DEPARTMENT OF MEDICAID SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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THURSDAY, JANUARY 23, 2025
9:30 A.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

MAC Members:

Dr. Sheila Schuster, Chair
Elizabeth Partin
Nina Eisner
Susan Stewart
Jerry Roberts
Heather Smith
Garth Bobrowski
Steve Compton
John Muller
Ashima Gupta
John Dadds
Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace
Annissa Franklin
Bryan Proctor
Peggy Roark
Eric Wright
Phillip Travis
Commissioner Lisa Lee

MS. BICKERS: Good morning. This is Erin with the Department of Medicaid. Is it is not quite 9:30 and we are still clearing the waiting room so we will give it just a few moments before we get started.

It is now 9:30.

Dr. Schuster, have you snuck in under a different name?

I don't see her yet. We'll wait just a moment longer. We are still clearing out the waiting room.

DR. SCHUSTER: Good morning.

MS. BICKERS: Good morning, Dr. Schuster.

DR. SCHUSTER: I am sorry to be a moment or two late. I don't know what happened to the last five minutes.

How are we looking in terms of a waiting room and quorum, Erin?

MS. BICKERS: The waiting room, as soon as I clear it, it fills right back up, so we are working on clearing that out.

DR. SCHUSTER: Okay.

MS. BICKERS: And we have several members on that I have accounted for so far.

DR. SCHUSTER: Yes. We have a couple of notices of people who are not going to be able to attend today.

MS. BICKERS: The waiting room is clear. I will hand it over to you.

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

And good morning all. This is the first MAC, Medicaid Advisory Council, meeting of 2025. Welcome to you. I am Sheila Schuster, the chair.

Mackenzie, if you are ready, we'll turn it over to you for the roll call, please.

MS. WALLACE: Yes, ma'am. I am happy to do so.

Dr. Partin? Elizabeth Partin?

(No response.)

Nina Eisner?

MS. EISNER: I'm here.

MS. WALLACE: Susan Stewart?

MS. STEWART: I'm here.

MS. WALLACE: Dr. Roberts?

(No response.)

Heather Smith?

(No response.)

Dr. Bobrowski?

DR. BOBROWSKI: Here.

MS. WALLACE: Dr. Compton?

DR. COMPTON: Here.

MS. WALLACE: Phillip Travis?

(No response.)

Dr. Gupta?

DR. GUPTA: I'm here.

MR. TRAVIS: Phillip Travis is here as well.

MS. WALLACE: Phillip, got you, thank you.

John Dadds?

(No response.)

Dr. Hanna?

DR. HANNA: Here.

MS. WALLACE: Barry Martin?

(No response.)

Kent Gilbert?

MR. GILBERT: I'm here.

MS. WALLACE: Mackenzie Wallace?

Here.

Dr. Schuster?

DR. SCHUSTER: Here.

MS. WALLACE: Bryan Proctor?

(No response.)

Peggy Roark?

(No response.)

Eric Wright?

MR. WRIGHT: I'm here.

MS. WALLACE: And Commissioner Lee?

(No response.)

DR. SCHUSTER: Commissioner Lee will not be here today. She is on vacation this week.

MS. JUDY-CECIL: I am here for Commissioner Lee.

DR. SCHUSTER: Yes. Welcome, Veronica. Thank you.

MS. WALLACE: Got it. So (counting), twelve.

DR. SCHUSTER: Is that a quorum for us?

MS. BICKERS: It is. I have 11 minus the commissioner, so we have a

quorum.

DR. SCHUSTER: Okay. I know that Beth Partin is going to be joining us, she may just be a few minutes late. So we may have some others.

I would like to welcome Phillip Travis as a new member of the MAC. He is replacing Dr. John Muller and representing the Kentucky Association of Healthcare Facilities.

So welcome to you, Mr. Travis.

The minutes were distributed -- the court report of the meeting of November 21st so I would entertain a motion for their approval from one of the voting members, please.

MS. EISNER: This is Nina Eisner. I will make that motion.

MR. GILBERT: This is Kent Gilbert. I will second it.

DR. SCHUSTER: Thank you very much.

Any additions, corrections, omissions? If not, please signify your approval of the minutes by saying, "aye."

TAC MEMBERS: Aye.

DR. SCHUSTER: Okay. Great. Thank you.

The old business item is the quick language access resources for providers. And I think that we had some good discussion about that at the last meeting. And I think that the Commissioner was going to verify where we are with that.

Veronica?

MS. JUDY-CECIL: I apologize. I might have to phone a friend.

Angie?

DR. SCHUSTER: We will let you phone a friend.

MS. JUDY-CECIL: Thank you. I was not prepared for that one.

DR. SCHUSTER: Yeah. I think that there was going to be a distribution to providers.

MS. JUDY-CECIL: Right. I knew we were working on the one pager.

MS. PARKER: Yes, and I will take responsibility for that.

This is Angie Parker with Medicaid.

DR. SCHUSTER: Hi, Angie.

MS. PARKER: I have been working with our internal communications person. We do have a one-pager that has all of the MCO information, so I will get that out to you all today or tomorrow.

DR. SCHUSTER: Wonderful. We appreciate that.

And I want to thank Dr. Gupta. Ashima has really pursued this and I think that the Consumer TAC has also done a lot of work on language access. So this is a great step forward. Thank you very much. And we will look forward to getting that.

MS. BICKERS: Dr. Schuster, if I may for just a moment.

DR. SCHUSTER: Yes.

MS. BICKERS: If I can ask everyone who is not speaking, please mute. There is a lot of feedback and small conversations. It is hard for the court reporter to capture everything when there is background noise. Thank you. Sorry

about that.

DR. SCHUSTER: No problem. That is a good reminder, Erin. Thank you.

And we also need the voting members of the MAC to keep their cameras on, right? Isn't that part of the open meeting law?

MS. BICKERS: During voting.

DR. SCHUSTER: During voting. Okay.

So we were looking forward to hearing from Commissioner Lee, first about the survey results, the MAC changes, and the creation of the BAC.

And Veronica, I will hand it over to you.

MS. JUDY-CECIL: Thank you, Dr. Schuster.

I do just want to provide a couple of updates before we dive into that, if that's okay.

DR. SCHUSTER: Sure.

MS. JUDY-CECIL: The Commissioner wanted us to convey, first of all, as you all know, there has been a

change of administration at the federal level and so we are closely monitoring that.

There will be changes at Health and Human Services -- the Department for Health and Human Services -- as well as the Centers for Medicare and Medicaid Services, so we are -- there have been some leaders nominated for those two agencies, but they have not been confirmed yet by the Senate.

So there are acting representatives including with the Center for Medicaid and CHIP services, the Children's Health Insurance Services. The deputy director is stepping in and we have a great working relationship with her.

I did want to share that the current guidance from CMS is that, you may have seen there were some executive orders that were issued on Inauguration Day to repeal some of the previous administration's executive orders. That makes no changes to our current program. If there is a change in what we are

permitted to cover and what we are currently covering, that would have to occur either through a change in federal law, so a congressional action, or they would have to go through the administrative procedure process which means posting in the Federal Register and repealing regulations that way.

So I just wanted to give everybody kind of a sense of calm in terms of what you may be hearing at the federal level. We are very closely monitoring it, both actions out of the White House and in Congress, and we will keep you guys updated as, you know, something that actually changes and requires us to do something, we will keep you guys posted on that. So just wanted to let you all be aware of that.

I just wanted -- go ahead, Dr. Schuster.

DR. SCHUSTER: I was just going to say, you know, we have a 1915(i) state plan amendment at CMS for signature for a month or so, and we heard at the BH TAC

yesterday, our Kentucky people are still working with the idea that it will be approved, but I assumed that those things are still safely in limbo and not thrown out somehow.

MS. JUDY-CECIL: That's correct. And we are seeing, you know, we are hearing from some of the staff at CMS that we work with very closely, indicate that there are some things that they will be able to move forward on and some things that they will have to be hold up, so they are communicating with us to let us know kind of what the current status is. So we at least know that they are holding it.

But we have not -- for anything that's pending with CMS, which we have been maintaining a list to keep track of those things, any state plan amendments, or other approvals that are necessary.

We have not been told that they have been denied so they are just a little bit in limbo until they can take action.

DR. SCHUSTER: Okay. Thank you. That is reassuring.

MS. JUDY-CECIL: Absolutely.

DR. SCHUSTER: And good to be calm at a difficult time. So thank you for that.

MS. JUDY-CECIL: Yes. We have to try.

DR. SCHUSTER: Absolutely.

MS. JUDY-CECIL: The other thing we wanted to mention, you have heard us speak to a replacement of our current MMIS, the Medicaid Management System that processes claims and encounters. We were going to implement a new system called Medicaid Claims Administration and Financial Solution, MCAFS, as we love our acronyms and we constantly refer to it as MCAFS.

We wanted to let everyone know that we have stopped that implementation and we will maintain the current MMIS at this time, and we will notify providers and members and other interested parties on when we plan to make a change other than maintain the current MMIS.

We are just having some problems

with implementation and kept having to move the go-live date and have just decided not to move forward with that new solution at this time.

We had talked a little bit about the impact to providers, and the changes that would come with it that, so just as of right now, there are no changes.

And then just, I know the Commissioner always likes to give an update on Medicaid enrollment and later on in the agenda I can talk more about this, but we are just seeing, we are hovering around 1,450,000 individuals. That is kind of the sweet spot right now for Medicaid enrollment. We are continuing to monitor that, but we have sort of flattened out as we have come out of unwinding.

I will give more information about that later on as well as the Anthem transition. We would like to provide an update on that, but I see that it is on the agenda.

DR. SCHUSTER: Right.

MS. JUDY-CECIL: So if there aren't any other questions about those few topics, we will move in to the Medicaid Advisory Committee and Beneficiary Advisory Council as we refer to as MAC and BAC.

As you know, we did do a survey and I am happy to introduce Nicole Comeaux. She is with Mercer who is one of the consultants that's working with the department on all of the federal final rule implementations and in particular related to the MAC and the BAC. So Nicole has some information to share.

MS. COMEAUX: Thank you. I am going to go ahead and pull up a slide deck for you all to refer to while I am speaking so you don't just have to hear me rattle away.

It is great to be with you all here today. Bear with me as I pull this up here so we can do this successfully without any issues.

You can probably see my full notes. I am going to change it to

presentation mode. Sorry. Just give me one more moment.

DR. SCHUSTER: There we go.

MS. COMEAUX: Thank you for your patience.

Let me switch this over. Hopefully, you all can see the slides here. Again, I am Nicole Comeaux and I am a partner with Mercer. I am very happy to be working with you all. I spent some time in a prior role in a prior life at Kynect.

So we have been working to conduct, not only an environmental scan of all Medicaid, MAC and BAC and prior versions of MAC and BAC activity across the country, but also working with the department to put together this survey and some presentations with you all.

I am going to go ahead and advance slides here and talk about how this was conducted and the feedback that we saw.

All right. So the webinars were held on Monday, December 16th and

Wednesday December 18th from 1:30 to 3:30 Eastern to provide background on the federal rules for the MAC and the BAC requirements and to see public opinion on the key decision points, both to ensure compliance with the federal regulations and ensure that we can enhance the process for external partner feedback which really was outlined very clearly in the role for these CMS partners. They want to ensure that states going forward really have robust voices from their membership.

The GovDelivery email distribution list, social media, and DMS website were used to inform the public about the webinars in early December. And the number of registrants was certainly far higher than we expected, but we were happy to see it.

Ultimately, folks who were able to attend were smaller than those registered, but overall, we had about 350 participants in these webinars. For those of you who attended, we hope that -- or watched the recordings, we hope that you

will agree that the topic of the MAC and the BAC resulted in really thoughtful discussion with diverse voices. An individuals spoke during the facilitated discussion to provide comments through the Q&A function.

The webinars included a QR code to the survey and the QR code survey links and recordings were all posted on DMS's website after the forum.

Thanks, Veronica. I see a note in the chat just making folks aware of where those recordings are should you want to take a look.

So let's look at some of the survey results. The survey questions focus on the aspects of the current advisory structure in Kentucky, which is the MAC and the TACs, as you all are well aware, and what aspects of that structure work well and what aspects of that structure may not work so well and have opportunity for improvement.

We also want to know how MAC and BAC participants can be supported to

maximize participation. We know folks have busy lives and a lot going on and sometimes it is hard to make time to participate in these efforts, so how can we best support that.

The selection process for MAC and BAC members and any input on how that should happen, and any other comments related to the advisory groups in general.

In addition to posting the survey link, the invitation was sent to 500,420 people and it was posted on social media.

We received about 668 submissions and 502 of those submissions were really responsive to at least one of the survey questions, as to be expected and often is the case when we have engagements with these agencies. Some of the respondents provided comments relating to other matters in the program and were their individual circumstances or issues that they were hoping to have addressed by the department, so we excluded those, obviously, from the count.

You can see some of the social media analytics and how many folks viewed those posts on Facebook so there was some significant interaction there as far as views. Similarly with the LinkedIn post, about 269 and a 6 percent engagement rate.

So we dug in to the survey results and talked about who was actually responding. We used the self-reported affiliation to actually get a determination of who had responded to the survey.

That said, there is some kind of nuance there that I will share as we walk through the slide a little bit. The self-reported affiliation is presented here but may not be reflective of all forum attendees given that many more folks participated in the forums than may have responded to the survey and many submissions had multiple selections, so just to give you all a sense of what those numbers may actually mean.

Despite that, based on the responses that we received, we do feel

very confident that those with lived Medicaid experience were actively participating in these forums. You can see there about 388 of the total affiliations selected were from folks who indicated that they had some sort of Medicaid lived experience.

Common themes. Given the time today, we are going to walk through things at a high level. We are happy to answer questions and provide more information but these slides will give a high-level summary of the key responses across decision points for the implementation of the MAC and BAC and some of the themes are relevant to both the MAC and BAC and I will try to call out which portions are for each as we go through, but a lot of the comments tended to be more general in their response to the questions, so kind of associated with both the MAC and the BAC implementation.

Again, I think it's important to remind folks that the agency will have discretion to make some decisions about

this implementation and then there are other places where federal partners are very prescriptive about how these two entities had to be established and how they needed to be operated.

As we go through, we are going to talk about external partner representation, the size of the MAC itself, publicly available information, virtual meetings, frequency of meetings, and open discussions were a view of kind of the very frequently commented on areas that we saw in the responses.

First, meeting frequency and format. Most respondents felt that the current every other meeting cadence for the MAC was appropriate and should remain, however, this would require -- and it is important to note for you all -- would require under the federal rules that BAC members that sit on the MAC would have to meet basically every month or potentially twice within a month. This is because the federal rules require that the BAC must meet before the MAC meets going after this

implementation this summer.

Respondents also encouraged continued use of virtual meeting platforms and recommended meeting times outside of regular working hours.

When it came to questions about the selection process, the federal rules require that the Medicaid Commissioner select the MAC and BAC members, but if an application process is used for the BAC, respondents said they would like it to be available in multiple formats and that individuals should have access to assistance to complete the application.

Several respondents felt that the current nomination process by professional or advocacy groups worked very well and that the commissioner could then select from the nominations.

A number of commenters also stated they had interest serving on the MAC and BAC, so certainly we shared that with the department as well.

Once selected, we heard support for terms, the length of time that folks

are allowed to serve on committees. We heard support for terms for the MAC for two to six years. People shared that becoming knowledgeable about Medicaid can be time-consuming. Certainly all of you are well aware of that. And others said that it is important that people have an opportunity to participate and that we have a broad range of folks able to participate so shorter terms would obviously support that.

Next, we want to talk about publicly available information. We received several comments from individuals that were unaware of the MAC and TACs, so generate some opportunity there for some additional ways to make sure that the information is being disseminated.

For those that were familiar were generally very positive about the scope of publicly available information, but they also stated that watching three-hour recordings could be difficult and they would request more digestible information under the new structure.

When we looked at the responses to representation for the MAC, we saw a lot of comments around expanded representation.

For the MAC, in particular, there was request for expanded representation for providers, including FQHCs, federally qualified health centers and rural health clinics, as well as certified mental health clinics, chiropractors, dialysis providers, social workers.

And there were also comments to make sure that providers who have the most engagement with Medicaid members were included, so kind of a nod to looking at utilization potentially across the Medicaid population and ensuring that those providers with the highest utilization and engagement with the population are clearly represented within the MAC. A very thoughtful comment, I think.

There was also a desire to expand MAC to include representatives from

legal aid agencies and a number of notes about the importance of behavioral health representation from a number of the respondents.

When it came to the BAC, there were suggestions on both sides of the coin around Medicaid members and caregivers and how those numbers should be split and represented.

I think the bottom line that came across in those comments were a desire to ensure representation of both so Medicaid members were certain to have a voice in addition to caregivers.

There were also comments to ensure representation based on gender, age, geography, engagement with the behavioral health system, dual eligibles, and children with special healthcare needs.

When you got towards the end of the survey, there is kind of an open-ended question for other suggestions and comments or questions on the developing of new advisory groups.

So there were a number of comments there that we wanted to share here. I think the most salient message was about member engagement, which was stated a little bit earlier, but there was a really strong desire for more opportunities for public engagement within the department, and there was also a desire for two-way communication.

So not just information being shared outwardly and posted publicly, there was a desire for additional surveys and online forums where members could communicate back to the department that was shared frequently in responses.

Later in the survey, there were questions about what supports might be helpful as noted earlier on, and there was a lot of feedback here from respondents.

For BAC member supports, there were comments that the department should consider having dedicated staff to provide orientation, address public questions, et cetera.

And current MAC members could

also be considered mentors to both incoming MAC and BAC members.

For BAC membership, there were requests for interpreters and stipends, meetings that were accessible in a number of formats, and also caregiver support.

There were requests for transportation and childcare if meetings were in person, and a number of commenters wanted to ensure that individuals on HCBS waivers that may rely on caregiver and attendant support during those meetings were not having to use waiver services or hours for meeting participation.

And I think that brings us to the end of the high level overview. Again, we will share this final version with the department and it will be available to folks.

And I think, with that, Veronica, I will pass it back to you.

I really applaud the participation from folks who attended and the survey responses that we saw. It is really great to see folks engaged actively

in how these new organizations will be formed.

MS. JUDY-CECIL: Thank you, Nicole.

We will open it up for questions if anybody has a question.

DR. SCHUSTER: I have a question, Nicole. I should have asked while your slides were still up.

MS. COMEAUX: That is okay.

DR. SCHUSTER: I am trying to make sense of what slide goes with what you were saying, I guess. There was a listing toward the end of, I think representation on the MAC, there were two columns -- back before that, yes, that one. That one.

Behavioral health and mental health are highly represented. What is not clear to me is representation on what? Because I don't see that on the slide. Representation on the BAC or the MAC? Is that what we are talking about here?

MS. COMEAUX: Yeah, the comments were pretty general. Folks didn't always

necessarily indicate where they wanted that representation, and we do know that there is a Behavioral Health TAC currently and representation there, but it seems that there was a desire --

DR. SCHUSTER: Representation on the TAC is not visitation on the MAC.

MS. COMEAUX: True. It seems that there was a desire for representation on both, but there wasn't specifics on who exactly who they wanted represented.

MS. JUDY-CECIL: There was feedback to include somebody with -- a provider with behavioral health or at least a member with behavioral health background on the MAC and then to ensure that the BAC has representation as well from individuals with behavioral health or mental health diagnoses.

DR. SCHUSTER: Okay. I guess it would be helpful if you are not there to narrate this, Nicole, it is a little bit difficult from the slide, sometimes, to know what the responses are, to what question they are applying, I guess.

MS. COMEAUX: That is fair feedback. We can adapt this to give some more clarity on what the questions were and how the answers broke down between MAC and BAC.

We weren't sure how much time you all would give us today so we will update so that is more clear before we send it back.

DR. SCHUSTER: Yes. I would appreciate that. And then go to the next slide because I think the next one has a bunch -- again, I don't know what this is responding to.

Is it both -- and it may be both -- but for instance, inclusion of social workers and case managers, that is a very specific thing. Were people responding to the MAC needing that or the BAC, because you didn't have it listed in the list before. I'm just trying to wrap my head around what people are responding to.

MS. COMEAUX: We will put some more clarity around those responses,

Sheila. So the desire for case workers and social workers in case managers was for representation for the MAC.

DR. SCHUSTER: So you see where I am coming from.

MS. COMEAUX: Yes.

DR. SCHUSTER: Because we are looking at two different entities, although they are going to be intertwined, but any clarity that you can give around that would make the results more useful to us.

MS. COMEAUX: We will try to break up the representation and some of the other questions as well in a more simplified document.

DR. SCHUSTER: Thank you.

DR. PARTIN: So all of these groups, are they for the MAC on this particular slide?

MS. COMEAUX: No. So just so that it is a little bit more clear for folks, there was a question on the end that was a little bit more open-ended and asked for additional feedback with folks

we have, so we got a lot of responses kind of all lumped in different places, but the variety of demographic representation, we saw across both the MAC and the BAC.

For example, the MAC, there was desire to ensure that there were federally qualified health centers and rural health center participating from a provider perspective.

On the BAC, again, wanted both Medicaid membership that were residing in both rural and urban areas. So I think it went across both of the committees.

We can break this down and try to make it more clear about where folks wanted each of these groups to be represented so that folks can see.

I agree that the consolidated version for presentation makes it a little harder to understand who folks wanted to see where so we will get that together and get it over to you all before the end of the week.

DR. SCHUSTER: That would be great.

And Nina, you have your hand up.

MS. EISNER: I do. I'm just wondering about the recommendation that meetings be held outside of regular working hours. Was that for the BAC or the MAC or both?

MS. COMEAUX: I believe both. There were comments about difficulty getting provider engagement during working hours. Providers -- busy providers -- bringing up their time to participate and that that would be challenging in some cases. And similarly for members, difficult for people to take time away from work in some cases to participate.

MS. EISNER: I am just not sure that has been a barrier for the MAC, but I can be wrong.

MS. JUDY-CECIL: Another point to all of this that I think we described to you all previously as we look at the changes coming forward, is that we are looking at other states. There are states that already have a BAC -- I think every state has a MAC -- but we are looking at

best practices across the state and across the country to see if they hold evening meetings, how is that attendance? What kind of supports are they providing to BAC members? How many resources does that state Medicaid agency need to provide that support? So we are trying to learn those lessons across the country to bring that into Kentucky as we make these changes as well. So I wanted to note that because, obviously, and this goes to the next item on the agenda, we are working on the draft legislation, and so the feedback absolutely is being incorporated, but also those best practices that we have seen across the country were also trying to create something that we know has been successful in other places to bring that to Kentucky.

So we do not have the legislation available yet to share. We are quickly pulling that together. The General Assembly is set to come back on February 4th and so we've got a short window that we have been working on it to

try and get it in really great shape that we think is reflective of the feedback.

DR. SCHUSTER: Nina, to your point, because one thing for us to keep in mind -- and I forgot the time frame -- in the first two years of the creation of the BAC, 25 percent of the MAC membership will be made up of BAC members.

MS. JUDY-CECIL: That's correct.

DR. SCHUSTER: So that will really change the makeup and the flavor, certainly bring the voices of recipients and their families and their caregivers to the MAC in greater numbers than we have had.

So the timing, I agree with you, that since we have gone virtual, when we were meeting in Frankfort we often had quorum issues with the travel to Frankfort and so forth, and it is a lot easier for people to get on Zoom and so forth. So thank you for bringing that up.

Do you have any other comment on that?

Ashima has a question.

DR. GUPTA: Veronica, I have a question for you. Is there any particular state that seems to be a good role model for us right now?

MS. JUDY-CECIL: Nicole?

MS. COMEAUX: Yes. I'm happy to jump in. There are a variety of states that we have looked at, and just last week CMS actually released a toolkit for states on how to come into compliance with these rules, and they highlighted a number of states that they worked with pretty extensively to get some best practices out of.

I don't think there is probably one specific state that I would say is a best example for Kentucky, but there are a number of states with different pieces that I think, based on the feedback that we are seeing, and how you all have operated to date, that will be very good fits to share with you all for how to move forward.

I would say there are probably about four states that have similar

geography, similar type of Medicaid enrollees, similar Medicaid population, and similar benefit structure that will help put together an appropriate set of states to look at. So that is also being compiled to share with you all in the very near future.

DR. GUPTA: Thank you. I was just curious.

DR. SCHUSTER: Ashima, I know I was on a national call about this and they had Pennsylvania on. I think Pennsylvania is a state that has had a BAC for a long time and it was very helpful to hear from them. I don't know, geographically, and the kinds of ways that Nicole was talking about, how similar -- we don't usually direct our legislators to look at -- we usually look at other states in the South, but Pennsylvania has had a BAC and provided support for them for a long time so they have had that experience certainly.

I don't know how many states, Nicole, have TACs like we do. Not all

states have TACs or have the number of TACs that we do, right?

MS. COMEAUX: Yes. You all are unique in that structure. I think many states in the work that we have done -- and I didn't introduce myself fully -- but I was the state Medicaid director for the state of New Mexico for four years.

Many states have structures where they have subcommittees that are made up of a lot of the representation that you all have for your TACs. So that is something that we will share with you all as an opportunity as you look ahead.

Pennsylvania is one of the studies that was listed, and I think also North Carolina and Illinois have some good similarities to look at.

I think, also, the number of TACs that you have is unique. Folks tend to have smaller numbers of subcommittees that they use for representation so that will be something that I know that you all will be looking to evaluate as you move forward.

DR. SCHUSTER: I see that Veronica put the link to the CMS toolbox in the chat if anybody wants to look at that and follow up with that.

Good question, Ashima.

Beth, did you have a question?

DR. PARTIN: I did. I can't figure out how to raise my hand.

DR. SCHUSTER: Just wave at me.

DR. PARTIN: Okay. I guess this is to Veronica. Are we looking at keeping the TACs?

MS. JUDY-CECIL: To be honest, I am not able to talk about what the proposed legislation is, there was feedback about how many TACs we have -- and I will be candid and maybe go a little rogue and say that we are concerned about maintaining the MAC, the new BAC and 18 TACs. Especially if we are looking for representation on the MAC and somebody who is also on a TAC -- that goes both to provider and member.

We already have members that sit on several TACs. We are trying to pull

together a very robust BAC and make it meaningful and engaging. I think it really has to be a discussion about can we maintain the current framework. We are going to be utilizing a lot of resources to support the federal requirements around the MAC and BAC already.

DR. PARTIN: So when you are saying supporting the TACs, you're talking about DMS staff-wise, or?

MS. JUDY-CECIL: I think it is a combination of DMS staff, but also as I mentioned, if we are going to have representation on the MAC, on the BAC, and then also on the TACs, I think we are just a little bit concerned about the pool of interested parties who want to be on the advisory committees, and our focus, I think, should be on the MAC and the BAC and making sure that that representation is robust and engaging, including as Nicole mentioned, the subcommittees.

So we are trying to figure out a way to make sure that. We understand that providers like the TACs and they feel like

that is their seat at the table. That doesn't have to go away by moving towards a more robust MAC and subcommittee structure.

DR. PARTIN: I guess I would just like to say based on my long experience of being on the MAC, that the input from the TACs is valuable because we on the MAC don't know all of these things and all of the intricacies that the TACs bring to us.

So subcommittees that might be more generalized may not bring the same detail to the MAC, and I guess, logistically, DMS is going to have to look at that, of course. But from the perspective of a MAC member, trying to make a good decision on advising DMS, the information that we receive from the TACs is invaluable. So that is my input on that.

MS. JUDY-CECIL: I can't disagree with that, Dr. Partin. I think the other thing to consider is that what we have seen in addition to my previous

comments, is that we see a lot of similarity in agenda items across TACs, so the department is coming and speaking to the exact same agenda item across multiple TACs.

So I think we are just looking at a way of, to your point, what is feasible that maintains that interaction and ability for providers to engage, and as Nicole mentioned, there is no other state that has the TAC structure that we have. They have advisory groups, but they are generally on the subcommittee level.

DR. PARTIN: And to your point about the same issue being brought forward by multiple TACs, kind of, is also informative, because it tells us that whatever that particular issue is, is affecting a broad range of groups.

DR. SCHUSTER: I think that the commissioner at a previous MAC meeting mentioned subcommittees and I think -- one on quality and one on some of the audits and that kind of thing having just survived a year of sometimes rancorous

discussion on the BH TAC on audits, it is hard for me to imagine that being done in as meaningful a way, Veronica, if it is across all provider groups, because I think all provider groups see audits very differently and are probably treated very differently. Which is not to say that the Medicaid rules about audits are not the same, but I think the impact that is going on right now in behavioral health is fairly unique, and I cannot imagine not having that forum for airing that.

And I may run that TAC very differently than some of the TACs, because we have probably 100 people on the TAC meetings every two months, because they are a source of good information and dialogue that would be lost, quite frankly, for both providers and advocates and consumers for that matter.

I guess I would have some problem with it, I think. I understand where you are coming from.

Also, and I have to say, disappointed that we are this close to the

session going back in, and it is a short session, and there has been essentially no meaningful discussion with the MAC about this legislation. I am just going to be honest and say it's very disappointing. We are supposed to be advisory to Medicaid and it's really hard for us to act in an advisory capacity when we don't know what the discussions are behind-the-scenes.

And when the commissioner gets back, I think I will take the opportunity to say at what ever point this legislation is going to get rolled out, I think we have to create an opportunity for MAC members, at least, to have some dialogue with the department about it.

MS. JUDY-CECIL: That is fair, Dr. Schuster. You should know that we have indicated up the leadership chain that we feel that it is important for the MAC to see the legislation and comment on it. So we have made that commitment to the extent that we have control over it. We have made that request.

DR. SCHUSTER: I appreciate

knowing that, because what I don't want to see happen, but what will happen if we don't work this out, is that a piece of legislation is going to get dropped and all of the various groups, and that is everybody who deals with Medicaid -- lots and lots of provider groups and lots of advocacy groups and lots of consumer groups are going to be upset with another piece of it and they are going to talk to legislators about it and it is going to be a mess over in the General Assembly in a very short time frame, so let's continue talking about how to make that happen. Thank you.

Kent, you have your hand up?

MR. GILBERT: I wanted to very briefly, Dr. Schuster, underscore what you said.

I appreciate the complexity of this, but it was last year when we talked about legislation and ways that we can better communicate with the legislature and there have been no responses from the department about that.

We've had no interaction, as far my knowledge, none of the MAC members have even been invited to speak with legislators, or now that there is legislation coming in, I think we know how this works. A lot of random things will be shoved into a basket is my fear and not all of them are going to be helpful nor will they help legislators know what is needed, or us to best serve clients and providers, so I want to just add my me too to what you just said.

DR. SCHUSTER: Thank you, Kent.

Anyone else on the MAC who wants to say anything at this point?

DR. PARTIN: I just want to echo what you said as well, Sheila.

I think that we need to be able to have input before the legislation is draft, rather than after.

DR. HANNA: I'll voice the same. Thank you.

DR. SCHUSTER: Yes, Cathy, thank you.

I think the message has been

conveyed, and I'm sure Veronica will take that up the chain, and I understand, Veronica, that DMS is not the final decision-maker in this type of process, that it is a top down process, but I hope you will convey that you are going to have a mess over in the chambers. And I am not threatening, I am just saying that people want to see this before it gets dropped.

MS. JUDY-CECIL: Absolutely. Thank you.

DR. SCHUSTER: Yeah, thank you.

Updates from the staff on Anthem leaving as a Medicaid MCO.

MS. JUDY-CECIL: That would be me, and I've got a presentation -- very short.

And if it is okay, Dr. Schuster, I will take that item and then the third item down was the renewals, but I've got them both in one presentation, so if it's okay with you I will --

DR. SCHUSTER: That is absolutely fine. Thank you.

MS. JUDY-CECIL: Thank you.

As you all should recall, we did announce that we were terminating Anthem as a Medicaid managed care organization. Effective January 1, 2025, they would no longer be an active MCO.

So we took the necessary steps in accordance with our contract with them, which was a 60-day transition period. So we did start with the termination notice on November 1st, 2024, and then we had various steps leading up to the very last day as an active MCO, which was December 31st, 2024.

During that period of time we transitioned approximately 170,000 Anthem members to other MCOs. Primarily, they were split between an automatic redistribution between Humana and United Healthcare, but members were always given the opportunity to change MCOs to whoever they wanted to, and that was honored during that period of time. So if a member was transitioned or redistributed to an MCO, they could go in and update that and that would be effective January

1, so that their choice was honored.

We sent out notices to members and providers, and I'm happy to say that we saw a very, very smooth transition. We saw very little issue in that redistribution or changing of MCOs for those members.

Actually, we saw little to no complaints to access to services, and for all intents and purposes it went very smoothly and we were very happy for that, and that was a large number of individuals being transitioned.

Just a reminder to folks that Anthem is required to maintain operations for various activities for run out. That includes -- they still have to pay claims for any service through December 31st. So if you are a provider out there wondering about the payment for claims for those dates of service, you can still submit it the same way that you did previously.

If they are denied or a claim is denied and you want to appeal, they have to maintain all of the appeals,

operations, and activities, all the way through it being completed.

So if it goes to the extended third-party review or if it goes to administrative hearing, Anthem has to maintain those operations. So just know that those are still being done during the couple of years that now follow their termination.

We are maintaining the website. So for those of you who want to learn a little more, we have a robust frequently asked questions on that website. It's Kentucky Medicaid Anthem Kentucky Medicaid transition as you see there on the slide.

We are also maintaining for at least 90 days, the dedicated number for Anthem members. This is only for Anthem members. They can call that number and receive support for any questions they may have navigating that transition.

So we certainly encourage Anthem members to reach out if they are having any trouble, but the call volume for that number has been extremely low. Even prior

to January 1, we were receiving only a couple of calls a day and, generally, it was to request information of how to change their MCO. So they were fairly easy, not really about their access to care issues.

So any questions on the Anthem transition from folks?

DR. SCHUSTER: I think there was a question in the chat, a follow up from a provider who has accounts receivable, and if they are having trouble getting a response from Anthem, who would they contact at DMS, Veronica?

MS. JUDY-CECIL: The regular MCO complaint process and we can post that information in the chat.

MS. AGEE: Veronica, I'm going to put that email address in the chat.

MS. JUDY-CECIL: Thank you.

DR. SCHUSTER: Nina, did you have a question?

MS. EISNER: A comment. I was pleased that on our January 17th KHA/DMS/MCO call, Anthem did answer

what I thought was an important question, and that was if a patient is in an inpatient bed prior to January 1st, then Anthem will continue to cover the whole stay. I thought that was very valuable input.

DR. SCHUSTER: That is good to hear.

MS. JUDY-CECIL: Thank you for mentioning that. They are required, in accordance to our contract, for any patient stay it is until discharge, so even though they have been terminated, they are responsible for that.

DR. SCHUSTER: Certainly that is the appropriate thing to do for the patient and not have any disruption in payment and concern and so forth.

So thank you for sharing that, Nina.

MS. JUDY-CECIL: The only caveat to that is if it is a residential say, if it is a per diem, that is handled a little differently when the date of service past January 1, Anthem is responsible for

payment of that per diem up until December 31st, and then starting January 1 the new MCO takes over.

The new MCO is required to honor any prior authorizations, and again, we have not heard from providers having an issue with that transition for the per diem stays. And by per diem, I mean they get paid a daily rate as opposed to on discharge, as a typical in-patient hospital is.

MS. EISNER: That confuses me a little bit, Veronica -- it's Nina -- because all of our hospital inpatient stays are per diem.

MS. JUDY-CECIL: Okay. That is hospital, right.

MS. EISNER: Okay. Got it.

MS. JUDY-CECIL: Sorry. That's residential.

MS. EISNER: Okay. Thank you.

DR. PARTIN: I have a question.

DR. SCHUSTER: Yes.

DR. PARTIN: Why was the disbursement of the participants just to

Humana and United instead of all of the MCOs?

MS. JUDY-CECIL: As part of our contract and our managed-care model, we like to ensure a competitive component to the distribution of the enrollment.

As you know, WellCare has the largest, Molina has the second-largest, so looking across -- and Aetna has SKY -- so looking across the MCOs and their enrollments, Humana and United were the lowest and that was one of the factors for distributing between those two.

MS. EISNER: Okay, thank you.

DR. SCHUSTER: But people could change after they were told who it was, so they could pick any of the MCOs to go to if they wanted to change.

MS. JUDY-CECIL: We did see, in the end, probably between November 11th and the end of the December, we probably saw around 5,000 transitions.

So in fact, members came in the week after they got their notice and made a change. We did make sure that that was

easy for them to do, with no question, they were allowed to make that change.

DR. SCHUSTER: Any other questions for Veronica? That is very helpful information to have, Veronica. Thank you.

MS. JUDY-CECIL: You're welcome.

DR. SCHUSTER: Do you want to go on to the unwinding and flexibilities? This is your favorite thing to report on, I know.

MS. JUDY-CECIL: Thank you so much.

As I mentioned, we are hovering around the 1.45 million individuals. We have seen them leveling out from the beginning of the unwinding. And then that ended in April. You saw just a couple we mentioned beyond April there were handfuls of redistributed members. We might have extended the members' renewal if they didn't respond as one of our flexibilities, but once we kind of got through that and August was sort of the last month for any of the handful of

renewals that were still tied to the public health emergency unwinding, we have now kind of landed in a little bit of a steady state.

We do have our public health emergency flexibilities still in place through June of 2025. As far as we know, that will say the same. We will let you know if that changes with the federal changes, but that includes the approval to automatically renew children.

When a child has a renewal right now, we automatically renew them and give them that 12 months continuous coverage.

Starting with July renewals, we are required by CMS to actually perform a redetermination. So those renewals will be going out -- we generally send it out about 60 days before. So in May, we will start sending redeterminations to cases with children for July.

We are planning a lot of outreach and communication around that to make sure that everyone knows that that is happening. We are waiting a little bit

longer before we do that as we get closer so that is fresh in people's minds to do that.

So you will probably see a lot of social media and other campaigns around children having to go through redetermination.

There is also -- there have been two additional federal rules that have happened. One is in November, CMS did release guidance on advising states on the some of the flexibilities and how to make them permanent. They reviewed their federal laws and regulations to see within the discretion of CMS, what could we make permanent. So we have been reviewing those. There is interest, obviously.

We care about our members and we want to try to keep people covered, so there is interest in trying to make some of those permanent as well as the final rule that came out around eligibility and enrollment, and to make things easier on members. There are a lot of requirements around notice and just helping members

navigate that renewal process.

So that was federal rule issued, Mercer and Hiltech (sp.) is helping us to understand those requirements, so some of our flexibilities are actually captured in that as well in terms of something that we can do permanently and a change that we can make permanently.

So we are reviewing those as well and we will keep you all updated on what those permanent flexibilities we are going to be able to keep in place.

A caveat that this is a federal final rule so not subject to just an executive order or the pause that you may have heard at the federal level asking the agencies to pause any new regulations. So these are final. It would take additional action from either Congress or federal rule making the administrative process through the federal register to make a change to that. So we will keep you posted.

And we are continuing our reporting both monthly for the previous

months renewal and then after 90 days, reporting any pending actions.

So just to talk about that, very quickly, I'm going to talk about September as the last month that we did report our 90-day update.

On the left-hand side, we are seeing the number of individuals that were renewed, so 52,369 for September, the number of approvals which was 49,833, the number of terminations was 1,234, and we had only one pending case, the pending case means we crossed over end of the month and the member had responded, but just the state had not process it yet.

So we did process that one within that 90-day period and as you can see here, they have been bucketed under the termination. That's because we were able to determine that person ineligible.

Moving to the past three months that we typically cover with you all, the last month being the December one.

Just to walk through this slide, in December, we had 38,604 members who

went through renewal, 3,235 were actually approved, 819 were disapproved, we had one that was pending as we crossed over on December 31st, and then the extended, I spoke about was one of the flexibilities.

So for all individuals, if they do not return their renewal, we can extend them for one month automatically, and then for long-term care and 1915(c) waiver members, we can extend them for up to three months for each month that they don't return their renewal. That gives us additional time for outreach and additional time for the member to return that information.

In December, when we crossed over -- December 31st -- we had extended for 4,549 individuals.

And then we were also tracking this far right column here reinstatement, currently under our flexibility, if a member comes in within 90 days following their termination, and they are able to provide information and be determined eligible, we are able to automatically

reinstate them back to their termination date within that 90-day period.

So tracking reinstatements so far, we do see for December we've already got 280 folks who have been able to be reinstated and then, you know, back to October, 848 have been reinstated. That is a great number to see, obviously out of the number that were terminated.

These reports -- and a lot more information are available on the unwinding website, so feel free to go out and check those out. It's medicaidunwinding.ky.gov, and we are maintaining a lot of information -- all of the information, in fact -- including the flyers and informational bulletins about renewal and navigating renewals. These are helpful if providers, advocates, anyone wants to pull them down and have them available in your offices, to help somebody coming in who might be going through a renewal.

We continue our request that providers, when they're checking eligibility and they see Kentucky health

Net, that a member has an upcoming renewal, is mentioning that and making sure that they are aware and responsive if they receive a renewal packet.

That is what I have to share.

DR. SCHUSTER: Great. Will you send that PowerPoint over to Erin to be put up on the website and distributed?

MS. JUDY-CECIL: Yes.

DR. SCHUSTER: Thank you very much, Veronica. It is always good to get those and I do feel like the Anthem transition has gone remarkably smoothly. We have not heard anything -- at least I have not heard anything -- so glad that that is going well.

Let's go back to an item that is the possible restoration of prior authorization on behavioral health services.

MS. BICKERS: Dr. Schuster, there was a question in the chat about Veronica's presentation, requesting if we know how many terminations were appealed and reinstated.

Said, "Would like to see the stats for reasons on terminations, also the stats on appeals, how many people appeal because of the lack of knowledge of beneficiaries. On this process, but it is intimidating to them, et cetera. Did they have to go through the actual appeal process."

MS. JUDY-CECIL: Dr. Schuster, if it's okay, I will respond.

DR. SCHUSTER: Yeah, if you can respond quickly, otherwise let's give that person somebody else to talk to. Go ahead.

MS. JUDY-CECIL: So the numbers that I reported for reinstatement are not related to an appeal. Those are individuals that are, just through the normal process of discovering that they no longer have coverage or who responded late have sent in the information, so it is not related to the appeal.

I do not have actual appeal numbers available to me today. I am happy to get those out to folks.

DR. SCHUSTER: Yes. I don't think we have talked much about appeals in your almost monthly presentations on these to these on the various TACs and so forth. If there is an easy way to include that when you send your PowerPoint, that would be great, or as a follow up to it.

MS. JUDY-CECIL: Absolutely.

DR. SCHUSTER: Thank you.

Thank you, Erin.

Now the question of prior authorization being possibly restored on behavioral health services.

MS. JUDY-CECIL: So the department is currently in the process of obtaining feedback from various individuals, both from the managed-care organizations and from providers, and then that just concluded that, sort of, that open call for information just concluded and we are putting that information into a document so that it can be reviewed and discussed.

So there has been no additional decisions on restoring behavioral health,

prior authorizations, but certainly we will have those conversations with providers prior to making any decisions.

DR. SCHUSTER: I hope with providers and advocates.

MS. EISNER: Veronica, how was the request made for obtaining information or input from providers? I don't recall any.

MS. JUDY-CECIL: I was not directly involved in that process, but I think they tried to identify just various associations and representative associations and then, you know, for the largest behavioral health providers in the state to engage in that process.

MS. EISNER: Okay. I will have to follow up with KHA. They should have been included and I don't recall that. I don't believe they were on that. Thank you.

MS. JUDY-CECIL: And I can follow up with that, Nina.

MS. EISNER: Okay. Thank you.

DR. SCHUSTER: I think it came

in an email from Commissioner Lee, Nina, and I think it was all of the MCOs. And as Veronica said, some of the big providers.

I was not included, which did not make me happy, since the BH TAC has talked about this more than any other group. And so I got a copy of the invitation and I inserted myself into the process and sent feedback based on the discussions of the BH TAC and some other information, and so forth. I would not say that it was a comprehensive list.

Steve said the CMHCs and KARP received a letter, so big provider groups of behavioral health, I think. There were a number -- I recognize some of the SUD providers -- the larger SUD providers.

My impression from the letter was that this was going to be an ongoing process. So I'm sure they are looking at the input that they received, but I think that there will be further steps and I think that AHA needs to be in that table, as do probably other provider and advocacy

groups.

MS. EISNER: I just received feedback from KHA and the president did receive the email that you all are talking about, and that has just been resent to me, so I will follow up with that, Veronica. Thank you.

DR. SCHUSTER: Okay. All right. To be continued.

The BH TAC is, obviously, very involved in talking about this and so forth and we will continue to be.

The next thing is an update on waivers.

I think Leslie said that she was not going to be able to be here, but Sherri Staley has that information for us.

MS. STALEY: Actually, Angela Sparrow is on and she is going to give the update.

DR. SCHUSTER: Oh, all right.

Well, we are glad for whoever is giving the update, but always glad to have Angela give us updates.

MS. SPARROW: Good morning.

Yes, happy to provide some updates on the 1115 demonstrations. Again, do want to provide updates on the re-entry, 1115 as we know.

Again, there was a lot of work that was occurring in 2024, so again, I do want to report that we were able to meet all of our deliverables that was due to CMS for the reentry project by the end of the year.

So again although that we had received the approval of the demonstration, there were several deliverables that were still due so we were able to submit those implementation plans, monitoring protocols, reinvestment plans that we spoke to evaluation designs. So all of those are with CMS for review.

We have not received any feedback from those yet, so again, we continue to work with them and communicate with them on the reentry project as well as the other 1115 projects.

We will continue to move forward in 2025. We have kicked off what the

project plan looks like for 2025, still moving forward for a 10/1/2025 implementation date.

So the first couple quarters of 2025 will continue to kick off some design sessions in developing those IT requirements, working with our managed-care partners and we will have some additional subgroups that are kicking off as well, and then we will move through the spring and summer with readiness testing, all of those activities that will occur prior to implementation. So good news there.

In terms of the broader Team Kentucky 1115 that includes the SMI SUD 1115, so we did receive approval, an extension in mid-December from CMS on those and other components that had been pending. So we do have approval, again, for the SUD substance-use disorder extension -- another five-year extension, and the approval of the SMI 1115.

So very similar to the re-entry project that we have spoken to. There are

still deliverables that are due to CMS so we are taking a look at those and building out the timeline for the broader Team Kentucky extension and implementation and what that looks like through 2025.

DR. SCHUSTER: Angela, those are the pieces for SMI and SUD, would include more days in the hospital and medical respite -- or, I forgot, you call it something besides medical respite, right?

MS. SPARROW: Yes, it is, Dr. Schuster. So medical respite recuperative care is included in the broad Team Kentucky so it is actually outside of SMI.

After discussions and negotiations with CMS, it's considered what they call health-related social needs, so those health-related social needs demonstration opportunities, so it is under a health-related social needs 1115 opportunity.

So again, it will have its own implementation plan in components very similar to the others. But all

components, again, were approved through December 31st of 2029.

DR. SCHUSTER: Okay.

Nina, you had your hand up.

MS. EISNER: I do. I have a question for Angela and then back to another question for Veronica.

Angela, if you could clarify for me please, which provider groups are being involved in the re-entry, the 1115 waiver conversations? Incarceration is a really big issue with hospitals, particularly with local jails.

DR. SCHUSTER: Yeah, unfortunately, local jails are not part of the re-entry waiver yet. It is prisons and juvenile detention.

MS. EISNER: Ah.

DR. SCHUSTER: Yes.

MS. EISNER: Okay.

DR. SCHUSTER: I understand -- and maybe Angela could speak to this -- that they have been getting some outreach to local jails, but that is not part of what's currently going to be implemented

in October, Nina.

MS. EISNER: Okay. Well, that is good to know.

DR. SCHUSTER: Is that right, Angela?

MS. SPARROW: That's correct, yes.

MS. EISNER: And then a question back to Veronica on prior auth, sorry. I'm a step behind.

If prior auth is restored, will DMS give direction to the MCOs based as to how much notice providers have to get before that PA is turned back on or will that be up to the MCO's discretion?

MS. JUDY-CECIL: No. They will have give to give a minimum of 30 days, but we have been trying, when there are changes, to give 60, even up to even 90 days, if possible. So there would be at least a minimum of a 30-day notice.

MS. EISNER: Thank you.

MS. JUDY-CECIL: You're welcome.

DR. SCHUSTER: Sorry, Angela. We interrupted your train of thought in

your presentation.

So you were telling us about the 1115 SMI SUD waiver.

MS. SPARROW: Correct. Yes.

Again, we received those approvals. The substance-use disorder demonstration, again, that does not require any additional implementation plans. We can continue forward.

So again, the SMI 1115, we will need to still submit monitoring protocols, implementation plans to CMS, and those deliverable dates so we will continue working forward on those.

And then, again, I think we can provide, in the next -- an update and what that implementation timeline looks like.

DR. SCHUSTER: And then what about the timeline for the SMI 1915(i) SPA?

MS. SPARROW: Ann Hollen might be on to provide an update.

MS. HOLLEN: I'm here.

As you heard yesterday, Dr. Schuster, DMS officially submitted the

1915(i) state plan application back to CMS on Friday, January 17th. As of today, we do not have approval and our timeline is really contingent upon that approval.

We are still looking towards a 7/1/25 implementation date. Our goal is to begin training and onboarding providers two to three months in advance of the go-live of RISE.

System changes, of course, for provider enrollment, billing and integration, the functional assessment tool are all key factors associated with implementation.

I will say that the regulations for the RISE initiative have been drafted and are under internal review, and that DMS does anticipate filing those with LRC in February.

DR. SCHUSTER: There was a question in the chat from a provider about when would providers be trained, so if we are a go on July 1st, then two or three months before that would be training; is that right?

MS. HOLLEN: Yes. Two or three months before we would implement where we will start taking on assessing individuals for services. I don't want to say it would be April. I don't know -- it may be April, it may be that we start in July. I don't know yet that exact date, but we plan to have the providers on-boarded. That is definitely first.

DR. SCHUSTER: Okay.

MS. HOLLEN: Which is a certification process to the Department for Behavioral Health Developmental and Intellectual Disabilities.

DR. SCHUSTER: Right.

MS. HOLLEN: Similar to waiver, but there are certain things that are similar to waiver, but this is a state plan and community-based services.

DR. SCHUSTER: And I think that there was some discussion at the BH TAC meeting yesterday that somebody would reach out to CMS and make sure it is still sitting over there.

MS. HOLLEN: I do believe Deputy

Commissioner Hoffman stated that she would have Jodi -- Jodi, if you're on here, I'm sorry, but maybe tomorrow if she hadn't heard, that she would reach out to CMS on Friday is what she reported.

MS. ALLEN: Hi, everyone. Yeah, this is Jodi Allen, a behavioral health specialist with Medicaid and I'm working alongside and on this project for the 1915(i) SPA. Our plan is to reach back out on Friday.

There has, obviously, been a national administration change and we know that the timing of this is pretty tricky, so we plan to reach out on Friday to see if we can get some additional information.

DR. SCHUSTER: Right, because there is a lot of anxiety and the absence of information is bad for anxiety.

MS. ALLEN: Trust me, Dr. Schuster, we are definitely in that boat.

DR. SCHUSTER: Right. You are living with it, too.

MS. HOLLEN: We are doing a lot

of deep belly breathing to remain calm.

MS. ALLEN: And we are continuing to work on everything as if we are moving forward, so we are not losing momentum at all. We just need that official word.

MS. HOLLEN: Yeah, we meet quite a bit, weekly, but communication all week long. We are not waiting on anything. We are moving forward.

MS. ALLEN: Moving forward.

DR. SCHUSTER: Moving on. Good. That is what I wanted to hear. Thank you very much.

And then, Angela, are you doing the current HCBS waiting list numbers?

MS. SPARROW: I am going to actually pass that over to Sherri. I think she has those.

MS. STALEY: I do. It is a round-robin here today. Yes. I have those numbers and they went ahead and re-pulled them yesterday, so these will be updated just a little from the Behavior Health TAC.

As of 1/22, three waivers have a current waiting list. The HCBS is 2,823; the Michelle P. waiver is 9,434; and the SCL waiver is 3,531; and the total unduplicated waitlist members is 13,992.

DR. SCHUSTER: Thank you, Sherri.

Have all the people that were funded in this last budget session -- I'm sure not all of them have come off the waiting list and been enrolled, but do you know where we are with that process? And if you don't have that right now, but I know we got a lot of funding to put a lot of people into waivers.

MS. CLARK: Dr. Schuster, this is Alicia Clark.

All of the funding from the legislator in the budget for those slots, they all have been released. That finished up the end of October.

Obviously, you know, everybody is in different phases in getting services, applying for eligibility, all of that. So spots aren't really -- I'm going

to say earmarked -- saying that this is this budget year, that kind of thing, because we are constantly reconciling all of the time, because people, unfortunately, might be deceased, we can open those slots back up; individuals might not be interested in waiver anymore so those slots can be opened back up. We are constantly reconciling.

But as far as all of the slots, we had a plan that started in August and that ran through the end of October for our Michelle P. waiver and our HCB waiver and all of those slots were released to individuals on the waiting list.

DR. SCHUSTER: So I guess my question -- that is really helpful information, Alicia -- my question is are those numbers, have they been subtracted from the waiting list numbers, so they're not being listed as still as being on the waiting list?

MS. CLARK: That's correct. Once they get capacity, they are like in a different bucket. So we do have new

people coming on daily. That's why you can pull our waiting list numbers today and they will be slightly different than they were yesterday. It is really a fluid in that.

But, yes, those people that were on the waiting list that received slots would not be on the waiting list anymore.

DR. SCHUSTER: Okay. So while we were celebrating funding from the General Assembly for many, many more waiver recipients to get services, it has not really made a dent in our waiting list when we look at these numbers. Unduplicated numbers are almost 14,000 people.

MS. CLARK: I do hear what you're saying.

DR. SCHUSTER: Do you see what I'm saying? I was actually hoping that maybe they hadn't been subtracted out yet.

MS. CLARK: No.

DR. SCHUSTER: No. So we've got 14,000 people again waiting for waiver services.

MS. CLARK: Yes, that is correct, and there are additional slots and I do apologize, I don't have those numbers right in front of me. I want to say -- and again, don't quote me on this because I'm not 100 percent sure -- but I believe for HCB and Michelle P. waiver, there are 500 additional slots that will be available for fiscal year '26, and we are coming up with a plan to start releasing those in July when they are available within the budget.

And, you know, again, we come up with this plan and we don't want to release all 500 at once, right, because then you create a bottleneck, which we definitely don't want to do. We understand our providers have to have the individuals, the staff, to be able to take care.

So we will come up with a similar plan like we previously completed this past year to address those new slots starting in July.

DR. SCHUSTER: Thank you.

MS. CLARK: You're welcome.

DR. SCHUSTER: Kent, you have your hand up.

MR. GILBERT: Thank you. Several of them are in the chat as well. I have a lot of questions about the data that I think is not clear to me, and that might just be my lack of understanding, but this seems substantially higher numbers of waitlisted folks.

So I guess I have the question of, how are we -- what is our plan here? Because the numbers going up is not part of the hope, I know of the department, and certainly not of us.

We have increased funding, yet the numbers have tripled -- or not tripled, but have gone up. Is that because we have more applications and are there more folks applying?

MS. CLARK: We do have folks every day that are applying. We are currently in one of our -- I want to say reports that were due to the legislators -- that is one thing that we

are currently working on, how we can better manage our waitlist, so we are working through that.

Of course, that is going to take time. Possible regulation changes and all of that. But we are doing the research right now to see what we can do to assist. Obviously, I think -- I'm sorry because, I can't remember if it was Cheri or Angela or who spoke on this, but we do have the possibility of maybe a children's -- I'm going to call it waiver -- it's not a 1915(c) waiver, but maybe like a 1915(i) or an 1115, but we are looking at something that would be driven towards kids, and just overall, what can we do as a state to get services that are necessary for individuals.

And I don't have the latest numbers in front of me. I believe they were at the beginning of this month, but it runs about 80 percent of the people on waiting lists do have current Medicaid eligibility. So they can get services through all of these state plan services.

Those are available.

MR. GILBERT: Are we doing any sort of triage? I mean in other words, clearly everyone is in a different kind of setting, and pediatric patients in particular, I think Ms. Browning's comments are apropos that we are ending up causing -- by delays -- we're causing expenses to be shifted down the road. I mean, do we have any system by which certain cases are prioritized?

MS. CLARK: So that is one of the things that we are looking at with the waiver waitlist management workgroup. Currently, the way that the regulations are written, except again, every regulation is different for every waiver, but with SCL, there is more of a prioritization with future, emergent, and urgent categories. Whereas, for instance, Michelle P. waiver and our Home and Community-Based waiver do not have that information within the regulation, but that is something that we are taking a look at if we need to establish categories

and what that looks like.

Again, that is all in the works very early on, but we are working on that.

MR. GILBERT: I appreciate the complexity, but I also want to communicate strongly the urgency of this. This is families' lives, and certainly the folks that I know who depend on the kind of support that can only come -- can only come -- with a waiver. Being on Medicaid is not a substitute.

There are supports that can only come -- so the anything that we can do as a MAC, on TACs, in whatever ways we need to, find other ways to either fund or process these.

I feel like that has got to become a priority that is higher up on the list than we have been able to achieve.

MS. CLARK: Were you -- I apologize if I missed -- but were you speaking to pediatric patients?

MR. GILBERT: No. I mean them all.

MS. CLARK: Okay. I thought you

had said something --

MR. GILBERT: I did.

MS. CLARK: -- about early intervention definitely is key. Wholeheartedly, I agree with that, and a lot of the medically necessary services, those are available in state plan, therapies, all of that. So just wanted to make sure that people are getting the services that they need.

I apologize, I think Deputy Commissioner Veronica Judy Cecil had maybe come off mute -- I think she went back on mute, but if she had something to say, I would definitely let her speak up and take over.

MS. JUDY-CECIL: Thanks, Alicia.

You mentioned the waitlist report that we submitted to LRC, that legislative research commission, that included some recommendations, and we are reviewing that right now in how can we improve management of the waitlist.

Ultimately, the only thing that is going to solve this problem is more

money. We need more money.

DR. SCHUSTER: Absolutely.

MS. JUDY-CECIL: It will not be solved with waitlist management. The children's waiver, we hope might help with some of it and we do have some funding for that, but ultimately, people are going to continue to be put on the waitlist.

I would just like to clarify that being on the waitlist does not mean that you are actually eligible. The eligibility is not determined until a slot is available and the person then goes through an assessment to determine eligibility and that has been part of the problem, too.

We understand that that is hard to understand that people can just put themselves on the waitlist. There is no assessment to determine that you are actually eligible for that waiver until that slot is available.

So that is part of what can we do with the waitlist management, too, to make sure that those on the waitlist are

truly eligible to benefit from that waiver.

DR. SCHUSTER: I just want to reiterate -- thank you, Veronica -- that what we are seeing, Kent, is a combination of things, but the major factor here is the lack of funding from the legislature over many years where they have dribbled and drabbled out maybe 150 new slots in each of the waivers each year of the biennium, and that the most we thought it was wonderful if we got 250 slots, you know, and so forth, and it was huge, this last go around, when we got funding for 1,950 slots in combined waivers.

We were celebrating, because we had never got that much money, and that's why I was so disappointed when we asked Sherri or Alicia, are those numbers still reflecting in those 14,000, and they are not.

So part of it is, I think the waivers have not -- they are increasingly being known by people. The network of parents of young children who were born

with significant disabilities is growing and people are just learning about waivers that they were never told about when the child was first diagnosed, which is a problem in the system.

We have talked here in the MAC about how to make Medicaid waiver services more available and one of the things that the commissioner has said is, you know, there is a downside to that.

We get more people who put themselves on the waiting list because they know that they need those services, and yet they find out that their child can be available for those services even though their family income would not make them eligible for Medicaid, and all of those kinds of things.

So I think that is the increase in numbers. The need is there. The need has always been there.

So anyway, there are lots of pieces of this and I do think that has to be an ongoing -- and I would hope -- in fact, there's a lot of interest in serving

on the BAC from some of these parents and some of these caregivers. Some of them were children who are now in their adolescence or early adulthood who have struggled with this system over many, many years and really want to have a voice on the BAC and eventually on the MAC.

So I appreciate you bringing up those issues, Kent, because we probably have spent more time since I have chaired the MAC talking about waivers, because that is the world that I have lived in with children.

And, you know, it is a critically important part of Medicaid, and I think a lot of the provider groups that are on here really have not had a lot of knowledge of, or been very concerned about, because that is not who they are serving, but it is, you know, it is a critically important part of Medicaid, and we really need to pay attention to it, so I appreciate this discussion.

Anybody else have anything?

Let's go on then to the TAC

reports. I think that is next on the agenda.

And I apologize that I don't have a written report. We just met yesterday afternoon so it was a little bit hard to do that. We did meet yesterday. We had a quorum and read a presentation from Medicaid from their statewide behavioral health needs assessment, and some excellent dialogue around that with some -- we are going to get an updated version of that with more information.

We did receive updates on the waivers and we were disappointed that the 1915(i)SPA, which is the one that would get supported residential services to people with severe mental illness, did not get across the finish line with the CMS approval before the change in administration so we very much appreciate that DMS is continuing to work on it, and still holding to, hopefully, a July 1 go-live date, but the future is unclear.

We were also pleased to hear that the folks working on the re-entry

waiver had begun to do some outreach to local jails, many of which, when that waiver was first submitted, we were very strong in the fact that the local jails needed to be included in that.

We continue to discuss pre- and post-payment audits by the MCOs and the possibility of prior authorization being reinstituted for at least some behavioral health services, and it certainly has been the impression by the members of the Behavioral Health TAC and those in attendance, that as prior authorization has been suspended, the number in scope and extent of these audits has skyrocketed, so it is clearly a punishment in a sense.

It is the MCOs way of saying, "You are not going to let us do prior auth, so we are going to audit the heck out of you after the fact."

Anyway, there was a lot of tension about that.

We do not have any recommendations and we will meet again on

March 13th. Thank you.

How about the Children's Health TAC? Is there anybody here?

MS. BICKERS: I do not see anyone on. They met January 8th.

DR. SCHUSTER: Okay. I am concerned that I don't think we've had a report from the Children's Health TAC since I have been chairing the MAC.

MS. BICKERS: They only had two members present at the last meeting.

DR. SCHUSTER: Yeah, thank you.

Consumer Rights and Client Needs?

MS. BROWN: Yes.

DR. SCHUSTER: Oh, there is Miranda. Great.

MS. BROWN: I serve on the Consumer TAC and we met remotely on December 17th. We did have a quorum.

We discussed language access and really appreciated today hearing an update on that.

We also discussed the access to services and care in the complaint form

and linking to the network adequacy one-pager.

And then we discussed how all surveys, public forums, and meetings, and public comment periods, that they really should be shared with all Medicaid stakeholder distribution lists and social media channels.

But our specific recommendations that we agreed to put forward were regarding the BAC and MAC -- really the BAC. The first one was that current Consumer Rights Client Needs TAC organization membership be included as part of the BAC, in addition to other seats included in the nomination process.

And the second recommendation in December was in planning for full diversity of members on the BAC, that DMS consider literacy in any materials.

Then we met again in January, specifically to spend more time discussing the BAC. We were short on a quorum, but would still like to share the recommendations that we discussed.

In January, that was:

1) That the BAC should conduct meetings that are open to the public at least four times per year, but not be required to follow public meeting laws for flexibility in planning meetings and technical assistance.

2) That the BAC and MAC should adopt a formal policy on accessibility and accommodations to support meaningful participation. These accommodations should include, but not be limited to language services, personal assistance, communication supports and other supports and resources as needed.

3) That DMS should work with the Consumer TAC to create a BAC nomination form and process for selecting BAC members.

4) That DMS should provide dedicated staff support with one or more DMS policy staff assigned to support BAC members with individual technical assistance between meetings.

5) The BAC should have

staggered terms of a minimum of three years and a maximum of six years to allow members to develop and share expertise. For BAC members selected to serve on the MAC, their term should be extended.

6) That DMS should consider that BAC members are offered reimbursement for expenses and compensation/stipends for their time, modeled after standard boards and commissions.

7) The BAC should include a minimum of 25 members with seven of those members nominated by the existing organizations that make up the Consumer TAC, being the National Association of Social Workers Kentucky, Kentucky Legal Services Corporation Office of Kentucky Legal Services Programs, the ARC of Kentucky, Department of Public Advocacy, American Association of Retired Persons, AARP, Family Resource Youth Services Coalition of Kentucky, FRYSCKy, the Kentucky Association of Community Health Workers, KACHW.

Finally, the additional team

members of the BAC should include a diverse range of representatives based on geography, age, race and ethnicity, sex and gender, LGBTQ+, disability, language, and physical, behavioral, or oral health needs.

That is my report. Thank you.

DR. SCHUSTER: Wonderful. I love those recommendations, Miranda. Thank you and thanks to the Consumer TAC for their input. They are in the ideal place to be making those recommendations so I appreciate that very much. Thank you.

I think the Dental TAC did not have a meeting.

DR. BABROWSKI: I've got just a little report here, though, Dr. Schuster.

DR. SCHUSTER: Sorry, Garth.

DR. BABROWSKI: We did not meet since the last TAC meeting, but we do have a meeting scheduled in two weeks.

We do have some new members that are coming on the TAC for now, and thank you, Erin for sending out those

orientation packets, but we don't have any official report today. Thank you.

DR. SCHUSTER: Thank you very much, Garth.

The Disparity and Equity TAC.

MS. BICKERS: They have not met. They are working on having their members reappointed and a couple have applications pending. So they are working on rebuilding their membership currently and are scheduled to meet in April.

DR. SCHUSTER: Okay. Thank you.

EMS? I think Keith got back to us and said that he couldn't be here today and I have forgotten, Erin, did they say that they had not met?

MS. BICKERS: They meet next week and their goal is to discuss legislation that impacts ambulances.

DR. SCHUSTER: Thank you.

Home Health?

MR. REINHARDT: Thank you, Dr. Schuster.

Evan Reinhardt with the Kentucky Homecare Association.

The Home Health TAC met on December 10th and discussed an update on electronic visit verification, as well as the supply fee schedule from MCOs and supplies limits, which continues to be an issue for us.

We asked for a update on our home health reimbursement rate recommendation from a ways back.

And then on the new business side of things, we discussed credentialing issues, that providers are having their numbers expire prior to being revalidated, and finally, one area of concern for us is home health aide utilization and how that has been decreased and seems to be somewhat associated with the launch of managed care in our space.

So we are keeping a close eye on that and asking for some data there, and we did not have any recommendations from the December meeting.

DR. SCHUSTER: All right. Thank you very much, Evan. That is a good report.

Are aides not being approved by the MCOs? Is that what you are seeing?

MR. REINHARDT: That's correct. So aide services are typically not authorized in the way that they had been historically so that has, obviously, led to a decrease in hiring of home health aides from our side, from the workforce perspective, and likewise, workforce issues. Those individuals are an important part of our industry so we are just keeping a close eye on that.

DR. SCHUSTER: Certainly the workforce issues continue to affect all of us, I think, but that is an important part. Thank you for sharing that and I know that you will keep an eye on that one. We will be interested in hearing that.

MR. REINHARDT: Absolutely. We will have an update next meeting.

DR. SCHUSTER: Thank you very much.

Hospital Care?

MS. BICKERS: Russ was on. He

may have had to drop. I believe their last meeting was in December and they are scheduled to meet in February.

DR. SCHUSTER: And I assume they didn't have any recommendations, Erin?

MS. BICKERS: No, ma'am.

DR. SCHUSTER: Okay. All right. Thank you.

Intellectual and Developmental Disabilities?

MR. HARVEY: Good morning, Dr. Schuster. I'm Wayne Harvey, the new chair of the IDD TAC.

We don't have any formal recommendations to bring forward to the MAC, but we do have two particular items that have kind of dominated discussion over the last couple of meetings.

One is involuntary terminations. This has been a long-standing issue for the IDD TAC, and we are in the process of continuing to gather information and bring forward a formal recommendation to the MAC.

The biggest thing that is of

concern to us is the number of people that have been terminated that still haven't found another provider, and the number is 12 for over a year.

Just to give you some background on this, back when SCL transitioned in to the SCL II waiver, they changed the involuntary requirements around termination and they made it where providers had to continuously serve someone, even though they are indicating that they can't meet their needs, and in some cases, they can't safely meet their needs.

They have to continue to serve them until another provider is secure, so that continues to be a huge concern, not just to providers, but to the participants themselves, family members, guardians, advocates. And that is certainly something that we'll be bringing a recommendation forward on soon.

The other issue that continues to concern the IDD TAC is the implementation of the rate study itself,

that Medicaid require providers to participate in and complete.

We completed the rate study almost two and a half years ago now and they implemented 70 percent of the rate study itself on January 1st of this year.

The issue that providers have, and people on the committee that is concerned about this, is that by the time we get to 100 percent implementation of this, the numbers are going to be four to five years old and, obviously, there were things that were contained in this rate study that pertain to inflation and things of that nature that were built into this.

So those are the two primary things that are really on the radar of the IDD TAC and really causing us a lot of concerns.

DR. SCHUSTER: All right. Thank you for sharing that, Wayne. I'm glad to have you join us.

And both of those -- I hear about involuntary terminations and I know that that is a big issue, and obviously,

all of us are concerned about rates, but when you make a recommendation two or three years ago, and then it takes that long for it to get implemented, you are right. The rates are already too low or outdated, or whatever, before the ink is dry.

So keep us posted on that and we will look for your report in another two months, because you all would have met and we will come back with some formal recommendations.

MR. HARVEY: We met in December and we have a meeting coming up on February 4th, so we have one that is very soon.

DR. SCHUSTER: Thank you very much.

MR. HARVEY: Thank you.

DR. SCHUSTER: Nursing Home Care, please.

MS. BICKERS: They have not met. They are scheduled to meet in March.

DR. SCHUSTER: Okay. Thank you, Erin.

Nursing Services?

MS. BICKERS: I believe they are scheduled to meet next month. They met in, I believe, October last.

DR. SCHUSTER: Okay. Thank you.

Optometric?

MR. COMPTON: Steve Compton from the Optometric TAC.

We have not met since the last MAC meeting. We do have a meeting scheduled for February the 6th.

DR. SCHUSTER: Thank you, Steve. We will hear from you, then, when we meet in March.

MR. HARVEY: Yes, ma'am.

DR. SCHUSTER: Thanks.

Steve Shannon, Persons Returning to Society from Incarceration, the longest named TAC?

MR. SHANNON: Correct. And perhaps the most important TAC. I'm not sure. Just kidding.

We met in January and it was really nice, because Angela Sparrow kind of gave my report for me.

Obviously, we paid a lot of attention to that re-entry waiver and the progress being made. I want to commend Medicaid for hitting all of the time frames they had to with their implementation plan, their monitoring protocol, and their evaluation plan.

Again, we are all looking forward to July 1. We are also pleased with the CAA that's serving youth in jails, 18 to 26, or youth development centers. I think that creates a vehicle to develop a relationship with local jails.

Obviously, there are waivers for Department of Corrections facilities. There's a lot of local jails and there are state inmates there, so we were pleased to hear that report as well.

Always looking forward to it. We always get updates from our five MCO partners. They really started doing a lot of in-reach, working on that re-entry piece even though it's not a waiver, making those connections as soon as they

can. Partnering with local groups on councils to facilitate that process of transitioning back to society.

That is a big challenge and a lot of questions and a lot of needs are at that point. So we appreciate that work.

We have no recommendations. We anticipate once we see the waiver and start implementing it, we will probably have more ideas of what we are going to moving forward, but right now we have no recommendations and we are scheduled to meet again in March. So thank you.

DR. SCHUSTER: Thank you, Steve. I think we are all excited that that waiver is going to move forward, because the number of Kentuckians that would be served is pretty astronomical, particularly if we get the jails involved.

Thank you for hanging in there all of these years on this TAC.

MR. SHANNON: It has been good.

DR. SCHUSTER: How about the Pharmacy TAC?

DR. HANNA: Good morning. The

Pharmacy TAC did not meet the last time, but I'll report for the October 2nd meeting because both the chair of the Pharmacy TAC and myself could not attend at the last meeting. I was going to report on that, if that is okay with you, Dr. Schuster, on October 2nd.

DR. SCHUSTER: Sure.

DR. HANNA: The first thing that came up was a little bit of discussion about vaccine counseling because although that has been in place for awhile, because we do have a couple of MCOs that are not reimbursing on that, which was WellCare and Aetna according to the report here, for the other six, of course, one them is no longer in that group, that was discussed.

There is also, at the previous meeting, it seemed like there were some question as to if the report had been submitted and considered by DMS, so a review of the following motions I will include just to make sure that those are addressed, because there was some question

about that.

The first one, and I think we did discuss this before, is there was a motion and an ask for the Department of Medicaid Services to pay pharmacists for the administration of long-acting psychotic medications.

There was discussion around that this would reduce the cost for an office visit and also allow the patient to better access to that care which can be provided in a pharmacy, and thus ease it and give it better adherence.

So some of those medications as we all know are Abilify, Zyprexa, Invega, Risperdal, and others. And, of course, this is a very vulnerable group and when you have them there, important to give it. But pharmacists aren't being paid for the administration of this, so I think it would really help if we could do that.

Other maintenance medications as well, which could be administered at the pharmacy and also decrease the burden on our patients and cost for additional

visits and stuff, such as B12 injections, allergy shots, testosterone, those types of things. So that is some ask there from the Pharmacy TAC.

Other things that were discussed, obviously they were asking for Medicaid to consider providing clinical or counseling on monitoring for community health workers that can be done under deal of services as in Senate Bill 74. There was a little discussion on that.

But additionally, they just wanted to bring this up that Medicaid and other states are covering many things such as diabetes self-management, MTM, which is very critical, medication therapy management for these patients, including compliance counseling, packaging, those types of things.

Those really help with adherence. They help with patients who may have trouble managing their medications. They come in the form of packaging, but also digital compliance monitoring where people can actually

see -- where your providers can see what's going on and monitor those patients, which in my experience, albeit I came from the long-term care world and servicing a lot of patients out in the community, that is critical.

They need to be able to take their medications and people might be able to help them better if we had some of the services for our patients. So I think that's very important.

The other thing that came up was TB skin testing. That is something that pharmacists can do within their scope of practice, and it is critical for public health as well.

Just to support this, there is some discussion around -- and we brought this up in this meeting before -- Senate Bill 48 was passed in 2021, which did allow for pharmacists to be paid for services that are provided by other practitioners at the same rate of a non-physician practitioner. I am summarizing this, obviously, within their

scope of practice. So there is precedent for that within our state that we have seen.

At the end of the game, I was asked to mention that they discuss that it appears that many of their concerns are not being heard and addressed and that they would like for the department -- I've got a little note here. Hold on. I apologize.

They would like to see the Department of Medicaid services place patient care in front of all priorities and that work be done within the department to understand what patient care and services that pharmacists currently provide to better care for our Medicaid beneficiaries. And that centers around access to these services and making them billable for pharmacists within the community so they can help take care of the patients that they know and care for at this time. Thank you.

DR. SCHUSTER: All right. That is a long list, but I am delighted to know

that long-acting injectables are on there because you and I have had that discussion.

DR. HANNA: And I think it's very critical, because that's a very vulnerable population, as are all of our patients, but these, in particular, the reimbursement for these medications, pharmacies are lucky if they get paid the cost of the drug. So they really need to be reimbursed for the administration as well.

It's a clinical service and I really, really, feel strongly for some of these medications that we need to try to take a forward step in that direction, if we can.

DR. SCHUSTER: Just to be clear, are these in the form of recommendations that we need to vote on and to be forwarded?

DR. HANNA: These two recommendations were brought up at the past meeting and there was some confusion as to whether the report had been

submitted, so there was also some confusion to see if these two recommendations had been addressed by DMS.

DR. SCHUSTER: And Erin, I think I saw that DMS did respond to the pharmacy recommendations.

MS. BICKERS: Yes, ma'am.

DR. SCHUSTER: Because we had some BH TAC recommendations, Cathy, and they came literally the morning that we were meeting that afternoon.

DR. HANNA: I appreciate that.

DR. SCHUSTER: And they were later getting out than usual, so they have been responded to.

DR. HANNA: So say that we don't need to. Thank you. That was more of a clarification.

MS. BICKERS: Cathy, just so you know, I noted on the responses that they were brought to the MAC in, I believe, the September and November. The November had a few extra medications so we kind of combined that into one, so that is noted on the response.

DR. SCHUSTER: Thank you.

Ron had submitted that report in November. I do think that the discussion about putting patient care at the top is what we all are about, but you brought up some other food for thought I think, Cathy, in terms of, you know, people go to the pharmacy, particularly when they are located inside the grocery store or whatever, or they are out and about, so instead of just going with the sole purpose of picking up a bag of medicine or whatever, that there are lots of other things.

I mean certainly the COVID shots, and flu shots, and so forth are really being touted by the pharmacies, at least here that I am familiar with.

So important to bring that forward, yes.

DR. HANNA: Yes. I think it's very important because making sure that all of this, reviewing the medications and all of that is so critical for these patients. So we would like to see some

form or way to be appropriately compensated for those services.

DR. SCHUSTER: Thank you.

Did you want to say something, Eric Wright? No? Okay.

Physicians TAC, please.

DR. GUPTA: This is Ashima Gupta representing the Physicians TAC.

We have not met since the last meeting. Our next meeting is planned in May.

DR. SCHUSTER: All right. Thank you, Ashima.

Primary Care?

MR. MARTIN: Hi, Sheila. This is Barry.

The Primary Care TAC met on October 24th and we didn't have any recommendations.

We do have new members and a new chair, John Lillibridge. He apologizes for not being here so that is why I am giving the report.

DR. SCHUSTER: Okay. Thank you. New members are always good, new chair is

good.

Thank you, Barry. When are you all meeting again?

MR. MARTIN: March 27th.

DR. SCHUSTER: Okay. So are you all only meeting every six months?

MR. MARTIN: No. I think we just -- yeah, I guess we are. Our next meeting is March 27th, and then we have one in December scheduled. Should we meet quarterly?

DR. SCHUSTER: I would assume that there would be more business that would necessitate at least a quarterly meeting.

MS. BICKERS: March 27th is our next MAC. Give me just a second there.

MR. MARTIN: I apologize.

MS. JUDY-CECIL: I think the Primary TAC --

MS. BICKERS: It is on the 27th of February.

MR. MARTIN: Okay. I'm sorry. I've got too many text messages rolling in to figure out which one is which.

DR. SCHUSTER: Yeah. I guess I would be surprised knowing how broad primary care is, that you don't have more business to talk about.

MR. MARTIN: I imagine we are meeting quarterly.

MS. JUDY-CECIL: I believe the Primary TAC has moved to a quarterly meeting and it is up to the TAC to make the decision on their meeting cadence.

MR. MARTIN: I will take that back. I may have misspoke. Sorry.

DR. SCHUSTER: Yeah, Veronica thinks that you all are meeting quarterly so I'm just trying to get it.

MS. BICKERS: You are meeting quarterly, but if the TAC decides they want to rearrange that schedule, that is something that we could discuss in the next meeting or just in an email.

So just let me know, Barry, but I do have you guys scheduled for February 27th.

MR. MARTIN: That was John and I, we were texting back. Apparently the

MAC is March 27th.

DR. SCHUSTER: Right. All right. Thank you, Barry, and we will look forward to meeting your new chair when we meet in March.

MR. MARTIN: You are very welcome.

DR. SCHUSTER: And then last, but certainly not least, the Therapy TAC.

MS. BICKERS: I do not see someone on, but they are scheduled to meet the 1st week of February. Oh, no, my apologies. I'm sorry. My calendar just froze. If you will give me just a moment, I will let you know their next day of meeting.

DR. SCHUSTER: Okay. Thank you.

So we have recommendations -- a number of recommendations for the Consumer Rights and Client Needs TAC, and I would entertain a motion from a voting member to accept those recommendations and send them on to DMS.

DR. HANNA: I'll accept those and make a motion to accept and move on.

DR. PARTIN: I'll second.

DR. SCHUSTER: Kathy and Beth, great. Any discussion?

All those in favor of moving along the Consumer Rights recommendations to DMS, signify by saying "aye."

TAC MEMBERS: Aye.

DR. SCHUSTER: All right. Opposed, like sign.

All right, wonderful. Thank you very much and we appreciate the reports for those of you who were here.

I do think that hearing what the issues are is helpful to the MAC members.

So under new business, we have a couple of things that Dr. Eric Wright, who is a voting member of the MAC, brought forward. Let me see if I have this right.

Eric, United Healthcare is covering, now, equine therapy and you were wondering if they have an update or could give us some more information about that, and then we wondered if any of the other MCOs are also covering that service.

Is that right, Eric?

DR. WRIGHT: Yes, that's correct. I received an email from Kelly Dugan, who works out of St. Louis, that they are contracted with United Healthcare Kentucky, just putting together a provider network for to offer other therapeutic riding services or equine assisted therapy beyond PT, OT, and speech, but also mental health as requested by the members.

The benefits cover they said reimbursable, and they are piloting this, and it appeared to be Warren, Jefferson, and Fayette counties. The reimbursement rates are for therapy sessions for a path certified instructor, which is one of the requirements. It's $75 per session for therapeutic riding for 45 minutes, and then 45 minutes therapy service by a licensed psychologist, behavioral therapist, mental disorder specialist, social worker, physical speech, and occupational therapist is $120 per session.

I just wanted to make sure that I'm understanding that correctly. Is that

actually something that United Healthcare is offering here in Kentucky? Sometimes you get this information and this is in fact true, and if it is true, kudos, but the other question, are other MCOs going to be offering these services?

So I'm hoping that somebody from United Healthcare can speak to this and see if the other MCOs are going to be involved as well.

MR. IRBY: Dr. Wright, this is Greg. I'm our Chief Operations Officer at United Healthcare in Kentucky.

So you are right. We have implemented a new program with equine therapy. We are also doing music therapy alongside of it.

DR. WRIGHT: She mentioned that as well, yes.

MR. IRBY: We are excited about it. I will tell you that we are piloting it small so the eligibility for members is not every member. It is open to our members who have an autism diagnosis, members who are in an adoption assistance

category, and/or former foster members between the ages of 18 and 26, so those would be the opt outs from the SKY program.

We are testing this in a small group of folks and hoping that it can be a benefit to those families.

I can confirm -- I won't get into all of the fee schedules and things like that -- we are working with the vendor to manage this program. It is not localized right now so we are open to all requests from our members who fit those categories.

But you are right. We are excited about it, because we think that it can be a benefit to families. These services have made an impact on people who are close to us.

I will tell you Dr. Wright, we think about this, we think about things that impact our families. My adopted son, he was adopted out of foster care and he has benefited greatly from equine therapy. Another of our team members, her child

with autism has benefited greatly from music therapy.

So the members that we interact with, we hear these needs and I got to speak to some of them personally. Some of our members who are in an adoption assistance category, I got to speak to their families, and when I introduced this new benefit, they were very excited about it, because some benefits that exist within a foster care program do not go with the child after foster care ends, and once they are in an adoption assistance category.

So we are really excited to extend that out to these families, and we are hopeful that it makes a difference to them.

MR. WRIGHT: Greg, my background is a licensed professional counselor and former school counselor. I've adopted two children, one of which is from Ukraine and one of which is domestically adopted here locally, and then we have a daughter with Angelman syndrome. Our family has been

involved with equine assisted services and we run a small nonprofit and that's how I was reached.

When I heard about it, first-off, I wanted to give your all's organization credit for be willing to step into this realm. A lot of this is in response to what I think is happening in Colorado with Temple Grandin and her research at Colorado State University and I am extremely pleased to hear this.

I am curious that if your infectious excitement will bleed over into some of the other MCOs because I would surely love to hear from them, but regardless of such, I just want to give you guys credit for making such a move.

MR. IRBY: Thanks so much.

MS. HENSEL: Thank you, Dr. Wright.

This is Krista Hensel, I'm the CEO for the plan. And Greg, I just want to validate as well.

We are introducing this program as part of our value-added benefits and

services, so where we take a look at things that are not necessarily covered by corporate Medicaid, but we believe are worthwhile for the families and members that we serve.

And with Greg piloting, and seeing what kind of impact we can make, and what better thing than equine therapy for the Commonwealth of Kentucky which is the heart of horse country.

Is that right, that is one of our value-added benefits, correct?

MR. IRBY: Exactly right.

DR. SCHUSTER: Well, that is very good news. I am sure we have other MCOs in attendance here at the MAC. Are there other MCOs that are offering this kind of coverage?

MR. OWEN: Good morning, Dr. Schuster --

DR. SCHUSTER: Good morning, Stuart.

MR. OWEN: -- and everyone. This is Stuart Owen with WellCare. I would like to sign up for the equine

therapy. That was one of my questions. Is this a value-added benefit? And you are saying that it is.

MR. IRBY: It is. We added it as a value-added benefit this year.

MR. OWEN: Okay. We are not doing this, but this is fascinating. We will absolutely explore it. This is really cool.

MR. IRBY: No better place for equine therapy than Kentucky.

DR. SCHUSTER: Than right here in Kentucky.

MR. OWEN: No shortage of horses.

DR. SCHUSTER: So Greg, is it restricted to those counties that Eric Wright mentioned, or is it statewide?

MR. IRBY: It is statewide, of course that depends on adequacy as every service will, but we will make an attempt to get every person who requests -- who meets those criteria that we talked about -- we will make an attempt to get them connected with an equine therapist or

a music therapist, if that's what they're interested in.

DR. SCHUSTER: So it's not restricted to those populated counties necessarily. All right. Wonderful.

DR. WRIGHT: Can I ask another question to Greg?

DR. SCHUSTER: Sure.

DR. WRIGHT: Obviously, I am passionate in this realm, therefore that is the reason that we run Cope's Hope Equine Assisted Services in Jefferson County, my family does as part of my private practice.

My question is, Greg, do you have the language that you can share related to who and who is benefiting from this value-added benefit, because I would love to get a copy of that and I would be happy to send you a private chat, I guess, if I can to send you my email, or you can search my website.

And the music therapy is something that here at the University of Louisville, where I work full time, I have

worked with that department to see that benefit be realized as well, so I am really excited about that.

I actually went up and spoke to Morgan McGarvey, his team a few years ago just to start that process, and I think that we are moving in that direction as well. So I am extremely proud of United Healthcare for moving into this area and I am hoping that other MCOs will follow suit, too.

MR. IRBY: I really appreciate that. I will put my email in the chat so if you've got questions about it, please feel free to reach out to me.

This is something, obviously, that Dr. Wright, you and I are very excited about and if others have questions about it, I'm always happy to talk about it.

DR. SCHUSTER: All right. That is a great way to do it. And thank you very much for being on.

DR. WRIGHT: Yes.

DR. SCHUSTER: As a clinician

who worked with kids on the spectrum for years and years and years, I think this is very exciting.

Eric, you also had a concern that you are hearing from people about the respite rate changes and you are hearing from participant representatives of waiver recipients. Do you want to talk about that?

DR. WRIGHT: I am engaged with a number of social media channels related to the Michelle P. waiver in particular, related to respite and I guess the news came out that there was going to be some changes in billable rates related to that.

I think the concerns that I wanted to bring forward and see if I am understanding this correctly, the biggest concern is that a lot of these individuals are using Participant Directed Services. They have been hiring for respite for many years. Most of those are contracted typically when they renew for that benefit and those contracts tend to use rates that have been approved by Medicaid and their

case managers through their fiduciary agencies for years, what we are hearing is at the rate is reduced now, which I guess there are two rates: Rates for individuals within the individual's families specific to siblings and parents, but there is a rate that is outside of that with potential PDS workers of $21.63, I think, for an hour, if I am not mistaken, and if I am, someone can help clarify, but a lot of these individuals have already signed contracts with their case managers fiduciary agents for rates that are higher than that based upon precedents that have been set for rates previous.

Additionally, I have some questions. One of my questions is how does that work? Does it work that it is billable hours while in the care of the respite provider, or is it just certain hours like non-sleeping hours? I wanted to get some clarity to that, and then the other thing is that some agencies and nonprofits, even, for example, Easter

Seals used to provide a service of respite, but it was for a camp that was over a week period of time.

Just a lot of questions that I think are coming with the change in respite and billable rates. So I am bringing this to the table to get some clarity to this and hopefully get some answers.

DR. SCHUSTER: Is there anybody on from DMS that can respond to Eric's questions?

MS. JUDY-CECIL: There are a lot of requests within what you have asked for, Dr. Wright.

So we did -- and I think we did our best to communicate the proposed rate changes last year. We posted the waivers with the rates in them and those are tied to the budget -- the budget that we received to cover the increase for pretty much most of the services related to the rate study that was performed. I don't know, Alicia, if you can speak to that a little bit more.

MS. CLARK: Yes. I can give you a little bit more about the rate changes.

Previously, you are correct that it was based on just a dollar amount per year, and that is not the way that usually services are set up, so within the rate study and all of this was out for public comment and all of that, but the new rate for respite is $5.92 per 15 minutes.

We looked at -- with the limit of 1,312 units per plan of care year, that actually is up to -- instead of the $4,840 that they had the option of using prior years, they actually have $7,767 now -- and 4 cents -- to use.

While it may be a reduction based on how somebody may have historically paid over the $23.68 per hour. Participants really have an access to an increased number of units at a rate that meets those CMS requirements for the efficiency, economy, and quality of care.

Again, participants should always utilize the service, this method consistent with their level of need

documented in the assessments. Of course, it is person-centered.

DR. WRIGHT: Can ask a couple of follow up questions?

MS. CLARK: Yes, sir.

DR. WRIGHT: The $23.68, I am hearing differing things across there. Is that just for a specific population or is that across-the-board rate?

MS. CLARK: That is across the board, but we don't get into determining taxes and all of that with the participant-directed population so sometimes there are -- I would say -- an amount that is withheld maybe from a paycheck, kind of like ours with taxes and stuff like that.

Definitely I do not get into the whole participant directed and those requirements, but that maybe what they are referring to and that all depends on do they live with the participant or do they not? There are some different qualifications maybe on those.

DR. WRIGHT: Another follow-up

question. Waking hours -- are sleep included in the unit?

MS. CLARK: I want to go back. I don't have the waiver application or everything pulled up in front of me, so I would like to go back and take a look at that. I know you had said waking hours, I wrote down, and also weeks at camps.

DR. WRIGHT: Yes. There was some flexibility of that rate that allowed a lot of individuals to have flexibility with the provider of that service whether it was traditional or even a non-traditional provider. A traditional or PDS provider. So obviously, I am not trying to dig too deep into the weeds here but there are some things with the constraint on units -- first off, thank you for the increase in the amount if you use the units in the way that they are. The concern seems to be what if these individuals had signed some contracts with these individuals at a rate, what is -- so that is a concern that came up.

Are those individuals that are

contracts would be considered legally binding with these AAA agencies, like KIPDA, and then all of a sudden you have a rate change within the employee. That was a big topic of discussion that I think still needs to be addressed, because I don't think your case managers were aware.

The biggest thing is that while there may have been a discussion about rate changes and rewrites, the rate changes weren't informing them when they were doing renewals and contracts were signed at a higher rate. That is a big concern.

So then the next is truly about the flexibility of the waiver. So I appreciate if we can get any other clarity to that, I think it's going to be important.

MS. JUDY-CECIL: With CMS, CMS has approved for us to pay up to $5.92 a unit -- somebody might get paid $4 a unit -- not everybody is going to get paid the max rate, but with CMS, that is what they have approved, if there are contracts

that are higher than that $23.68, those will need to be redone, but again, the participant -- I will go back to saying this -- the participant can now instead of $4,840, they can now receive up to $7,767 if needed, based on their person-centered plans. So this is really a great thing for our participants in allowing them to be able to use respite.

Dr. Wright, since this is a new business item, it might be helpful to us if you could send us your questions in writing so we can make sure that we are addressing exactly what your questions are.

DR. SCHUSTER: Yes. We brought this up pretty last-minute when Eric put these items on, and why don't we carry this item forward, Eric, to the next meeting.

DR. WRIGHT: Thank you.

DR. SCHUSTER: And in the meantime, why don't you and others who might have questions -- the folks over on the IDD TAC might also be interested in

following up, or some of the folks who are in the audience today may be interested with questions that they have, so let's get those together.

Veronica, you should we send those to?

MS. JUDY-CECIL: You can send them to Erin or Kelli.

DR. SCHUSTER: Yes. Send them to Erin, Eric -- and Kelli -- and then we can gather those and put them on the agenda. I will put a note here to put this on the agenda for the March meeting.

Thank you. And thank you, Alicia and Veronica for responding. I think you got some information, Eric, and then we can follow up to get the rest of it.

DR. WRIGHT: Thank you, Dr. Schuster for allowing us to have a conversation and we will get a few questions out that I have been receiving. I will get it over.

DR. SCHUSTER: And this other thing is something that we touched on very

briefly at the last meeting and it has to do with closing the care gaps.

And I think that what I was hearing from some providers that they were hearing from their patients that the MCO had been to visit them and provide some services, but nobody seemed to know accept the patient that those services had been provided, and they were screenings and maybe even some direct care things, so I am trying to get a handle on what closing the care gaps activities are.

Is that what we decided to do, Erin, to kind of put it out there so the MCOs would have a chance to respond?

MS. BICKERS: Yes, ma'am.

DR. SCHUSTER: Okay.

MS. BICKERS: And then if we need to request it in writing, a review for the MAC, we can request that since it is under new business.

DR. SCHUSTER: Yeah, okay.

MS. HENSEL: I can address, Dr. Schuster, from a United Healthcare perspective, if it is closing care gaps,

we have provider quality consultants that go out and meet with especially large primary care practices where we have a lot of members and review what we call our PCORE or our Patients Conditions and Outcomes Reports that are produced on a monthly basis that display care gaps.

We have a variety of different programs, value-based programs with providers to close some of those quality gaps, oftentimes associated with one or more HEDIS measures from NCQA.

So that is the backbone of what our program is, actually is centered around PCPs, ensuring that all of the claims data that we have, we are able to share back, so if somebody got a vaccine at a pharmacy, that the primary care physician sees that gap was closed and they are not trying to chase down that particular patient for that particular item. So that is one of the items that we try to keep the primary care office as the quarterback in the system.

DR. SCHUSTER: So it sounds like

if you are aware of information because of the claims, you are doing that feedback loop back to the primary care provider.

MS. HENSEL: Yes. Through a monthly report.

DR. SCHUSTER: Okay.

Are you all interacting directly with patients at any time, home visits or that kind of thing? That's what I was wondering.

MS. HENSEL: Our community health workers will sometimes go out as part of if somebody is enrolled in a case management program, but that typically is not providing a medical service. It's more helping the patient advocate, helping them get scheduled, helping reduce any transportation barriers, that kind of thing.

DR. SCHUSTER: Okay.

MS. HENSEL: We do have people who are engaged with members.

DR. PARTIN: Sheila?

DR. SCHUSTER: Yes, Beth?

DR. PARTIN: It seems like we

are talking about two different things, because there is one thing that we get letters from the MCOs about items where the patient hasn't had certain tests done, or basically routine screenings and things like that, like mammograms, hemoglobin A1c for diabetics, screening for colon cancer, that kind of thing.

We get notices and I can't tell you, specifically, which MCOs send out those notices. I haven't paid that much attention to it, but it is just a notice saying that they need these things or the last time that they had it.

And sometimes they had it, but the insurer doesn't know that they had it. I don't know why they don't know, but then we just respond that they did get that testing done and when they got it.

But then there is another thing, though, that actually has either a physician or a nurse practitioner or PA, mostly it's nurse practitioners, I think, who go out to the patient's homes and actually examine the patients and talk to

them about their needs and their health and what the patient thinks that their needs are, and we get reports on that as well.

And I can't tell you, again, which MCOs are doing that, but we get those reports as well. It may be two different things that we are talking about.

DR. SCHUSTER: Yes. That latter is what was described to me is that there was some provider type who was going into the patient's home and doing some exams or maybe even doing some screenings.

DR. PARTIN: Sometimes screening, but mostly exams and questions to the patient about what their needs are and what they think that they could benefit further from and that kind of thing.

MS. HENSEL: I want to make sure that if you can provide any examples, we can help understand, there are programs in other lines of business for United Healthcare, as an example, like Medicare

Advantage where what you are talking about is more of this house call.

In those house calls, a report is also generated when a house call occurs and is sent back to the primary care physician so they understand the nature of that appointment, and what activities occurred, and next steps, et cetera.

MS. WEIKEL: This is Michelle Weikel from Passport by Molina.

We have a similar process to that. It is primarily nurse practitioners, but they do go out and meet with targeted members in their homes.

They can do in-home assessments, trying to get an idea of what chronic conditions are happening for that member, help coordinate their care with their primary care physician, they can do some in-home diagnostics so they can do an A1c, they can do a urine, they can leave the patient a Cologuard, those kinds of actual care gap closures when it comes to HEDIS can happen in those visits, and then we will -- there is a notice or a summary of

that visit that goes out to the primary care physician that the member identifies during that visit.

So if the member says, "I don't have a primary care physician," then there is nobody to send that document to. But the attempt of those in-home visits is to reach members who are not seeing their doctors on a regular basis, or who appear to have chronic conditions that are not being appropriately managed, and that is how we target who we go out reach.

I am not sure who was speaking for United, that certainly does happen, I think, more prominently in the Medicare space than it does in the commercial or Medicaid space, but that does occur, at least for Passport by Molina, that does occur across all lines of business.

I wanted to -- somebody had said something about sometimes the MCOs don't know when a care gap has been closed. A lot of that, there is definitely an issue between a true gap in care where the service needs to be rendered versus a gap

in data and that is because a member might have had something done with their prior MCO.

Colonoscopies are a great example because they last for ten years, and we may not have record of that even though the member had that particular diagnostic test a prior year.

Or we don't get actual lab values, so the member might have had an A1c completed, but we don't know that the members results was 7.5.

So there is definitely a strategy that, at least at Passport, we try to address both of those lanes of, is it a gap in care, or is it a gap in data, because the call to action for each of those is different.

DR. SCHUSTER: So you are doing that with Medicaid clients; is that right?

MS. WEIKEL: Yes. Yes, we absolutely do that. And all of our providers who are in value-based contracts get monthly reports from us that tell them who their members are that are assigned to

them, when the last time they were seen in their office, when the last time they were seen for a well visit, as well as any open care gaps, and that is defined by NCQA HEDIS, but, you know, this is a member that we don't think has had their mammogram or we don't believe has had the appropriate immunization that is recommended for their age, that kind of thing.

And then we work through if there are any data issues. We certainly -- and I think all of the payers like to the degree that we get automated data sharing to get feeds out of people's EHRs that will help reduce the times that we go out and ask a provider for a record because we don't have documentation that the care gap was closed, that automated data sharing, data connectivity, is huge for reducing the abrasion in the provider office and then also accurately reflecting what are truly care gaps.

DR. SCHUSTER: I am curious about how you notify the person that you

are making a home visit and how clear that they are about who you are.

MS. WEIKEL: Yes. So at least for Passport, we are very clear in communicating. Our team is called Care Connections. Those nurse practitioners are very clear in communicating that this is -- they are not their PCP, and they are not replacing PCP visits, what the intent of that practice is.

And then they will actually, while they are there, help schedule a visit with the member's primary care physician if they are willing to do that.

So I think we do a really nice job of communicating what the intent is of that visit, and that it is in no way a replacement of the need for that member to engage with their primary care physician.

DR. SCHUSTER: Do you have interpreters?

MS. WEIKEL: We do have interpreters.

DR. SCHUSTER: So do you take an interpreter with you if you are aware that

English is not the primary language?

MS. WEIKEL: No. Those will be telephonic interpreters with the exception of Spanish. We do have some Spanish-speaking Care Connection nurse practitioners, otherwise, the number of languages that is spoken is too diverse for us to be able to bring an in-person translator to those kind of visits.

DR. SCHUSTER: Do you use the telephonic while you are making the visit?

MS. WEIKEL: Correct. That is the same as, I think, a lot of the providers would do in their own offices. You dial in and get the interpreter for the appropriate language to adjust to those members' needs.

DR. SCHUSTER: Okay. All right.

Well, that may be what I have been hearing about. That sounds like the concern or the question, I guess, that I was hearing from PCPs. Thank you.

Stuart, do you have something from WellCare?

MR. OWEN: Yeah, well, I was

going to say, extremely well described by both Michelle and Krista.

Bottom line is there is member contact and provider contact. It's both that is involved.

And then also, even the claims lag can be a lack of data insight as well. You know, we don't know until we get the claim. It's a combination of both member and provider contact with different teams, quality team, care management team, provider relations even, as well.

DR. SCHUSTER: Do you make home visits as Passport was describing?

MR. OWEN: I believe we do, but I don't know for certain, and I don't have anyone on that can verify that. I can check, but I believe we do.

DR. SCHUSTER: Okay. All right. So that is very helpful.

Anybody else?

Thank you, Michelle, for that as well.

Anybody else have anything they want to share?

MS. JOHNSON: This is Megan Johnson, Health Services Officer for Aetna.

We provide very similar to a Michelle described, with quality practice liaisons that meet with our providers that are in VBS arrangements and notify them of open care gaps, as you mentioned, and then any care gaps that have been closed elsewhere where they are not at that PCP.

Our care management team does not provide direct patient care. We use a vendor solution to do those visits, as Michelle mentioned, that Molina does as well, and then that information is communicated with us. But that's -- that is not intended to replace the PCP. It is used as an adjunct for those members that may not be able to visit their PCP or have some barrier in the in-home visit.

DR. SCHUSTER: And what is the name of the vendor, Megan?

MS. JOHNSON: We have Signify.

DR. SCHUSTER: Okay. I don't want to misconstrue this. I don't think

that the PCPs were feeling like the MCOs were stealing their patients. I think it was the confusion that they were hearing from the patient as the patient was trying to tell the PCP that they had their blood drawn or somebody came and listened to their heart and talked to them, and the PCP was like, "Well, you are not getting home health." There was a disconnect.

MS. JOHNSON: Yes, and I think we can probably all do a better job of communicating that with the member.

DR. SCHUSTER: I would suggest that strongly. I am so glad that you recommended that, Megan.

MS. JOHNSON: Yes, appreciate that feedback.

DR. SCHUSTER: Particularly, Michelle with Passport by Molina, because you all are doing a lot of that, and I love nurse practitioners, and I'm glad that they are out there doing that work, but a little more communication with your provider community, just reminding them that you provide that service and how you

choose people, and the feedback that they should be getting.

Because I think the concern was coming from the providers, because the patients were like "I don't know who these people were. I was confused. Was that okay?"

And the providers were trying to figure out who the heck was going into the home and do whatever they were doing. So a little more communication, I think, would close that gap.

Okay. Thank you all very much. This has been very helpful and I will relay this all back to people that I was hearing from. But very helpful, I appreciate it.

I don't want to shut anybody out. Was there anybody else?

Okay. I think we are at the end of our business. I will give you back ten minutes of your day, which is a good thing.

So we are going to meet again on Thursday, March 27th, same time, same

station, and I thank you all for your participation and input.

And Erin will help, and Kelli will help us get the PowerPoints out that were shared with us and so forth.

And if you have some other questions about the change in respite rates and so forth, get those to Erin so that we can get those answered at the next meeting.

Have a good day and we will see you in two months.

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C E R T I F I C A T E

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

Dated this 5th day of February, 2025.

/s/ Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M