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2 CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
3 CONSUMER RIGHTS AND CLIENT NEEDS
TECHNICAL ADVISORY COMMITTEE MEETING
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13 Via Videoconference
August 15, 2023
14 Commencing at 1:31 p.m.
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Shana W. Spencer, RPR, CRR
23 Court Reporter
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1 **APPEARANCES**

2

3 **BOARD MEMBERS:**

4 Emily Beauregard, TAC Chair

5 Miranda Brown

6 Arthur Campbell, Jr.

7 Brenda Mannino

8 Melanie Tyner-Wilson

9 Christy Hardin (not present)

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

2 CHAIR BEAUREGARD: Hi, everyone.

3 Good to see you all. Good afternoon.

4 I'm Emily Beauregard. I'm the director

5 of Kentucky Voices For Health and the chair

6 of the Consumer TAC.

7 It's good to see all of our members on

8 today and wanted to just get started by doing

9 introductions. So if our TAC members can

10 introduce yourself and who you're

11 representing, that would be great, and then

12 we'll go on with the rest of the agenda.

13 I see Arthur, Miranda, and Brenda, and I

14 think Melanie is also on so -- yep. Arthur,

15 do you want to introduce yourself? I saw you

16 unmute, but I can't hear.

17 MR. CAMPBELL/INTERPRETER: He said

18 he is Arthur Campbell. He is with P&A. He's

19 Arthur Campbell, and he's with P&A.

20 CHAIR BEAUREGARD: Thanks.

21 Miranda, Melanie, and Brenda.

22 MS. BROWN: Hey, everyone. I'm

23 Miranda Brown. I'm a connector and an

24 outreach coordinator for Kentucky Equal

25 Justice Center.

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1 MS. MANNINO: Hi. I'm Brenda
2 Mannino. I am representing AARP in -- and I
3 live in Lexington.
4 MS. TYNER-WILSON: And hello. I'm
5 Melanie Tyner-Wilson. I'm representing the
6 Arc of Kentucky, and I live in Lexington.
7 CHAIR BEAUREGARD: Great. Well,
8 thank you all and welcome. I'm glad this
9 time worked for everyone, and I appreciate
10 the various agenda items that you all sent me
11 in advance. So we'll touch on some of those
12 under new business and discuss, Arthur, your
13 issue next month in October.
14 So I first wanted to establish a quorum,
15 and we do have a quorum of members. So we
16 can go ahead and approve the minutes from our
17 previous meeting. That would have been our
18 June minutes.
19 Did everyone receive that transcript,
20 and does anyone have any questions or issues
21 that you want to clarify before we move for
22 approval?
23 MS. BICKERS: Brenda, can you make
24 sure your camera is on while voting, please?
25 MS. MANNINO: Okay. I'm trying to

1 figure out how to turn it on. Where do I go
2 to turn it on?
3 CHAIR BEAUREGARD: That worked.
4 MS. MANNINO: Okay.
5 CHAIR BEAUREGARD: We can see you
6 now. Thanks. So I'll ask for a motion to
7 approve the June minutes.
8 MS. BROWN: I motion to approve the
9 June minutes.
10 CHAIR BEAUREGARD: Thank you,
11 Miranda.
12 Second?
13 MS. MANNINO: So moved.
14 MS. TYNER-WILSON: Second. Oh,
15 sorry.
16 CHAIR BEAUREGARD: Who was that?
17 I'm sorry.
18 MS. MANNINO: I said second.
19 CHAIR BEAUREGARD: Is that you?
20 Okay. Thank you very much. Brenda, second.
21 All in favor, say aye.
22 (Aye.)
23 CHAIR BEAUREGARD: Any --
24 (Aye.)
25 CHAIR BEAUREGARD: Okay. That

1 motion carries, so thank you very much. I'm
2 just taking some notes here.
3 All right. So we'll start with our old
4 business, the items that we touch on every
5 meeting. And I know that Deputy Commissioner
6 Veronica Judy-Cecil will need to leave our
7 meeting early today for another meeting, so
8 I'd like to start with the unwinding update
9 or the Medicaid renewals update.
10 DEPUTY COMMISSIONER CECIL: Good
11 afternoon, everyone. Thank you, Emily. I
12 appreciate that.
13 So the data that was requested was for
14 July and August renewals and how many were
15 passively and actively renewed. Before I get
16 to that, I wanted to just let the TAC members
17 know that we are currently revamping how we
18 share the data. CMS -- and we're also
19 revising our CMS report that was filed on
20 August 8th based on feedback that CMS has
21 given to states on how we're supposed to
22 report any extended renewals.
23 So as you all may recall, in May, we had
24 some renewals that we extended to June and
25 then we extended some of those on to July.

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1 We could extend certain individuals up to 60
2 days.
3 And in Kentucky, we have prioritized the
4 nursing facility and long -- so long-term
5 care and 1915C waiver populations are who
6 we're specifically extending for the very
7 purpose of conducting outreach due to the low
8 number of responses to renewal notices. So
9 that gives us additional time -- by extending
10 them, it gives us additional time to do that
11 outreach.
12 As a result, the original CMS unwinding
13 report did not contemplate states extending
14 renewals and also reporting on pending
15 renewals. So every month, as the end of the
16 month comes for somebody's renewal, if we
17 have something pending, we will extend them
18 as well so that they are not getting
19 terminated based on the fact that there's
20 something the State needs to process.
21 So there's a couple of additional
22 buckets that CMS did not anticipate really
23 kind of understanding as the states move
24 through the unwinding period. So we are
25 trying to revamp our data reporting to -- to

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1 comply with CMS and also to make it just a
2 little bit easier to understand as we're --
3 as people look at the CMS report and then
4 compare to what we're reporting in Kentucky.
5 So that being said, then, I -- by the
6 stakeholder meeting on Thursday, we -- and by
7 the way, we're having a stakeholder
8 meeting -- let me put a plug in for that --
9 11:00 on Thursday, our regular monthly. You
10 can find information about that on our
11 Kentucky unwinding page. But we should have
12 everything ready to -- in the new format to
13 better report approvals and terminations and
14 pending and extensions so -- so definitely
15 stay tuned for that.
16 So for today, I'm really only reporting
17 things at that high level that was requested
18 and happy to share as a follow-up after the
19 stakeholder meeting when we have our report,
20 or our PowerPoint presentation is looking a
21 little nicer and giving more information,
22 share that with the TAC members afterwards.
23 So I'm going to share my screen after
24 that long introduction. My apologies. Okay.
25 So just to give you guys a heads-up on --

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1 oops. It's not being friendly to me today.
2 One second. Let's close out and then close
3 out. Okay. So sorry. I can't get that to
4 drop off.
5 So for July renewals, you asked sort
6 of -- the other thing we're doing -- in the
7 past, we've been reporting once the monthly
8 renewal is upon us. So, like, you know, if
9 we're reporting this month for September or
10 we're reporting next month for October, we've
11 been doing it at the case level because
12 that's how we process our cases.
13 Going forward, we're going to be
14 reporting at the individual level because
15 that's what we put in our CMS monthly
16 unwinding report. We were afraid that's been
17 causing some confusion as well. So going
18 forward, everything we report is at the
19 individual level.
20 So this is looking at those renewals
21 that were just due on July 31st. We had
22 54,476 individuals that were subject to a
23 July 31st renewal date. Of those, 40,230
24 were considered passive cases and then the
25 14,246 were considered -- not cases, were

1 considered active renewals, individual
2 renewals.
3 Keep in mind that the active renewals
4 are generally those individuals in, like,
5 long-term care, nursing facility that we have
6 to ask for additional resources, to verify
7 additional resources that we can't always go
8 out there and ping all those databases to
9 find. So that's what really constitutes an
10 active renewal.
11 We've sent out 13,797 requests for
12 information for those July renewals. And we
13 sent out 14,246 renewal packets for those
14 July renewals.
15 For August, we have 64,649 individuals
16 going through a renewal for August 31st. Of
17 those, 42,078 were passive renewals, and
18 22,571 are active renewals. Of those
19 individuals, 15,038 were sent a request for
20 information, and 13,078 were sent renewal
21 packets.
22 So that's kind of the high-level
23 information for unwinding for --
24 CHAIR BEAUREGARD: Can we stop and
25 ask a couple of questions?

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1 DEPUTY COMMISSIONER CECIL: Yeah.
2 Absolutely.
3 CHAIR BEAUREGARD: So you don't
4 have the eligibility determination data
5 there. That's what you're going to be
6 sharing on Thursday; right?
7 DEPUTY COMMISSIONER CECIL: That's
8 right. Yep. Yep.
9 CHAIR BEAUREGARD: When you shared
10 that second screen, the August numbers --
11 DEPUTY COMMISSIONER CECIL: Yes.
12 CHAIR BEAUREGARD: -- and the
13 active renewals, and there was a difference
14 there between the number of individuals that
15 needed to actively renew and the number who
16 got a renewal packet, what's that -- why is
17 that lower? It looked like there were a few
18 thousand individuals who had an active
19 renewal but didn't receive a packet.
20 DEPUTY COMMISSIONER CECIL: So this
21 is where it gets a bit wonky where -- an
22 active renewal might include more than one
23 person. So the active renewal is sent to the
24 household and includes all of the
25 individuals, but we're counting it as a

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1 renewal -- one renewal packet.

2 CHAIR BEAUREGARD: Okay.

3 DEPUTY COMMISSIONER CECIL: So

4 this -- like I said, we're still kind of

5 trying to work on it. It's an excellent

6 question for that very reason.

7 And then some others might not have

8 received packets because maybe there's some

9 information that we were able to get, or it's

10 very possible we've extended them. And if

11 they've been extended, then they would not

12 have gotten a renewal packet. So there are

13 just some various other reasons why that

14 might happen.

15 CHAIR BEAUREGARD: Okay. So even

16 if they were extended, they still fall into

17 the number that were supposed to renew that

18 month --

19 DEPUTY COMMISSIONER CECIL: Yeah.

20 That's their original renewal month. Yeah.

21 CHAIR BEAUREGARD: (Inaudible.)

22 DEPUTY COMMISSIONER CECIL: Yeah.

23 And that's the other thing we're trying to

24 track, is keeping people -- even though they

25 were extended, keeping them in their original

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1 renewal month because that's what we're --
2 that's basically how we're, you know,
3 calculating them, is by keeping them in that
4 renewal month.
5 CHAIR BEAUREGARD: Okay. Yeah.
6 No. That's helpful to know. Thank you.
7 MS. MANNINO: Can I ask a question,
8 too? Would you remind us what "passive"
9 means?
10 DEPUTY COMMISSIONER CECIL:
11 Absolutely. Yep. Yep. So a passive renewal
12 is a renewal where the individual has to take
13 no action whatsoever. So we're able to go
14 out and ping all the databases available to
15 us, like IRS, state tax, income tax, all
16 these various databases. And we can verify
17 their Medicaid eligibility without them
18 having to take any action.
19 MS. MANNINO: Okay. Thank you.
20 DEPUTY COMMISSIONER CECIL: And
21 since you asked that question, Brenda, just
22 to expand on that a little bit. If we go out
23 and we do that for a passive renewal but, for
24 some reason, something comes back and we're
25 not actually able to verify them, then we'll

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1 send them a request for information. And
2 that's -- so they're part of that kind of
3 bucket as well.
4 MS. MANNINO: Okay.
5 DEPUTY COMMISSIONER CECIL: It
6 doesn't always mean that we can determine
7 them that way.
8 CHAIR BEAUREGARD: Veronica, would
9 you say that the RFIs, the request for
10 information, are typically for income?
11 DEPUTY COMMISSIONER CECIL: That's
12 correct.
13 CHAIR BEAUREGARD: Like most --
14 most of them?
15 DEPUTY COMMISSIONER CECIL: It is.
16 CHAIR BEAUREGARD: Yeah. So that's
17 information that obviously changes over time.
18 And there are times when you have older
19 information in your data sources, and you'd
20 be asking people for -- to verify?
21 DEPUTY COMMISSIONER CECIL: Yeah.
22 That's -- that's very possible. The -- you
23 know, keep in mind, the other thing that
24 we're trying to do -- it's a good thing and a
25 bad thing -- is that if we can't absolutely

1 verify them, I told you we're dropping them
2 to our request for information. You know, we
3 want to give them that opportunity to verify
4 or report back to us so that we can make an
5 actual determination.
6 They're the ones that really are falling
7 into that termination for procedural reasons
8 because they get that RFI, and they're not
9 responding by the due date and by the end of
10 the month that they're due. And so we have
11 to terminate them because they haven't
12 responded.
13 So it makes the number look higher. I
14 think what's challenging here is that a large
15 number of them aren't eligible. Like, we --
16 the reason we sent them the RFI is because we
17 couldn't verify them, and that's because
18 they're likely not eligible. So it looks
19 like a larger number of people being
20 terminated who might -- might likely be
21 Medicaid eligible but aren't truly.
22 CHAIR BEAUREGARD: Yeah. I'm sure
23 it's a mix of people. I do think that we
24 have a lot of people who are probably
25 eligible who are being terminated as well and

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1 for various reasons, whether it's because
2 they're not responding in time or because of
3 system issues.
4 One thing we've heard more and more
5 about -- and I'm actually -- I'm at Morehead
6 State University today. We've been doing our
7 ThriveKY Roadshow around Kentucky and talking
8 about Medicaid renewals at every stop.
9 And we had, I don't know, maybe ten
10 people here talking about how -- how
11 difficult the renewal process has been for
12 some of their clients and specifically
13 uploading documents that are not being --
14 their coverage isn't pending. They are being
15 terminated before a document has been
16 reviewed and determined eligible --
17 DEPUTY COMMISSIONER CECIL: Oh,
18 okay.
19 CHAIR BEAUREGARD: -- ineligible.
20 DEPUTY COMMISSIONER CECIL: Okay.
21 CHAIR BEAUREGARD: And I've heard
22 that more and more, and I see Miranda shaking
23 her head. So I think -- I know that we've
24 talked about the policy that DMS has, is that
25 it should pend. There shouldn't be a

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1 termination if there's a document that needs
2 review.
3 DEPUTY COMMISSIONER CECIL: Right.
4 CHAIR BEAUREGARD: But something is
5 happening.
6 DEPUTY COMMISSIONER CECIL: Okay.
7 CHAIR BEAUREGARD: And I think that
8 it's probably a glitch in the system.
9 DEPUTY COMMISSIONER CECIL: Well, I
10 will -- so I will say if somebody waits until
11 between the 20th and 30th of -- or end of the
12 month, especially as it gets closer to the
13 end of the month, our system has to do kind
14 of a refresh on the first day of the
15 following month to capture those folks who
16 might have sent something in because, you
17 know, our system has to run at various times
18 to make sure that other -- the downstream
19 effects of that happen. So before, like,
20 sending the managed care organizations their
21 roster and so forth.
22 So if somebody has sent something in
23 late in the month, as it gets closer to their
24 renewal, because we have to do this special
25 run, that, you know, it's very possible that

1 people fall off during that time.
2 But want to -- please, please, please.
3 We want to know. If it's a huge problem, if
4 it's systemic, if, you know, people are
5 inappropriately being terminated, certainly,
6 it's not what we want to see.
7 CHAIR BEAUREGARD: Yeah. No. I
8 understand and appreciate that. We want to,
9 you know, provide you all with as many
10 examples as we can so that you can figure out
11 what the system issue might be.
12 Miranda, I don't know if you have
13 anything you want to add there.
14 MS. BROWN: Just that, you know, I
15 handle a small volume of cases, but I've seen
16 this happen in at least two where the -- you
17 know, I think the documents in both cases
18 were due by the end of July. And on July
19 31st, they were terminated without the
20 documents having been processed. And so --
21 and they're still pending now, and so that
22 seems like --
23 CHAIR BEAUREGARD: The document is
24 pending; the coverage was terminated. Yeah.
25 MS. BROWN: The eligibility has

1 already been processed and denied, and the
2 reason for denial is that the documents were
3 not submitted when we definitely submitted
4 the documents, and they're still in the cases
5 pending.
6 DEPUTY COMMISSIONER CECIL: Were
7 the documents submitted towards the end of
8 the month?
9 MS. BROWN: Yes.
10 DEPUTY COMMISSIONER CECIL: Okay.
11 Okay. Yeah. So thank you for -- really,
12 examples are helpful, so we can go back to
13 our system and make sure that -- whatever
14 it's doing isn't right. It's making sure it
15 goes back and capturing anybody with those
16 last -- you know, those late submissions.
17 MS. TYNER-WILSON: Ms. Veronica,
18 this is Melanie Tyner-Wilson. Hello.
19 DEPUTY COMMISSIONER CECIL: Hi.
20 MS. TYNER-WILSON: I had a question
21 specifically about when an individual has a
22 case manager, and does the -- does the
23 correspondence from your office -- because
24 I've had situations where I've spoken with
25 people. And the correspondence went to the

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1 case manager, and the actual individual did
2 not receive the information because it was
3 information about -- you know, your Medicaid
4 is going to end by such and such a date.
5 And is that the -- is that the case,
6 that if somebody has a case manager -- this
7 is involving individuals that are on some
8 kind of waiver, if you will. And so I didn't
9 know if that was just a fluke or if that
10 was -- that happened frequently or not.
11 DEPUTY COMMISSIONER CECIL: The
12 correspondence should always go to the
13 individual or their designated
14 representative. We -- we have been working
15 closely with case managers, but unless
16 somebody has somehow put the case manager's
17 information in there -- you know, that is why
18 that could have happened.
19 Happy to check on that specifically if
20 you want to send me information so that we
21 can -- can see what's going on. Because it
22 is -- we generally, even when there's a
23 personal representative, we always try to
24 send documentation to the individual as well.
25 MS. TYNER-WILSON: Yeah. Okay.

1 DEPUTY COMMISSIONER CECIL: To --
2 kind of covering both bases. But yeah,
3 unless that -- the case manager's information
4 has been put as the designated correspondence
5 or contact, then, that might --
6 MS. SMITH: Veronica, I can say
7 we've seen that happen before, where the case
8 manager has -- where the individual has ended
9 up with the case manager being documented as
10 their designated representative. So I do
11 know that it does occur in some cases.
12 Typically, it's very specific to where
13 someone doesn't -- they're not able
14 themselves to do what needs to be done and
15 don't either have reliable natural supports
16 that can do it, or they do not have anyone
17 else --
18 MS. TYNER-WILSON: Oh, okay.
19 MS. SMITH: -- that can act in that
20 respect for them but...
21 DEPUTY COMMISSIONER CECIL: Thanks,
22 Pam. But it is important that if a case
23 manager is going to take on that
24 responsibility, that, you know, they need to
25 communicate that to the member.

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1 MS. SMITH: Absolutely, that they
2 follow through with every part of it. Yes.
3 DEPUTY COMMISSIONER CECIL: Thanks,
4 though, for that question, Melanie.
5 CHAIR BEAUREGARD: I have one other
6 question, but does anyone else have a
7 question for Veronica?
8 (No response.)
9 CHAIR BEAUREGARD: I'm just looking
10 at the time. I know you have to go in a few
11 minutes.
12 One thing that we brought up on a
13 previous call, and we've communicated back
14 and forth over email, but SSI cases have been
15 something that we've been concerned about.
16 People with SSI who are getting an
17 active renewal packet when SSI should make
18 them automatically eligible but then also
19 people who have recently lost SSI who are
20 having their coverage terminated rather than
21 being sent an active renewal packet so that
22 they can actually be considered for other
23 types of Medicaid eligibility rather than
24 having to reapply. And people falling into
25 kind of a gap where they're losing their

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1 Medicaid, but they're still in the system.
2 So even trying to reapply isn't, you know,
3 working for them.
4 Is that something you all have found
5 any -- have you figured out what might be
6 happening in the system?
7 DEPUTY COMMISSIONER CECIL: Yeah.
8 We are definitely looking at inappropriate
9 terminations for SSI. If somebody's SSI is
10 active, as you noted, they should not be
11 getting -- they're categorically eligible.
12 So they shouldn't be getting any kind of
13 notice like that.
14 So yes, we are digging into those, and I
15 just don't -- I don't have an update on where
16 that stands yet. We have our next response
17 meeting tomorrow, so I'll probably get an
18 update then.
19 But the challenge with somebody who has
20 lost SSI -- a couple of things. So the
21 notice they get does clearly tell them you
22 need to file an application, and it gives
23 them all the various ways to do that. I know
24 that that can be challenging, but I'm not
25 quite sure what else we can do.

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1 We are outreaching to those individuals
2 to -- we're contacting them to say want to
3 make sure you understand that you need to
4 file an application.
5 Because it's not a renewal packet. If
6 you're categorically eligible, that made you
7 eligible for Medicaid. We don't have any
8 information in our system to try to cascade
9 them down to some other eligibility or type
10 of assistance. So we have to have them
11 submit the information to us. It's not a
12 renewal packet because --
13 CHAIR BEAUREGARD: But what I -- I
14 think my concern is that their coverage is
15 being terminated before they can, you know,
16 put that application in. And if the renewal
17 packet could collect the information and
18 they'd never go through termination, I think
19 that would be the more appropriate way of
20 keeping them --
21 DEPUTY COMMISSIONER CECIL: Well,
22 so regardless of if they have a renewal
23 packet and return it or submit an application
24 and return it, it's the same thing. I mean,
25 they still have to submit something to us.

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1 CHAIR BEAUREGARD: Yes.
2 Understood. Yeah. I'm not suggesting that
3 they wouldn't need to submit anything, just
4 that --
5 DEPUTY COMMISSIONER CECIL: Yeah.
6 The renewal packet --
7 CHAIR BEAUREGARD: Couldn't they be
8 asked for that information, and could it be
9 run through the system for eligibility
10 without a termination occurring or before --
11 you know, at least given that opportunity to
12 submit all that information before a
13 termination would occur?
14 DEPUTY COMMISSIONER CECIL: You
15 know, we're taking it back to see what we can
16 do to lessen the -- the issue. But a renewal
17 packet does not have the same information
18 that we need.
19 CHAIR BEAUREGARD: So they would
20 need to be sent an application?
21 DEPUTY COMMISSIONER CECIL: Yes.
22 But we are trying to see -- you know, we're
23 trying to give them as much notice as
24 possible, obviously, which, you know, they'd
25 get at least 45 days or more to submit that

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1 application. You know, we're taking a look
2 at it to see what we can do.
3 CHAIR BEAUREGARD: The one that I'm
4 aware of, you know, did try to submit an
5 application, but they were told that they
6 were in the system. And so the application
7 was, like -- it was denied. That's the part
8 where it was pending. I can't remember.
9 But it wasn't going through. Their
10 coverage was terminated and then, you know,
11 there was a gap before they could get a new
12 application approved. And that's where I
13 feel like people are getting stuck.
14 DEPUTY COMMISSIONER CECIL: Did you
15 send that example to us?
16 CHAIR BEAUREGARD: Yeah. That's
17 been reported.
18 DEPUTY COMMISSIONER CECIL: Okay.
19 Okay.
20 CHAIR BEAUREGARD: And I'm guessing
21 this has happened to others, but we know that
22 with SSI, just like with Medicaid unwinding,
23 like -- and renewals resuming, some of the
24 SSI determinations have also resumed, you
25 know, and looking more closely at people's

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1 eligibility. And so I think more people
2 probably are losing their SSI now than, you
3 know, in a regular period of time.
4 DEPUTY COMMISSIONER CECIL: Yeah.
5 CHAIR BEAUREGARD: And that is just
6 a great, you know, combination, isn't it?
7 DEPUTY COMMISSIONER CECIL: I know.
8 I know.
9 CHAIR BEAUREGARD: Okay. Anything
10 else for Veronica? Or, Veronica, were you
11 planning on covering any of the other issues
12 on the agenda?
13 DEPUTY COMMISSIONER CECIL: No. I
14 think other staff have those covered.
15 CHAIR BEAUREGARD: Okay. Great.
16 Thank you.
17 DEPUTY COMMISSIONER CECIL: Thank
18 you all.
19 CHAIR BEAUREGARD: Appreciate your
20 time.
21 DEPUTY COMMISSIONER CECIL: Take
22 care.
23 MS. MANNINO: Thank you.
24 CHAIR BEAUREGARD: All right. We
25 can jump back to the standing data requests

1 that we have in terms of how many people are
2 currently covered under different types of
3 Medicaid. Does anyone have those numbers?
4 MS. GRIFFIN: Sorry. This is
5 Jordan. I'm branch manager of eligibility
6 and enrollment with DMS, and I do have some
7 numbers for you.
8 So these are as of yesterday. Our total
9 presumptive eligibility members, we have
10 1,108. Total number of members receiving
11 emergency time-limited Medicaid are 270.
12 Those individuals that have traditional
13 Medicaid, we have 144,007 members. For KCHIP
14 and CHIP expansion, we have 129,881. And for
15 the number of members who are in our managed
16 care Medicaid program is 1,489,573.
17 CHAIR BEAUREGARD: All right.
18 Thank you.
19 Any question about those numbers?
20 (No response.)
21 CHAIR BEAUREGARD: How about the
22 waiver programs? That might be a Pam
23 question but -- actually, before we go to the
24 waiver numbers.
25 Jordan, one thing about presumptive

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1 eligibility that I just wanted to flag, it
2 seems like -- I know there was a bit of a
3 chilling effect with House Bill 7 that was
4 passed last year in 2022 where, you know, the
5 State is no longer able to make presumptive
6 eligibility determinations, and some versions
7 of the bill had limitations for hospitals and
8 some penalties for hospitals although those
9 were removed in the final version.
10 But I do think that some hospitals are
11 doing less presumptive eligibility, and with
12 individuals who are kind of, you know, right
13 in the middle of, like -- if their coverage
14 was recently terminated and they're trying
15 to, you know, get back on but PE would be the
16 fastest way, it seems like hospitals are
17 either not doing it or sometimes running into
18 barriers getting that submitted and approved,
19 so just something to look into.
20 MS. GRIFFIN: Yeah. We're taking a
21 really close look at our presumptive
22 eligibility program right now because of
23 House Bill 7. You know, we've identified
24 some problem points and issues with the way
25 that the program was being administered.

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1 We're trying to implement better
2 auditing and, you know, better ways that we
3 can kind of engage the hospital staff in the
4 eligibility and requirements of the
5 presumptive eligibility program so that they
6 feel more comfortable doing those without
7 feeling like they're going to be penalized.
8 So we are doing a complete overall of
9 the PE program right now. That is something
10 we're definitely looking into.
11 CHAIR BEAUREGARD: Okay. So when
12 you say without being penalized, I -- I don't
13 recall there being penalties.
14 MS. GRIFFIN: There's going to be.
15 Because of House Bill 7, we have to have some
16 kind of, you know, monitoring program.
17 CHAIR BEAUREGARD: I think it was
18 reporting. Uh-huh. There's more reporting
19 that hospitals have to do.
20 MS. GRIFFIN: Yes. So we're
21 working on, you know, developing a better
22 training program for the administrators at
23 the hospitals just to let them know what kind
24 of information they need to be hanging onto,
25 how long they need to hold on to that

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1 information.

2 We're also developing reports so that we
3 can better identify who from the hospitals
4 are completing the presumptive eligibility
5 applications to make individuals more
6 accountable rather than the whole
7 organization so that if they -- if they
8 identify an issue within the organization,
9 they can try to remedy that without us having
10 to take action to remove them from having the
11 ability overall as an organization to do
12 presumptive eligibility applications.

13 So that's -- we're currently -- we have
14 kind of a high-level overview of the things
15 that we know we need to work on. But we
16 definitely know that the training and
17 accountability procedures need to be reworked
18 quite a bit. So we're in the process of
19 talking about how to go about that.

20 CHAIR BEAUREGARD: Okay. Thank you
21 for that update.

22 MS. GRIFFIN: Yeah.

23 CHAIR BEAUREGARD: Pam, if you're
24 still with us, do you have the numbers for
25 the 1915C waiver enrollment?

1 MS. SMITH: I am just -- I just
2 realized I did not get the -- my window
3 closed with my updated wait list number. So
4 if you want to give me -- I know I have PACE
5 next. So if you want to, I can go to PACE
6 and then I can come back, and I can get
7 the -- or no, PACE is -- oh, I have rate
8 study next. Huh.
9 CHAIR BEAUREGARD: We have the rate
10 study and PACE --
11 MS. SMITH: And PACE, yeah.
12 CHAIR BEAUREGARD: -- but in
13 whatever order --
14 MS. SMITH: I can have them for you
15 by the end. I just realized that I was
16 working on something else and just realized
17 that that -- that closed -- that the window
18 closed out on me.
19 CHAIR BEAUREGARD: That's fine.
20 MS. SMITH: So I will tell you
21 enrollment, we are above 30,000 now of people
22 that we're actively serving. So it has
23 continued to grow, which is great news. But
24 I'll get you the wait list numbers before we
25 end. I'm sorry.

1 CHAIR BEAUREGARD: All right. Why
2 don't we go ahead and do -- talk about the
3 rate study and the PDS rate increase.
4 MS. SMITH: So the rate study is --
5 essentially, it's still with -- it's with
6 executive staff. It's with, you know, all of
7 the budget people and the people that know
8 way more about money and all of that than I
9 do and will ever pretend to know. So the
10 final outcome of the rate study and what
11 that's going to look like has still not been
12 determined yet.
13 However, we have successfully
14 implemented the full increase that was called
15 for in the budget. So we -- the rates for
16 the second 10 percent to go in to make the
17 full 20 actually went in in -- towards the
18 very end of July. I think it was about a
19 week before the end. So we went back and are
20 doing adjustments on those so that providers
21 don't have to do that, but they are in the
22 system now for all of those.
23 The PDS -- how many participants in PDS
24 that have increased their rates, I don't have
25 a number on that. I can try to get that.

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1 It's a little difficult, because of the way
2 PDS is structured, to know for sure because
3 it's -- you know, an employee may have five
4 different employees, and I can't tell if they
5 haven't increased their rates or if they're
6 choosing not to because they have the option.
7 So it's difficult to determine if it's
8 because -- if the rate looks the same because
9 they just haven't increased it yet or because
10 they're choosing not to increase it so...
11 But we have been getting a lot of
12 questions that have been helping individuals
13 navigate any -- any trouble that they're
14 having with their agencies on getting
15 meetings set up to get those rates, to get
16 the forms and everything filled out and to
17 get those meetings done so that the rates can
18 increase. So we have been actively working
19 on that.
20 CHAIR BEAUREGARD: Okay.
21 MS. SMITH: And I don't know if
22 Arthur has any specific -- if he's had any
23 problems or if he's heard from anybody or has
24 any specific examples he needs me to look
25 into, I'd be happy to do that. He can either

1 give it to me now, or he could email -- he
2 can email those to me, too.
3 CHAIR BEAUREGARD: Anything,
4 Arthur? Okay. Thank you, Pam.
5 MS. SMITH: Oh, and I've got the
6 wait list. Thankfully, to my little --
7 little workers in the background, I've got
8 the wait list numbers. So Michelle P, as of
9 today, 8,545.
10 I do know that there's an allocation
11 that's going to be coming up next week of
12 slots for Michelle P. I think we have about
13 200 slots available right now, and the waiver
14 year renews on September 1st. And a couple
15 weeks ago, when I looked at it, there were
16 going to be about 300 more slots that were
17 going to get added into that to be available.
18 So we have -- so beginning in September,
19 we'll have about 500 slots that we can
20 allocate.
21 For SCL, we are at 3,282. None of those
22 are on the emergency list. And ABI long-term
23 care, we have two individuals on the wait
24 list. HCB, we are at zero. We were able to
25 allocate everybody that was on -- briefly on

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1 the waiting list in -- at the end of June and
2 July. And so all of those got allocated on
3 August 1st.
4 CHAIR BEAUREGARD: And, Pam, could
5 you -- I'm sorry. Arthur, were you about to
6 say something?
7 MR. CAMPBELL/INTERPRETER: He said
8 he will email what you asked him.
9 MS. SMITH: Okay. Sounds good,
10 Arthur. I'll watch for it.
11 CHAIR BEAUREGARD: Pam, I was going
12 to ask if you -- I'm just remembering that on
13 our last call -- I think it was our last
14 Consumer TAC meeting. You had said that you
15 reserved some spots for people who may
16 temporarily lose eligibility.
17 So, for instance, with Medicaid
18 renewals, if they got that packet or didn't
19 get it, let's say, and maybe their case
20 manager got it and somehow it just -- things
21 didn't get submitted in time. Do you reserve
22 slots so that they can get back in?
23 MS. SMITH: We do. We actually --
24 we get notified. So MWMA will get a
25 notification if their Medicaid eligibility

1 changes. So, for example, it gets terminated
2 or they go into a type of assistance that's
3 not compatible with waiver, we get a
4 notification, and so we prevent the case from
5 even closing.
6 But in case that it were to close, we do
7 hold usually up to 50 slots that we can give
8 so that people -- if, for some reason --
9 because there's always an issue, especially
10 with kids. When they become adults and they
11 have to have a -- they have to have an SSI
12 review, that there's sometimes a period of
13 time where they -- it will look like they're
14 not eligible.
15 So we always keep some of those slots
16 available in case somebody loses their slot
17 for some -- for no fault of their own. So we
18 do -- we do always hold on to those.
19 But the ones right now that are going
20 through the renewal process, we have staff
21 that they catch those, and they don't let
22 the -- they don't let the waiver case close.
23 So they never lose the slot at all.
24 CHAIR BEAUREGARD: Okay. Well,
25 that's good to know. Do you think that the

1 members know that?
2 MS. SMITH: We try to communicate
3 that. Do all of them know or understand?
4 I'm not sure.
5 CHAIR BEAUREGARD: I think with
6 some of the --
7 MS. SMITH: We try to work --
8 CHAIR BEAUREGARD: I'm sorry.
9 MS. SMITH: No. Go ahead. I'm
10 sorry.
11 CHAIR BEAUREGARD: With some of the
12 notices that people have received, I think
13 they may be under the impression that they're
14 losing the waiver or that they have been
15 determined ineligible for Medicaid; and,
16 therefore, you know, you would lose your
17 waiver.
18 MS. SMITH: We're working on --
19 CHAIR BEAUREGARD: It may just be a
20 perception -- you know, just a misperception.
21 MS. SMITH: Right.
22 CHAIR BEAUREGARD: Or that the
23 notice is inaccurate, and you all are doing
24 something different in the background.
25 MS. SMITH: Well, and it's

1 confusing, too. I mean, the whole process is
2 confusing and complex. So we actually are
3 working with a couple advocate groups as well
4 as I've talked to a couple parents. And then
5 working with our internal staff, we've been
6 trying to work on this and getting it out as
7 soon as we can, but trying to work on a --
8 what do I need to know or kind of a very
9 plain-spoken, "This is what this means if you
10 hear this. This is what you need to do if
11 you get this," to try to help with that.
12 But in the meantime, you know, we're --
13 our help desk is answering lots of questions
14 as well as, you know, we get multiple emails
15 and things. So we're just trying to -- as
16 people have questions, just answer those
17 individually. But we are trying to work on
18 some just really easy, one-page documents
19 that kind of help break it down.
20 Because I'll be honest. I work in it
21 every day, not the eligibility piece of it.
22 But it gets really complicated, so we want to
23 do what we can to help individuals to
24 understand that and especially how the waiver
25 and eligibility work together.

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1 CHAIR BEAUREGARD: Okay. Yeah.
2 Thank you. If there's any kind of
3 communication that you're putting out there
4 that we could look at, that would be great.
5 MS. SMITH: I will absolutely let
6 you all look at it before we do that.
7 CHAIR BEAUREGARD: Thank you.
8 MS. TYNER-WILSON: And, Pam, this
9 is Melanie Tyner-Wilson. Hello. I wanted to
10 ask about the -- because I got a chance to
11 listen to your stakeholder session that you
12 did in July about the unwinding and the
13 waivers and Appendix K.
14 Are the folks that you are hiring for
15 case management -- I remember hearing that
16 you were going to be having more people to be
17 able to be case managers, like, with -- those
18 with an associate's degree or LPNs or lived
19 experiences. Are they -- are they the ones
20 that are kind of reaching out and being able
21 to provide support for individuals on the HCB
22 waiver?
23 MS. SMITH: So we're doing -- two
24 ways we're expanding. One is we're expanding
25 and we're going to continue the expansion of

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1 the qualifications that were allowed during
2 Appendix K.
3 And then the other thing that we're
4 doing is on -- for individuals that
5 participant-direct their services who right
6 now have been limited to choosing the AD or
7 the CMHC from their region. We are expanding
8 that to any traditional case manager.
9 So it can be the AD, it can be the CMHC,
10 or it can be a regular case management
11 agency. And so, yes, it would be part of the
12 case manager's expectation to help to support
13 that and to help walk individuals through
14 that.
15 MS. TYNER-WILSON: That's great.
16 No. That is great. Because I know there
17 were a lot of people that were on the wait
18 list because there wasn't enough case
19 managers or support brokers or PDS
20 coordinators, or whatever the title was. And
21 so I'm excited that that's going to be --
22 that resource is going to be expanded. Thank
23 you.
24 MS. SMITH: We're almost -- we're
25 almost done with the system changes, so we --

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1 to allow those individuals to begin providing
2 services and -- that they can put the plans
3 of care in MWMA right now, but we will do
4 something specific targeted to the case
5 managers to let them know, you know, things
6 that are different if they're going to be
7 doing work with an individual with PDS.
8 But we've had multiple providers,
9 traditional providers reach out to us that
10 are just waiting. They're very interested in
11 providing case management to individuals that
12 participant-direct, and so they're just
13 waiting. They are just waiting to be able to
14 do that.
15 And then I see Steve's question about:
16 Will they also become fiscal intermediaries?
17 So what -- our guidance from CMS is that we
18 had to open this up to allow freedom of
19 choice even for -- even in the fiscal
20 intermediary or the FMA or FMS role as well.
21 So there will be some training that will
22 have to go along with the -- you know, in
23 addition to on-boarding them, there's going
24 to have to be some training that some of them
25 will need to go through to understand new

1 responsibilities.
2 But we're hoping that this will
3 really -- will expand out so that we don't
4 have individuals waiting to get services.
5 CHAIR BEAUREGARD: Thank you, Pam.
6 Any other questions related to that?
7 (No response.)
8 CHAIR BEAUREGARD: Why don't we get
9 an update on the PACE program.
10 MS. SMITH: Okay. So PACE, we now
11 have three active providers serving 17
12 counties, including Jefferson County. We
13 have 132 individuals that are actively
14 enrolled. At our highest point, we had 153.
15 You know, some of the individuals
16 unfortunately have passed away, and some
17 individuals decided that, you know, they --
18 they tried PACE, but they've decided maybe
19 they wanted to go back to waiver as well as
20 we've had, you know, a couple that moved out
21 of a service area that PACE was serving.
22 So -- but still have 132 that were
23 actively -- that are actively getting
24 services from one of the three.
25 As far as what services are covered, it

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1 is all-inclusive. So for that individual, if
2 they need -- their medicines are covered. If
3 they want to go to, you know, adult day care,
4 that is covered.
5 If they have -- the PACE organizations
6 have to have contracts with hospitals and
7 nursing facilities. And if an individual who
8 is enrolled in their PACE program needs to go
9 to the hospital or needs to go to the nursing
10 facility, say, for a short rehab stay --
11 maybe they fell and broke a hip or they need,
12 you know, a short rehab stay in a nursing
13 facility, it is the PACE organization's
14 responsibility to cover that.
15 They get paid a -- and it just left -- a
16 capitative rate for each of those individuals
17 per month that are enrolled in their PACE
18 program.
19 CHAIR BEAUREGARD: So when people
20 are deciding between a waiver and the PACE
21 program, you say it's all-inclusive, but
22 there -- there must be a difference in what
23 services are provided between the two.
24 MS. SMITH: Well, for example -- so
25 waiver, for example, is not going to cover

1 their medicines. They're not going to
2 cover -- you know, their Medicaid may cover
3 it but, you know, they're not going to be the
4 ones that are ordering that.
5 They're not going to -- you know, for
6 PACE, a lot of the times, they're the primary
7 care provider. So the nurse practitioner or
8 the physician or the -- (audio glitch).
9 They, you know, have therapy at the PACE
10 center. They have -- you know, they can get
11 supplies there.
12 And I hope you all -- I'm having -- I
13 didn't come on camera because I'm having
14 Internet stability, so I hope you all can
15 still hear me okay.
16 CHAIR BEAUREGARD: We can --
17 MS. SMITH: But they -- they can
18 get -- so -- and they could also -- in
19 addition, can get those services the waiver
20 would provide. So, like, the attending care
21 or the personal care assistance, the supplies
22 that they would get under goods and services.
23 It really depends on -- we've seen some
24 individuals that have transitioned from
25 waiver to PACE really like PACE because

1 they -- you know, it's kind of a one-stop
2 shop, and they're able to -- everything is
3 coordinated for them. You know, the PACE --
4 the treatment team, all of that is done.
5 And then we've seen some that really
6 didn't like that and wanted to go back to
7 waiver to where they just had somebody maybe
8 come to their house a couple days a week, and
9 they were good with that. And they were good
10 with, you know, having to go to get their
11 medicines at whatever pharmacy they chose
12 and, you know, doing their physician visits
13 and all of that the way they always had.
14 CHAIR BEAUREGARD: Okay. That
15 helps. So PACE essentially covers more.
16 It's more comprehensive and a little more
17 intensive.
18 MS. SMITH: It is, yes.
19 CHAIR BEAUREGARD: Okay. Good to
20 know. Any other questions about the PACE
21 program that people wanted to cover?
22 (No response.)
23 CHAIR BEAUREGARD: All right.
24 Well, thank you. Why don't we move on to the
25 DMS report on the hospital rate improvement

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1 program.

2 MS. PARKER: Hello. Good

3 afternoon. This is Angie Parker, Director of

4 Quality and Population Health.

5 I can say that as of this morning, I

6 have received a draft report for calendar

7 year 2022. So maybe by the next meeting, I

8 will have the final report.

9 CHAIR BEAUREGARD: So, then, do you

10 have anything you can share with us from the

11 draft report?

12 MS. PARKER: Well, since it's a

13 draft, I'd rather not --

14 CHAIR BEAUREGARD: Probably not,

15 yep.

16 MS. PARKER: -- because there may

17 be some changes or whatever that -- to that.

18 But it looks -- the draft looks pretty good.

19 CHAIR BEAUREGARD: Okay. Great.

20 We'll add that to the October agenda, then.

21 Thank you.

22 MS. PARKER: Uh-huh.

23 CHAIR BEAUREGARD: The next item

24 here is certified CHW reimbursement.

25 MS. PARKER: I'm going to hand that

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1 over to Justin Dearinger.
2 MR. DEARINGER: Thank you,
3 Ms. Parker. This is Justin Dearinger. So
4 I'm going to let you -- or, actually, I'm
5 going to have to get back to you on that
6 and -- so I can make sure that I give you the
7 exact information so --
8 CHAIR BEAUREGARD: Okay.
9 MR. DEARINGER: -- because I do
10 not -- I'm not quite sure.
11 CHAIR BEAUREGARD: Okay. I guess
12 you know some of the concerns and questions
13 that I've had.
14 MR. DEARINGER: Absolutely.
15 CHAIR BEAUREGARD: One other thing
16 I'm curious about is whether you've had any
17 CHWs bill and how that's worked so far.
18 MR. DEARINGER: So we have had some
19 CHWs bill. I haven't had any problems or
20 complaints yet, but I don't know how many.
21 Like I said, we started July 1st, so I
22 don't -- we haven't ran any reports. We were
23 going to wait.
24 Actually, I had that for October 1st.
25 I've got a data request in for October 1st to

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1 run reports of who all has billed and how
2 many and what they've billed and what
3 provider types and the whole nine yards to
4 give us a look at the first three months'
5 snapshot.
6 We didn't want to pull data from --
7 because we really, you know, didn't -- it
8 didn't get publicized till, you know, parts
9 of the middle of July, so we don't have a ton
10 right now. But -- so October 1st, we're
11 going to pull all those reports, have kind of
12 that first three months.
13 But I haven't had anybody discuss any
14 real issues. You know, dentists, of course,
15 are having some issues with billing. They're
16 having to kind of right now bill on paper
17 claims, and so that's a little different than
18 what we had originally thought.
19 CHAIR BEAUREGARD: I heard that
20 they needed a different kind of code.
21 MR. DEARINGER: Yeah. And so, you
22 know, unfortunately, there's not a D code for
23 that so that they can go through our system.
24 The CPT codes (audio glitch) --
25 CHAIR BEAUREGARD: Justin, I think

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1 you just cut out.

2 MR. DEARINGER: I'm sorry. The CPT

3 codes were originally designed -- everybody

4 thought that they would, you know, be able to

5 work in our system. And once we tried those,

6 found out that they didn't work quite like we

7 thought they would.

8 So anyway, we are working -- we're still

9 working on it. We're working around it. I'm

10 hoping to have a resolution within the next

11 two to three months so that we can still use

12 the CPT codes or some type of, you know,

13 other work-around. But for right now, that's

14 been really our only issue with billing that

15 we know about.

16 We have an updated FAQ that we'll have

17 probably on the website hopefully one day

18 this week. We'll get that on there, just

19 expanding some of the information and making

20 some adjustments and changes. We've expanded

21 the limitations and some other things. As

22 we've gotten feedback from providers on

23 different topics and issues, we've made

24 changes so -- but that's -- that's kind of

25 where --

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1 CHAIR BEAUREGARD: Okay. That's
2 good to know. And if -- Erin, once that FAQ
3 is added to the website, if you could just
4 alert us and send us a link, that would be
5 great.
6 MS. BICKERS: Yes, ma'am.
7 CHAIR BEAUREGARD: Thank you. And,
8 Justin, to -- you mentioned the limitations.
9 And that's on -- for anybody who's not
10 familiar with the regulation, the CHWs who
11 could bill Medicaid for certain services are
12 limited to two units, billing two units a
13 week at this time, which is -- units are 30
14 minutes, so that would add up to an hour.
15 But I think I heard you, Justin, say on
16 a different call that that would be for the
17 same service but that if they were getting a
18 different service in that same week, a
19 different limitation -- like a different
20 two-unit limitation would apply; is that
21 right?
22 MR. DEARINGER: You are correct.
23 CHAIR BEAUREGARD: Okay.
24 MR. DEARINGER: And that's going to
25 be updated on the FAQ. So, you know,

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1 originally, if an individual went to their --
2 just say they went to their primary care
3 physician, saw them twice and utilized CHW
4 services twice that week, that would end
5 their limit of how many CHW services they
6 could have.
7 However, you know, we've expanded that
8 so that if you go to your physician, you
9 get -- you can still get two a week. But
10 then you'd just -- you go to your dentist,
11 you can still get two. If you go to see your
12 optometrist, you still get two. Two
13 additional is what I mean.
14 And so you get multiple CHW, you know,
15 services depending on the provider type. And
16 we have those provider types kind of grouped
17 together, and all that's explained on the
18 FAQs.
19 But, basically, it allows for an
20 individual to be able to get CHW services
21 from multiple provider types and not just,
22 you know, be stuck with -- because a CHW's
23 services can be one thing at your primary
24 care physician. But when you go to, you
25 know, your dentist or when you go to a

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1 behavioral health provider, they may be
2 something totally different. So that's why
3 we've expanded those services and allowed for
4 more based on the provider type specifically.
5 CHAIR BEAUREGARD: All right.
6 That's helpful. That's good to know. Thank
7 you. And I'll add this to the October agenda
8 so that you can share more information at
9 that time.
10 Also, just want to let everyone know, if
11 you haven't really been following this
12 regulation for CHW, or community health
13 worker reimbursement, it's currently in a
14 comment period, a public comment period. And
15 so if you have interest in submitting public
16 comments, you can do that, I think, through
17 the end of September. Is that right, Justin?
18 MR. DEARINGER: That is correct.
19 So I think the last day is the last day of
20 September to get your comments in.
21 CHAIR BEAUREGARD: All right.
22 Well, thank you very much. Any questions
23 before we move on?
24 (No response.)
25 CHAIR BEAUREGARD: Okay. Why don't

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1 we move on to dental, vision, and hearing
2 regs. Are there any updates there?
3 MR. DEARINGER: Is -- I don't know
4 if -- is Jonathan on? I'm not sure if
5 Jonathan Scott is on the call.
6 MR. SCOTT: I'm on. The -- hello,
7 everyone. Jonathan Scott, DMS reg
8 coordinator. Also, I wanted to say thank you
9 all for coming and participating in the
10 process this month at the ARs meeting. There
11 was a lot of testimony. There was a lot of
12 really interesting discussion at that
13 meeting.
14 The E regs made it through the process.
15 The O regs will be on the ARs agenda next
16 month. We have already turned in our
17 statements of consideration, and we will be
18 amending the vision regulation a little bit.
19 Just -- it'll be the same things that were
20 made to the E reg.
21 And then I believe we were also going to
22 make a slight change to the dental regulation
23 to allow for an expansion of limited oral
24 evaluations as well. We discussed that with
25 the Dental TAC this last week, and we think

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1 that makes a lot of sense to make that change
2 as well. That has been researched
3 internally, and that agreement has been made.
4 I'm not sure. I think we would expect
5 the E regs to get a hearing in the Health and
6 Family Services possibly this month, possibly
7 next month. And then we would also just
8 expect the O regs to continue going through
9 the process. Not sure that I have a lot more
10 of a meteor update than that right now.
11 CHAIR BEAUREGARD: Yeah. I was
12 mainly interested in whether you were
13 planning on making changes, any amendments to
14 the regs. And then you mentioned the E regs
15 going to the health services. I'm assuming
16 the ordinary would probably go to the same
17 committee eventually.
18 MR. SCOTT: Yes.
19 CHAIR BEAUREGARD: Just on a
20 different timeline?
21 MR. SCOTT: Yes.
22 CHAIR BEAUREGARD: Okay. But it
23 hasn't been assigned yet?
24 MR. SCOTT: That's correct. I
25 don't think it'll get assigned until the LRC

1 meeting this month, so we have not heard yet.
2 CHAIR BEAUREGARD: All right. Any
3 questions about dental, vision, and hearing
4 regs?
5 MS. BROWN: I'm just going to make
6 sure I followed. Jonathan, you said that you
7 will expand the dental reg regarding the
8 limit of oral evaluations. What did you
9 mean?
10 MR. SCOTT: Yes. Let me pull up
11 the dental reg, so I can -- it's -- you know,
12 it's far enough in the future that I
13 haven't -- I haven't drafted my agency
14 amendment yet. Just to -- I believe that we
15 will be amending -- so we're going to amend
16 Section 6, Subsection 2, and I think all of
17 Subsection 2 is coming out. But don't quote
18 me on that just yet even though I did just
19 state it in a public meeting.
20 CHAIR BEAUREGARD: In effect,
21 people will have a little bit more access to
22 an oral evaluation than currently?
23 MR. SCOTT: That's right. We're
24 not --
25 CHAIR BEAUREGARD: No service is

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1 being taken away.

2 MR. SCOTT: We're not sure if it's

3 going to be a huge change. We do believe

4 that it is available, and private insurance

5 may also be available already within the

6 MCOs. So we're really not sure that it's

7 going to be a huge change, but that is the

8 change we're tracking right now beyond the

9 changes that we made to the emergency regs.

10 CHAIR BEAUREGARD: Got it. Okay.

11 Thank you.

12 MS. BROWN: Thank you.

13 MR. SCOTT: Anytime.

14 CHAIR BEAUREGARD: All right. Why

15 don't we move on to the next item, which is

16 the value-added benefits side-by-side with

17 the behavioral health items. And thank you,

18 Erin, for sending that to us earlier.

19 I was able to take a quick glance at it,

20 but this might be something, Angie, that

21 you're going to talk about. I mostly want to

22 know what's changed with the document that

23 you just shared. I wasn't able to do, like,

24 a side-by-side comparison.

25 MS. PARKER: Well, basically, we

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1 tried to categorize everything so that it's
2 easily -- more easily understood. So
3 hopefully, after you've looked at it a little
4 bit closer, kind of based on our
5 conversations that we had at the last TAC,
6 ensuring that what's actually a behavioral
7 value-added benefit versus what's an actual
8 benefit like case management or certain
9 things like that.
10 So that's -- hopefully, that's where
11 we've gotten it down to at this point, as
12 close as we can anyway. Because we went back
13 to the MCOs and said: Okay. What is
14 actually a value-add benefit? Because there
15 is a difference between a value-add benefit
16 and a Medicaid benefit.
17 CHAIR BEAUREGARD: Right, right,
18 right. And that's what I wanted to make sure
19 was clear in the document. If I'm -- when I
20 did look at it, it looked to me like maybe
21 any Medicaid-covered benefit had been removed
22 from the table. Is that accurate to say?
23 MS. PARKER: It may have been
24 removed, or it would have been categorized
25 differently.

1 CHAIR BEAUREGARD: There was only
2 one category for behavioral health so -- and
3 then there were --
4 MS. PARKER: No. I mean, there are
5 asterisks --
6 CHAIR BEAUREGARD: I saw a lot of
7 asterisks.
8 MS. PARKER: -- associated with
9 certain things.
10 CHAIR BEAUREGARD: Okay.
11 MS. PARKER: So hopefully -- now,
12 I'm not going to say 100 percent that there
13 is no benefit -- behavioral health benefits
14 at all on there but --
15 CHAIR BEAUREGARD: What's
16 confusing, I think, is that even though -- a
17 lot of them said, you know, smoking cessation
18 program, for instance, or case management
19 program. So maybe that's a program that is
20 unique to a particular MCO, and it's not the
21 same as case management or smoking cessation
22 as a service. But I think that it could be
23 confusing to people who are looking at the
24 table.
25 You know, something that we had

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1 requested last time was for the benefits --
2 covered services to be listed at the top, not
3 in the table, so that it was really clear
4 these are services every single MCO covers
5 that are behavioral health services and then
6 here are the additional, you know,
7 value-added services. And that might help
8 make the distinction more clearly.
9 So that would be my input on -- and I
10 don't know if anybody else on the -- any of
11 our TAC members have had a chance to look at
12 it, but I do appreciate the work that has
13 gone into the different iterations of it.
14 MS. BROWN: I took a quick look,
15 and I really appreciate, you know, the time
16 that you put in to making the adjustments and
17 making it more clear. I liked how you
18 divided up the different types of benefits.
19 Like, behavioral health, child benefits,
20 medical, diabetes 2, learning,
21 transportation, et cetera. That was helpful.
22 It was still -- and I see -- you know, I
23 see why -- it's a long document. So, like,
24 it would be nice for them to be visually
25 aligned by category, but I understand that

1 would make the document longer. So I really
2 appreciated how you separated out those
3 different types of benefits.
4 But I also agree with Emily that I think
5 it's -- it is confusing for members. If the
6 covered benefits that all of the MCOs should
7 provide that are -- are included in the table
8 at all because then we're not -- it's like
9 some MCOs might tout that more than others,
10 and so it's not actually transparent to
11 consumers.
12 MS. PARKER: Well, all I can say to
13 that is this was provided to the MCOs for us
14 to provide the information. So if it wasn't
15 provided, it's not on there. So what is on
16 that is only what the MCOs provided. As far
17 as a side-by-side, it was provided right back
18 to them if there was anything else they
19 wanted to add.
20 So I think at this point, that's the
21 information, and it could change next year
22 because we are going to do a 2024 value-added
23 benefit. I don't know if I'm going to go
24 down to the degree of the behavioral health
25 like this one has been, but there is going to

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1 be a general value-added benefit side-by-side
2 even though we're not doing open enrollment
3 this year on a routine basis like we usually
4 do because of unwinding. But there will
5 still be a side-by-side that will be
6 performed or put together for 2024.
7 CHAIR BEAUREGARD: Well, it would
8 be good if we could review that whenever
9 you're working on it before it goes out to
10 consumers.
11 MS. PARKER: Sure.
12 CHAIR BEAUREGARD: That would be
13 helpful.
14 MS. PARKER: Sure.
15 CHAIR BEAUREGARD: And like I said,
16 if you are going to be focusing on something
17 specific, like behavioral health, looking at
18 what is covered versus what is value-added
19 and just making that distinction is really
20 what we're most interested in. But I think
21 it's a little clearer now than it was before.
22 MS. PARKER: I hope so. Good.
23 CHAIR BEAUREGARD: I think part of
24 the problem --
25 MS. PARKER: I tried.

1 CHAIR BEAUREGARD: -- is that the
2 MC -- like, when you have a program, like I
3 said, you know, it's called the case
4 management program, or it's called a
5 cessation program. It's hard to understand
6 how that's different from, you know, the
7 service that you would get from any other
8 MCO. So that just makes it tough.
9 Anything else about that before we move
10 on?
11 (No response.)
12 CHAIR BEAUREGARD: Okay. We have
13 network adequacy next, and I appreciate all
14 of the MCOs submitting information about the
15 number of out-of-network services that were
16 provided that were approved last year in
17 2022. Thank you for that.
18 I did kind of just add it up very
19 roughly, and it seems like there are --
20 across all six MCOs, there were, you know, a
21 few thousand out-of-network services that
22 were approved. Definitely less than 10,000,
23 you know, for our entire 1.7 million
24 Kentuckians who are in managed care, so a
25 relatively small number if you kind of do

1 that math. I'm sure it's, like, one percent
2 or something.
3 And it looked like very different
4 numbers for very different types of services
5 so -- which is kind of what I was suspecting,
6 is that it's inconsistently -- you know,
7 every MCO does it differently. And, you
8 know, I think it would be helpful to have a
9 little more consistency in how things are
10 approved with, you know, some ability to have
11 discretion in certain cases.
12 But from a consumer perspective, not
13 knowing, you know, what criteria is being
14 used to approve those services, that just
15 makes it difficult. And only having the
16 option of, you know, then having to switch
17 MCOs and not knowing if the MCO you choose is
18 going to have that available provider just
19 means that some people end up not getting the
20 care that they need.
21 But it is good to have that information.
22 And we had requested a couple of times for
23 some of these additional reports and just
24 wondering if we -- those reports are
25 available now.

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1 MS. PARKER: Well, this is Angie
2 again. And, Erin, if you could give me
3 access, I want to be able to show you a list
4 of what DMS MCO reports we get regarding
5 network adequacy and the challenge it would
6 be to give these reports unless you just
7 wanted one for a month or a quarter based
8 on -- and I'm going to show you one of those
9 reports as well.
10 MS. BICKERS: You're now a cohost,
11 Angie.
12 MS. PARKER: Thank you. Okay. I'm
13 hoping you are seeing it, this geo-mapping
14 and access report.
15 CHAIR BEAUREGARD: Yes.
16 MS. PARKER: Okay. Because I've
17 got two or three screens up here, and I want
18 to make sure you're seeing the right thing.
19 Okay. So these are the four reports that we
20 are currently getting from the MCOs either on
21 a quarterly or a monthly basis. This PSN-05,
22 03, 09, 04, that's just for our DMS purposes,
23 to know how to pull these reports.
24 So this first report for geo-mapping and
25 access is they are to supply this on a

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1 quarterly basis. And someone from our
2 quality and population health division looks
3 at this report, and it's basically what it
4 says. It's geographical access reports for
5 each county addressing all provider types by
6 the department.
7 The provider network status report is
8 reviewed -- or is received monthly. And this
9 is reviewed by someone in our program
10 integrity division, and this talks about
11 additions and terminations to the network by
12 type and region, and termination reasons are
13 provided.
14 The next is a timely access report, and
15 this is reviewed -- received quarterly, and
16 it's currently been reviewed by someone in
17 our health plan oversight division. But in
18 looking at this report, we're going to be
19 changing that to someone in the quality and
20 population health division because of the
21 access issues that we know we have. And it's
22 basically a quality or a social determinant
23 of health issue that we are addressing. So
24 that's why it's being changed to someone in
25 quality and population health.

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1 And then we have the provider network
2 adequacy exceptions report, and this is
3 where -- this is a quarterly report that's
4 reviewed by someone in program integrity that
5 shows the exceptions to the network adequacy
6 standards for reasons such as provider
7 shortages in a particular specialty or
8 geographic location.
9 So those are the routine reports that we
10 receive and are reviewed by a subject matter
11 expert either on a monthly or quarterly
12 basis. Any questions about this?
13 CHAIR BEAUREGARD: It's good to see
14 the description. I was hoping that you would
15 share the reports with us.
16 MS. PARKER: Well, I am going to
17 show you one. And the reasons I'm showing
18 you -- I'm giving you the description -- and
19 I'm trying to stop sharing for now -- to let
20 you know that these reports are being looked
21 at. We're getting them from all six MCOs, so
22 trying to compare apples to apples is a very
23 big challenge for that person who is
24 reviewing each one.
25 We have been working -- when I say "we,"

1 the Department For Medicaid Services,
2 primarily in my division, have been working
3 with the Office of Data and Analytics for the
4 past year and a half on the PSN 05 report and
5 pulling those -- all of those MCO reports
6 together in one system and then comparing it
7 to what we are seeing via claims.
8 And we finally have gotten to a point
9 where we can play with this report to see
10 what they -- what the MCOs are telling us and
11 what is actually happening because that's
12 always been the challenge. Like, we'd get
13 these reports from the MCOs, and we can't --
14 in order to verify -- I hate not to be
15 looking at you, but I can't. I'll talk with
16 my hands.
17 It's always been a challenge to say,
18 okay, this is what they're saying, but is
19 this actually true because of X, Y, Z and
20 these complaints or whatever that we're not
21 able to -- that people are not able to get in
22 to see these providers.
23 So we are this close. And I'm hoping,
24 maybe by the next meeting, that we can show
25 you a demonstration of what that report looks

1 like. Because, basically, what the Office of
2 Data Analytics has done is, like I said,
3 based on claims -- now, we're, like, a
4 three-month backlog -- not backlog. It's the
5 wrong word. But in order for -- to compare
6 actual claims to what we are seeing as far as
7 access and the providers who are billing, and
8 so that's where it's been very exciting to
9 see.
10 And, actually, on our preliminary look
11 at this last week, we didn't see much
12 difference in what the MCOs are reporting and
13 what we're seeing in the claims. But, again,
14 we're still fine-tuning this report. And,
15 hopefully, if not the next one, maybe the
16 next time period, I can have someone from the
17 Office of Data Analytics unless someone in my
18 shop becomes an expert in pulling -- showing
19 all this information. But it is very
20 exciting to see.
21 So I want to show you what one of these
22 reports -- and this is the timely access
23 report, and I'm going to go off camera again
24 because it's easier to share. All right.
25 And what you should be seeing is a

1 quarterly report, and it shows where the MCOs
2 have done calls out. This is what you would
3 call a secret-shopper-type report. The MCOs
4 are required on a quarterly basis to do these
5 calls to check on urgent care, routine care,
6 and after-hours calls and the percentage of
7 how many they completed as far as audits,
8 where they were not being able to pass the
9 audit.
10 And as you can see, in this quarter for
11 urgent care, primary care -- now, this is
12 broken down into one, two, three, four, five,
13 six different provider types. Now, we are
14 looking at this internally to see what's more
15 beneficial and -- or to break this down more
16 specifically.
17 Because PCP could be general
18 practitioner, family practitioner. You know,
19 a pediatrician is a primary care doctor. An
20 OB/GYN can be a primary care. And then, you
21 know, also breaking it down by specialists
22 because some specialists may be easier to get
23 into than others, so we need to be able to
24 look at that as well.
25 And this -- the next -- I just pulled

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1 one MCO. So this is what the trending looks
2 like as far as quarters, and they're to meet
3 80 percent or better. In some areas, PCP for
4 quarter two did not meet.
5 CHAIR BEAUREGARD: Right. Well,
6 the standard is 95 percent; right?
7 MS. PARKER: Yeah. I believe
8 you're right on that one.
9 Obviously, we're fine-tuning that and
10 making sure that -- that these are correct.
11 Now, like I said, someone is reviewing these,
12 and if there is something, for example, that
13 is below standard, that that subject matter
14 expert would go back to that MCO and say:
15 What's the deal?
16 And they are to report back and if
17 there's consistency and challenges with that.
18 I mean, it may go to a letter of concern or a
19 corrective action plan, but this is what one
20 of the reports looks like.
21 CHAIR BEAUREGARD: That was good.
22 Thank you for showing us that. It's helpful
23 to see it and to just better understand
24 exactly how you're tracking things. You
25 know, I think we've just heard concerns and

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1 not for one particular MCO, just generally,
2 that people aren't always able to get the
3 services that they need and especially in
4 particular areas of the state. And it seems
5 like it's chronic, you know.
6 So whether this is -- whatever the
7 corrective action plans are, the way that --
8 you know, you're trying to kind of remedy
9 this. It seems like there's still some gaps,
10 and we're trying to figure out exactly what
11 these are.
12 But one way that I think we could make
13 an improvement is if DMS had a reporting
14 mechanism so that people could report when
15 they're unable to get care and have, you
16 know, attempted to get out-of-network care
17 approved or attempted to get, you know, an
18 MCO to help them identify a provider and just
19 haven't been able to.
20 I think that would be easier for
21 consumers, and it would be a way for us to
22 really understand a little bit more of the
23 issue because, like you said, every MCO does
24 things a little differently. It's not apples
25 to apples and --

1 MS. PARKER: Even though we try to
2 be apples to apples, sometimes different
3 systems or whatever, it just doesn't come out
4 that way.
5 CHAIR BEAUREGARD: Well, and the
6 nature of managed care is that MCOs have
7 discretion in how they do many of these
8 things, so...
9 All right. Well, that's helpful to
10 have. It sounds like we'll get more
11 information at the next meeting. So I'll put
12 on our October agenda the demo from the
13 Office of Data Analytics, and we might have
14 some other, you know, questions in the
15 meantime. But it's good to see that.
16 And I think just in the interest of
17 time, unless people have any burning
18 questions about network adequacy, we should
19 probably move on.
20 I forgot to mention -- when I told you I
21 was at Morehead State University, I forgot to
22 say that I have to be out of the room at 3:00
23 or a little after, but I can't stay here
24 until 3:30. So I apologize for that. I
25 should have mentioned it at the beginning.

1 But we have new business, and I wanted
2 to make sure we got to that. I know that,
3 Miranda, you wanted to talk a little bit
4 about connector listings. I'm wondering if
5 that is similar to the "get contacted" issue
6 that we already had on the agenda for agents
7 and just generally how people are able to
8 find somebody to assist them.
9 And then we'll talk about housing
10 issues. The item that Arthur had suggested
11 for this month's agenda, the proposal to
12 overhaul the Michelle P and other waivers,
13 we're going to move that to October because
14 there was a guest that he wanted to come and
15 speak to that issue who was unavailable
16 today.
17 So we can also just get a quick update
18 on the MAC TAC orientation packet. But --
19 actually, why don't we start with orientation
20 and then we'll address the other two.
21 MS. BICKERS: It's in the works. I
22 think Kelli is close to having that ready to
23 review by upper management before it goes
24 out, so I know she's been working on it.
25 Kelli and I are also the SPA coordinators, so

1 we are -- been very busy, so it is in the
2 works.
3 CHAIR BEAUREGARD: Well, thank you
4 for the update and for your work on it. Is
5 there any other input that you need from us?
6 MS. SHEETS: No. Thank you, Emily.
7 This is Kelli. It's actually been reviewed
8 by upper management once, and so now we're
9 just kind of tweaking it. So I do expect it
10 to be complete very soon, I hope.
11 CHAIR BEAUREGARD: Okay. That
12 sounds good.
13 Miranda, why don't we talk about the
14 connector listings.
15 MS. BROWN: Okay. Yes. I have
16 raised this issue before, but I can't
17 remember if I've raised it in this committee.
18 But maybe last year -- sometime not too long
19 ago, when Kynect did some update, or maybe it
20 was just with the new Kynect.
21 Essentially, though, when a consumer
22 goes on -- when anyone goes on to the public
23 Kynect website and searches for a connector,
24 it is now possible for them to click a box,
25 and they can search for just public

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1 connectors or also private connectors.
2 This did not used to be the case with
3 the old Kynect or when we were on the
4 Marketplace. It used to be that anybody who
5 was listed as a private connector was not
6 publicly searchable on any public website.
7 And, therefore -- like, so, generally, people
8 couldn't -- a consumer could not just add a
9 private connector to their case without
10 contacting that connector first.
11 Kind of the idea, from what I've always
12 understood as to the intent of having that
13 division between private and public
14 connectors, is to allow organizations that
15 have certified application counselors or
16 connectors the ability to just take on the
17 clients that go through their normal intake
18 and referral processes rather than receiving
19 referrals, for instance, from the State or
20 just a consumer adding them to their case
21 first, if that makes sense.
22 So the problem is with this -- the way
23 it is now, anyone can search for a private
24 connector. But when private connectors
25 signed up to be private connectors, they did

1 so with the understanding that they would not
2 be publicly searchable.
3 And so it's causing a problem for us
4 internally, and I've heard from other
5 organizations as well that, you know, we're
6 really -- we're really not set up to take
7 that many clients on. And so it's
8 problematic when we get referrals for clients
9 that we actually did not consent to take on
10 and then we have to take extra steps to reach
11 out to them and make sure that they get the
12 help they need.
13 And then I've actually heard from some
14 of the legal aid organizations that this is
15 actually a major barrier to them even
16 deciding to take on and have connectors on
17 staff, which is, like, huge to me that I
18 would love for there to be more organizations
19 who feel like they can take this on and have
20 CACs, connectors on staff to help more people
21 because there's so much need.
22 But if this kind of thing is keeping
23 them from being able to do that, I'm just
24 really expressing, again, that this -- it
25 would be great to change that back so that

1 private connectors could actually be private
2 and not publicly listed and searchable.
3 MR. VERRY: Hey, Miranda. This is
4 David Verry. Pardon the noise. I'm in the
5 airport but absolutely heard -- we're working
6 on kind of redoing the whole search tool for
7 connectors and agents alike. It's going to
8 have, like, a Google pin and that kind of
9 thing. And we've tried to increase the
10 messaging to steer people away from private
11 connectors, but we'll see what we can do
12 about suppressing private connectors
13 altogether.
14 CHAIR BEAUREGARD: Thank you. So,
15 Miranda, if I understand correctly, this is
16 something that -- it had been suppressed in
17 the past, and it is no longer. So what we're
18 really asking for is to just go back to the
19 way that it was.
20 MR. VERRY: Yeah. And I --
21 CHAIR BEAUREGARD: And I will agree
22 with -- yeah. Just to echo what Miranda is
23 saying, the same is happening for KVH's
24 connectors. And I was a connector way back
25 when, original. And I also was getting

1 referrals for years after I was ever even --
2 I was no longer trained as a connector. So
3 there are some glitches that probably could
4 be worked out, but thanks for looking into
5 it, David.
6 So a related issue but different is the
7 "get contacted" option, which is now on
8 Kynect and only for agents at this moment.
9 And just wondered, David, if you have an
10 update on when connectors are going to be
11 added to that feature so that if a consumer
12 would, you know, rather have a connector,
13 they can --
14 MR. VERRY: Let me speak to that.
15 It was designed and implemented so it looks
16 exactly like it does on healthcare.gov. If
17 you go to healthcare.gov, you have those same
18 options.
19 CHAIR BEAUREGARD: Right.
20 MR. VERRY: You choose an agent,
21 and you have those two options. You get the
22 agent on demand or Kynect on demand, whatever
23 you want to do it. If we're assisters and go
24 on the federal site, you have the search tool
25 only.

1 With all the change requests that are
2 going on because of the unwinding, we don't
3 have the bandwidth to do anything about it
4 this year, just being honest. But as we go
5 into next year, what we wanted to do is have
6 it so you still have that on demand feature
7 for both agents and connectors and even
8 enhanced so that maybe a few gateway
9 questions can be asked so -- very general but
10 just to get people generally moving in the
11 right direction.
12 So that if people are looking for SNAP,
13 for example, they'll be routed to a SNAP
14 connector queue. And if someone is looking
15 for just health insurance -- I'm using the
16 two extreme examples -- they could obviously
17 just go to the agent queue, so to speak,
18 and -- to try to do a little bit more sorting
19 right now.
20 The agents are presenting that they're
21 getting people that they are not equipped to
22 help like people looking for other programs,
23 and the connectors are jumping up and down
24 saying: How come we can't get more of those
25 people?

1 CHAIR BEAUREGARD: That's been --
2 MR. VERRY: So we just have to --
3 CHAIR BEAUREGARD: Yeah. I'm
4 sorry. That's been our concern all along.
5 And that for consumers who are, you know,
6 thinking this is going to help them but then
7 they end up just prolonging their -- you
8 know, being shuffled from one place to
9 another.
10 MR. VERRY: Yeah. When we saw that
11 happening, really, it was -- I'm not going to
12 lie. It wasn't very pretty in the beginning.
13 We increased messaging on the website and at
14 the contact center especially. And now the
15 contact center will only put someone in that
16 queue if they know they are absolutely ready
17 to enroll in a QHP and not send them down the
18 wrong road and find them a connector if
19 that's more appropriate, hopefully with them
20 on the line.
21 We have a long ways to go. I absolutely
22 hear that and know that. Those mitigation
23 efforts were helpful, that we've gotten
24 reports back that there are less people being
25 sent to the wrong place because that's --

1 that's the biggest frustration there could
2 be.
3 CHAIR BEAUREGARD: Yeah. I guess
4 I'm wondering how -- how helpful it's been
5 to -- you know, and if we're to look at pros
6 and cons here, is it worth having before you
7 make some updates and improvements to it and
8 add connectors and have more sorting? Or is
9 it something that we can just, you know,
10 maybe suspend, put on pause until after we --
11 there's time to really work on it.
12 MR. VERRY: Well, it absolutely is
13 helping generate people to the QHP market,
14 and that's what its -- that's what its
15 primary focus was. During the unwind, as
16 people are losing their Medicaid, to keep
17 that bug in the ear and get them enrolled in
18 appropriate care, especially since, generally
19 speaking, QHP enrollment does not go
20 backwards, so there's, you know, a clock
21 ticking.
22 CHAIR BEAUREGARD: Right. Right.
23 Okay. Thank you.
24 MR. VERRY: Yeah. I mean, I --
25 that's definitely worth a look to see how

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1 effective it is versus what the cons are,
2 Emily. We'll look at the numbers again. You
3 know, I'll keep you updated as we move
4 towards phase two.
5 CHAIR BEAUREGARD: Okay.
6 All right. Thank you. I appreciate that,
7 and I apologize again that we are running a
8 little bit short on time now.
9 Did you have something else to add,
10 David?
11 MS. BROWN: I was just going to say
12 maybe that's something we could get a report
13 on next month, is --
14 CHAIR BEAUREGARD: Yes.
15 MS. BROWN: -- what you said,
16 David, just now about some numbers on how
17 many people are actually getting helped this
18 way.
19 CHAIR BEAUREGARD: That would be at
20 October -- at our October meeting, David.
21 MR. VERRY: Yeah.
22 CHAIR BEAUREGARD: Okay. Great.
23 Thanks. I'll add that to that agenda, then.
24 That's a good suggestion, Miranda. Thank
25 you.

1 And so why don't we spend the next few
2 minutes talking about housing. And, Melanie,
3 I can stay on -- I can stay in this room for
4 a few more minutes, so why don't we -- you
5 know, if you want to present kind of the
6 issues and then this federal funding that you
7 shared with me, we can have a brief
8 discussion now and then perhaps a longer
9 discussion in October.
10 MS. TYNER-WILSON: Yes. And this
11 is -- I guess, like other people have used a
12 high level. I'm still learning about it, so
13 please, I'm not a total expert. But what is
14 going on right now is there is a large number
15 of individuals that are homeless or at risk
16 of being homeless and/or a member of a family
17 that has an aging caregiver. The person
18 might have a disability. So we're talking
19 about people that are low income, people that
20 are disabled, and as well as seniors.
21 And so what has happened since, like,
22 2021, that there has been discussions between
23 HUD and Medicaid -- because Medicaid does not
24 cover the cost of housing. Housing, of
25 course, would be covered under Social

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1 Security or SS -- SSI or SSDI.
2 But what has been happening is with the
3 American Rescue Plan dollars that were
4 available, they began to have conversations
5 between these two federal organizations. And
6 they've been attempting to work together, and
7 they've been using some of these APRA (sic)
8 dollars to provide rental assistance to
9 individuals that are at risk of being
10 homeless or aging or disabled. And so you
11 can kind of see that's a very wide, extensive
12 population.
13 And what's happening in communities, and
14 it's happening in our state, is communities
15 are bringing stakeholders together to
16 something called a continuum of care. And
17 there would be representatives from, like, a
18 human rights commission, from different
19 agencies, community action disabled
20 populations, you know, that would all be at
21 the table to sit and look and review the
22 funding that has come down that might be
23 eligible or available to the community to
24 determine, you know, how it should be spent.
25 And so in talking with her, I just

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1 shared that what -- in my humble experience,
2 what I've seen is that there's been wonderful
3 advocacy for low-income,
4 at-risk-of-homelessness seniors. But the
5 disabled population isn't always present and
6 at the table.
7 And so I've been kind of pushing more in
8 my community to have a better representation
9 so that they can be at the table, too,
10 because this population of individuals needs
11 additional supports that, like, maybe a HUD
12 Section 8 housing might not be able to
13 provide. They would maybe be considered a
14 more vulnerable population or would need to
15 live with some kind of care provider and also
16 live somewhere where those wraparound
17 services could be provided.
18 So that's what prompted me to reach out
19 and say could this be something that we have
20 some kind of discussion -- because I know
21 that there is a waiver in the works, the SMI
22 waiver, that they're trying to incorporate
23 housing needs in that waiver as well.
24 And so just to try to make sure we
25 really have an understanding because there

1 are many people that are aging caregivers
2 like me who have adult loved ones that have a
3 disability that live themselves week to week
4 and have not had the ability to save and be
5 able to plan for the care of their loved one
6 after they're gone.
7 So, obviously, my lens -- my focus is
8 real specifically on that segment of the
9 population. But what's hopeful is that
10 there's funding and resources and things that
11 are going on right now as we speak, and I
12 really think there needs to be representation
13 at these community or continuum of care
14 groups that HUD is supporting in communities.
15 So I don't know if that makes sense or
16 not, but that's what I know so far.
17 CHAIR BEAUREGARD: Thank you,
18 Melanie. And one thing I was wondering is
19 whether Medicaid is involved at all in this
20 continuum of care with --
21 MS. TYNER-WILSON: Yes.
22 CHAIR BEAUREGARD: -- the agencies
23 being involved.
24 MS. TYNER-WILSON: Yes. At the
25 federal level, I've listened -- and I can

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1 share those different webinars with you. But
2 at the federal level, there was a very
3 concerted effort where CMS was present in the
4 meetings and began to have discussions, you
5 know, at that level with HUD to go: How can
6 we work together?
7 And so that is -- that's kind of come
8 from 2021 efforts. And so what's wonderful
9 now is some of these funds are coming down
10 into the states in the form of grants and
11 rental assistance and those kind of things
12 where the desire is to decrease the siloing,
13 if you will. You know how we get in our
14 silos, you know, in terms of Medicaid versus
15 housing.
16 And I think what they're trying to do
17 with these continuum of care groups is to
18 have everybody at the table, but there's
19 actually money available in the community
20 where they're making joint decisions in terms
21 of how this -- these funds, you know, will be
22 utilized.
23 And they're grants and whatnot, but it's
24 something that I -- I'd love for us to know
25 and understand more about it, so we can find

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1 ways to let the -- get the information out to
2 other consumers in our state.
3 CHAIR BEAUREGARD: Pam, if you're
4 still on, is that something -- are you aware
5 of DMS being involved at all with the
6 continuum of care?
7 MS. SMITH: Sorry. I had to get to
8 my unmute button.
9 So yeah, there are -- so I know that
10 there are lots of discussions, and I'm not --
11 I don't really -- I can't speak to much of it
12 other than I do know there are -- there are
13 individuals that are involved in that and
14 that they're --
15 I will say, though -- I can speak to --
16 on the SMI waiver because that is going to be
17 within my group, the 1915(i), the State Plan
18 Amendment. And the housing that is covered
19 in that is much like the waivers.
20 It's not actually covering the cost of
21 the housing. It's covering the cost of the
22 supports the individual will need. So they
23 still will have to pay room and board or
24 whatever their cost -- the cost is for the
25 living arrangement.

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1 But I do know there's a lot of work
2 being done and discussion being done and
3 housing collaboratives. And then, of course,
4 with MFP within -- so money follows the
5 person, the transition waiver within my area,
6 we also -- we work very closely with housing
7 and -- because, you know, that's one of -- a
8 large time a barrier for
9 someone -- us transitioning someone out of a
10 nursing facility back into the home, is
11 finding that affordable housing and --
12 MS. TYNER-WILSON: Yes.
13 MS. SMITH: And getting that --
14 getting all of that set up. So I do know
15 there are people that are working on that
16 together. I just -- I'm not the best person
17 to speak to it.
18 CHAIR BEAUREGARD: Pam, if there's
19 anyone that you could invite to our next
20 meeting -- and I was thinking Leslie
21 Hoffmann, of course. But maybe we can just
22 add this to that agenda and give you some
23 time to prepare.
24 MS. SMITH: Right. I'll talk to
25 Leslie.

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1 CHAIR BEAUREGARD: And we can maybe
2 get a little bit of an update on the SMI
3 waiver as well.
4 MS. SMITH: Okay. I can do that
5 next time.
6 CHAIR BEAUREGARD: All right.
7 Thank you. So I think we're down to
8 recommendations, and I had a couple that I
9 wanted to kind of pass by you all, see what
10 you think.
11 MS. BICKERS: Emily, I think Arthur
12 has a question.
13 CHAIR BEAUREGARD: Oh, I'm sorry.
14 Arthur?
15 MR. CAMPBELL/INTERPRETER: Will
16 you tell him --
17 CHAIR BEAUREGARD: I think Arthur
18 froze.
19 MR. CAMPBELL/INTERPRETER: -- about
20 this? I guess about what you guys are
21 talking about. I don't know exactly why he
22 want to know more about --
23 CHAIR BEAUREGARD: About housing
24 support?
25 MR. CAMPBELL: Yeah.

1 CHAIR BEAUREGARD: I think because
2 it is an issue that many people with
3 disabilities and -- who are enrolled in these
4 waiver programs are facing and so if there's
5 federal funding and a way for DMS to be, you
6 know, involved, collaborating with these
7 other agencies. I think that's -- that's
8 what I took from our conversation; right,
9 Melanie?
10 MS. TYNER-WILSON: Yes. Yes. Yes.
11 Because the reality is, is that there are
12 limited HUD options, so vouchers that you can
13 access through HUD. And -- but there's -- I
14 think sometimes there's a waiting list for
15 those. Not all (audio glitch) in this 815
16 HUD housing are appropriate for all
17 individuals.
18 And so, you know, kind of, I guess,
19 having an opportunity to have a -- to talk
20 with individuals. So as they look at
21 accessing this funding and maybe helping
22 somebody access a voucher or whatnot, to be
23 able to truly find a place for them to live
24 that's -- where they're -- that is
25 appropriate and safe and meets their unique

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1 needs, you know, in terms of accessibility,
2 in terms of where in the community it is, and
3 just kind of the big picture of things.
4 CHAIR BEAUREGARD: Yeah. Well,
5 we'll continue that discussion in October.
6 Thank you for bringing it to us, Melanie, as
7 an issue.
8 And as far as recommendations go, I
9 wanted to make a recommendation that -- in
10 terms of Medicaid renewals, that anyone who
11 has SSI is considered automatically eligible
12 and does not receive a Medicaid renewal
13 packet or RFI.
14 So does that sound like a good
15 recommendation for folks?
16 MS. TYNER-WILSON: Yes.
17 CHAIR BEAUREGARD: Okay. I'll ask
18 for a motion.
19 MS. BROWN: I motion that anyone
20 who has SSI to be considered automatically
21 eligible and that they not have to receive a
22 Medicaid renewal packet or RFI.
23 CHAIR BEAUREGARD: Maybe it could
24 have been worded a little bit better. Do you
25 feel like we need to reword it, Miranda? I'm

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1 working off, like, handwritten notes right
2 now. It's not my usual style but maybe that
3 anyone with SSI not receive a Medicaid
4 renewal packet or RFI in order to maintain
5 their eligibility. Is that better?
6 MS. BROWN: So we're talking about
7 people who are still on SSI?
8 CHAIR BEAUREGARD: Who have SSI.
9 MS. TYNER-WILSON: Yes. Yes.
10 CHAIR BEAUREGARD: Okay. Can I get
11 a motion?
12 MS. BROWN: I motion.
13 CHAIR BEAUREGARD: Thank you.
14 Second?
15 MS. TYNER-WILSON: Second.
16 CHAIR BEAUREGARD: All in favor,
17 say aye.
18 (Aye.)
19 CHAIR BEAUREGARD: Any opposed?
20 (No response.)
21 CHAIR BEAUREGARD: Okay. I would
22 also make a recommendation that for anyone
23 who has recently lost SSI, that they be sent
24 an application before their coverage is
25 terminated and -- be sent an application and

1 given the opportunity to submit that
2 application before their current coverage is
3 terminated.
4 MS. TYNER-WILSON: Do you mean SSI
5 or Medicaid?
6 CHAIR BEAUREGARD: SSI. If someone
7 loses SSI, then they don't have that
8 automatic eligibility. They do need to apply
9 for Medicaid. But my understanding from
10 other states is that they are considered --
11 they are reviewed for being Medicaid eligible
12 in other categories, which I know gets really
13 complicated, and that they wouldn't
14 necessarily be terminated first before they
15 would have to reapply so that they could
16 actually complete that application before
17 termination.
18 MS. BROWN: Maybe we should include
19 a recommendation on how much time they should
20 be given.
21 MS. TYNER-WILSON: That's a good
22 point.
23 CHAIR BEAUREGARD: I mean, I would
24 say the same amount of time that anyone else
25 is getting for the Medicaid renewal process.

1 I wouldn't change the time period personally.
2 MS. BROWN: I just think that maybe
3 we should spell that out, like that they
4 should be given the same amount of time as
5 any other --
6 MS. TYNER-WILSON: I think that's
7 90 days with the Medicaid renewal.
8 CHAIR BEAUREGARD: I think it's up
9 to 90 days. Not everybody is getting the
10 notice at the same time, but they're being
11 told -- so I think the average is, like, 45
12 days. I'm just afraid that if we give them
13 one specific number --
14 MS. BROWN: It made me think of
15 something. Melanie, thank you for saying
16 that, that with the PHE unwinding, people are
17 being given -- like, if they -- if their
18 Medicaid ends because they came up for
19 renewal during this time, then they are
20 given -- like, they can have that -- how is
21 it worded?
22 CHAIR BEAUREGARD: Reconsideration.
23 That's the 90 days.
24 MS. BROWN: For the 90 days, and so
25 I think that should be applied in these

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1 cases, too.

2 CHAIR BEAUREGARD: It would be

3 applied in any case.

4 MS. BROWN: Oh, okay.

5 MS. TYNER-WILSON: There's also

6 a --

7 CHAIR BEAUREGARD: Well, no. The

8 difference is that because they have never

9 submitted the Medicaid application, they

10 would have to submit that application to be

11 determined eligible.

12 MS. TYNER-WILSON: I know it

13 happens a lot when a child becomes 18 and

14 that type of, you know, Medic- -- SSI for a

15 child ends and then they -- and then the

16 individual, the youth would have to reapply.

17 And that's always -- that -- just in my

18 world, that's always been a challenge because

19 the -- maybe the individual -- the caregiver,

20 the case manager wasn't aware that that was

21 required.

22 CHAIR BEAUREGARD: That's right.

23 MS. TYNER-WILSON: And it's a

24 cumbersome process, then, to go back in and

25 reapply and -- as an adult. And, oftentimes,

1 you have to go through additional assessments
2 and all that kind of stuff, and it's very
3 challenging. So being alerted would be
4 wonderful.
5 CHAIR BEAUREGARD: I think -- okay.
6 Let me try this again. So yes, that's true,
7 and it creates a gap where sometimes people
8 lose coverage and then it takes time to
9 get -- to finish the application, have the
10 application submitted and approved and be
11 actively enrolled for Medicaid. You'll often
12 have a gap.
13 So I think we could say that people who
14 have lost SSI within the last year be given
15 the opportunity to complete a full Medicaid
16 application within the Medicaid renewal
17 period -- within their Medicaid renewal
18 period or within the standard Medicaid
19 renewal period.
20 I think we can't give a specific number
21 of days because that could just complicate
22 matters. But people need to be able to
23 submit that application and have it reviewed
24 and approved or denied within the same time
25 frame that people are going through a

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1 Medicaid renewal.
2 MS. BROWN: So you said people who
3 have lost their SSI within the last year?
4 CHAIR BEAUREGARD: Right.
5 MS. BROWN: Do you mean in the last
6 12 months before today?
7 CHAIR BEAUREGARD: We could say the
8 last 12 months. I mean, we can just give any
9 amount of -- any time frame.
10 MS. BROWN: People who lose their
11 SSI, just --
12 CHAIR BEAUREGARD: Well, you could
13 lose your SSI five years ago.
14 I don't know. Maybe we need to just put
15 more thought into this. I -- this is also a
16 recommendation and, you know, if we -- we can
17 always make another one at the next meeting
18 and continue to work on it.
19 MS. TYNER-WILSON: There's a note
20 in the chat from a Rachel with Kentucky DMS
21 saying they receive two months of ex parte
22 Medicaid coverage when SSI ends to allow time
23 for them to prepare and apply for Medicaid.
24 CHAIR BEAUREGARD: Yeah. Thank you
25 for that, Rachel. I understand that that's

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1 true for some but not for all. Maybe the --
2 maybe, instead, we should say that anyone
3 losing SSI receives two months of ex parte
4 Medicaid coverage when SSI ends to allow time
5 for them to prepare and apply for Medicaid.
6 That can be our recommendation.
7 Because right now, I understand that
8 that's only true for some of the people who
9 are losing SSI. So if we apply that across
10 the board to anyone who loses SSI, that could
11 work. So can I get a motion for that?
12 MS. BROWN: Yes. I --
13 CHAIR BEAUREGARD: Thank you.
14 MS. TYNER-WILSON: Yes. Do it.
15 I'm sorry. Excuse me.
16 CHAIR BEAUREGARD: A second?
17 MS. TYNER-WILSON: Second.
18 CHAIR BEAUREGARD: All right. All
19 in favor, say aye.
20 (Aye.)
21 CHAIR BEAUREGARD: And any opposed?
22 (No response.)
23 CHAIR BEAUREGARD: All right.
24 Thank you all. Sorry that we didn't have
25 that totally, like, workshopped out

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1 beforehand, but I appreciate you sticking
2 with me.
3 Our next meeting is October 17th at
4 1:30. And a number of the things that we
5 discussed today, we'll have on that agenda.
6 And if you have other ideas for agenda items,
7 send them to me, but now we will adjourn by
8 acclimation. Thank you. Good to see
9 everyone. Have a good afternoon.
10 (Meeting concluded at 3:19 p.m.)
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CERTIFICATE

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 31st day of August, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR