CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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Via Videoconference
May 22, 2025
Commencing at 9:30 a.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

MAC MEMBERS:

Dr. Sheila Schuster, Chair
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Heather Smith
Dr. Garth Bobrowski
Dr. Steve Compton
Philip Travis
Dr. Ashima Gupta
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace
Bryan Proctor (not present)
Peggy Roark
Eric Wright
Commissioner Lisa Lee
Elizabeth Partin

DR. SCHUSTER: Dawna Clark is subbing for Erin today, and we appreciate that, Dawna. Dawna, I'm sorry. Will you let me know when the waiting room is emptied?

MS. CLARK: We still have some people joining, but I will let you know when it seems like everyone's in.

DR. SCHUSTER: Great. Thank you so much, and thanks for helping us out today.

We may have more people coming in than usual because we're having the public forum at 10 o'clock on the Medicaid 1115 Demonstration on community engagement. So welcome to our regular MAC people and to those who are joining early for the public forum.

We about there, Dawna?

MS. CLARK: We have definitely slowed down on people joining, but we do still have some that are joining slowly. So if you want to go ahead and start, we will get them admitted as soon as we see them.

DR. SCHUSTER: All right, thank you. I think we'll go on because we've got a very tight agenda today. So we'll call the

meeting to order. This is the MAC meeting of May 22nd. And Mackenzie, if you could do the roll call, please.

MS. WALLACE: Yes, ma'am.

DR. SCHUSTER: Thank you.

MS. WALLACE: All right, here we go. Elizabeth Partin?

MS. PARTIN: Here.

MS. WALLACE: Oh, okay. Nina Eisner?

MS. EISNER: Here.

MS. WALLACE: Susan Stewart?

MS. STEWART: Here.

MS. WALLACE: Dr. Roberts?

DR. ROBERTS: Here.

MS. WALLACE: Heather Smith?

MS. SMITH: Here.

MS. WALLACE: Dr. Bobrowski?

DR. BOBROWSKI: Here.

MS. WALLACE: Dr. Compton?

DR. COMPTON: Here.

MS. WALLACE: Philip Travis?

MR. TRAVIS: Here.

MS. WALLACE: Dr. Gupta?

DR. GUPTA: Here.

MS. WALLACE: John Dadds?

(No response.)

MS. WALLACE: Dr. Hanna?

DR. HANNA: Here.

MS. WALLACE: Barry Martin?

MR. MARTIN: Here.

MS. WALLACE: Kent Gilbert?

MR. GILBERT: Right here.

MS. WALLACE: Mackenzie Wallace?

(Raises hand.)

MS. WALLACE: Dr. Schuster? You are here.

DR. SCHUSTER: Here.

MS. WALLACE: Bryan Proctor?

(No response.)

MS. WALLACE: Peggy Roark?

MS. ROARK: Here.

MS. CLARK: Eric Wright?

(No response.)

MS. WALLACE: And Commissioner Lee?

COMM. LEE: I'm here. Took me a minute to get off mute, but I'm here.

DR. SCHUSTER: I was going to say, I had heard your voice earlier.

All right. We've got a very good number of our MAC members, and there may be

a few others joining us late. So thank you all, and welcome.

I would entertain a motion for approval of the minutes of our March 27th meeting.

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

DR. SCHUSTER: Thank you, Nina. And a second?

DR. BOBROWSKI: Bobrowski, second.

DR. SCHUSTER: Thank you, Garth. Any additions, corrections, revisions?

(No response.)

DR. SCHUSTER: All in favor of approving the minutes of March 27th, signify by saying "aye."

(Aye.)

DR. SCHUSTER: And opposed, like sign.

(No response.)

DR. SCHUSTER: And abstentions?

(No response.)

DR. SCHUSTER: Thank you very much.

Commissioner Lee, we're going to start with you with the updates, and then at

10 o'clock, we will take that break to start the public forum on the Medicaid demonstration.

COMM. LEE: Okay.

DR. SCHUSTER: But let's start with the changes to the MAC and initiating the BAC.

COMM. LEE: Yeah, and I think I will turn that over to Deputy Commissioner Veronica Cecil to give us an update on the status of that.

DR. SCHUSTER: Thank you.

MS. JUDY-CECIL: Good morning. I do have slides, but in the interest of time, we'll be submitting those, and they can be posted. I'm just going to provide just a verbal update rather than go through all the slides.

I think what's of most interest is that we did launch on April 28th, the -- we went ahead and launched the changes that are required by a federal rule to create a new Beneficiary Advisory Council, and to make changes to any state's current Advisory Council on Medical Assistance. That's been

renamed as the Medicaid Advisory Committee. So we did launch on April 28th to meet that requirement. We are working on regulations, and hope to have those filed soon, but in the meantime, we're moving forward. We have opened up for our applications to both the BAC, the Beneficiary Advisory Council, and the MAC, the Medicaid Advisory Committee, and new websites and applications are online. We also have a frequently asked questions document for folks if they kind of want to get some more information about, you know, what's happening, and the process, and, you know, what does this all mean.

We are transitioning the current Advisory Council to become our new Medicaid Advisory Committee. All members of the current Advisory Council should have received a letter, as all of the nominating organizations that are a part of KRS 205.540, which is the state statute that create -- originally created the Advisory Council -- oh, gosh, back in 1960, I think, is when that was created. So what we're doing is taking that membership and the

requirements in that state statute and adding in just what the federal rule requires states to do. We're not making any other major changes except to incorporate those federal rule changes. That includes, for example, that we have to add a Medicaid Managed Care Organization representative to the new MAC. That's a federal requirement, as is making sure the Commissioner of Medicaid, or Medicaid Director in other states, appoints all of the BAC and MAC members. Currently, under the state statute, the governor appoints, but that will move to the commissioner appointing.

We are -- another federal rule change that impacts this is that members cannot serve consecutive terms. So they have to wait a period of time, and since we're going to have four-year terms, we're putting four years as the time that if someone is interested in serving again, they'll have to sit off of either the council or the committee.

We are doing staggered terms for the initial appointment on July 9th to both the

council and the committee. Those staggered terms will be two years, three years, or four years, and we've kind of allocated them across the different representations to make sure that when we have to reappoint, you know, we're not doing it all at once. We did post and send out to all of the MAC members a crosswalk of how the current Advisory Council members and their terms crosswalk over to the new MAC. So that is posted online, and we'll put the links for both the MAC and the BAC into the chat.

I think maybe the only other thing to cover is the BAC will be 15 members. There'll be ten of the members are actual current or former beneficiaries, and the five additional are representing parents, guardians, or paid or unpaid caregivers. So, you know, that's what we're looking for right now. We already have 15 applications for the BAC that we've received, so we're happy to see that. And the other thing to note is the three current Advisory Council members that represent a current or former Medicaid member, or a parent, guardian, or

caregiver, they'll continue to serve on the advisory -- on the new MAC, and they're also being appointed to the BAC, so they'll serve that dual role. We have to have seven members of the BAC that are part of the new MAC. So in addition to those three, we will be appointing four additional members of the BAC to the MAC.

So as I said, you know, we will share the slides. It has a lot more information that kind of has all this information actually in it, and then we will post the -- in the chat, we'll post the links. And there is contact information, we'll post that as well. We have an email address. We have a new email address for the BAC. We have phone numbers if folks want to call.

And then the last thing I'd just like to add is for those members, we really are going to provide a lot of support. So if someone is interested in applying for the BAC, we can take that application over the phone. Happy to do that. We will also be working with the appointed members in identifying what needs they have to be able

to participate in the BAC and the MAC if they get appointed to the MAC. So, you know, we want to make sure that they can fully participate and there aren't any -- there's nothing that is preventing them from being able to participate. That includes calling them on a regular basis, making sure they have transportation, helping them understand any documents or information that is presented. So a lot of -- we're going to have dedicated staff to support members for participation.

So I'll pause, and happy to take any questions.

DR. SCHUSTER: Veronica, Kent Gilbert has posted in the -- would you post the link to the BAC and MAC application portal?

MS. JUDY-CECIL: Absolutely.

DR. SCHUSTER: He has some names to submit. And I don't know that you mentioned it, but I think the deadline for applications is May 29th, right?

MS. JUDY-CECIL: Thank you for that.

DR. SCHUSTER: Yeah.

MS. JUDY-CECIL: That is correct, May

29th.

DR. SCHUSTER: So one week from today, folks.

MS. JUDY-CECIL: That's correct. That's correct. And, you know, if folks are having trouble, especially for the applications for the BAC, you know, we'll be sensitive to that and understanding and work with anyone who may be interested that contacts us beyond that date.

DR. SCHUSTER: So --

MS. JUDY-CECIL: So our goal is that we need to have everybody appointed by July 9th.

DR. SCHUSTER: So it's great that you can help someone applying for the BAC to do it by phone. Is there a certain phone number that they should call?

MS. JUDY-CECIL: Yes, I'll put that in the chat --

DR. SCHUSTER: Okay. That would be helpful.

MS. JUDY-CECIL: -- and it's on the slides as well and is on our website.

DR. SCHUSTER: Okay. And the slides

will be posted on the DMS website under the MAC information under the MAC meeting?

MS. JUDY-CECIL: Yes, that's correct.

DR. SCHUSTER: Okay. All right. Are there any questions for Veronica about the BAC and the MAC? And just a reminder, that none of the TACs are affected by this at all? There was some earlier discussion at our meetings about maybe some changes, for instance, in the terms for the TAC, but the TACs are not touched at all, right?

MS. JUDY-CECIL: That's correct.

DR. SCHUSTER: Yeah.

MS. PARTIN: I have a question.

DR. SCHUSTER: Yes.

MS. PARTIN: Will the meeting schedules for the committee be the same as the schedule that we've already scheduled for the year?

MS. JUDY-CECIL: No, they will not. You know, the new members will be -- we will communicate with the new members to choose dates and a meeting cadence that's convenient to them.

And the other kind of a wrinkle to

that is the BAC has to meet before the MAC. It's a federal requirement that the BAC meets before the MAC. So we'll have to work out -- no, we're going to look for dates that are convenient for the members. And so, you know, that's something we'll do as soon as the appointments are made and we're able to communicate with the new members.

MS. PARTIN: Okay, thank you.

DR. SCHUSTER: When you say members, Veronica, are you talking about the BAC members, or the BAC and the MAC?

MS. JUDY-CECIL: Both the BAC and the MAC, yeah.

DR. SCHUSTER: Okay. Because we've got lots of providers, as you know, on the MAC, and they have cordoned off this three hours on the fourth Thursday of the month every other month to be a time to commit. Are you --

MS. JUDY-CECIL: I understand, but, you know, we're really focused on the BAC members and those seven members that will be -- become -- you know, especially the four new ones that will become members. I

think we have to be -- you know, we have to work with the new members on what's convenient for them.

DR. SCHUSTER: Since there'll be actually two meetings to coordinate, are you assuming that the BAC and MAC will meet more on a quarterly basis than on a bimonthly basis?

MS. JUDY-CECIL: We're trying not to make those decisions.

DR. SCHUSTER: Okay.

MS. JUDY-CECIL: We're really going to leave that up to the membership.

DR. SCHUSTER: Okay. Because I worry, we sometimes don't even get through our full agenda.

MS. JUDY-CECIL: Right.

DR. SCHUSTER: And biweekly, you remember, we used to meet quarterly.

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: And then we went to bimonthly because there was so much, and I -- we squeeze the TACs as it is, and I, you know, am concerned about that.

Okay, any other questions? Thanks

for your question, Beth. Any other questions for Veronica?

(No response.)

DR. SCHUSTER: All right. And we will look for those slides. Several of us have seen those slides, and they're very informative. So I advise you all to take a look at them. Thank you very much.

Commissioner, implementation impact of House Bill 695, which was kind of the Medicaid overhaul in a sense. What are you looking at there?

COMM. LEE: So we have been entrusted to present to the Budget Subcommittee in just a couple of weeks on our implementation of the various requirements in that bill. We have, as you know, a community engagement. We needed to file that waiver before -- within 90 days of passage of the bill, so that's coming up. So the Community Engagement Waiver has been posted for public comment. We are in compliance, we believe, with everything that we can be in compliance. I think that it would be very interesting for this group to watch the

Budget Subcommittee, which is next week -- or on the fourth, I believe. It's on the 4th of June, and we'll go through every single provision in the House Bill 695 as it relates to Medicaid and show where we are in the process of compliance with that.

The one thing we're a little bit -- that does concern us a little bit, is the requirement that we have to receive approval from the General Assembly before -- or LRC before we file any state plan or waiver related to eligibility, benefits, that sort of thing. Because in the event we have to wait and discuss that with them when they're in session, that would be a little bit of an issue, but hopefully, the Medicaid Oversight and Advisory Board that is newly created would take up some of those issues and kind of help walk through some questions that we have as we move forward.

We do, you know -- we're grateful that there are provisions in there for which we must -- for us to comply with federal rules, because, as we know, there's a bill that just passed the House last night with

lots of provisions in it related to Medicaid and how we operate our program. We're keeping an eye on that because it still has a long way to go, but as far as 695, I believe we're in good shape. Right now, we can't really tell if it's going to have a huge disruption in the way we operate and administer the program, so time will tell on that, but we are in compliance with all the provisions in 695.

DR. SCHUSTER: Okay. Any questions from any of the MAC members? And that meeting, you said, is on June the 4th?

COMM. LEE: June 4th at 11 a.m. And you can watch that on the LRC website or on YouTube.

DR. SCHUSTER: Okay. Yeah, it may be -- it probably will be televised by KET I would guess --

COMM. LEE: Yes.

DR. SCHUSTER: -- because that's going to be an important meeting. Thank you for letting us know that.

So speaking of feds, we had a general item on the agenda about impending changes

to Medicaid from the federal government. And of course, since they didn't finish last night or this morning until the wee hours, I won't expect you to look at that, but just looking at what you -- was being discussed, what's your overall sense of the impact on Medicaid in Kentucky?

COMM. LEE: Well, first of all, we're very thankful that there are no provisions related to a block grant or a per capita -- a per member cap. But looking through some of the changes -- and, you know, working with the National Association of Medicaid Directors, they're keeping us very involved. Of course, it still has a long way to go, the bill has a long way to go. It has to now go to the Senate. And I think the Senate has made it clear that they're going to make some changes, but as far as Medicaid goes, you know, there's a work requirement for adults in Medicaid expansion, and that's going to -- the new language has that starting in December of 2026. The old language had it in 2029, so that's moved that up a little bit more.

More frequent eligibility checks and disincentives for us to cover unauthorized migrant children. So some of the provisions that were in the House bill that we have kind of looked at, you know, definitely increasing those eligibility redeterminations. And it moved that date up for states to be in compliance from October 1 of 2027 to December 31st of 2026.

Talked a little bit about reducing expansion FMAP for states that cover certain individuals, but they -- the newest language did remove -- or did add language that said it's not applicable to children or pregnant women who are lawfully residing in the state. So that language around undocumented individuals, and I'm glad that they specifically spelled out "not for a child or pregnant women lawfully residing."

We still have questions about how that may impact emergency time-limited Medicaid. We'll need to get guidance on that. I'm trying to think of what else is in -- oh, of course, it prohibits federal funding for -- it included CHIP this time,

and it prohibits federal funding for CHIP for gender transition procedures, and it removed the word "child" and makes that applicable to every individual covered in Medicaid.

So those are some of the -- the community engagement date has been moved up from January 1st, 2029, to December 31st, 2026. HHS has to issue guidance by December 31st of 2025, so that should come out later this year. But again, we're just keeping our eye on everything that -- you know, the community engagement piece. There was a provision in this new one that we need to look at a little bit more about cautionary reductions to insurers on the exchange. So we're keeping an eye on that to see if that'll help us keep members on Kynect, how that may impact them. As you know, Kynect is now administered through Medicaid.

So again, it's still got a lot of ways to go going through the Senate now. So while we have some concerns, not as major since there are no -- from our

interpretation right now, our FMAP does not seem to be impacted. And the block grants are not in there, so that's a good thing, but still some concerns on particularly the changes that we have to make around community engagement, what will that look like. As you know, we have a waiver that's out for public comment right now, and then guidance from CMS is not going to come out until December of 2026. So that's a little bit of a concern on how we -- you know, what we do as we go forward.

DR. SCHUSTER: And on that point, Commissioner, I am assuming that regardless of whether -- I assume that our waiver will be approved on community engagement, but when this December of 2026 rolls around, then does the federal take precedent?

COMM. LEE: Yes. And we're -- you know, we're not sure what CMS will do once we submit our waiver, because if they have a vision in mind, we're not sure if they may have us amend our waiver before they approve it. So just a lot of unanswered questions related to what we want to do versus what's

the vision that CMS may have for community engagements as we go forward.

DR. SCHUSTER: Yeah. And there had been a lot of talk about changing the FMAP for the expansion population, but that also was not in there; is that correct?

COMM. LEE: From our interpretation of what's in there right now, there was an FMAP for states who have not expanded Medicaid. There was an enhanced FMAP to promote expansion in other states, so they have decided to reduce that enhancement for states that newly expand. There's a few more things in there, but from what we can see, unless something changes at the Senate level -- of course, it's all a moving target. Unless something changes at that federal -- or at the Senate level, where there's no language in there about reducing FMAP for Medicaid expansion members in states that were early adopters of expansion.

DR. SCHUSTER: So if there is a change, it's for those states that have not yet gone to expansion, right?

COMM. LEE: That's the way we're interpreting it right now.

DR. SCHUSTER: Well, that's good news because we've certainly heard a lot of talk about going after the expansion population. So --

COMM. LEE: Yeah, I think that what, you know, our, you know, the work requirement -- or the community engagement, they're not calling it work requirements -- community engagement and the six-month redetermination is -- you know, those are the two I think that's going to have the most impact on everything we've seen so far. But the National Association of Medicaid Directors has been on top of this, and they are -- you know, later this week they hope to have a summary out of the changes that was in this latest bill, and then we will have to wait to see what the Senate does. And I'm hearing that they want this finalized before Memorial Day or shortly after Memorial Day, so just keeping an eye on that date because that's just in a couple of days.

DR. SCHUSTER: Yes, that's exactly right. Any other questions from anyone on the MAC for the Commissioner on this very important topic?

(No response.)

DR. SCHUSTER: I think we'll all be going through and trying to figure out what's in that since it was passed -- all of the work on this bill has been done in the middle of the night, I just want to point out.

COMM. LEE: Yes, ma'am.

DR. SCHUSTER: So you have to be a night owl to stay up and watch it. Are there actual changes to the state exchanges in there?

DR. SCHUSTER: No, I'll have to look. I don't think there are any changes to the exchanges, but, you know, the -- there was some enhanced APTC that was available for individuals to purchase a product on the exchange that reduced their -- reduced their premium.

DR. SCHUSTER: Right.

COMM. LEE: So that was going to go

away, I think, very soon. I'd have to go back and look at the date. So I think there may be a provision to maybe continue some of that to promote individuals receiving insurance on the exchange. So that's -- we're looking at that, too, to make sure because if people -- you know, if we see that individuals are starting to lose Medicaid, we want to make sure they have some form of health coverage, and moving them to the exchange or helping them get coverage on the exchange would be something that we would definitely want to explore.

DR. SCHUSTER: Yeah. I do think -- back to the Medicaid, I do think that six-month rechecking of people is going to bump people off. We know that that happened with the unwinding. People have a hard time responding to that, so that's an issue.

COMM. LEE: And my question there, and I will see if it's in the -- any guidance that comes out, is if we have the ability -- right now, you know, we have several systems that we connect with to verify income, all of that stuff. So if we

can verify that for our members and take as much burden off of our members as we can as far as submitting documentation or actually doing anything, then I think that will help some, but there's always going to be those few that maybe slip through the cracks. So I think it's just something we keep our eye on as we go forward, how -- what is the process, how can we assist those members with staying on the program?

DR. SCHUSTER: Yeah. And Kent Gilbert asked if, is there -- are you aware of a link to that revised bill?

COMM. LEE: I can get the revised bill and put it in. It's a very lengthy document.

DR. SCHUSTER: Sure.

COMM. LEE: But I think that later, if you want, the National Association of Medicaid Directors always comes out with a summary. So if you'd rather have the summary, which would be a little bit better, I could also send that out as soon as we receive that.

DR. SCHUSTER: That would be great.

Probably both.

MR. GILBERT: Both, yeah.

DR. SCHUSTER: Yeah, Kent would like to see the bill and the markup, but we would love to see that summary. And Dr. Wright has a question. Eric?

DR. WRIGHT: Shifting a little bit of gears, too, and Commissioner, thank you always for the good updates, and we're hopeful for the federal legislation to benefit -- you know, to remain consistent to what we've had in the past.

My question is related to this third-party news media information that came out in Louisville related to waiver recipients and the non-renewals. So I've had a number of parents reaching out to me through social media channels about that. Can you speak to what we're doing to mitigate those issues and address the concerns that were brought up by the media?

COMM. LEE: Absolutely. So as Dr. Wright mentioned, there have been a few -- some children who have lost waiver eligibility. We have researched and looked

into the cause -- the root cause of that. As you know, we contract with a vendor to do those assessments. So in January, there was a change in personnel that resulted in a different interpretation of that level of care. As you know, the individuals in waiver programs, in those 1915(c), have to meet nursing facility level of care, and it does get kind of complex when you start applying that criteria to children. So we believe there was a different interpretation. We have gone -- come back internally. We have pulled every one of those denials. We have re-reviewed them, we have overturned some, and we are making sure that the criteria going forward is applied correctly.

So we believe that that was the issue, and we continue to monitor the situation and work with our vendor to make sure that the criteria is applied uniformly across all waivers.

DR. WRIGHT: Thank you.

DR. SCHUSTER: Yes, thank you for that. If there are no other questions right

now for the Commissioner, we're a couple minutes after 10 o'clock. So I want to shift over to the public forum Number 1 on Kentucky Medicaid 1115 Demonstration, community engagement. And I assume, Dr. Hoffmann, that that's you.

DR. HOFFMANN: That's correct. Thank you, Dr. Schuster.

DR. SCHUSTER: Thank you.

DR. HOFFMANN: First of all, we'd just like to thank the MAC Committee, as well as Dr. Schuster with the deepest appreciation to let us do this forum today, and for CMS to allow a MAC meeting to actually be considered an official public forum. So I do have a couple of housekeeping items to go over since this is the official public forum before we get started with a PowerPoint.

So again, hello and welcome to Kentucky Community Engagement Program Public Forum, which is embedded today in our Advisory Committee for Medicaid Assistance, the MAC. My name is Leslie Hoffmann, and I'm the Deputy Commissioner -- or one of the

deputy commissioners in the Department for Medicaid Services, and I have been overseeing our community engagement activities. This forum is part of a 30-day public period as required by the federal government for proposed new demonstration programs. During this presentation, we will provide details about the proposed new program and allow for all attendees to make comments. We will not be responding to the comments, however, with Q&A or question and answers; however, we do want to make sure that we gather everything that folks want to say today, and to get you engaged in the process.

We will be submitting the final demonstration application to the Federal Center for Medicaid and Medicare Services after we receive all public comments, go through those, compile them. We will put those on our website for easy access, and they will be posted fairly soon. I can get a timeline for you fairly shortly, Dr. Schuster.

So for Zoom instructions today, the

commenters may either submit public comment through the chat option, and you will want to include the "CE Public Comment" in the chat before you make your chat. You will see that Paige has listed that instruction in the comments already -- or in the chat already. You will also be able, at the end of this time, at the end of the presentation, to raise your hand to come off mute and make comments. And I will let you know at the end of the presentation when that option is available.

Please be reminded that -- just to be respectful of all attendees so that we can get as many public comments in today as possible that you only take a few minutes for your public comment. Again, you can put them in the chat, or we'll have time at the end, and there are other options if you don't get your comment in today.

If you decide not to make your comment today, but you go back and you think, "Gosh, you know, I wish I had made some comments," you still have the opportunity to do so. We will have a public

forum tomorrow in person at the auditorium room in the Transportation Building, which I will go over that at the end of the presentation, or you can still utilize the email option, or you can still utilize the -- just the general Postal Service, U.S. Postal Service mailing.

Okay. Let me get the presentation --

DR. SCHUSTER: So this forum is not a Q&A, Leslie, is what I'm understanding.

DR. HOFFMANN: No.

DR. SCHUSTER: This is an opportunity only for input or comment from people that are in attendance.

DR. HOFFMANN: That is correct.

DR. SCHUSTER: Okay.

DR. HOFFMANN: It's for us to gather all comments today, and as you are aware, whatever method we receive those public comments, we go back and compile them into generalized topics, and then we answer those and will post those back on our website. And then those are required to go with our application to CMS on June the 25th. That's our proposed deadline.

DR. SCHUSTER: So if someone were to have a question that they just simply didn't understand some part of this, is there any way they can get that answered?

DR. HOFFMANN: If it's public comment right now, staff know to go ahead and answer -- I'm sorry. If it is public knowledge right now or in the bill, we can answer those questions, but anything in the application, we will not be able to answer today. And it's mostly it's for consistency to ensure that everybody gets one consistent answer for their questions, if that makes sense.

DR. SCHUSTER: Okay.

DR. HOFFMANN: And Dr. Schuster, can you see my PowerPoint?

DR. SCHUSTER: Yes, I can.

DR. HOFFMANN: Oh, good. Okay.

DR. SCHUSTER: The slides are showing on the side.

DR. HOFFMANN: I usually keep --

DR. SCHUSTER: You may want to put it in slideshow.

DR. HOFFMANN: I usually keep those,

if that's okay.

DR. SCHUSTER: Oh, okay. Yeah, that's fine.

DR. HOFFMANN: Is it big enough for everybody to see?

DR. SCHUSTER: Yes, we can see it.

DR. HOFFMANN: I usually keep those in case my bad eyes need to go back and reference a page, so I'm so sorry.

So today is the Kentucky Community Engagement Section 1115 Demonstration Program Public Forum for May the 22nd, 10 to 11. I will be going over the introduction, the objectives, the overview of the proposed community engagement program, the public notice, and the comment process today.

And again, you can make your chats now -- your comments in the chats from now until the end of the meeting. And Dr. Schuster, we're going to allow those comments as long as they're marked "CE Public Comment" all through the MAC meeting, if that's okay, even after I finish.

DR. SCHUSTER: That's fine.

DR. HOFFMANN: So the introduction is

to comply with Kentucky House Bill 695, the Cabinet for Health and Family Services, CHFS, is requesting federal approval to implement our community engagement program. To request federal approval, CHFS is submitting a Section 1115 Demonstration proposal to the Center for Medicare and Medicaid Services, that's our authority, or CMS. The CHFS Department for Medicaid Services, DMS, that's us, will be implementing the Community Engagement Program tentatively 24 months after receiving federal approval.

What are our objectives today? To inform you, the public, of the new Section 1115 Demonstration proposal to implement the Community Engagement Program; to provide you information about the public comment process prior to submission to CMS of the official demonstration proposal in accordance with 42 CFR 431.08.

So let's just start out with something basic. What is the Section 1115 Demonstration? An 1115 Demonstration is to test a project. It's to think outside the

box. It helps us to support the goals of the Medicaid program. The aim is to give states more freedom or flexibility to create and improve healthcare programs. An 1115 Demonstration project allows states to try new ways to improve healthcare beyond routine medical care. These new methods focus on proven ways to make people healthier and to improve lives. The Demonstration must also be what we call "budget neutral" for the federal government to approve and to continue to approve over a five-year period of time. This means that the government will not spend more on Medicaid during the Demonstration with or without the Section 1115 Demonstration. The cost of services must be same or less than the cost of services that we are currently providing today.

And what is Community Engagement Program? So in 2025, as I mentioned before, Kentucky passed House Bill 695. The law instructs the Cabinet for Health and Family Services, CHFS, to start a Community Engagement Program. With this new program,

CHFS will automatically refer certain Medicaid individuals to the Department of Workforce Development, DWD, for job support and coaching. The DWD will reach out to these members to provide helpful information about job help.

Which Medicaid members are impacted? The Community Engagement Program will apply to individuals in the Medicaid expansion eligibility group who have been enrolled in Medicaid for more than 12 months, are between the ages of 19 and 60 years of age, are physically and mentally able to work as defined by our cabinet, are not caregivers of a dependent child under age 18 or a dependent disabled adult relative.

So you may ask, are there exemptions to this program? And we have several listed here on the screen above. CHFS will exempt Medicaid expansion eligibility group members who meet at least one of the following conditions from the automatic referral to DWD, the Department of Workforce Development. These are individuals that are under 19 or are over age 60 years of age.

These are individuals responsible for the care of a dependent child under the age of 18, or a dependent disabled adult relative. These are individuals with a diagnosis of SUD, Substance Use Disorder, or Serious Mental Illness, SMI; a chronic disease as determined by CHFS; an acute medical condition, physical or behavioral, that would prevent them from complying with the requirements; individuals with -- whose eligibility have been deemed based on disability, or who have been deemed disabled by SSA, the Social Security Administration; individuals with verified earned income; individuals receiving unemployment insurance income benefits; pregnant women; individuals who are homeless or who are recently homeless for up to six months post housing; individuals who are victims of domestic violence; individuals who have recently been directly impacted by a catastrophic event, such as a natural disaster; or a death of a family member living in the same household; individuals already participating in a workforce participation program that CHFS

has determined to meet the objective of the Community Engagement Waiver Program. I mentioned the other day, many of these individuals will already be cross referenced and are meeting that requirement through SNAP. Former foster youth up to age 26; other good cause exceptions as approved by CHFS.

So if you're asking how we will know some of these things, just to let you know, processes will have to be developed. There will be an implementation plan that will become -- that will come later with the 1115, and we will have to work a process in that will allow for some self-attestation.

Okay. How will members find out about this program? CHFS will send letters to members about workforce development and their services. Letters will also include information about how to request those exemptions that I just spoke about.

So let's talk about how members will find out again. New members, new applicants can choose to be referred to workforce development when they apply for Medicaid.

If not, CHFS will send letters to the new members when they enroll, once after six months, and again after 12 months. Current members, CHFS will send letters to current members who qualify, giving them a 30-day notice that they will be contacted by the Department of Workforce Development unless they are exempted. Managed Care Program enrollees, CHFS may also engage MCOs to tell members about the program. CHFS will also remind members about DWD resources during their eligibility checks and encourage them to use these resources.

So what are the goals for Kentucky's Community Engagement Program? Through this program, CHFS aims to help people in Kentucky by offering referrals and supports. The support will help individuals out of poverty by finding jobs through skilled training and job assistance programs. The goals of the program are really to expand efforts to help people achieve economic stability by connecting them with educational and job assistance programs; identifying individuals who qualify for

exemptions and may also need a higher level of care, and then we will connect them to those necessary supports as well.

Okay. So public notice and comment process. To comply with the federal regulations, CHFS will follow guidelines and procedures for collecting, reviewing, and responding to all public comments no matter what avenue that we received those. A draft of the Demonstration application and public notice are available and can be viewed at this link. And I feel like it's beneficial for me to show you the link, so I'm going to drag that over so you can just see it real quick. And I checked, it is working. So if you go to the link that I just had posted, you're going to see at the very top "Section 1115 Demonstration Waivers." We have other authorities here in Kentucky, but what you're looking for is the first one at the top "Section 1115 Demonstration, Community Engagement." What you're going to see is that the status is ongoing. You'll see a short synopsis of what we are aiming towards, and then you will see these quick

links here -- I checked those to make sure that they're okay -- these quick links here to go to what item you need.

So the full public comment notice is here, and it will tell you the processes that you can also include through this avenue your public notice. And I'm going to go over those as well. I embedded those into our link. So you can also receive comments or inquiries -- we can receive comments or inquiries that can be submitted via email received on or before June the 12th to Ky1115commengagement@mslc.com, and please include the "1115 Community Engagement Comments" in your title. You also have another option. You can write your comments and send them by the U.S. postal mail by June the 12th. If we receive them a little bit later, as long as they're postmarked by the 12th, it's still okay. So Kentucky Medicaid Section 1115 Comment, care of the DMS Commissioner's Office at 275 East Main Street, 6W-A Frankfort, Kentucky, 40621.

Again, just a reminder, if you

didn't -- are not making your comment today publicly, or that you did not put it in the chat option for this forum, you do have another option. Tomorrow is public forum Number 2. It is in-person only. It is from 10 to 11, the same time as today. It will be in person at the Kentucky Transportation Cabinet at 200 Mero Street, Frankfort, Kentucky, 40622, and it will be in the Auditorium C105. If you go into the building, there is a desk there that you can ask questions if you need to.

So I've thanked the MAC Committee, and I've thanked Dr. Schuster for allowing us to do this today. But I also want to thank you, all Kentuckians, for your participation. So at this time, participants can raise their hand, come off mute, and make your comments. Again, to be respectful of all attendees, keep your comments to a couple of minutes if you can. If you decide, again, not today to make your comment publicly or in the chat, you also have the public forum tomorrow, Number 2, but you can also still go to the public

notice link and use the email ability, and/or to use the U.S. Postal Service.

So I will give just a short time for -- until we get the hands lowered, Dr. Schuster, since this presentation took, you know, less than the hour, but we will take all chats till the end of the MAC meeting today.

DR. SCHUSTER: Thank you. Garth, you had a question or wanted to make a comment.

DR. BOBROWSKI: Yeah, just a question. What is the total number of enrollees that the state currently shows as employed? And you don't have to give me an answer today, but if you could just -- I wanted to get that in the comment section, and you can email me or text me or whatever. I know some of that data you gotta research and look it up, but --

DR. HOFFMANN: Yeah. We will take that comment back, and put it --

DR. BOBROWSKI: Thank you.

DR. HOFFMANN: -- into the Q&A and answer that for you.

DR. SCHUSTER: Kent, you have your

hand up.

MR. GILBERT: Yes, ma'am. You know, a quick review of the current data in states that have implemented or tried to implement these kinds of requirements does not seem to show that there's been any positive effect on workforce increases, nor has there been actually any health benefit. And in fact, the data are pretty clear that this shows very negative public health impact. It reduces -- it puts up barriers. It's very costly to the state. I wonder if -- has the state done any estimates of what it's going to cost to monitor all of this?

DR. HOFFMANN: And of course, we have worked on some of those items that you have mentioned. Again, we will take that back and answer it in the public comment.

MR. GILBERT: Yeah, I appreciate that.

DR. HOFFMANN: Absolutely.

MR. GILBERT: Yeah. And, yeah, I think that the -- I mean, in a cost-benefit analysis here, this -- the numbers so far that I'm seeing don't add up for this

waiver. Now, I realize that you're required to file it by the state legislature, but as far as the public comment that's going to go up the chain, this just doesn't seem to actually meet the goals. If we want to get people back to work, if we want to keep people healthy, they've got to be healthy to go to work, and these kinds of referral programs just don't seem to be supported by the data.

But, I mean, I'd like to see more data. I'd like to also see that the cost of these is not going to be -- I mean, it seems stupid to spend 30, 40 million dollars tracking whether people are getting care as opposed to spending 30, 40 million dollars giving people care. Thank you.

DR. SCHUSTER: Thank you, Kent.

DR. HOFFMANN: Thank you.

DR. SCHUSTER: Jeremy, and I don't know how to pronounce your last name, Scrimager?

MR. SCRIMAGER: There you go, you nailed it. Thank you very much.

DR. SCHUSTER: Ah, great.

MR. SCRIMAGER: I'm cooking lunch at the office.

So I'm a little lower down the totem pole. My area of specialty is supporting employment for folks who are already receiving services. So my question is more just a mechanical one. Obviously, the Office of Vocational Rehabilitation falls under DWD's purview. OVR is broke. They're on an order of selection for the foreseeable future, and I don't think anybody really knows how long that's going to last. So what mechanisms exactly are going to be able to handle the influx of people requiring vocational rehabilitation services? Thank you.

DR. HOFFMANN: Thank you, Jeremy.

DR. SCHUSTER: Any other -- Beth Partin had a question, just want to draw your attention to it. Will DMS list the chronic diseases or disabilities online that satisfy the exemption?

DR. HOFFMANN: And Dr. Schuster, I think we can give a list of expectations of those chronic conditions because we do

already capture many of those, especially through some adult and children reporting that we do. But the process will actually be more complete as we go through the implementation process. And then, of course, there is the other -- there is a catchall in here for any good cause exemption as approved by the cabinet.

DR. SCHUSTER: Thank you. Eric Wright, you have your hand up.

DR. WRIGHT: Dr. Hoffmann, do you all utilize the compassionate allowance list that's put out by the Social Security Administration as a factor when it looks at those types of qualifying exemptions? Have you considered that as an option?

DR. HOFFMANN: Dr. Wright, I'm going to take that one back, if that's okay.

DR. SCHUSTER: Eric, can you say again what you're referring to?

DR. WRIGHT: Yeah, under the Social Security Administration, there is a compassionate allowance list, what's often used when making determinations for consideration for SSI benefits. And so I

was asking if they are considering utilizing that list. It seems like it's a pretty well-vetted list that's been out for a considerable amount of time. Didn't know if that was a consideration when they were looking at those conditions which may request -- or need an exemption.

DR. SCHUSTER: Okay. Thank you very much for that. That's a new one for me.

I would comment, Dr. Hoffmann, that at least for people with behavioral health issues, you mentioned SMI and SUD, when this was tried in the -- or when a work requirement was tried in the Bevin administration, the process for designating those folks was complicated and onerous at best. And it was never clear to me whether the self-attestation was really being made by somebody who might not be capable of actually making a self-attestation and what accommodations would be made for that. And is there a role, either required or allowable, for a provider of services who knows that person well to be a part of the exemption process?

I will say, as a psychologist, that all of this is going to increase the anxiety level of all your Medicaid members because a lot of Medicaid members are not going to know whether they're in the expansion population or not to begin with. And so every time they hear about some other requirement -- and we just got through with unwinding, and we know that despite the heroic efforts of DMS and kynectors and everybody else to get people through that process, we lost a lot of people. So I'm not asking you to provide mental health care to all, although we should be providing mental health care to all Medicaid members, but just to be aware in your communications that people are highly anxious, and when people are highly anxious, they don't take in information very well. So a single letter may not be sufficient. Thank you.

DR. HOFFMANN: Dr. Schuster, I appreciate that comment.

Dawna or Dr. Schuster, do you see any more hands?

DR. SCHUSTER: I don't. Do you see

any more hands up, Dawna?

MS. CLARK: I do not see any more hands.

DR. SCHUSTER: Okay.

DR. PATEL: Hey, I have --

MS. ROARK: This is Peggy Roark --

DR. PATEL: -- I couldn't get my hand up.

DR. SCHUSTER: Oh, okay.

DR. PATEL: I apologize. My computer's not working or I'm not navigating it well. This is Chirag Patel, WellCare CMO. In this new format, when we have this public commentary, do we ask state legislature to come and listen to commentary from the public?

DR. HOFFMANN: They will have the comment from the public included into -- we compile all of them together in a Q&A session and document, and then it will go on the website, as well as it is required to send to CMS when we submit it as well. Does that answer your question?

DR. PATEL: Yes, ma'am. Thank you.

DR. SCHUSTER: Anyone else who's

having trouble raising their hand, which is sometimes tricky on chat and so forth, you can unmute and simply ask the question as Dr. Patel did. We don't want to miss anybody.

DR. HOFFMANN: So just as a reminder to everybody, we're going to allow comments to keep continuing through the chat function through the MAC meeting. Dr. Schuster does have a packed agenda, so one more time, if anybody wants to raise their hand. And if not, I'm going to turn it back over to Dr. Schuster to continue her MAC meeting.

Thank you so much for having us today and thank you for listening to the forum. We do want to hear from you. We want to hear from Kentuckians and have you to voice your opinions. So if you did not give your information today, please use one of the other functions, or meet us in person tomorrow. And again, just thank you.

DR. SCHUSTER: Thank you, Dr. Hoffmann. Is your PowerPoint posted as well?

DR. HOFFMANN: I will send this

PowerPoint to Dawna in just a few minutes so that we can get it out to the MAC.

DR. SCHUSTER: Okay. So it will be posted with the MAC meeting information. Do you --

DR. HOFFMANN: Yes.

DR. SCHUSTER: Can you also make it available if people go to the link?

DR. HOFFMANN: If you go to the link, what you're going to get is the application, and then a brief summary, and then a larger summary I believe is the two things. But I can make it available if somebody else needs me to send it to them. Do you want me to post it online for the MAC?

DR. SCHUSTER: Yeah.

DR. HOFFMANN: It will be under the MAC, right?

DR. SCHUSTER: Yeah, to the MAC. But I guess my question, Leslie, is can you attach your PowerPoint so when people go to that link that's one of the things they can access? I have said that only because sometimes it's easier for people to read the simple language that you provided as opposed

to the --

DR. HOFFMANN: Correct. I'll -- let me get through the PowerPoint tomorrow in the -- with the in-person, and then we'll get that posted; is that okay? I'll try to get that done.

DR. SCHUSTER: Yeah. Yeah. Did I see somebody that said they were having trouble getting on the Zoom? I thought I saw, but I don't see it in the -- there is another public comment in the chat right now. So all right. Well, thank you very much, Dr. Hoffmann, and --

DR. HOFFMANN: Thank you.

DR. SCHUSTER: -- this is an ongoing process, so for anyone who is remaining on for the remainder of the MAC meeting, please continue to put your comments in the chat. And also, let me encourage you to mail them or email them. And the deadline is June 12th; is that correct, Leslie? Do I remember that?

DR. HOFFMANN: That is correct. So if you send a letter, like to the U.S. postal, make sure it's postmarked by the

12th. And you can send an email, or you can come tomorrow, or you can still do the chat function today all the way to the end of the MAC.

DR. SCHUSTER: All right. And there's a good comment from Ashley Shoemaker about, again, that attestation and the role of the providers because I do think it's an important point. Providers' time would be better spent actually treating patients instead of filling out paperwork. We all are for that. Thank you very much.

And let's go on. I think, Commissioner Lee, we're back with you restarting of prior authorizations for Medicaid behavioral health services. And we had quite an active discussion about this at the BH TAC meeting last week.

COMM. LEE: I think maybe Angie Parker is on here. She may be able to provide an update and give some -- give an update. Angie, are you on?

MS. JUDY-CECIL: I'm not sure she's on, Commissioner, but I'm prepared to talk about this.

COMM. LEE: Okay. All right.

DR. SCHUSTER: Great. Thank you, Veronica.

MS. JUDY-CECIL: I have slides.

DR. SCHUSTER: Good. We want clarification. There's a lot of angst out there. It seems to be my job as a psychologist to point out how much angst is out and about.

MS. JUDY-CECIL: Well, I -- so I don't know if I'll be able to relieve angst but certainly have some information to share. Just for folks that might not have been part of the Behavioral Health TAC or other discussions that we have had -- we also talked about this on our monthly virtual forum. House Bill 695, we're talking a lot about that today and the requirements that have come out of that legislation. One of those included requiring the department to restart behavioral health prior authorizations.

So we -- to be in compliance with that because we had to do it within 90 days, which is June 25th, we did send out a

provider letter, an April 8th, 2025, provider letter that is on our website. That letter was notifying providers of that requirement, and that the Managed Care Organizations will be sending out information individually about the restart for their prior authorizations. That letter rescinded two previous letters that we had sent out about and related to behavioral health prior authorizations. One, we had tried to work together. There was a workgroup with Managed Care Organizations, DMS, Secretary Friedlander was part of it, and we had providers represented. We tried to work on beginning the resumption of prior authorizations, but unfortunately, we've had to rescind that letter. We also rescinded the service limits and prior authorizations that were part of a November 8th, 2024, provider letter that related specifically to psychoeducation and peer support services, so that has been rescinded as well.

I do want to make sure folks understand that in that letter, there was additional information, and that included

rates, service descriptions, who can bill and provide the service, all of that remains in effect. We were just rescinding the service limits on prior authorizations.

So the MCOs are required to provide at least a 30-day notice. Our understanding, I believe at this point, all MCOs have sent out a notice if they are -- about their prior authorization restart specifically. We also are requiring the Managed Care Organizations to provide training, definitely online, also in person, prior to the restart and after, and also to provide one-on-one support because we all recognize that there are providers new to the Medicaid program and have enrolled after the prior authorizations were put on hold, and that they've not had to navigate that before. So they're going to have to learn the process, and make sure that they are able to access that process.

So we have also asked the MCOs to be accommodating for this change, to give additional time, to be more proactive in that one-on-one helping providers navigate,

and so we're going to be monitoring this very closely. We are setting up a process to monitor them to make sure that folks are being able to still access services, because I think that's the primary concern of everyone is that during the public health emergency and up until now, behavioral health services were pretty liberally accessed. And we don't want to see an unnecessary or burdensome process to continue access to those services. So we will be monitoring it.

Here's the contact information for each of the MCOs. We are -- we have collected all of the MCOs' information, their links to their website, what they're going to prior authorize. We have -- we're working on trying to find a way to post that so that it's easy for providers as a one-stop shop as we move forward with the resumption and as it comes closer, so very soon -- we've been working on it these past couple of days, and hopefully, very soon we'll be able to launch that.

We encourage folks -- so we'll send

out something to our distribution list to -- so if you're not signed up through GovDelivery, we'll post that. I recommend to sign up for emails through GovDelivery. We don't waste people's time with unnecessary emails. We really try to only send emails through that distribution list that really are important updates to the program. So I do encourage you, if you want to make sure that you're receiving those updates, including that we posted the information online for the behavioral health prior authorizations, to get signed up through GovDelivery.

So I'm happy to take any questions.

DR. SCHUSTER: Yeah. Let me start with the one that caused a great deal of discussion and angst in the BH TAC meeting, and that was about the billing for targeted case management. As you are probably aware, Veronica --

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: -- a reg that has to be billed as a monthly service and a start date of June 25th does not get us to the end

of the month.

MS. JUDY-CECIL: Right.

DR. SCHUSTER: One of the MCOs made it very clear that even though the billing really should have been without prior-auth until June 24th, and then anything -- or up to the 25th, and anything after that would've been under prior-auth, that they're going to treat the entire month's billing as a retroactive review. And, you know, that felt -- well, it felt lots of things. I won't get into it.

MS. JUDY-CECIL: Sure.

DR. SCHUSTER: But it caused a lot of angst because there is no other way to bill that service.

MS. JUDY-CECIL: Right.

DR. SCHUSTER: So --

MS. JUDY-CECIL: We did take that back. I don't know if somebody from the behavioral team's on. We took that concern back, we have inquired, I believe, with the Managed Care Organizations. I agree that, you know, they probably for anything that's within that month, they should -- this is an

area where we have said the MCOs really should be very lenient, you know, working with the providers on -- because it's going to be wonky as we restart, especially for several providers, and as you mentioned, for services that are a month pure.

I see, Leeana, you have your hand up.

MS. TRAINER: Hi, yes, thank you. Leenna Trainer with the Division of Quality and Population Health. Just wanted to add to the discussions that my team is currently reviewing the Kentucky universal PA form. We are working with the MCOs to get their updated information, assess what methods of submission are available to providers, and we're looking to hopefully publish that within the next couple of weeks.

MS. JUDY-CECIL: Thank you, Leenna. Do you -- is there anybody else on the DMS team that has an update on the targeted case management question specifically? And if not, we will follow up with you, Dr. Schuster, and with providers.

DR. SCHUSTER: I would appreciate that. And it's also the ACT teams as Steve

points out.

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: So yeah, we really need some response from Medicaid for that because we're caught between a rock and a hard place obviously. We can't --

MS. JUDY-CECIL: Right.

DR. SCHUSTER: -- the reg says you have to bill at the end of the month, and, you know, I understand that the timeline set in 695 is not movable either, but some compassion, leniency --

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: -- whatever you want to call it on the part of MCOs particularly because we know how important both targeted case management and the ACT services are. You know, ACT in particular is being delivered with our, you know, most -- some of our sickest members, the ones that are in need of immediate care, and that's true also of targeted case management. So I appreciate that.

Nina has a question.

MS. EISNER: Yes, thank you. Did I

just understand that there's going to be a universal prior-auth form required of all the MCOs to use?

MS. JUDY-CECIL: We had already created one many years ago, and the only problem with it is it is a written form. So the only way to submit it is to fill it out and to usually fax it.

MS. EISNER: Right.

MS. JUDY-CECIL: So I don't know how useful it is in this day and age of trying to go to electronic PA, but we've had one out there for a long time. We are updating it because it needed updating, and certainly, the MCOs are required to use it. So if an MCO says "we can't accept this," let us know --

MS. EISNER: Yeah.

MS. JUDY-CECIL: -- because it's in their contract they're required to use this universal PA.

MS. EISNER: That's great news.

MS. JUDY-CECIL: So definitely relay that to us. I think what we did --

MS. EISNER: Good, thank you.

MS. JUDY-CECIL: -- take back and want to do is -- and heard loud and clear -- trying to create some consistency in the process for prior authorizations across the MCOs. And so how do we take that written PA form, and work with the MCOs on what they could do to their systems to duplicate it, I think is a legitimate question and something that we're taking back. It's not going to happen by June 25th, but certainly, it's something that we're going to work on.

The other thing we're working on is, you know, talking with the MCOs about the consistency across them on what is prior authorized. So that's something we're going to continue to work on. Not something we can mandate at this time but that we're going to do our best to try to bring some consensus to, you know, these are codes or services that everyone agrees needs to be prior authorized or doesn't need to be prior authorized. So we're going to continue to work on that.

MS. EISNER: That's terrific. Thank you so much.

MS. JUDY-CECIL: You're welcome.

DR. SCHUSTER: How does one see the form or find the form that's out there right now?

MS. JUDY-CECIL: We can send the link to it.

DR. SCHUSTER: Okay, thank you.

MS. CLARK: Yeah, so I'm going to post the GovDelivery -- how to sign up for GovDelivery, the email distribution list, and then we'll send a link to the current PA form.

MS. PARTIN: Sheila, I have a question, and I can't figure out how to raise my hand.

DR. SCHUSTER: We're happy to hear from you, Beth.

MS. PARTIN: Are these -- and maybe, Veronica, you were answering this kind of, but preauthorization, is this for medications, or for visits, or referrals, or procedures? What is it that we have to preauthorize?

MS. JUDY-CECIL: It's behavioral health services. So it's behavioral health

services, not all behavioral services, but we're required to resume behavioral health prior authorizations. And so this doesn't change what's required for medication through Med Impact. That's not changing, but just as -- it's primarily services.

MS. PARTIN: So if I want to refer somebody for behavioral health, do I have to get that pre-authorized?

MS. JUDY-CECIL: I can't answer that question. I think we'll have to check with the MCOs on that.

MS. PARTIN: Okay. That would be really helpful to know.

MS. JUDY-CECIL: Okay.

DR. SCHUSTER: So you're talking, Beth, about somebody that you're seeing in your office, and you're not, strictly speaking, a behavioral health provider, you're a family nurse practitioner, but you want to make a referral.

MS. PARTIN: Yeah. Do I have to have that pre-authorized?

MS. JUDY-CECIL: That's up to the Managed Care Organization's procedures.

DR. SCHUSTER: Boy, I would be really concerned -- let me just weigh in here --

MS. JUDY-CECIL: Yeah.

DR. SCHUSTER: -- if referrals to behavioral health have to be pre-authorized. The most important thing about somebody in a behavioral health situation is that they get care as soon as possible. So we already know that it's difficult, as I'm sure Beth can -- particularly in a rural area where Beth practices to find behavioral health care readily available. But if there's an additional delay because she has to get a prior-auth to even make the referral, that's going to be a real problem.

MS. JUDY-CECIL: I've never heard a prior-auth needed for a referral. It's usually for the actual service delivery --

DR. SCHUSTER: Yeah.

MS. JUDY-CECIL: -- and not a referral, but we'll get -- we'll take that back to clarify.

MS. PARTIN: Okay. There have been -- I can't speak specifically right now, I can't pull it out of my memory, but I

know that there have been times, not necessarily that I remember behavioral health, but for other referrals that we've had to get a prior authorization. So I just want to make sure that we don't have to do that.

MS. JUDY-CECIL: Okay. Thank you for that.

DR. SCHUSTER: Yeah. And Michelle Sanborn puts in the chat something that was talked about at the BH TAC meeting, Veronica, just so you're aware of that, and that is, you know, we know the effective date of 695 was June -- is June 25th, but obviously, if the MCOs would start their prior-auth for targeted case management and ACT on July 1st, that solves the problem. That would seem, as she says, would make the most sense.

MS. JUDY-CECIL: And that -- yeah, that's what we took back, and we have -- my understanding, communicating with the MCOs on that.

DR. SCHUSTER: Okay. Any other questions?

(No response.)

DR. SCHUSTER: I make -- I had something, and I can't remember it now, but I may come back to it. You're going to be here for a little bit.

MS. JUDY-CECIL: Yeah, absolutely.

DR. SCHUSTER: Okay. Here's a mom of a 38-year-old with severe mental illness, does she need to contact his insurance company on these prior authorizations or his doctors?

COMM. LEE: So typically -- there's been a lot of chatter in the chat. I've been monitoring it. So typically, the individual -- the provider delivering the service has to get the prior authorization for the services being delivered because they're going to be the ones that bill. So they would need to make sure that they have that prior authorization on their claim form. So we have had another -- for example, Passport has written in here, "Certain behavioral health services will need a PA, and it goes to the rendering provider to obtain the PA," and that has

been typically the process is the person delivering the service.

The only exception that I would -- could ever think to that would be certain medications. Sometimes it could either be the provider or the pharmacist getting a certain prior authorization for medications, but as far as services, it should be the rendering provider.

DR. SCHUSTER: So it's not the responsibility of the parent or guardian. It's really a -- it's a reimbursement issue more than anything.

COMM. LEE: Right. And in the event that a member gets a service denied, they do have an appeal process that they can go through to get that service delivered if they go through that process and it is determined that it was inappropriately denied. So there is an appeal process, but it is typically up to the rendering provider to deliver that or to obtain that prior authorization. The member should not have to call and get a prior authorization because they wouldn't have all of the

information that the utilization management agency, which authorizes that PA would need in order to get that prior authorization.

DR. SCHUSTER: Right. Right. I know what my --

MR. MARTIN: Hey, commissioner Lee?

DR. SCHUSTER: -- yes?

COMM. LEE: Yes?

MR. MARTIN: This is Barry. So really, it's going to pre-COVID operations once again, right?

COMM. LEE: Correct.

MR. MARTIN: So everybody should be pretty used to this process. Has anything changed as far as more restricting for PAs?

COMM. LEE: No, but I think during the COVID period, you know, we have had new providers come on who may have not had to go through that prior authorization process before, so therefore, the Managed Care Organizations are entering into -- I mean, they're completing training for that process. And it's been quite a while, and maybe some individuals are like me, if I haven't done something for a while, I forget

how to do that. So just need guidance on how to go through, but you're right, Barry, it is going back to pre-COVID processes.

MR. MARTIN: Okay.

DR. SCHUSTER: Well, and we have an MCO, United, that wasn't here pre-COVID, so they're new to this prior-auth.

I guess this is a good time for me to be reminded of the question I was going to ask. And that is I understand that some of the MCOs have communicated with DMS that they want to add new services to be prior-auth'd that they were not prior authorizing -- requiring prior-auths back pre-COVID, and that those are being approved; is that right?

COMM. LEE: I would have to follow up on that and double check to see.

DR. SCHUSTER: Okay. I believe that Angie told us at the BH TAC meeting that they were being allowed to add new services, which to me is very different than what's in the bill. I just -- just saying the bill very clearly says, you know, back to January 1st of 2020. And obviously, for

United, that has to be different, but --

MR. MARTIN: I got a feeling that relates back to BH and SUD I would imagine.

COMM. LEE: And there -- you know, there could be certain services that have been added. You know, procedure codes are added and removed, you know, quite frequently, and if there are new codes that have been added since COVID-19, you know, those could be subject to prior authorization. And as far as prior, when we look at prior to COVID, the MCOs had authority over their managed-care -- or over their prior authorization process. So we just need to keep these conversations going and make sure that we're doing everything we can to ensure compliance, number one, with House Bill 695, and that we're not putting up any undue barriers for our children.

And I see Krista has her hand up, and I think she's probably going to talk a little bit about their PA process.

MS. HENSEL: Yeah. I just wanted to -- Sheila, I appreciate that you recognize United wasn't in the market at the time the

regulation was referring to.

So we've worked with DMS. Obviously, we do business across multiple markets across the country, and so we leverage care coordination lists or prior-auth lists and use our standard across the country.

A couple of Kentucky nuances, Commissioner Lee, as you highlighted there, and, Barry, you referenced. There are some codes that are covered in Kentucky that aren't covered in other markets, and so that is an area where there might be variance or difference, but we've worked closely with the department in getting that list approved.

DR. SCHUSTER: And are all of those lists now approved? Do you know, Commissioner Lee?

COMM. LEE: If the new -- any new services have been approved?

DR. SCHUSTER: Yeah, just generally. I think --

MS. HENSEL: So that's the prior-auth lists --

DR. SCHUSTER: Yeah, the prior-auth

lists. I think providers are still waiting to hear from the MCOs, and we had understood that they had those lists and communications had to be approved by DMS.

MS. HENSEL: Correct. And the department -- I would -- Dr. Schuster, I would just actually applaud the department. It has been remarkably fast as we've submitted the lists, and then now the communications for approvals. You know, we work both with the department on getting those approvals, and our internal teams and our legal teams also have to approve before things go out to our network providers.

DR. SCHUSTER: Right. Right.

MS. HENSEL: So I think we are on track to get those out. I'm going to say, United's should be going out next Tuesday was the last that I heard. So I'll be curious your feedback when that comes out, but we try to be clear and concise in those communications.

DR. SCHUSTER: Thank you. That was what I was talking about, Commissioner Lee, was the MCOs have been telling providers,

"We can't send anything out because it has to be approved by DMS." And at the BH TAC, Angie said that, you know, DMS was working very hard to get through those lists. So I guess I'm just looking at time frames again as we're getting closer to the end of May, just a month away. So --

MS. JUDY-CECIL: We had approved either same day or next day --

DR. SCHUSTER: Good.

MS. JUDY-CECIL: -- pretty much everyone. There was one or two that needed additional time to review, and honestly for -- I think that reason is to ensure that, you know, what new services they may be asking for. So all of those have been approved as of -- or, like, last week sometime.

DR. SCHUSTER: Okay.

MS. JUDY-CECIL: So we are -- you know, the priority is on getting these above any other requests that come in from MCOs for review. These are priority, and again, trying to get those out same day or next day.

DR. SCHUSTER: Right. Appreciate that. Any other questions about prior-auths?

(No response.)

DR. SCHUSTER: I'll ask a question, and it will be rhetorical because you can't answer it but let me state that from the BH TAC's point of view, we are certainly hopeful that with the reinstitution of prior-auths that the number and extent of audits will decrease. Because I think there has been an incredible increase over the last two years in the number of cases required and the short time frames. And this is nothing new I'm sure, Veronica, to you and DMS, hearing about this. We had Jennifer Dudinskie on the BH TAC, who's always so helpful, but, you know, if we've got to go back to the onerous process of prior-auths, then we sure as heck hope that the onerous process of hundreds of case records and almost no time will go away or certainly be more reasonable. So I will make that as a rhetorical statement. Thank you.

MS. EISNER: I can't figure out how to raise my hand so I'm doing it the old --

DR. SCHUSTER: Oh, all right, Nina.

MS. EISNER: So Veronica, will all the MCOs be required to use the same list of codes and services that have to be prior-auth'd?

MS. JUDY-CECIL: Not at this time.

MS. EISNER: Oh.

MS. JUDY-CECIL: That's something that we're going to work towards.

MS. EISNER: Okay.

MS. JUDY-CECIL: Yeah, we're -- that's a workgroup -- something we're going to work on following, you know, this initial resumption. That and the PA form are things that we're going to take back to work on, an electronic PA form that's universal, is what we're going to take back.

MS. EISNER: Good. Thank you.

DR. SCHUSTER: Any other questions, then, before we move on?

(No response.)

DR. SCHUSTER: All right. And thank you for the information being posted in the

chat as well.

We understand, and I think, Beth, this was your item about the 2024 Telehealth Fee Schedule is still being used?

COMM. LEE: I think Justin Dearinger is on here to address that topic. Justin, are you on?

MR. DEARINGER: Yes, ma'am. Hi, my name's Justin Dearinger. I'm the director for the Division of Health Care Policy.

So we don't have a Telehealth Fee Schedule, but we do have, on the Physician's Fee Schedule, all of our telehealth codes. So that Physician's Fee Schedule, like all of our fee schedules, we try to get that updated as soon as possible in the beginning of the year. We're a little late this year and I apologize for that; however, all changes have been approved and have been placed into our system. So they're working on those system changes. The website will be updated by close of business Friday of next week. They'll probably be updated before Monday as we have people working on it over the weekend. Our Physician's Fee

Schedule, which the telehealth codes are on, is our biggest fee schedule. We have thousands upon thousands of codes listed on that fee schedule, so that is the hardest one to update.

But we are almost complete with that, and it will be completed and updated by Friday of next week. It's already in our system, and it will be retroactive back to January 1st.

MS. PARTIN: Okay. The concern from the providers that contacted me was that they would be -- the reimbursement would be changed, and so then they would be facing a big recoupment.

MR. DEARINGER: Yeah, so no reimbursements were changed on the 2025 Physician's Fee Schedule. All of those stayed the same. We only added or removed codes, so there were no decreases. We had several decreases that came down from Medicare, as you all probably were aware. We did not include those decreases into the Physician's Fee Schedule, so we were able to leave those the same with our budget to

assist you all. So no recoupments.

MS. PARTIN: Oh, great. Thank you.

DR. SCHUSTER: Well, that's good news. So if anybody is -- so other providers use telehealth obviously. They need to go to the Physician's Fee Schedule to look at those fees?

MR. DEARINGER: That's correct. So most providers know if they're using codes that are listed on the Physician's Fee Schedule for telehealth. Now, we do have a lot of telehealth codes listed on specific fee schedules, as well. Therapy Fee Schedule, for instance, will have telehealth codes, and then a lot of the codes that other therapy providers, dental providers, all the different other provider types that we have fee schedules for, their codes will have a place of service that lists telehealth. So it's not actually a specific telehealth code, but a place of service that they bill. And they'll be able to see that either on the fee schedule, or that'll be in the billing instructions in the system when they go to bill, that they're allowed to

bill that through telehealth.

DR. SCHUSTER: Okay, thank you. Nina?

MS. EISNER: Yes. Thanks, Justin, for that update. I'm wondering whether or not there is going to be a provider notice sent out about the ability of PHP and IOP behavioral health services to be provided via telehealth?

COMM. LEE: So Nina, you're requesting guidance on that? I think I have been talking -- you know, I've spoken with you several times on that.

MS. EISNER: Yeah.

COMM. LEE: Just different authorities have just kind of put that a little bit on the back burner for now, but we are still looking at that. We'll hope to have some information out soon.

MS. EISNER: Thank you.

DR. SCHUSTER: Thank you. I know that you've asked about that several meetings, Nina, so we'll keep asking about it until we see the guidance. Thank you.

MS. EISNER: Thank you. Thank you.

DR. SCHUSTER: Any other -- I think there was also a question at the BH TAC about the behavioral health codes. And I think, Justin, you said that they are being worked on by BDID, but are not completed yet?

MR. DEARINGER: Well, they're -- right, there's a couple of fee schedules that we kind of collaborate with them on, but I think the Behavioral Health Fee Schedule, which I'm not sure if there's anybody from behavioral health on to talk about where those are, but I'm pretty sure that those are in the same spot. They've been approved and they are working on those, and I would say, again, within the next couple of weeks, theirs will be posted as well. I know I saw a change order go through, so they've -- they're kind of in the same exact spot where the physician's is. So you all will be seeing those in the next couple of weeks.

DR. SCHUSTER: Okay. Because I know that that was one of the questions that came up. Thank you. Any other questions about

telehealth or about fee schedules?

(No response.)

DR. SCHUSTER: All right. Thank you, Justin, for being on.

MR. DEARINGER: Thank you.

DR. SCHUSTER: We have the timeline for implementing the SMI 1915(i) SPA, which is now called RISE, R-I-S-E, which was, hooray, recently approved by CMS. That's the best news I've gotten in a long time. Any update on that? Oh, and Ann Hollen --

DR. HOFFMANN: Dr. Schuster, Ann Hollen should be on.

DR. SCHUSTER: Great.

DR. HOFFMANN: Sorry.

DR. SCHUSTER: You're good.

DR. HOFFMANN: Ann Hollen should be on.

MS. HOLLEN: I'm trying to share. I've got a slide to show you, but obviously, I'm not -- am I sharing it?

DR. SCHUSTER: Yes.

MS. HOLLEN: Do you see it?

DR. SCHUSTER: Yeah, I see it.

MS. HOLLEN: Okay. All right.

DR. HOFFMANN: We can see it, Ann.

MS. HOLLEN: Okay, thank you, because I can't tell if it's on or not.

Good morning, everyone. My name's Ann Hollen. I'm an executive advisor from the Department for Behavioral Health Developmental and Intellectual Disabilities, and I'm leading the 1915(i) RISE initiative for our department. We are in a partnership with DMS. It is a brand-new benefit package that we will administer on behalf of Medicaid.

So we wanted to give a timeline of how we're going to get things rolled out. So we're almost to the end of May. DBH, we are actively interviewing staff to help us administer the 1915(i). I can say that so far, the applications we've got are -- people have mental health experience, and some experience with trainings and things. So it's very promising, and I'm very excited about that.

We are putting last-minute touches on our communication plan, and we'll have a website page. I -- Sheila, you know, I

learned early not to give dates, but I've put -- I've said I'd like to see it go live by June 15th, so I'm hopeful that we'll have something up there live June 15th. I'll make sure that the website page is put in the chat here, and I can make sure that it gets shared as well from Erin when she sends out other items for the MAC. And we also have two email boxes for anyone that has -- you know, wants to get put on a listserv. One is for providers, and one is for just anyone.

Then in June, we're getting the certification curriculums recorded in Medicaid's Adobe Learning Management System for providers and staff to complete part of the certification process. And then we're also going to start our outreach to the public targeting providers and anyone that wants to hear me rattle on about the services and how you can become a provider.

July, we will begin certifying providers and getting them Medicaid enrolled. We will have our independent assessors will be trained on the interRAI

Community Mental Health Assessment. So that is the needs-based assessment we will be using to determine the needs and eligibility for individuals with serious mental illness.

August, the independent assessors will apply that training and conduct testing assessments. We want to make sure that they are ready and understand fully how to provide that assessment. And then we're also, you know, getting some system things finalized, and we plan to begin assessing participants for eligibility and services, September.

So that is the course that we are planning right now. Any --

DR. SCHUSTER: That sounds good, Ann. I was writing the minutes for the BH TAC meeting, and I was racking my brain trying to remember what RISE stands for, so tell me that again.

MS. HOLLEN: I will tell you. Hang on. I should have it memorized. I really should.

DR. SCHUSTER: Well, it makes me feel better that you can't just rattle it off.

MS. HOLLEN: No. Recovery, Independent, Support, and Engagement. RISE reflects the initiative's focus on helping individuals rise above their challenges through services that promote recovery, independence, and community engagement.

DR. SCHUSTER: So it's Recovery -- what's the I?

MS. HOLLEN: Independence.

DR. SCHUSTER: Independence, okay.

MS. HOLLEN: Support and Engagement.

DR. SCHUSTER: All right. Thank you very much.

MS. HOLLEN: You are welcome. Thank you.

DR. SCHUSTER: I really tried -- I came up with some other words, but you probably don't want to know what those words were.

MS. HOLLEN: Thank you.

DR. SCHUSTER: To say that we are excited about this rolling out, this -- for those of you who don't know about -- well, the MAC members should know because we hear about it. But this would give to people

that qualify with severe mental illness supported housing. In other words, housing with all of the wraparound services that they need, and we have been --

MS. HOLLEN: In-home --

DR. SCHUSTER: -- wanting this -- in-home, yeah.

MS. HOLLEN: In-home, independent living services.

DR. SCHUSTER: In-home and independent, yeah.

MS. HOLLEN: Yeah, supported education, supported employment if they want to get an education and work towards a job.

DR. SCHUSTER: And respite for caregivers --

MS. HOLLEN: Respite, yes, ma'am.

DR. SCHUSTER: -- which has never been there for family members and so forth, so we're very excited about this.

MS. HOLLEN: You've been -- as I've heard you say before, you've been waiting 30 years for this.

DR. SCHUSTER: It feels like about 100, but yes. Thank you very much, Ann.

MS. HOLLEN: Thank you.

DR. SCHUSTER: Any questions for Ann about this?

MS. HOLLEN: Justin, it's not a waiver. It is a 1915(i) State Plan Amendment.

DR. SCHUSTER: Amendment, right.

MS. HOLLEN: That is -- it is a home and community-based program. It's like -- there are certain components that are federal requirements that apply to the (i), that apply to the (c), but I'm trying really hard to get people not to call a waiver.

DR. SCHUSTER: Yeah, that's right. And I finally have -- that's why when it went to RISE, I was like, oh, I gotta figure out what RISE stands for, so.

MS. HOLLEN: Because there is no slots.

DR. SCHUSTER: There are no slots, right.

MS. HOLLEN: If you -- yeah, if you qualify, you can --

DR. SCHUSTER: You're in.

MS. HOLLEN: -- you can utilize the

benefit, yes.

DR. SCHUSTER: Yeah.

MS. HOLLEN: And it is statewide.

DR. SCHUSTER: And it was funded by the General Assembly in the 2024 biennial budget, so that's huge. So we're very excited about this. There are a lot of family members and a lot of folks waiting for this. So thank you, Ann. Appreciate that.

And then just to continue with the waiver discussion, do we have anyone to talk about the implementation of the Reentry Waiver?

DR. HOFFMANN: Dr. Schuster, Angela Sparrow should be on.

DR. SCHUSTER: Okay.

MS. SPARROW: Good afternoon, everyone. Thank you. Angela Sparrow, one of the project technical specialists within the Department for Medicaid Services. So I wanted to provide some updates on the Reentry 1115 Demonstration.

Lots of initiatives and work occurring as we continue to target, again,

an October implementation date. There has been, again, as we've continued to discuss a lot of focus around system requirements for changes, again, to support implementation of the waiver and the services. So again, there will be some changes that we need to make to our eligibility system to identify the populations, the reentry populations, the new youth provisions, the new CAA youth group, again, that is also eligible for pre-release services, those targeted pre-release services.

So we will need to make some system changes so that we can identify those populations appropriately, that we can identify them in terms of the settings that they are placed in appropriately, and also, for the time frames that they're eligible for those pre-release services appropriately. So again, it is complex system changes, again, to be able to appropriately do that, to be able to reinstate or instate that eligibility as quickly as possible.

And so from there forward, again,

that means that we'll have some billing changes to our MMIS systems to allow the correctional facilities to bill for those services, be reimbursed for those services in that pre-release time period. That also means that our correctional partners, Department for Corrections, Department for Juvenile Justice, they are also, again, needing to make some system changes to support implementation to their health records, again, being able to capture Medicaid IDs, identify individuals, the services, again, etc. So again, they continue to work on system changes as well.

There will be some system changes to Med Impact to allow for that 30-day supply of medication at the time that individual is released. Again, this is not going to be pharmacy changes to our community pharmacy providers. Again, that will be more so for the vendor and for that pharmacy that DOC and DJJ are contracting with.

And also, again, exploring some changes with KHIE for our DOC and DJJ partners to allow for that data exchange,

and again, be able to provide that information timely to the MCOs to support those case management services pre-release and post-release.

So again, we continue to move forward with developing those requirements, understanding the system impacts, and again, through the summer, we'll move forward with deploying those system changes and the testing, again, around that.

There are several workgroups that continue to meet to support program design and implementation. So again, DOC, DJJ, meeting with them routinely, our pharmacy workgroup, finance again, in terms of any changes to capitation payments to support those pre-release services. Again, any changes for rate settings for the pre-release services. So again, some of those items, and then also working with MCOs, meeting with the MCOs to develop, again, that case management policy to support, again, those efforts, both pre-release and post-release. So again, clearly defining roles and responsibilities

with our MCOs and with our correctional partners will be very important for collaboration to ensure that we have, again, a smooth and successful implementation. We, again, will kick off some additional workgroups in the next few weeks, but again, want to wrap up some of these initiatives before kicking those off.

I think we've talked in the past, again, DOC and DJJ, they will be enrolling as a provider. So again, they will be providing some of those pre-release services, being reimbursed for those services, so we are supporting them through that provider enrollment process. We've developed that new provider type, Provider Type 53, Reentry Organizations, that they will be enrolling as. So again, we'll also be supporting them with contracting with the MCOs through that process, and so that will be new, and again, will occur over the next quarter and into, again, the fall.

We'll move into readiness assessments through, again, the summer -- into summer and again, early fall. And so again, lots

of things, lots of moving parts, but we're excited that we do, again, have great collaboration with our justice partners, and with our MCOs, and many agencies involved in the process. And it is very complex, so we -- again, we'll keep moving forward as a -- again, this is kind of the first step to be able to provide these services.

Any questions? I know it's a lot of information there, so.

DR. SCHUSTER: We always appreciate your updates, Angela. Any questions for Angela? You know, this Reentry Waiver is going to be a huge help. The idea is to get people started on their services six months prior to release so that they really have that warm hand off to the MCO and will just be continuing their services, as opposed to getting released from incarceration and then having to start once they're out in the community. So we're really hoping that people will be well on their way to recovery services when they get into the community.

So great work, Angela. And just a reminder that Steve Shannon has that Reentry

TAC that meets the second Thursday of every other month starting in January at 9 a.m. And so if you're interested, particularly in reentry, you can certainly plan to attend the Reentry TAC. Any questions from anyone?

(No response.)

DR. SCHUSTER: All right. Well, thank you very much, Angela.

MS. SPARROW: Thank you.

DR. SCHUSTER: How about the current HCBS waiting list numbers?

MS. HANCOCK: Yes, good morning, everyone. Good morning, Dr. Schuster. I'm Carmen Hancock, the Department for Medicaid Services division director of Long-Term Services and Supports. So I've got that information for you.

Current waitlist numbers as of today on our Home and Community-Based Waiver, we have 4,423 individuals on the waiting list. The Michelle P. Waiver, we have 9,459 individuals on that waiting list. Supports for Community Living, so our SCL, is 3,626. Within those numbers, we have a little over 2,100 people that are on multiple waiting

lists. So that total of unduplicated individuals on waiting lists, is 15,369. And I can drop this little chart in the chat for you to have.

DR. SCHUSTER: That would be great. Are there any on the either emergency or urgent waiting list, Carmen?

MS. HANCOCK: Dr. Schuster, I would have to check on that. I know that we do have some within SCL, but I don't know how many right off the top of my head.

DR. SCHUSTER: Okay. If you might be able to get that and just drop it in the chat, if you're able to do that.

MS. HANCOCK: Yes, ma'am.

DR. SCHUSTER: That question has been asked, and so we might want to have that as part of the waiting list discussion going forward, if you would.

MS. HANCOCK: Okay.

DR. SCHUSTER: That would be very helpful. And nobody's on the ABI, the Acquired Brain Injury waiting list?

MS. HANCOCK: No, ma'am.

DR. SCHUSTER: Okay.

MS. HANCOCK: Or Model 2. No, ma'am.

DR. SCHUSTER: Okay. All right. Thank you very much. Appreciate that.

MS. HANCOCK: Thank you.

DR. SCHUSTER: And I see it in the chat, thanks.

And how about an update on unwinding flexibilities in the upcoming child renewals.

MS. JUDY-CECIL: Good morning, Dr. Schuster. Veronica Judy Cecil, senior deputy, again.

DR. SCHUSTER: Oh, it's Veronica, good.

MS. JUDY-CECIL: I do have slides.

DR. SCHUSTER: Okay, good.

MS. JUDY-CECIL: So I will quickly share that.

Okay. Just to touch on -- and I'll do my best to do this very quickly. Just to touch on the flexibilities, and we do want to talk about it because they are ending on June 30th. So we have been maintaining flexibilities from the unwinding of the public health emergency. And those have

been very helpful to Kentucky, and to, you know, our members in ensuring that they do not inappropriately lose coverage as we've gone with the restart of the renewals.

So some of those flexibilities we really want to focus on because we think they're the most impactful as they start to end on June 30th. One is -- and we'll talk about this a little bit more but is the automatic renewal of children. We have been able to automatically renew children when their renewal month came up for 12 months, and that flexibility is going away.

We also have been extending members. If they received a renewal form, and they didn't respond by their original renewal date, we could extend them up to one month for all members, or up to three months if they were long-term care or 1915(c) members. We will -- after June 30th, we will no longer be able to extend folks if they don't respond by that date. So that's something we're very concerned about because we did see a lot of folks use that additional time to get those renewals in, so we're just

going to have to stay on top of folks making sure that they know they're going through a renewal, they know they have to send information back to us to make a determination. So that's going to be very critical.

And then the last -- or two others, one is during the unwinding we had a flexibility that allowed an authorized representative to sign an application or a renewal form via the telephone. That -- you can still do that post June 30th -- after June 30th, but we will have to have a signed designation on file for that member's case for that authorized representative to be able to do that. It's a MAP 14 is what the form is called. We'll post it. We've been trying to get the word out on this as well. I will like to say, a kynector does not need this form. This is really only authorized representatives that are trying to act on behalf of the member to access services or to file an application or to go through their renewal.

And then the last one that I want to

focus on is the 90-day reinstatement. So during the unwinding, one of our flexibilities was being able to reinstate a member if they were terminated and they came back in during a 90-day period following their termination. They provided the information we needed, and we were able to determine them eligible. We could reinstate them back to that termination date as if there was no gap and coverage. So that has been automatic, and that is going away on June 30th as well.

What that means for folks is currently we do have the capability to retro eligibility. We're very limited in the circumstances in which we can do that, and in some cases, we have to treat that is a new application and folks don't get that automatic reinstatement. So that is also a flexibility going away.

So these really are the five we think are most impactful to members as we come out of unwinding on June 30th.

What are we doing for that? What our message has been this entire time, which is

we really need our members to make sure they're updating their contact information, their address, email, a phone number, if possible, because we do try to communicate with our members through all of those different ways. So the more information and contact information we have for a member, the better chance we have of reaching them, especially if something happens with the mail and their notice, we're at least calling them or emailing them or texting them to let them know that they have to take action. So we always ask, you know, if providers in particular, if a member comes in and is updating their contact information with you, please ask them if they've also updated that contact information with the state. That's kind of the biggest one that we ask providers to help us with. So just making sure that that information is updated.

This is the enrollment trend, and as I've been saying for many months, we really have leveled out. We're staying pretty much hovering around the 1,450,000 mark. So that

hasn't changed.

I'm not going to go through this like I generally do for the interest of time, but just for folks that are seeing this, especially maybe for the first time, this is a summary of the reporting that we do to CMS on a monthly basis. On the left-hand side, is what we call our original monthly report to the Centers for Medicare and Medicaid Services. It is a report that's given -- that's sent by the eighth of the month following the month of renewal. And then on the right-hand side is an updated report that we submit to CMS that provides information on any pending cases that we processed. And that's what's in the middle there, in that column are the processed cases.

This is a summary. All of these reports are on our unwinding website, and we'll post that link for those of you who don't have it. And it has a lot more information in each report, so if you're really interested in what's going on on a monthly basis, you can check that out.

The past three months, we generally show in this format. And we'll take April as the most recent month that we had renewals, and there were 75,162 individuals that went through a renewal, 64,401 of those were approved, 1,798 of those were terminated, and we had no pending cases that crossed over that last day of April. And there's that extended bucket, so you can see the number of individuals that have been taking advantage of that extended bucket. Again, we're going to work really hard to reach folks, and we just need everybody's help in making sure that members who are navigating the renewal process are taking action. We want to make it as easy as possible. There are multiple ways in which they can submit information, and all of that information is in their letter and on our website. It's also contained in a lot of the communication materials that we have, and I'll get to that in a minute. And then that far right bucket is those reinstatements I talked about. So the automatic 90-day period, you know, would

be -- so for April, we've already had 451 folks that have come back in in that 90-day period and have been determined eligible for April. So those are really important buckets. The extended and the reinstatement are concerning for us.

Let's talk child renewals. So as I said, the automatic extensions are going away on June 30th, which means children with a July renewal, will start to have to actually go through a redetermination. The way that works, as a reminder, is we always send 60 days prior to the renewal date, which is always end of the month, we always send a notice to members. There is a process where we go out and try to automatic -- automatically renew cases by checking what we call trusted data sources, and if we can confirm the information, that child could get automatically renewed without even having to take any action on the case. And if we're able to do that, then they'll get a notice saying, "you've been renewed." But if we can't, it will drop to what we call an "active renewal,"

and they'll be sent a renewal form or a request for information, and that has to be acted on. So again, we're going to be really monitoring these as the child renewals start for the July renewal. So they'll get the notice in early June as to whether or not they're going to have to take action on their renewal.

We've got a communication toolkit for child renewals on our unwinding website. It has a lot of frequently asked questions, it just sort of talks about, you know, what's going on and why is this happening. And then what you see here are an example of some of the flyers that we have. We're really asking folks to please share this, you know, and distribute it. If you know organizations that work with Medicaid members, especially children, you know, to please distribute it, post it. We're asking providers if they don't mind posting it and reminding folks that child renewals are coming up. So lots of information.

We do also, on our unwinding website, have non-child renewal flyers. So if you

want to post just general flyers to help Medicaid members go through that renewal, again, we've got a lot of communication materials on our website.

So this is the website. I'll post it in the chat. The communication materials is where that child renewal toolkit is, and please, please, please, just share it. We greatly appreciate getting the word out and making sure that we're doing all that we can to support our members going through that.

DR. SCHUSTER: All right. As always, Veronica, great information. Are there any questions for Veronica?

(No response.)

DR. SCHUSTER: And let's do try to get the word out. Again, we don't want to lose coverage for any of the kids in Kentucky.

MR. MARTIN: Hey, Veronica, the kynectors can help recipients with that, right?

MS. JUDY-CECIL: Yes. Oh, Barry, thank you for bringing that up. Because something I normally share is that we have

been working with the FRYSCKys. If folks are familiar with the FRYSCKys, they're in all the schools, and they help members apply, get connected on how they can apply, and if they're having problems with the renewal process. So we have shared the communication toolkit with all the FRYSCKys in all the schools. Our kynectors can be of assistance, and in fact, we have kynectors attend pretty much all of the large school events across the state. So we will keep doing that. There's a lot of back-to-school events that happen, you know, in the summer, we have kynectors that attend those. And their focus is going to be on making sure that those parents and guardians and others know that those children are going through renewals. So kynectors are across the state and can help families navigate this.

MR. MARTIN: I know sometimes it takes them a day or two -- it takes a day or two longer to cycle through, but yeah, that's a good point. Thanks.

MS. JUDY-CECIL: Thank you.

DR. SCHUSTER: Thank you for that

question, Barry. Any other questions? Peggy?

MS. ROARK: Yes. This is Peggy Roark. I could share at my local doctors, but also at the library.

DR. SCHUSTER: Good point.

MS. ROARK: A lot of people go to my library here, and I see some doctors and can talk and help spread the word any way I can do to help.

MS. JUDY-CECIL: Thank you.

MR. GILBERT: Veronica, is there a kind of a portal or a conduit to the public libraries? That's a really great idea, Peggy. I think that if we had just a conversation with a spot on the bulletin board could always be for particularly children, but I think, in general, there could be a bulletin board in every public library that had cool flyers like that.

DR. SCHUSTER: Right.

MR. GILBERT: And you get the librarian to replace them once a month or whatever, that could be huge.

DR. SCHUSTER: Yes.

MS. JUDY-CECIL: It is a great idea, and happy to take that back, and we'll find a way to contact the librarians and get it out that way. There's a lot of kynectors that go to libraries.

MR. GILBERT: Mm-hmm.

MS. JUDY-CECIL: That's where they -- that's sort of their community location and they do outreach there, but that's a great idea. Thank you for that.

DR. SCHUSTER: Yeah. And I think that there is some centralized thing for all the public libraries. I'm also thinking that during the summer, they do a lot of activities for kids, reading groups, and story time, and so forth because kids are out of school. So great, great idea, Peggy. Thank you for that.

MS. ROARK: You're welcome.

DR. SCHUSTER: Any other -- I think the -- getting the word out about the kids but then reminding people that ending those flexibilities is really going to be huge. That 90 days has really saved a lot of people, and they could come back, as

Veronica pointed out, and reapply, but that's a very different process than, you know, getting reinstated during that 90-day grace period or extension period.

So there's a question in the chat that I would like to ask, and I'm not sure who can answer it, and it's "Will those who meet criteria for the developing children's waiver who may be on the waiting list right now for HCB, Michelle P., or SCL, be moved to the children's waiver once it's being implemented, or will they need to apply?" And just a reminder that the children's waiver, it doesn't exist yet. This is a waiver for kids who are on the autism spectrum, kids who are in the severe emotional disturbance category, or those with chronic health and behavioral health problems.

Do you have any idea, Veronica, or anybody else, what that process will be? I'm looking at you, Veronica, because you're in my bull's-eye.

DR. HOFFMANN: I'm on, Veronica, if you want me to speak.

DR. SCHUSTER: Oh, that would be great.

DR. HOFFMANN: So Dr. Schuster, we're -- you know, we're still working on this, and we hear you, and we will have, you know, stakeholder forums and workshops and group meetings to talk about what we would like to see. I just wanted you to be aware that we're just kind of in the middle of a multiphase, multiyear, wonderful initiative to help transform children's services. So I can't answer those questions for you right now today. There's processes in everything that you just mentioned, of course, so just bear with us, and we are working on, like I said, a multi-phased approach. The (c) waiver that was listed in and approved in last budget that we're currently addressing some things right now, and it will just be a piece, right, of our multifaceted family first approach, if that makes sense.

DR. SCHUSTER: Okay. Yeah, that does make sense, thank you. Thank you very much.

Let's go on to the TAC reports. And I had indicated to the TACs that we probably

would not have time for everybody to give a report, so I'll ask first for those three TACs that do have recommendations so that we can get through those, and then if there are other TACs that want to make a very brief report.

I think behavioral health is up first, and I mentioned several things that came up at the Behavioral Health TAC on May 22nd. We did have a quorum. A lot of the discussion was about the resumption of prior authorizations, and we brought up a lot of those issues.

We also had a lot of discussion, as always, about audits. And as I mentioned, Jennifer Dudinskie was on and reminded us of some of the processes.

We also had an interesting discussion about waiting lists for person-directed services, and the request that that really not be seen as a waiting list but as a kind of interest list because they don't really move people off of it. So there are people that are enrolled, interested in traditional Medicaid, no longer interested, and so

forth.

We did have a recommendation to the MAC moved by Steve Shannon and seconded by Valerie Mudd: "The BH TAC recommends that Kentucky Medicaid Services issue guidance to the MCOs and providers on the prior authorization process and forms to ensure consistency across all MCOs." I think that's been the consistent request from providers as we've heard that across the various TACs. So that's the recommendation from the BH TAC.

Wayne Harvey, I think, is on from the IDD, Intellectual and Developmental Disabilities TAC, and they have a recommendation.

MR. HARVEY: Good afternoon, Dr. Schuster. The IDD TAC met on April the 1st, and they came out with a formal recommendation related around a long-standing topic for the IDD TAC, and that's around involuntary terminations.

And the recommendation is as follows: "The IDD TAC recommends and requests that CHFS modify the involuntary termination

requirement within the SCL and Michelle P. Waiver regulations to establish a time frame within which the certified provider is obligated to continue supporting an individual that they have indicated they can no longer safely support. This TAC recommends a similar time frame as the state of Virginia allows, which is 60 days with their involuntary termination process, as discussed in earlier TAC meetings. This recommendation is made in the interest of preserving the health, safety, and welfare of the individuals receiving waiver services funded through Medicaid."

DR. SCHUSTER: Thank you very much for that, Wayne. And we will take a vote on approving these recommendations here very shortly. Thank you.

And then the Physician TAC I believe has a recommendation.

DR. GUPTA: Yes. Thank you, Dr. Schuster. This is Dr. Ashima Gupta from the Physicians TAC. We met on May 16th, last Friday, and our recommendation: "The Physicians TAC recommends to the MAC that

DMS amends 907 KAR 3:005 to remove the daily per patient limitation on billing for E&M services."

And we would also just like to thank DMS for all -- for having recognized this issue and for already taking steps to amend the regulation.

DR. SCHUSTER: And I'm sorry, Ashima, to end the --

DR. GUPTA: To amend --

DR. SCHUSTER: Amend, okay.

DR. GUPTA: -- its regulation.

DR. SCHUSTER: Okay. For E&M services.

DR. GUPTA: Right. To remove the daily limitation -- daily per patient limitation of services.

DR. SCHUSTER: All right, great. Am I correct -- are there any other TACs that have a recommendation to come before the MAC?

(No response.)

DR. SCHUSTER: Let me then have a motion from the voting members of the MAC to adopt the TAC recommendations from the BH

TAC, the IDD TAC, and the Physicians TAC.

MS. STEWART: This is Susan Stewart, I'll make that recommendation.

MS. PARTIN: I'll second.

DR. SCHUSTER: Okay. Thank you, Susan and Beth. Any discussion?

(No response.)

DR. SCHUSTER: All those in favor, signify by saying "aye."

(Aye.)

DR. SCHUSTER: And opposed, like sign?

(No response.)

DR. SCHUSTER: And abstentions?

(No response.)

DR. SCHUSTER: So Dawna, I think you have in writing those recommendations, and those are the ones that we will be sending onto DMS.

We do have a couple of minutes as it turns out. Are there any of the TACs that would like to briefly give a report of their most recent meeting?

(No response.)

DR. SCHUSTER: Okay. Hearing none,

we will move on to new business. And I think, Kent, that you had an item.

MR. GILBERT: Yeah, thank you. My concern has been raised by a number of issues that we've already just touched on, including what do we do about folks who are erroneously targeted for terminations. What to -- those we've discussed in previous meetings about various forms of our sort of checks and balances generating false positives on fraud detection, etc. It's a question about due process. I'm interested, Commissioner, if you can tell us what assurances do our constituents and our providers, anybody who's suddenly found themselves without recourse, what can we do to make sure that there is due process being followed?

I realize that due process is not currently in vogue in every quarter of our governmental systems, but I would very much like for us to be assiduous about attention to making sure we don't cause both public health crises inadvertently and also don't disrespect either a provider or a recipient

because we've suddenly decided to just move ahead.

What -- I'd love to hear some comment about that, and maybe there's better ideas. What support do you need from us in order to have transparent, clearly available resources for those who might need due process, and what are the assurances for due process in dispute problems?

MS. JUDY-CECIL: We appreciate that question, and I think we're always trying to improve on how -- and how can we make it easier for folks to access the process for appealing? And I think we can do better, and make it more understandable, make sure we're talking about it, you know, make sure -- it feels like sometimes it can be redundant, but I don't think it is if it's really about trying -- you know, like on the call today, I think we have new people that have for the first time come to the MAC and haven't heard information that we've shared. So I think it's always -- I think it's incumbent upon us particularly, and you all as well, you know, the folks that are on the

MAC, the providers, I think it's just the community that I'd call "Medicaid," to make sure that we are always talking about how to access your rights in plain language, easy for folks to understand "what do I do?"

And, you know, we've been -- I think we've been trying to do better, especially with some of the new things that we've been launching and talking about, but I appreciate your attention to that, and I think something we can work on is how do we better communicate and ensure that everyone knows what to do if they've received a denial. Because it is critically important, and, you know, I'll talk about we're trying to be candid and transparent about what happened with the child recertification denials and the HCB Waiver. There are some that took advantage and appealed, and there were some that didn't, and that concerned us. In fact, it might've been about 50/50.

MR. GILBERT: Mm-hmm.

MS. JUDY-CECIL: And so we are looking at that. This is our opportunity to see what can we do better, and I think one

of the things we can do better is making sure we're communicating with members that have been denied, and make sure they understand what their appeal rights are. It's in a letter, and that's easy to say, but that doesn't mean that someone who receives that --

MR. GILBERT: Right.

MS. JUDY-CECIL: -- understands it, or maybe they don't even receive it because we don't have the most current address on file. So we've talked about how can we make that easier, not just for the HCB Waiver, but going forward to communicate with folks that have -- that are going through a denial, using maybe all the modes of communication we have on file. If we have an email address and a phone number, and, you know, not just relying on the mail as a way to communicate that.

So we're looking at that. I think it's a very timely question, and something that we should really focus on.

MR. GILBERT: I appreciate your response, and I think communication is

critical. And as you said, we all deal with information overload. I am a -- I look after several people, and one of them is on Medicaid in a nursing home, and I receive about 35 to 50 notices about her care a month. Not all from DMS, right? But it's very -- it is -- there is information overload, and it's just hard to sort through all that.

But I want to -- I want to underscore a second part of this. Communication of what's available is one thing. But the actual -- having actual appeal processes that are respectful of those making the appeal is one of the other parts that I want to emphasize. You know, the terminations that we've talked about that made the news, of course, reflect the due process in terms of terminating children who have chronic and ongoing conditions, should have raised red flags and there should never have been any kind of imposition on those families. That should've been caught sooner and earlier. Of course, we all know that.

But in addition, there needs to be

some accountability when mistakes are made, and not just, you know, "Okay, we'll put you back after we've scrambled your life and you've had to run for care and there's all these issues." Part of due process is making sure that there's accountability and reparation when mistakes have been made like that, and that's true especially for families, of course, receiving care, but it's also true for, you know, providers who have had to wait months and months and months for reimbursements or problems with, you know, helping to navigate various ways in which harm is coming to those while whatever process we have is. So it's not just communicating what process there is, but it's also ensuring that the processes are good.

MS. JUDY-CECIL: I can't disagree with that. And all I can say is that we don't have all the answers. If you all have recommendations on how we can make that process more respectful -- you know, I think we have tried to own the problem with what happened. It's something that happened

quickly. It was -- it started out small and then ballooned. And that's when it became -- you know, came to our attention. And I think we have been very open -- hopefully you all have felt that we've been very open to bringing concerns to us.

We -- I honestly, if it weren't for the fact that people were reaching out to us to make us aware, it -- that prompted us to be able to really investigate it. And the problem is that because that appeal process takes so long, and the reporting that we get -- which, by the way, we're revamping. You know, the reporting that we get is usually on a monthly basis, so you're not going to see the trend come if it's not being pointed out by our vendors early on. And that is something we've taken back to the vendor is you have to let us know when you're seeing these problems because they're ground zero in terms of they know immediately when they're seeing a trend, you know, happen like that.

So we are making changes in our processes internally to -- and not just with

the HCB Waiver, you know, kind of across all of our different programs and processes so that we can better identify things early on, but I'll be honest, we need you all. We need you all to tell us when you're seeing things, and I hope you know that we accept that and appreciate it. And I think, you know, as long as we continue to do that, I think we can always do better, so -- and work out the issue.

MR. GILBERT: Yeah. I mean, I think some of the things we've seen -- we've heard about, and I'll let others speak, is, you know, especially when we're talking about terminations in particular with children, although I think it should apply to all --

MS. JUDY-CECIL: Sure.

MR. GILBERT: -- which is it needs to be a "we're terminating you, but you've got -- that won't happen for 30 days." Not "we're terminating you, and in 30 days we'll review your case and maybe reinstate you," right? These kinds of things are the kinds of fair due process that we would have in various other legal systems, and that's the

kind of thing I'd like to see more of as we move ahead and as we sort of revamp and keep fine-tuning.

And I do want to say, I do deeply appreciate the efforts, that communication and transparency, which I think are very good. And I think you're right, we can all help get those out there better, but it also matters that it's not just here, we're going to tell you about a terrible system. It's that we're actually going to tell you about a system that's not as terrible. That's what I think our goal is.

MS. JUDY-CECIL: Yeah, I think it's also important to understand that we have federal requirements that we have to meet. And that includes the notices, the language that is required in the notices, which we have a workgroup, a notice workgroup, that for years works to try to improve those notices. In fact, for the waiver specifically, there was a workgroup trying to make those a little more understandable, and allow us to check the box on, yes, this is what CMS requires us to have in the

notice and make it understandable.

And I will say, we are -- you know, we have the National Association of Medicaid Directors, and we meet regularly. And on that, when all the states are on that, there's a lot of states that say, "Has anybody solved the making the notice understandable problem?" You know, how can you make it shorter? How can you reduce the number of notices that go out? So it's a challenge to try to meet that federal requirement, and -- you know, and make sure that members are receiving a communication that is understandable to them.

DR. SCHUSTER: And also --

MR. GILBERT: That's a --

DR. SCHUSTER: Go ahead, Kent.

MR. GILBERT: No, I was pointing out, Holly has a good comment in the chat that -- about perhaps some kind of reporting line. But I appreciate those responses. Thank you, Veronica.

DR. SCHUSTER: Yeah. I also think that we're on the verge of creating a Beneficiary Advisory Council, and that would

be the perfect place, obviously, for brainstorming, you know, communications and how people feel like they are treated. And I do think that a mechanism for quicker recognition, obviously, is one of the things. You want to nip these things in the bud before they grow.

Brian has his hand up.

MR. LEBANION: Yes. Thank you for allowing me to speak, Sheila. With all due respect, Veronica, I've heard you say that, you know, it takes the community, the provider community, and the recipients community to let you all know when things are awry in the programs, the Medicaid programs, and specifically, I'm talking about the waiver program today.

My background is that I worked for one of the largest Medicaid and waiver home health providers for over 20 years. So I'm very familiar with the waiver program. We were a safety net provider, which meant that we provided far and above the number of waiver services to recipients in the Commonwealth for many, many years. And I

actually, you know, was the administrator of the agency for a while, and am very familiar with the waiver program. And at no time -- we had pediatric patients on the HCB Waiver program since the 1990s all the way through the program. So whenever I hear someone tell or state that, you know, the waiver program is not for pediatric patients, that is simply not true. It should not be a blanket that pediatric patients are denied services simply because they are a pediatric individual.

But personally, I have a grandson who has autism that was denied services over two years ago. And I can tell you that we went through the appeals process, and at no time -- even though I communicated with members of the cabinet, at no time did I ever receive a response. Certainly, I'm not his guardian, but I would have expected some type of communication regarding just the general concerns that I brought to the Commonwealth, and I did this for over two years. Not only that, I've made public comments about the administration of the

waiver program and never received any feedback from the people that I've worked with, actually, for 20 years. So, you know, it concerns me greatly that the waiver program has continued to deny these services.

I will tell you that my autistic son, since I'm very familiar with the waiver program, definitely qualified for the services, but the clinician who administered the KHAT was in the home for less than ten minutes. That included grading, opening her computer, and completing the visit. And when she left, she said that the -- she saw no problems with him requalifying. Yet, we went -- had to go through the whole entire appeal process, and when I contacted the legal division of the cabinet, we were simply told to take it to court because they continued to deny his services even though we had his clinical therapist provide evidence, written evidence, that he -- his behaviors were related to his autism. So I do not think that the -- I don't think that we were heard. I think that I talked to

many people within the community where recipients are not heard. And unfortunately, you know, there's this misconception within the community that, you know, they have to be placed on the Michelle P. Waiver waiting list waiting for services, and that they can't get services any other -- through any other method when that has simply not been historically true, nor is it true today.

I understand that the criteria for the waiver, and I understand the criteria completely and thoroughly because of my background, and I can tell you that, you know, in my instance, that this child should have qualified. So with all due respect, I think that the cabinet has been informed of this problem for many years actually, and only recently have I seen this May letter to parents indicating that there was an issue with the waiver program. And I think I've had it in the chat, I think that, you know, this should have been publicly recognized, and to Kent's point, I think that there should be some accountability for these

children that have gone without services for many years that needed it. And, you know, what has the cost been to the Commonwealth while these children have not been given their option, and their option to receive services and the place where it's going to do them the greatest benefit?

And that's what I would say today. Thank you for listening.

DR. SCHUSTER: Thank you, Brian.

MS. JUDY-CECIL: Yeah, thank you, Brian. I promise you we'll take all that back, and I appreciate you sharing your story. It's helpful to us. You know, we can do better, and we will do better.

I will say, we are still -- I want folks to understand, we're still working through responding to the issue. We've developed solutions. One was sending the letter, re-reviewing every single denial, both for children and adults. That process is currently going, you know, we're doing it as quickly as possible, I promise you. All efforts, you know, Carmen is working on this at night, and we worked on it over the

weekend, last weekend. We're working on it. Part of the -- you know, part of the struggle that we have when we share information, especially something that is evolving, is that we want to make sure that we're communicating accurate information, and it takes us some time to really evaluate what has happened.

But I appreciate, Brian, your comments, and we will certainly take them back.

MR. LEBANION: And just really quickly, Veronica, there was a time frame mentioned in the letter that you all issued. Of course, my grandson's case goes back longer than that. So there have been issues with the waiver program farther back than what the letter indicated. Is there going to be any type of, you know, reparations or look back for children who have been -- were denied prior to the time frame within the letter?

MS. JUDY-CECIL: No. The change that resulted in the increase in denials happened in January. We are happy -- we have had

folks reach out and ask us, similar to you, Brian, that had an older case, and we were happy to take a look at it. But, you know, especially for folks that have gone through the appeal process, that is, you know, kind of the route that needs to happen for if someone disagrees with the fact that we have not overturned the denial. So again, we are happy to look at other cases if there's a concern, and certainly folks should reach out to the department.

MR. LEBANION: Thank you.

DR. SCHUSTER: Thank you, Veronica. Thank you, Brian, for those comments.

Are there any other issues to come before the MAC under new business?

(No response.)

DR. SCHUSTER: All right. And we actually are ending early, which is a surprise since we took time out for the public forum, but glad that we could do that. Just a reminder that there are ways for you to continue to comment on the 1115 Demonstration on Community Engagement, a.k.a. work requirement, and we will send

out those links, and they will be posted with the MAC meeting information on the DMS website.

So if there is not any other new business, we will adjourn. Our next meeting is scheduled for July 23rd. And I guess, Veronica, I have a question for you. And that is that's after July 9th. I mean, can the MAC meet on July 23rd?

MS. JUDY-CECIL: So we -- you know, we're pursuing the new -- to be compliant with federal rules, we will need to move forward starting July 9th with the new Medicaid Advisory Committee. So, you know, I don't think it would be appropriate for the Advisory Council to continue to meet past that date.

DR. SCHUSTER: Past July 9th?

MS. JUDY-CECIL: Mm-hmm.

DR. SCHUSTER: All right.

MS. PARTIN: And Sheila, I would like to make a comment.

DR. SCHUSTER: Yes.

MS. PARTIN: I don't know if I will be reappointed to the new Medicaid Advisory

Council, so I'd just like to say that it's been an honor and a privilege to serve for these years, and I hope that I get to continue because this is one of my -- one of the top things on my list that I feel is very important for the people in Kentucky. So if I don't get to see you all again, thank you.

DR. SCHUSTER: Well, and thank you, Beth, for your many years of serving on the MAC and serving as the MAC Chair for many years. We certainly appreciate that, and are hopeful that you can continue, since you are willing to continue.

MR. MARTIN: And this is Barry, and I'd like to echo the same thing because I don't know if I'll get reappointed or not. I've not been on here as long, but still, I've really enjoyed it, and would like to continue on. So if not, it's been great with you guys.

MS. EISNER: Nina, ditto.

DR. GUPTA: Sheila, this is Ashima Gupta, ditto as well. I will continue on the Physician TAC, but most likely, not on

the MAC. And it's been an honor.

DR. SCHUSTER: Well, I appreciate that. I appreciate the service and the input and expertise that you all have shared with us over the years.

So I'm a little bit concerned. I gotta think about this. That's a long, long time for us to go because we're talking about September to be determined, so I'll be sending out --

MS. JUDY-CECIL: Dr. Schuster, you know, you all are welcome to reschedule the July meeting to June, or to a date prior to July 9th certainly, and I understand that. And the reason for the time between July 9th and September -- a potential September date is we're planning training for the new members, and so there's going to be training done. And then, like I said, you know, we're going to work with them on dates that are convenient for them. So that's why there is a little bit of a lag between July 9th and when we might see the new meeting.

DR. SCHUSTER: Okay. Well, thank

you, Veronica. I might poll the members and see if we might want to schedule one more MAC meeting to give an opportunity for the TACs to report and to follow up on some of these things.

We've had great discussion today. And we'll have a better idea -- we may have a better idea even by the June 1st -- July 1st or 2nd or something like that, of who is going to be on the MAC going forward, which would be important. So to be determined. So we'll say farewell and thank you for now, but we may have one more shot at it.

Thank you all very much and thank you to the DMS staff for being on and responding to our questions and issues and so forth. If there's not anything else to come before the MAC, then we will adjourn at this time thank you. Thank you.

MR. MARTIN: Thank you all.

MS. ROARK: Thank you.

DR. SCHUSTER: Have a good Memorial Day weekend.

MS. EISNER: Thank you.

DR. SCHUSTER: Thank you. All right. Bye-bye.

(Meeting adjourned at 12:06 p.m.)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, herby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 4th day of June, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR