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CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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

Shana W. Spencer, RPR, CRR
Court Reporter

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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
Annissa Franklin (not present)
Beth Partin
Bryan Proctor (not present)
Peggy Roark
Eric Wright (not present)

COMMISSIONER:

Lisa Lee, Department for Medicaid Services

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P R O C E E D I N G S

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

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

MS. WALLACE: All right. Elizabeth
Partin?

(No response.)

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

Susan Stewart?

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

MS. WALLACE: Dr. Jerry Roberts?

DR. ROBERTS: I'm here.

CHAIR SCHUSTER: Great.

MS. WALLACE: Heather Smith?

MS. SMITH: Here.

CHAIR SCHUSTER: Good.

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 notate 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.

1 They have to streamline those, and there's
2 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 --

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

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

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 --

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

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

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

13 MR. GILBERT: MAC plus.

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

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

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

25 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

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

8 CHAIR SCHUSTER: Right.

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

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

22 And I do hear from people that go back
23 and check in with their connector when
24 something comes up. I mean, they become that
25 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.

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

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

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

12 CHAIR SCHUSTER: Well, thank you.

13 MR. VERRY: I'm always --

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

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

23 (No response.)

24 CHAIR SCHUSTER: All right. I have
25 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.very, 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.)

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

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

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

11 CHAIR SCHUSTER: Oh, good.

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

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

20 Erica?

21 CHAIR SCHUSTER: Well, and she was
22 kind enough to come and report to our BH TAC
23 at our last meeting, which we appreciate, so
24 we're looking at having ongoing reports from
25 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 miniscule.

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.

1 So excellent point. Thank you for
2 bringing that up.

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

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

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

20 DR. PARTIN: Right.

21 CHAIR SCHUSTER: The whole idea of
22 integrated care is that there's no wrong door
23 for people, whether they have a behavioral
24 health need or a physical health need, if you
25 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

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

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

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

23 DR. BOBROWSKI: Well, that was --
24 Sheila, that was kind of why -- and I just
25 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

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

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

8 (No response.)

9 CHAIR SCHUSTER: All right.
10 Thank you.

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

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

19 CHAIR SCHUSTER: Right.

20 MS. HOFFMANN: So just to give you
21 an update, we have been meeting regularly.
22 We're diligently working on the house bill
23 report, request for the report. We've
24 started initiating, or we have already
25 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

1 moved out of state.

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

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

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

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

24 CHAIR SCHUSTER: Okay.

25 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.

1 CHAIR SCHUSTER: IDD, Intellectual
2 and Developmental Disabilities?
3 MS. BICKERS: I am not sure if
4 someone is on for that. We will be voting
5 for a new chair. They also meet at the
6 beginning of August.
7 CHAIR SCHUSTER: Okay. And that's
8 been Rick Christman, but they're going to
9 have a new chair?
10 MS. BICKERS: Yes, ma'am. He is
11 retiring.
12 CHAIR SCHUSTER: Oh.
13 MS. BICKERS: And so we should vote
14 for a new chair in the next meeting.
15 CHAIR SCHUSTER: Okay. Thank you.
16 Nursing Home Care?
17 MS. BICKERS: They have not had a
18 meeting.
19 CHAIR SCHUSTER: Okay.
20 Nursing Services?
21 MS. BICKERS: I don't see anyone
22 on. They have a meeting coming up in August.
23 They have a draft agenda floating about.
24 CHAIR SCHUSTER: Okay.
25 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.

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CHAIR SCHUSTER: Yeah.

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

CHAIR SCHUSTER: All right.
Thank you.

DR. COMPTON: All right.
Thank you.

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

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

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

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

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,
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.

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CHAIR SCHUSTER: Yes. Bye-bye.
(Meeting concluded at 12:34 p.m.)

* * * * *

C E R T I F I C A T E

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

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

Dated this 5th day of August, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR