infection, that's what that stands for. C difficile is a GI type problem; hospital readmissions; sepsis; there were psychiatric specific measures; safe use of opioids, and rehab-specific measures, specific to discharge in the community; and also social determinants of health screening. That was started in 2022, and they will be being measured on that for calendar year '23. We are in the process of getting 2023 reviewed.

So here are the lists of all of the 2022 quality measures and what the benchmark was and the hospital goal for each measure, and then the results. So for the providers meeting the goal for 30-day readmissions, 78, and then there were 99 providers that were eligible for this. And below, just gives you the percentage for each quality measure, what was met, and as you can see, the catheter assisted urinary tract infections, the low-volume for rehab or LTAC was the least positive in improving or obtaining the benchmark. And I will let you look at

that for a second in case you have any questions and then, obviously, I will provide these to you after the meeting. I will send them to Erin.

Continued results on this screen, C difficile low volume for rehab or LTAC is the least positive, most negative, however, you want to look at that for achievement of those measures of the providers in which they were eligible. They did pretty well in certain areas.

MS. BEAUREGARD: And these are -- the numbers here are the number of hospitals; right? When it says providers meeting goals?

MS. PARKER: Yes. Most of those are rehab, it depends on, for example, this C diff. volume 9, and then you have the rehab, so it -- this gives you the total number who would be applicable or eligible for these particular measures.

MS. BEAUREGARD: Right. So when are you expecting to have data from 2023 available to share?

MS. PARKER: It is being

reviewed and audited now, so it probably will be the first of next year before we get the final.

MS. BEAUREGARD: Next year. Okay.

MS. PARKER: And I will put it on my calendar to do the same thing for you. How about that?

MS. BEAUREGARD: That sounds good. And then I am assuming that when you see rates that are lower, around C difficile, is the hospital association just working with those particular hospitals to improve those rates; is there anything that DMS is doing?

MS. PARKER: Well, they don't get paid for additional, depending on what this is based on, the quality measures -- in order for them to get additional payment, they have to meet certain qualifications as far as the benchmark for these, so they may not have --

MS. BEAUREGARD: Incentive is essentially --

MS. PARKER: Yes, yes. The

incentive is -- so they are all incentivized -- thank you for the word -- to perform to the benchmark or better.

MS. BEAUREGARD: Okay. That makes sense.

MS. PARKER: But we also look at trends as well, because for 2023, if the C diff is below this number, then obviously, that is something that we need to address a little bit more closely.

MS. BEAUREGARD: I think Arthur has a question.

MR. CAMPBELL: What does "hours of physical restraint use" mean?

MS. PARKER: That's a very good question, Arthur. I'm not exactly sure. It's in relation -- relationship to certain site facilities that would have been established in the benchmark. Let me go back and see if it is specifically addressed here. No. We are establishing a benchmark for 2022 data. So basically for that, they were just reporting what the average hours -- or hours of seclusion was, so we will know more about that for

2023.

MS. BEAUREGARD: I wonder, Angie, if the quality measure itself sets a parameter for what is considered appropriate.

MS. PARKER: Some of them are, but some of them we have to establish a benchmark based on the data that we are seeing. So for example, if the hours of restraint are ten hours, we don't want ten hours of restraint, obviously, so we would have to see what the average hours were, and then evaluate if that was appropriate based on certain criteria for the facility, or that type of facility for them to be restrained. Obviously, the lowest number is what we would be going for.

MS. BEAUREGARD: Yeah. I think the benchmark helps to measure if you are or declining, but do you have a reference for these measures that you can share with us that has, maybe, some additional details that Arthur could see?

MS. PARKER: I will look into --

I'm sure we do.

MS. BEAUREGARD: Yeah. That would be helpful.

MS. PARKER: I do believe this particular metric relates to -- this is hospital. So this is about hospital-based, inpatient, psychiatric is what the metric is tied to.

MR. CAMPBELL: Can you email me this document that is being viewed?

MS. PARKER: Yes. Absolutely.

MS. BEAUREGARD: Is it NCQA measures?

MS. PARKER: These are more hospital-specific measures so they wouldn't be NCQA HEDIS measures. Some of them, most of them are not, except for readmissions, but I can certainly get the more specific information on these for you.

MS. BEAUREGARD: That would be great.

And another question that I had, I know that now outpatient services are also participating in that rate program,

so is that something that you also have metrics established for?

MS. PARKER: Yes.

MS. BEAUREGARD: Probably a little bit later. Okay. I think that would be helpful to see next, too. So will be early 2025 --

MS. PARKER: For 2023.

MS. BEAUREGARD: -- for 2023 data, and at that point would you have benchmark data for the outpatient program?

MS. PARKER: I don't know. I will have to go back and look what all of those measures are. I'm thinking it won't. 2023 is the benchmark year for a majority of these, so we should have by that time.

MS. BEAUREGARD: The only other thing I wanted to bring up, I know with the social determinants of health assessment, that hospitals are now required to do.

MS. PARKER: Mm-hmm.

MS. BEAUREGARD: I think that's a very good step for hospitals to take and

then be tracking, but my understanding is while they can be technically doing it through KHIE, through the health information exchange. The hospitals aren't using KHIE right now, which would integrate it into their medical records, so is there anything --

MS. PARKER: KHIE and Connect, connect.

MS. BEAUREGARD: Right. But I don't think --

MS. PARKER: They share information back and forth.

MS. BEAUREGARD: -- they're using it, if from my understanding. They also can use -- do an assessment outside of the KHIE Connect system. Is there a way that you are able to collect that information from hospitals if they're not using KHIE?

MS. PARKER: If they are doing it through Connect, because Connect does connect. There is an exchange of information between the two systems.

MS. BEAUREGARD: Right. My

understanding is they are not doing it through Connect, generally speaking, in a way that it would be integrated into the system between their medical record and the state. I could be wrong about that, but when hospitals are choosing to do the social determinants of health assessment, it is not through Connect or KHIE. Is there a way that you can collect that information?

MS. PARKER: We do get that information through this project. We have to audit each of them, as well, but the majority of these measures are audited to see what they are collecting and the particular model that they are using to collect this information.

MS. BEAUREGARD: So would you actually get, then, the results of the assessment, or only that they completed the assessment?

MS. PARKER: We can do either. Right now, we are looking at if they completed the assessment.

MS. BEAUREGARD: Yeah. I feel

that if we are going to learn something from this, knowing what those assessments are telling hospitals, and knowing, then, how hospitals may be then following up with additional resources or care coordination or case management or whatever the case may be would be really helpful, but I think having the hospitals do the assessments, of course, is a good start.

DR. THERIOT: I think Norton Hospital, or that hospital system, is starting to use Connect to do this.

MS. BEAUREGARD: Good.

DR. THERIOT: So it is brand-new, and Andrew Bledsoe told me that last week. And so it is -- it makes sense, because if they do that, they can close the loop and the referral, but -- and it might be that they started doing it because of this new quality program that Angie has put together, so I, too, hope that more and more of them start using that system, because it already exists, and you can count things on it, but we

will see.

MS. PARKER: We didn't initially make it a requirement. We wanted them to get used to asking these questions, but they did have to ask, at minimum, the CMS questions so, initially, they were given the choice to do either, but I think in including that, the majority of them probably are using Connect, but I didn't find out the specific numbers, because it does help with that closed-loop and helps with that care coordinator at the hospital, whatever, that if there is something that they need at the hospital give them a resource, help with a resource, I think that is why a lot of the providers are using it.

MS. BEAUREGARD: Exactly.

Well, I'm glad to know that Norton has started, and if you could update us on other hospitals that might using it, and what we can learn from them. I think that is really where I am going here. But I'm happy to hear about Norton, because they are a large system, and they

happen to be mine, so I will give them kudos for that.

Anything else?

MS. PARKER: I have one more thing to share. It is showing the comparison of the three directed payments. If I can find it. All right.

I am hoping that you can see this. But this is the quality measure programs for '24-25, comparing the HRIP, the UK/UL, and the MCO Value-Based Purchasing Program. Yellow constitutes it is the same between the HRIP and UK/UL. The green is UK/UL and MCO VBP, and blue is all measures. So we are continuing to work with all of our HRIP programs to be more aligned. It is a little bit more challenging for the hospital-specific, because, you know, we are looking at certain things, such as sepsis, and blood cultures, and CAUTI and C diff, and you can't necessarily do those on an outpatient basis, but in the UK and MCO VBP are HEDIS driven, for the most part, and so there aren't HEDIS hospital --

inpatient hospital measures so there is little bit challenge there, but we are trying to get them more aligned in the next couple of years. We hope to see that.

MS. BEAUREGARD: This is very helpful to see. The legend -- I am trying to figure out if I understand.

MS. PARKER: Similar ones. So yellow -- it is in both HRIP and UK/UL measure. Green --

MS. BEAUREGARD: So you are just cross-referencing them between the two.

MS. PARKER: Yes. To help you to see what is similar.

MS. BEAUREGARD: All right. Thank you for sharing that. And I think you are probably going to email us.

MS. PARKER: Yes, I am.

I think I am done now.

MS. BEAUREGARD: Well, thank you, Angie. We appreciate it.

The next item here is language access. We've been, you know, talking about this for the past many meetings now

about a decision tree that could help people navigate what type of language service they need and how to get it, essentially, and looking at what services DMS and the MCOs are currently providing for the following populations, which we have listed here on the agenda -- people who speak different languages, people who are deaf or hard of hearing, people with speech impairment, and people who are nonverbal.

MS. COULTER: Hi, Emily. This is Danita. And I have put together just a short presentation just to talk about what we have done so far, and where we are now. I know, like you mentioned, we have been talking about this for awhile, but I think what this presentation would do, right now, as far as through that decision tree, is just give us an opportunity to answer some more questions and try to get some clarity about that specific document. So like Ms. Parker, I am going to turn myself off video and we will just start from the beginning of the presentation. I am

looking for my share button. Can you see my screen and am I in presentation mode?

MS. BEAUREGARD: Yes. Thank you.

MS. COULTER: Thank you.

So talking about language and communication, as I mentioned. This is a high-level overview. We have, not just from the Consumer TAC, but we have had several TACs ask this question about the interpretive services and language services; in general, what the MCOs are doing; and how DMS can better streamline those services. As we have been discussing this subject with the PAC, what we have been showing them that we have been using as a point of reference is the federal guidance for interpreter services. So the translation for interpretation services for Medicaid comes from the Health and Human Services, and this is the guidance that can be found on the Medicaid website that essentially tells us that we need to follow Title VI of the Civil Rights Act, that those language services

are available for those individuals with limited language proficiency. And then we have to follow the Section 504 of the Rehab Act of 1973. It talks more about the reimbursement, but we won't go through all of that, but this is part of that federal guidance that we use to help guide our managed-care providers -- managed care organizations, as well as the providers.

We also are following the Section 1557 final rules that have recently been released, so we have shared this also in all of the other previous TACs. This is just a breakdown of some of those frequently asked questions that specifically apply to the interpreter services, and I just wanted to include this is in the presentation just as a quick link and reference point to Section 1557. I don't want to go into this, because we are going to have some other guidance that breaks down and tells us how to specifically apply that to DMS, but just a reference point for you all to look at because it specifically addresses some

of the asks that you all have for DMS.

As far as the managed-care organizations are concerned, in regards to the guidance that we have very specifically to them, within their contracts, we have the following language that is available to all six of our managed-care organizations that talks about the appropriate foreign language or the oral interpreters, which is what we talk about a lot within these TACs, that they must also have those written materials and that they should have staff that should be able to address those very specific needs that they talk about in the decision tree document.

I just highlighted those very specific asks that you all have requested from us, and I wanted to put these in the presentation just to be sure that we are clear on your ask, and if you're not, this will give us an opportunity to make sure we have those correct. What I have here, is you wanted those very specific populations identified for that decision

tree, which were those limited English proficiency, American Sign Language, people with speech impairments and those individuals who are nonverbal.

You also asked for us to create this one-page document that we can share. We've been working with managed-care organizations to help us provide that information with the language access support. This decision tree is just one document, also.

So that would be two documents, if that is the clarity that we are looking for. So you wanted that one shared document, but there would also be a decision tree that we are looking for from those specific populations. That would be one point of clarity that we are looking for. And then, coming from all this information that you are asking from us, there were still some questions about what those pending recommendations would be for the MAC. We had mentioned a provider letter and then also a notice that was in plain language. Though we had worked on

that one-page document, and this is something that Angie had shared the results of with this TAC, specifically, and then just reviewing how the process on how we went about getting that information.

We requested from all of the managed-care organizations if they would please provide us with what they are doing in regards to their interpreter services, and any of their American Sign Language processes, as well as those internal processes that they had. So we gathered all of that information and we tried to take that information and create that one-page document.

So once we received all of that information, we worked with our communications team internally, they put that information together, and we worked with our human service compliance analyst who took the time to review all of that information, all six of our managed-care organizations.

Their phone lines, she looked at

their website, went through all of that information to see how easy it is to find an interpreter, if those phone lines, if you can directly get to an interpreter just by asking for an interpreter. She created a document for all of those managed-care organizations and outlined if there were challenges on the website, if this information was easily visible on the website, if when she contacted those phone lines, she could quickly reach an interpreter. If when she went to the website and typed in the word, "interpreter," could she find an interpreter easily? Did that information come to her with ease? So she took those steps to find that information and then we shared that information with the managed-care organizations. As she was doing that from the DMS perspective, we know there were some managed-care organizations that were also in the process of reviewing their websites, themselves, so as far as Phase II goes, so there may be some managed-care

organizations that are updating their website. That is the communication that are not yet established as far as Phase III. We don't know if there will be updates based on our finding yet, and then as far as Phase III, with the one-page document, we are still pending on what those next steps might be with that document, based on those findings, because as we mentioned, there were some challenges when we looked at that one-page document.

So I did a second request for information with the managed-care organizations to better understand the information in regards to those very specific populations, and how we could pull together this decision tree. We, again, were working with our internal communications team to try to get a visual document that best leads to this decision tree. So we were kind of coming up with some roadblocks on what exactly is the best visual. So thinking about how people come into the Medicaid system through

different doors, that is where we are coming up with the challenges, so we did a second request on, what are your very specific processes for these very specific populations. So there was lots of great information that the managed-care organizations provided to us, so I didn't want to put multiple slides up here, so I just, kind of, gathered what was common between all of the managed-care organizations, so these are kind of the common things that we find that all of them have that TTY line that there is an opportunity for individuals to have, you know, that three-way calling available, and they do have those opportunities for those in-person interpreter requests, acknowledging that we have talked about that there are some challenges with the three-day time period and the five-day time periods. Those were some things that we talked about, maybe, streamlining and addressing. We know that each of our MCOs offer that written material, which is one of the things that we saw back in our

federal guidance. Our MCO, they talk about that their website, and their information kiosk, they have all of the technology available and accessible to these very specific populations.

One of the things that was identified for this very specific population, is when they take their health risk assessments, the members are assessed in a way that helps to identify any special communication needs that they may have. Once that assessment is completed, there is an alert created on the member's record. When that alert is created on the record, they are assigned a case manager. That case manager then becomes available to help assist that member with any specific needs that they may have in regards to getting that interpreter services, or any additional supports and systems that they may need, or that they may need to get through the system. So this kind of leads me through the decision tree, and maybe this is where we can get some clarity for you -- from you. If they

provided that information, I'm looking at a decision tree like this and the question that I am coming up with from the decision tree is: As a member comes through the system, members come through in different ways. Some members come through and they may directly go through whatever that degree of outcome maybe for decisions from them. Some members may need additional supports and then there might be some members that are going through the system, we may not be able to address their specific needs without some external supports.

So the question for the decision tree is: Were we envisioning this to be a living document, or is each specific population that you have that is sick, because we know that those needs may change, and if that is the case, then the document may continue to grow and might create an unintended consequences.

So I think that is one of the barriers that as we talked about creating this document, so we might not answer that

now, but that will be one of the questions that we will want to answer, and I will move on through and we can just, kind of, table that question and come back there because this is very short, we are almost at the end. Just to say that this is where we are now. We are thinking about streamlining lining all system processes. That is our goal, because what we recognize, when we talk about these very specific populations, interpreter services; where ASL comes in, especially in including those with limited English proficiency; this is not just a DMS issue, this is a cabinet-wide goal, so we have established workgroups. So we are bringing in people that are not just from DMS, so we are wanting to hear what processes you may have in place for your organization, what are some other answers that we may have to address this.

We have a work group that is meeting. Our next meeting is September 3rd to try and bring in other ideas or perspectives to get through this. Again,

the one-pager is currently under review for those final edits, and the overall objective, of course, is to reduce these barriers that the Consumer TAC and other TACs have identified, and we know that that goal is to help achieve equitable outcomes and access in healthcare and have individuals that can talk to their providers in a way that helps them to achieve their goals.

So that is the end, and I think that maybe we can address those clarity questions, if you have any for us.

MR. CAMPBELL: Can you send me this document? I am really disappointed, but I have to read it before I say anything. Thank you.

MS. COULTER: We are happy to share with you, Arthur.

MS. BEAUREGARD: And thank you, Danita, for your presentation. Just to your question about whether it is one-page or multiple documents, potentially, and how things change over time, for me, I'm thinking of this decision tree as a guide

for someone who is a Medicaid beneficiary or maybe a family member or someone who is assisting the individual -- that could be a connector or a community health worker, but a guide that somebody could use to identify that, here is where I go for language services, and if I am unable to get the service that I need by calling the MCO or calling DMS or asking my provider for an interpreter, then this is the next step that I take. This is where I would report the program problem, this is the process that I go through to complain or file a grievance or appeal, or whatever that is. So how do you first access the service that you are looking for, if you don't get the service, what do you do next. That is what I have in my mind. And if there's more than one entry point, as you mentioned, I think that is worth including in the document too.

And now it may be that people have other thoughts on that, and because we have four populations that we have identified, I can see there being a guide

for each population.

MS. COULTER: I think that makes sense, because I think what we were thinking is that, how do each of these populations access service, as opposed to what you described, so I think that we weren't exactly thinking about the same end result as far as the decision tree document.

So that gets a lot more sense and tries to pull the plan together. I think that is something that we can definitely work with, and I appreciate that explanation.

MS. BEAUREGARD: Miranda, you may have thoughts, of course, any of our TAC members.

MS. BROWN: I think you clarified it well, Emily.

Danita, when you are talking about the working group, I'm assuming that is just an internal working group and not an opportunity for stakeholders to weigh in; correct?

MS. COULTER: It is an internal

work group, but we would never not say that we wouldn't want our stakeholders or our partners to provide feedback to us, but right now, it is an internal workgroup and we are trying to come together to find out, right now, what our internal process is and how we can streamline those processes, and figure out how to improve upon those. I think one thing that we can do is when we have these workgroup meetings, that we can come back to the TAC and report out what we are finding, if that sounds like something reasonable for the TAC.

MS. BEAUREGARD: Yeah.

MS. BROWN: That sounds great.

MS. BEAUREGARD: Any other thoughts now?

Okay. Well, I appreciate your work on this, and I think what our original thought was, let's make some recommendations, but we wanted to first take a step back and better understand how the system is currently working, and what services are being provided and where

there might be gaps before we make other recommendations.

One other thought is, of course, we talked about the other MCOs, but when I say DMS and MCOs, I want to make sure that we are including any Medicaid members that also are fee for service. And that may include the providers that are working with them in terms of the case management, Home and Community-Based Service waivers, and that sort of thing. Just to make sure that we are including them.

All right. Our next item is new business, and I know that we are short on time at this point, before I cover A, I just want to ask, Arthur, do you have your guest on to talk about the Michelle P. waivers? Okay. So we will continue to wait on that, and we will just include it on the next agenda, unless you tell me otherwise.

I did, just very briefly, with the new federal rules that have come out recently, I think we have had a little bit of discussion at the TAC, one of the

recent MAC meetings, commissioner Lee had given a presentation about the Beneficiary Advisory Council and DMS's plans to set that up. And I don't know that we have a whole lot of time to discuss that now, but I did just kind of want to put a plug in for the Consumer TAC being involved in that in some way.

Veronica, do you have anything to share there?

MS. CECIL: I can say that we will absolutely include stakeholder engagement, and we feel that that is necessary for how we move forward with most both the MAC and the BAC changes.

We are, right now, still evaluating and pulling together what that plan is going to look like for implementation. Of course, that has to happen by July 9th of 2025. We have a little bit of time, but that is going to come up very quickly for us.

MS. BEAUREGARD: It will happen fast.

MS. CECIL: Well, especially

because we are probably going to have to have some statutory changes as it relates to the MAC. So definitely plan on including the MAC and the TACs, not just for this particular implementation, but for a lot of the different final rules that we are going to have to implement.

MS. BEAUREGARD: Okay. That sounds good. And I know that, like I said, the commissioner had given a nice presentation to the MAC a couple of meetings ago, but it might be worth us including that on the next agenda, just so that our TAC members are more familiar with what those requirements are and how that BAC might operate.

MS. CECIL: Yeah. I would be happy to do that. We are just a little hesitant to talk too much about it, because we don't have our plan yet, about how we are going to implement it, but hopefully by October we will have some semblance of a plan of implementation.

MS. BEAUREGARD: That sounds good.

And the last item here is the dental services data request. We got that data report yesterday, and I took a really quick look at it and responded to Kelli with some questions, so I'm not sure that there is much for us to discuss now, but just to get a report that is a little easier for us to read and understand. Was anybody from DMS prepared to go over that report with us? Okay.

MS. CECIL: I don't think so, Emily.

MS. BEAUREGARD: We will wait for the next report and then if we have questions, we can address that either over email, or at the next meeting.

I think that brings us to general discussion. Does anyone have any other items that they want to bring to the meeting today? Recommendations?

All right. I generally have recommendations, but I feel like we have a lot of information to process right now, and I think maybe at our next meeting we can be prepared to make a few other

recommendations. But for now, unless I hear otherwise, I think we can just go ahead and adjourn our meeting.

Well, I will address these other two items quickly. I will be representing the TAC at our next MAC meeting. And the last two meetings of the year for the Consumer TAC -- it's hard to believe we are closing in on the final quarter of the year, October 15th and December 17th. So be thinking about those meetings and the agendas and any items that you want to add there, but we will plan for now to have a presentation about the Beneficiary Advisory Committee for council at the October 15th meeting, and I think that will be good timing in terms of preparing for the legislative session and any statutory changes that would need to be made. I appreciate everybody's time today. Thank you all. And have a good afternoon.

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C E R T I F I C A T E

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

Dated this date th/st/nd of MONTH/YEAR

/s/ Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M