CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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Via Videoconference
September 26, 2024
Commencing at 9:32 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

ADVISORY COUNCIL MEMBERS:

Sheila Schuster - Chair
Nina Eisner
Susan Stewart
Dr. Jerry Roberts
Dr. Garth Bobrowski
Dr. Steve Compton (not present)
Heather Smith (not present)
Dr. John Muller (not present)
Dr. Ashima Gupta
John Dadds (not present)
Dr. Catherine Hanna
Barry Martin
Kent Gilbert
Mackenzie Wallace
Annissa Franklin (not present)
Beth Partin
Bryan Proctor (not present)
Peggy Roark (not present)
Eric Wright (not present)

COMMISSIONER:

Lisa Lee, Department for Medicaid Services

P R O C E E D I N G S

CHAIR SCHUSTER: All right. Let's go ahead and get started since people are up -- our western folks are up extra early.

So good morning. This is the meeting of the Medicaid Advisory Council and welcome to you all. I'm Sheila Schuster, the chair.

And we'll call the meeting to order at -- what is it? 9:32. And Mackenzie Wallace is our secretary. So if you would call the roll, please, Mackenzie, I appreciate it.

MS. WALLACE: Yes, ma'am.

All right. Elizabeth Partin?

(No response.)

MS. WALLACE: Nina Eisner?

MS. EISNER: I'm here.

MS. WALLACE: Susan Stewart?

(No response.)

MS. WALLACE: Dr. Roberts?

DR. ROBERTS: Here.

MS. WALLACE: Heather Smith?

(No response.)

MS. WALLACE: Dr. Bobrowski?

(No response.)

MS. WALLACE: Dr. Compton?

(No response.)

MS. WALLACE: Dr. Muller? Sorry about my pronunciation.

(No response.)

MS. WALLACE: Okay. Dr. Gupta?

DR. GUPTA: I'm here. And can you confirm that you can hear me, please?

MS. WALLACE: Yes, ma'am. I can hear you just fine.

DR. GUPTA: Thank you.

MS. WALLACE: John Dadds?

(No response.)

MS. WALLACE: Dr. Hanna?

(No response.)

MS. WALLACE: Barry Martin?

MR. MARTIN: Yes. I'm here.

MS. WALLACE: Kent Gilbert?

MR. GILBERT: Yes. I'm here.

MS. WALLACE: Mackenzie Wallace, I am here.

Annissa Franklin?

(No response.)

MS. WALLACE: Dr. Schuster, you are here.

Bryan Proctor?

(No response.)

MS. WALLACE: Peggy Roark?

CHAIR SCHUSTER: She sent an email this morning that she's tied up.

MS. WALLACE: Eric Wright?

(No response.)

MS. WALLACE: Commissioner Lee?

COMMISSIONER LEE: I am here.

MS. WALLACE: One, two, three, four, five, six, seven, eight.

CHAIR SCHUSTER: Cathy Hanna is here. She was on a minute or so ago, and she's trying to get on on her computer --

MS. WALLACE: Okay. So that gives us --

CHAIR SCHUSTER: -- or on her phone.

MS. WALLACE: -- nine.

MS. BICKERS: I also see Dr. Bobrowski logged in.

CHAIR SCHUSTER: Yes. He's in the chat saying he's here.

DR. BOBROWSKI: Yeah.

MS. WALLACE: Yep. Got it.

DR. BOBROWSKI: Sorry. My screen popped up a new screen on me this morning all of a sudden, and I don't know if I got unmuted in time for my response. Sorry.

MS. WALLACE: That's all right. I got you now, so that gives us ten.

DR. BOBROWSKI: All right.

CHAIR SCHUSTER: Is ten a quorum, Erin? I've forgotten. I've lost track.

MS. BICKERS: Yes. I believe so.

CHAIR SCHUSTER: Okay.

MS. WALLACE: All right. Then we are good to go.

CHAIR SCHUSTER: Thank you very much, Mackenzie. Appreciate it.

MS. WALLACE: Yes, ma'am.

CHAIR SCHUSTER: The minutes of the July 25th meeting as done by the court reporter were sent out to you all. I would entertain a motion for their approval.

DR. BOBROWSKI: So moved.

MR. GILBERT: Second.

CHAIR SCHUSTER: Is that Garth and Barry?

MR. GILBERT: I also seconded, if

that helps.

CHAIR SCHUSTER: Oh, all right.

MR. MARTIN: No. That wasn't me.

CHAIR SCHUSTER: All right. Garth and Kent.

Any additions, corrections, omissions, revisions needed?

(No response.)

CHAIR SCHUSTER: If -- hearing none, all those in favor of approving the minutes, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: All right. We will assume that that speaks for the group, and the minutes are approved.

Good morning, Commissioner Lee. Good to see you.

COMMISSIONER LEE: Good morning.

CHAIR SCHUSTER: Our perennial opening old business item. What is the status of Anthem MCO?

COMMISSIONER LEE: We are still holding steady. There has been no news, no information from the Supreme Court. We do know that there could be a ruling today, but

we are not 100 percent positive. So just still holding steady.

CHAIR SCHUSTER: Okay. May I ask that if you do get a ruling, that you would forward that to Erin to be distributed to the MAC members? Is that something you can do?

COMMISSIONER LEE: I believe that's something we can do. We'll definitely check with our legal team and make sure that we can get it. I'm sure it will be -- there will most likely be a press release or something, but we can definitely get that to you.

CHAIR SCHUSTER: Yeah. That would be great. Thank you very much.

And then an issue very dear to Dr. Gupta's heart, the language access resource for providers. And you were going to get some further information and bring us back --

COMMISSIONER LEE: Yeah.

CHAIR SCHUSTER: -- an update with that.

COMMISSIONER LEE: Yes. And this is just a little bit more complex than we had thought of at first. I mean, our overarching

goal definitely is to make sure all of our members have access to services and that they can access those services in a language that is, you know, their primary language. We have been conducting some more analysis, looking at other states. We haven't -- I don't really have a good update at this time.

I may ask my staff, particularly the Program Quality and Outcomes -- I know they have been researching -- if they have any additional information they can provide at this time related to the access resource for providers.

MS. PARKER: Good morning. Hi. I'm Angie Parker. I'm the Director of Quality and Population Health. As the commissioner stated, it is challenging. We are talking with other states in how this is managed.

As you know, there is the federal law that providers are to provide this service. We can -- you know, each of the MCOs do also provide this service if they -- you can contact them, call them. Or you can also -- if you want somebody to come with them, if

you give them enough notice, they will arrange for an interpreter to come with the member, the patient, to the doctor's office.

So we do have those phone numbers. We can, you know, give the general information as far as the MCOs. But as far as having -- how we're able to do this longitudinally for all the providers, we're still investigating that.

COMMISSIONER LEE: And, Dr. Schuster, I did put in the chat the regulation that Director Parker referenced. It is, you know, part of the Civil Rights Act, Section 504, of the Rehab Act of 1973. So we put that in there.

But, again, our overarching goal, our primary responsibility is to make sure that individuals can access services and that they understand the directions that the providers are giving to them while they are in that meeting.

And there seems to be two different -- two different things we need to look at. The first one is just, you know, that language access line or language interpretation

services for individuals when they go in just for a regular office visit. And then there's the -- the other piece of it for an individual who is actually receiving an extended office visit maybe due to therapies or something like that. Those therapies can run into over an hour, hour and a half. What is the correct modality for that?

As Angie said, some of the MCOs will -- they do have language interpreter services. And if given enough advanced notice, they will -- and do have and will send some individuals with them to make sure that those interpretation services are there.

So, again, it looks like this is just something that needs to stay on the agenda until we have a really good resolution.

CHAIR SCHUSTER: Thank you. I know -- and I don't want to speak for Dr. Gupta. Yes. I was going to call on you, Ashima. Go ahead, please.

DR. GUPTA: Thank you, Commissioner Lee and everybody. So all the MCOs will provide translation services in person if they're given advanced notice?

MS. PARKER: I'm not sure it's all of them. I think at least two, and I can get that information to you which ones that specifically do that. I know WellCare does for sure. I think it's five days, but I can certainly get that information to the TAC -- or the MAC.

DR. GUPTA: Okay. Because, yeah, that would be helpful even if it's just a couple right now. But the other ones -- do we know if the other ones will provide it by phone?

MS. PARKER: Yes.

COMMISSIONER LEE: Yes. They do have a contractual obligation to provide those services. That's where it gets -- you know, where we were -- we were thinking that we could just have one service for everyone to use, you know, make it very simple.

And then when we started looking at the contractual obligations as relates to interpretation services for the MCOs, they all do have an obligation to provide those services. And we've noticed in the chat that Anthem also provides individuals to come to

the office if they have advanced notice. So WellCare and Anthem currently does.

So, again, something that we'll keep on the agenda. And I'm not sure -- Dr. Schuster, if you would like for the MCOs to just come maybe to the next MAC meeting and provide a little update on what all they do with interpretation services for this group.

CHAIR SCHUSTER: Yes. I think -- and, Erin, correct me if I'm incorrect. I think some of the individual TACs have had the MCOs come and provide that information.

MS. BICKERS: Several TACs, yes, ma'am.

CHAIR SCHUSTER: Yeah. And I see where UnitedHealthcare also, Dr. Gupta, provides both in person and telephonic. So that's three out of the six, which is good.

Yeah. I'll look at our agenda for November and see whether we might get just a very brief -- I think, also, Ashima, that you had a question about getting the service quickly.

DR. GUPTA: Yeah.

CHAIR SCHUSTER: You know, it's fine if you have a patient coming in that you know is going to need translation services. But I think you brought up a situation a couple of meetings ago where a patient walks in or brings a child, or whatever the situation is, and you don't know that in advance and then -- then what do you do; is that right?

DR. GUPTA: Right. That was my next question. The phone calls -- I mean, the translation by phone, I mean, yeah, is it pretty instantaneous that we can get that or, you know, are we going to be on hold for, like, a half hour? Things like that.

MS. PARKER: And that's -- that's the challenge when contacting the MCOs. You should not be on hold, but there is an IVR in order for you to get there. So we have been working with them on how to streamline that process.

CHAIR SCHUSTER: So that would be a good question for us to ask the MCOs if they're going to come and talk to us in November, I think, Ashima. And that is: How

quickly can you access that telephonic translation service? When somebody walks into your office, and you've got limited time to see them and provide the service, and you really need it pretty instantaneous --

MS. PARKER: I do know that on their websites, they have the information as well. I mean, obviously, that doesn't help you at the moment, but I do know that they have that information on their websites on how to obtain interpreter services.

DR. GUPTA: Ultimately, I think it would be nice to have just, like, a one-page chart with all the MCOs and how to access translation services. So we can put it, like, in every exam room and, you know, give it to the front desk and things like that.

MS. PARKER: We have a draft of that right now.

DR. GUPTA: Thank you.

CHAIR SCHUSTER: Oh, wonderful. Yeah. Yeah. I think that would be helpful. You're not -- you know, providers are not often in a position.

Passport offers in-person sign language

interpretation with advanced notice. That's the other thing that we ought to look at, is it's not just a non-English language interpretation, but it's also help for patients who come in who are deaf or hard of hearing and need sign language or so forth so...

MS. EISNER: Sheila, this is Nina.

CHAIR SCHUSTER: Yeah.

MS. EISNER: I can't find how to raise my hand on my computer today. I think I've mentioned before hospitals, of course, have an obligation for sign and language interpretation from the time a patient walks in the door. And so there are resources that hospitals use to access someone telephonically immediately.

And for the hospital stay in a behavioral health hospital, that requirement can extend eight, ten hours. Because during the entire course of care, which includes meals, which are an -- you know, an important part of the treatment day, sign and language interpretation must be available.

And so there are rather robust contracts

that hospitals, at least in the behavioral health realm, have access to ensure that there's provision of language and sign interpretation throughout the course of the care day.

CHAIR SCHUSTER: So Commissioner Lee mentioned those longer outpatient sessions, but an inpatient, obviously you're talking about --

MS. EISNER: Yeah.

CHAIR SCHUSTER: -- an eight or nine-hour period of time. So you have --

MS. EISNER: Correct.

CHAIR SCHUSTER: -- your contracts through the MCOs? Are your contracts through the MCOs?

MS. EISNER: No.

CHAIR SCHUSTER: Okay.

MS. EISNER: No, they're not. The contracts are through independent providers.

CHAIR SCHUSTER: Okay. And that's the way the hospitals are meeting that federal obligation?

MS. EISNER: Yeah. For as long as -- for decades.

CHAIR SCHUSTER: Yeah. Okay. That's very helpful.

MS. EISNER: It's expensive. Yeah. It's expensive, but it's essential to care.

CHAIR SCHUSTER: Yeah. All right. Well, that's very helpful. Thank you.

MS. BICKERS: Dr. Schuster, this is Erin. May I reflect for the record that Susan Stewart and Beth Partin have joined us?

CHAIR SCHUSTER: Great. Welcome, ladies. Glad to have you.

All right. We will keep that on, and we may look at -- probably will look at the November MAC for short presentations from each of the MCOs.

Next, Commissioner Lee, since you're front and center at the federal scene as the president of the national association. Anything -- anything going on in Washington?

COMMISSIONER LEE: Very little. Well, I think that one thing that this group is most likely interested in is there is a call today. I think several of you may have received an email related to a -- I think it's just an ad hoc call, they're calling it,

for this afternoon from CMS. I'm not 100 percent positive on the content of that call, but I believe that it is related to the early periodic screening, diagnostic, and treatment benefit within the Medicaid program.

CMS has developed guidance that they will be distributing this month. And since we are on the 26th of this month, I believe that that is most likely what that call will be about. And it is basically outlining, you know, the obligation of states as far as the EPSDT benefit is concerned and provides guidance. There is going to be some language specific to behavioral health around those services.

So we're very excited to get this information. We believe it may help us as we look at our continuum of care for children to see where there may be gaps and how EPSDT can be used to fill in some of those gaps to make sure that we are providing everything that our children need to lead their best lives.

So that is -- that, I think, is the main thing right now. Dr. Schuster, have you heard anything else that maybe I haven't

heard?

CHAIR SCHUSTER: No. I was just curious because a number of us did get that email about -- it was just weird to get an email from CMS saying join us at 4:30 for a press conference --

COMMISSIONER LEE: Yeah.

CHAIR SCHUSTER: -- and then there was no content to it. You know, I was like -- so thank you. And I was texting you this morning when, you know, this was happening.

COMMISSIONER LEE: I do believe it's about the EPSDT benefit.

MS. EISNER: I did not receive that. Is it possible for me to still join that call?

CHAIR SCHUSTER: I suspect so. I wonder --

COMMISSIONER LEE: I can just forward -- Nina, I'll forward the email --

MS. EISNER: Thanks.

COMMISSIONER LEE: -- that Dr. Schuster received to Erin, and she can send it out to the team; okay?

CHAIR SCHUSTER: Yeah.

MS. EISNER: I appreciate it. Thank you.

CHAIR SCHUSTER: That would be great.

And, Erin, if you have -- after you get that from Commissioner Lee, if you have a way to -- well, you would put -- it would go up on the website, too, wouldn't it, after the meeting? I'm just thinking about people that are attending this meeting but don't necessarily get emails from you. I don't know -- it's interesting. Nina, I don't know who they sent it to. I don't know in what capacity I got it, in other words. It just kind of came, and there were a number of us that work with the Thrive group or Kentucky Voices For Health that got it. And we were all kind of texting each other and saying this is like Halloween and the mystery -- you know, reach into the bowl of candy, and you don't know what you're going to get so...

MS. EISNER: Yeah. Well, I'll be --

CHAIR SCHUSTER: But, obviously,

you're interested in EPSDT --

MS. EISNER: Yes.

CHAIR SCHUSTER: -- and I'm sure that we have others interested as well.

MS. EISNER: Good. I'll be happy to join.

CHAIR SCHUSTER: Yeah. Thank you.

Speaking of CMS and federal changes and so forth, where are we, Commissioner Lee, in terms of -- we know we're going to need legislative changes to the MAC and to establish those Beneficiary Advisory Council. Where are we with that?

COMMISSIONER LEE: We have a lot of work to do as far as the final rules go. That's one piece of the final rule. We have contracted with an organization to help us with all the final rules, so we just had a kickoff meeting with them yesterday. This is part of our -- our obligation as the final rules go.

So by -- we are hoping that before our next meeting, which is November 21st, at our next MAC meeting, which is November 21st, to have some draft language for this group to

review before the session starts in January.

CHAIR SCHUSTER: Oh, that would be great. If any of the members of the MAC have any questions or suggestions -- I know I've heard from some -- a couple of groups about they would like to see the MAC change in some ways. Can I ask people to get those to me, and I can forward those to you, Commissioner Lee?

COMMISSIONER LEE: Sorry. I was taking a drink of water there. Yes. I think that Jonathan Scott -- you know, sending those to Jonathan Scott would be appropriate, and I can put his address in the chat.

And I did put the link to the meeting this afternoon at 4:30 in the chat. I do have a meeting with CMS prior to that meeting. So if I hear anything different, I'll let you all know.

CHAIR SCHUSTER: Otherwise, we'll just tune in and --

COMMISSIONER LEE: And find out.

CHAIR SCHUSTER: -- see if it's EPSDT or something else. All right. So we can look for something at the November

meeting by way of a draft from you. That would be great.

COMMISSIONER LEE: Yes. And Jonathan Scott just put his email in the chat for everyone.

CHAIR SCHUSTER: And I think all of us who do anything with regs and Medicaid and behavioral health and so forth are very familiar with Jonathan's excellent work so thank you very much.

How about -- I think there was a Medicaid workgroup that was looking at some of the discussion that we've been having and ways to improve communication with the general public but also with potential beneficiaries or potential waiver recipients. Anything on that?

COMMISSIONER LEE: Yeah. I think I can turn this over to Deputy Commissioner Leslie Hoffmann. Leslie?

MS. HOFFMANN: Good morning, Dr. Schuster. How are you?

CHAIR SCHUSTER: I'm fine. How are you?

MS. HOFFMANN: Fine. So we have --

we're not quite through with this because the more you think about this, the more you figure out you need.

So a couple of things that we're already working on, though, is -- and I know this is at a higher level. We're revamping our website to make it much easier to find. Alisha Clark has been working on that diligently in trying to ensure that there's easy links. And I can send a couple of screen shots later after the meeting is over, or to Erin to send out to you to show how easy they are. Like, it's just, like, choosing your path for services, Medicaid Waiver 101. How do you apply? Like these really easy just click on and there it is.

We also just recently started working with our connectors for training. We have also sent PowerPoints to them that we had, and I know that they are getting the training because a connector connected with me in Owensboro and said that she had already received the training and wanted to know, you know, if there's going to be updated information soon. So I do know that they're

getting it. It's trickling down.

Also, we're working on some one-pagers that we want to establish about the waivers and the processes. And so I think that'll be beneficial. As I get into this, though, I realize that there's some racial and health equity pieces I probably need to think about, and so we're going to try to -- excuse me, try to go through some of those pieces as well and how can we get the word out better.

As with any project, you know, even when we use a -- like the GARE tool to -- you know, to view programs or tasks through the racial and health equity lens, we often miss things. So I'm already starting to think I need to take this a little bit farther in conversations with our teams at Medicaid and maybe even outside of Medicaid.

So, again, that's what we've got done so far. We've been working on the one-pagers. We have already sent training. I know the connectors have received at least one kind of our Medicaid 101 training. And that is available on the website in the -- in the updates that I'll send you and then the

one-pagers.

So I know that's kind of high level. I still don't feel like I'm getting down to the grassroots. So, like, I still think we need to, like, maybe take it a little bit farther. Every time I get a step forward, I think maybe I need to go a little bit farther.

So we're also very interested, Dr. Schuster, in you making comments to help us to figure out what we might need to get out there as well.

CHAIR SCHUSTER: I appreciate that, Leslie, because we have had some -- mostly moms that I've been in touch with, some of whom have been in touch with Commissioner Lee who really found out about waiver services for their child just by word of mouth and Facebook. And we're really having a struggle to figure it out.

In fact, I met with a mom about two weeks ago, and she said, you know, if it weren't for coming across people at the school, you know, that have their children there -- and I -- you know, we get to talking and then I realize that there are things out

there that I don't know.

I'm delighted to hear that the connectors are being trained. And I want to thank again the Disparity and Equity TAC, Dr. Figueroa for having me come and talk with them. And in the course of that meeting, I think that's where the very clear recommendation came because we had some connectors on there.

And the idea is if you've got a connector and you're being asked some questions, they were not realizing that some of those were screening questions to direct people to a waiver. And so there was kind of that gap there.

MS. HOFFMANN: Absolutely.

CHAIR SCHUSTER: So I'm delighted to hear that the training is going on. I think that's excellent.

MS. HOFFMANN: You -- I think I've mentioned this to you before. But if we're asked to come to -- and we did this all the way back when I was the actual director for this division. If we're asked by schools to come in and do parent nights, we do. Our

staff have went in on Saturdays and did parent meetings and even, you know, school meetings to tell the school officials about the services as well.

And I think April maybe just completed those -- one of those not too long ago. So we do -- if we're asked to do that, we do especially come in and try to talk to schools prior to folks leaving.

So -- and grab any opportunity we can. So, oftentimes, things like supported employment, go into a school prior to the child leaving. And so those are things that we -- we try to grab onto anything that we can.

CHAIR SCHUSTER: Yeah. I also think that if you get some really readable one-pagers, that I would hope that you would run those by -- Rick Shekel (phonetic) is actually retired, but he wants to keep on doing that. He's the best translator I know to get things down to a -- you know, an easy-to-read, sixth-grade reading level kind of thing. Emily Beauregard and the Consumer TAC, I think, does some of that as well.

It would be really helpful to think about where we could put some of these one-pagers. Health fairs, obviously; provider offices; you know, any of the centers, the FQHCs, the CMHCs, and so forth just to get the word out there.

MS. HOFFMANN: Yeah. As we -- and it's going to take just a little while because, you know, we've got to make sure that we get them correct and easy. But once we get those completed, we could just share them with you, Dr. Schuster, and we could distribute to see. Because I'm sure you all might have comments or additional things that you might want to change.

CHAIR SCHUSTER: Yeah.

Dr. Partin, I see you have your hand up and welcome. Where did you go?

DR. PARTIN: I'm muted. Sorry. Can you hear me now?

CHAIR SCHUSTER: Oh, okay. Yes.

DR. PARTIN: Okay. I just wanted to tag on to what you just said about the one-pager and simplistic reading. I think for -- looking at some of my patients, large

font and very simple language maybe would be helpful to people. Maybe not have all the information on that page but maybe information about what it is that you're trying to communicate in a larger font and very simple language and then maybe directing them to who they might talk to or call to get further information.

Because I find that some of my patients, even at a sixth grade level, reading is difficult. So they bring me the letters, and sometimes I don't know what the letters mean either. So something really simple and along with what Sheila was saying about the one-pager and a larger font because some of them have trouble seeing as well.

MS. HOFFMANN: And we -- Dr. Partin, we can run that through our group here. There's rules around that and visual -- there are rules around the font, the level of reading. We have several rules around that, and maybe we can take a look at getting that into Spanish as well.

DR. PARTIN: Okay. Thank you.

CHAIR SCHUSTER: And you mentioned,

Beth, you know, where can they talk to somebody or call? Remember, we still have parts of Kentucky that don't have Internet access, and we have maybe parents who are not as savvy with computers, maybe don't have a computer and so forth.

And I think that they would need to -- and I know -- I'm pretty sure, Leslie, that, you know, there's a waiver phone number at DMS that people can call for information, that kind of thing. I think there's even a help desk maybe. But I do think that having telephonic access would be helpful.

MS. HOFFMANN: Okay.

DR. PARTIN: Yeah. Exactly. Some of my patients don't even have cell phones so, you know, somebody that they can talk to would be really helpful.

CHAIR SCHUSTER: Yeah. Dr. Gupta, your hand is up. Is that left over from --

DR. GUPTA: Left over. Sorry. Let me take that done.

CHAIR SCHUSTER: That's all right. I didn't know if you had a question or not.

DR. GUPTA: No. Sorry about that.

CHAIR SCHUSTER: That's all right. Anybody else have any suggestions? I would like, Leslie, if you can share some screen shots with us and maybe one or two of these things and let us get some --

MS. HOFFMANN: I still feel like the screen shots are higher level than what you're talking about because, like, what you just said, the access to the computers. But at least it's a start trying to make it simpler and easier. And Alisha has been working on that, and I think it's really looking good. So I'll go ahead and share some screen shots with Erin for this meeting; okay?

CHAIR SCHUSTER: Okay. That would be great. Thank you. And I've got my little group of moms that are eager to look at some of this and give you some feedback.

MS. HOFFMANN: Absolutely.

CHAIR SCHUSTER: And they may be some of our best. Maybe Beth can run it by a couple of her patients and others on the MAC. You know, we have access to, you know, people coming in the door who don't know Medicaid.

Thank you.

MS. HOFFMANN: You're welcome.

CHAIR SCHUSTER: And we are ready for the biannual maternal/child health update as well as implementation of the Momnibus bill. So that's typically Dr. Theriot.

DR. THERIOT: Hello, everybody. Good morning. How are you?

CHAIR SCHUSTER: Good morning, Dr. Theriot. Glad to see you.

DR. THERIOT: It's always -- you know, you feel successful when you figure out how to turn on your camera and your microphone. It's a good day.

Well, we've actually had a lot of things going on around maternal health. The first thing I wanted to mention is we're working on a doula report, and that report is -- it's an LRC report that will look at or is looking at what other states are doing. If they have benefits, how are they incorporating doula benefits into their Medicaid programs, how much they're charging -- or not charging but how much they're reimbursing the doulas and for what services. So that report is in the

works.

There's a public meeting this Friday at 10:30, and you all should have gotten an invite to that meeting. And there's also a survey going out, so we're trying to get everybody -- everybody's opinion and thoughts on the process.

CHAIR SCHUSTER: Dr. Theriot, excuse me. Can you put the link to that meeting in the chat?

DR. THERIOT: Oh, I can. I'll have to -- yes. I'll switch out and get that.

CHAIR SCHUSTER: After you do your report. I just want to be sure that -- if people have somehow not seen that. And I haven't seen the survey come out yet. Is it out? Is it being circulated?

DR. THERIOT: It will come out tomorrow as well.

CHAIR SCHUSTER: Oh, okay. Wonderful. Well, we will be on the lookout for that.

DR. THERIOT: And Leitha just put the link to the survey -- or to the meeting.

CHAIR SCHUSTER: Okay.

DR. THERIOT: And it's at 10:30 tomorrow.

CHAIR SCHUSTER: Okay. 10:30 Eastern. Thank you very much. Thank you, Leitha.

DR. THERIOT: So that's something big that's happening.

The other big thing that was incorporated into the Momnibus bill was the Lifeline for Moms. And we kind of touched on it back in January, but that -- that is a grant that public health received from HRSA, and it's a five-year grant to get this system up and running.

And it's not really a program. It's going to be a system. They're going to hire administrators and clinical personnel like psychologists and clinical social workers. And what that will be -- it's not a phone line for moms to call. It's for the doctors to call.

And we have seen -- we have a big problem with postpartum depression, and we have seen in our data that people -- providers do not necessarily screen for

depression even though it should be standard of care. And one of the reasons -- or they will screen people they think are depressed, which we all know that's not how screening works. But it's to help provide providers with supports when they get a positive screen.

And we unfortunately have seen in data that providers don't screen because they say, I'm not a psychiatrist. I don't know what to do. If somebody is depressed, you know, I can't help them. And I guess they're going to just stick their heads in the ground and, you know, hope it goes away. I don't know.

So this will give the providers a phone number, one number to call. They will get an administrative staff and will get back with them right away with a clinical provider who will talk them through a treatment plan. You know, that plan might be, you know, start this medicine or go -- you know, let me get you in contact with an actual behavioral health provider, something like that. But they won't leave them hanging.

And the thought process to start the

program will be to look at the Medicaid data and see where the areas of the state of highest need is and then we will start there. It will start 8:00 to 5:00 with the plan to open it up to 24 hours eventually. Also going to start with OB/GYN offices and then eventually open it up to family medicine and to pediatrics.

And so the Momnibus bill basically wrote that program into -- or that system into the regs and has public health having authority over that program. So that's the -- that was a really good thing in Momnibus.

The other things that were in there, like lactation consultants and breast pumps, we already cover those in Medicaid, but it was good to have it in there because that bill is for more than just Medicaid. And so other insurance companies, private insurance will have to cover those if they don't.

Let's see. Oh. And we have been working on the Transforming Maternal Health Grant that is through CMS. We've worked with public health on that as our sister agency, and we are right now currently waiting to

hear back from CMS on that proposal. And that's it.

CHAIR SCHUSTER: Okay. Do you typically -- I'm trying to think. When you give these reports biannually, do you also update the mortality data that you have?

DR. THERIOT: We haven't received new data. It comes out, I think, in November.

CHAIR SCHUSTER: Okay.

DR. THERIOT: With the new -- with the annual maternal mortality report.

CHAIR SCHUSTER: Okay. So it's annual. All right. So --

DR. THERIOT: So I can -- I can do that next time.

CHAIR SCHUSTER: Yeah, if you have it in November or do it in January.

DR. THERIOT: Okay. Sounds good.

CHAIR SCHUSTER: You'll have the -- yeah. Thank you. I was trying to think because I thought you had presented that and then I couldn't remember where. So that's annual. All right. Thank you.

Anybody have any -- oh, Beth. You have

a question?

DR. PARTIN: Yeah. Also, besides the mortality, could we get an update on any information about disparities?

CHAIR SCHUSTER: Yes.

DR. PARTIN: And where we are as providing maternal care, you know, in the state, if there's any updates on that?

DR. THERIOT: Yes. I can do that.

DR. PARTIN: Thank you.

CHAIR SCHUSTER: Thank you, Beth. Yeah. That's been an ongoing issue.

Anyone else have any questions for Dr. Theriot?

(No response.)

CHAIR SCHUSTER: We are very excited about Momnibus and so glad to see that things are moving along already, and the doula study and survey are coming at a great time.

DR. THERIOT: Lots of things happening. We're very excited.

CHAIR SCHUSTER: Yeah. There's a question in the chat about copying the link, that somebody is having trouble doing that.

I don't know which link was last put on there. Maybe for the meeting tomorrow?

MS. SHEETS: I'll send that information out in a follow-up email. This is Kelli.

CHAIR SCHUSTER: Yes. For the Friday meeting. Could that be put in there again? Thank you. I think that was Leitha that did that.

Thank you, Dr. Theriot. We appreciate that.

DR. THERIOT: Thank you.

CHAIR SCHUSTER: Quarterly update on PDS rate increases.

MS. HOFFMANN: Dr. Schuster, I'm going to try to answer this one. But when you say quarterly update -- and maybe this was something that Pam was doing earlier. I was going to answer the question. I think this come up not too long ago.

So the participant, if they choose to provide a raise for their employee -- and that can be based on a lot of factors; right? Like, they're -- they've got additional training that they've gotten. They're having

a hard time obtaining staff for whatever reason. And those are conversations that the employees -- the employee would have, not necessarily -- I'm sorry, that the person would have, not necessarily would the employee be in those discussions. This would be the employee making that decision.

The traditional and the PDS service have a max cap, or a maximum allowed amount, and they're equal. So you can -- you can pay equal amount. This might have been something -- I'm not sure -- that was put on the list earlier on.

Do you have -- like, am I answering the question okay, or would you like for me to follow up on that?

CHAIR SCHUSTER: I'm laughing because I'm, you know, relatively new at this still, so I'm going back and looking at previous MAC meetings. And it says "quarterly PDS," and I see that we haven't had a report since January. So I thought it was time for us to do it again.

MS. HOFFMANN: Oh, okay.

CHAIR SCHUSTER: I am not --

actually am not sure. Beth, do you remember? Because you were the chair for so many more years before this.

DR. PARTIN: Remember what?

CHAIR SCHUSTER: Where this PDS -- quarterly update on PDS rates.

DR. PARTIN: No, I don't.

CHAIR SCHUSTER: Okay. And I don't think that Eric Wright is on. He's our MAC member that's usually on top of particularly PDS and so forth because he's also a family member --

MS. HOFFMANN: So I think it did come up in another meeting, and I can't remember which one it was. But if you want to follow up on that and -- if I'm not answering your question. So folks do have a right to give an increase based on whatever additional, like I said, training, or they've had a hard time finding staff, they can do that. And the PDS and the traditional service right now have an equal allowed amount, so it's not unequal.

So if you find out that you need something else, let me know. But when I saw

that, I was like, I'm not sure what the quarterly update was.

DR. PARTIN: Sheila, I think that is an Eric issue.

CHAIR SCHUSTER: Yeah.

DR. PARTIN: And I think the reason I don't know the answer to that is because he kind of led those. I just kind of -- he would email me, and I would put it on the agenda and say, okay, Eric.

CHAIR SCHUSTER: Right, right. Yeah. That came up with the legally -- what's the terminology? Legally identified person or something, Leslie. There's something that we've had on here last time.

MS. HOFFMANN: Yeah. I can't remember now either. If I'm not answering the question, though, you can either revise your question --

CHAIR SCHUSTER: Or I'll -- yeah. I'll get with you after I talk with Eric because I'm not sure.

MS. HOFFMANN: No problem.

MR. SHANNON: Yeah. Sheila, Steve Shannon. It's LRI.

CHAIR SCHUSTER: LRI is the legally --

MR. SHANNON: Responsible individual.

CHAIR SCHUSTER: Responsible individual. Thank you, Steve. So do you know anything about these quarterly PDS updates? Does that make any sense?

MR. SHANNON: I do not. I know it's been on the agenda, and I don't know the specifics of why or what was discussed previously.

CHAIR SCHUSTER: So let me ask you this, Leslie. Because you're making the point that the PDS total amount per family or per person in the waiver is the same as if they were getting regular waiver services; right?

MS. HOFFMANN: And I thought that might have been the question, Sheila. Like, when were we going to get them equal?

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: But they're already equal, and I double-checked that this morning, that they already were equal.

CHAIR SCHUSTER: Okay. So there would not be an increase in one without there also being an increase in the other?

MS. HOFFMANN: That's correct. That's the plan. We try to keep parity on these two.

CHAIR SCHUSTER: Okay. So the --

MS. BICKERS: Dr. Schuster --

MR. SHANNON: There's no quarterly increase in waivers; right, Leslie?

MS. HOFFMANN: No. I was trying to figure out if the question just came from something that he had had -- somebody had had before and was asking me to give a quarterly update for something to be done. But, again, we can follow up, and I can re-answer the question later.

CHAIR SCHUSTER: Yeah. So the other question that's come up on PDS is in maybe some parts of the state, people are having a hard time finding a case manager who's able to do or willing to do PDS.

MS. HOFFMANN: Sheila, that was brought up in another meeting this -- we've had lots of meetings this month together, I

think. So we are working on figuring out a way to streamline the process and what our options are here in Kentucky. Nothing has been finalized.

We had a meeting with CMS that was supposed to be around the week of the 16th, and they said that they needed to move that meeting because they had a lot on their plate, too. So they've moved it to October the 3rd, I believe.

So we had some information that we were going to meet with them about -- I know this is getting confusing -- on the 30th. So I asked if we could have that meeting after the -- since they moved our preliminary meeting, I asked if they could move our finalizing meeting about going forth with some discussions about what steps Kentucky can take to streamline and to -- the bottlenecking of the access to -- we never want a bottlenecking or a decrease in access of services or a waiting list; right? So we are working through that.

And, again, I think I told you last time that we don't have an official cap. We're

just working through those options with CMS. And so, again, they moved their date on me. So I've asked if we can move our next date with them out after the preliminary date. I think it's October 3rd.

CHAIR SCHUSTER: All right. So maybe by November, we might be able to get some feedback from you about what's being done to streamline PDS --

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: -- and address the bottleneck because it's --

MS. HOFFMANN: We're working with our sister agencies on this. Department of Aging and Independent Living have been at the table. They now participate in all my CMS calls. So I just wanted to let you all know that we're very integrated on next steps with CMS.

CHAIR SCHUSTER: Okay. Thank you.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: I appreciate that. So we'll put that on November's agenda.

What about changes to NEMT, nonemergency medical transportation?

MS. DOWNEY: Erin, do you have a slideshow you can put up for me?

MS. BICKERS: Yes, ma'am. Give me just a second. I've got to switch screens.

MS. DOWNEY: Thank you. My name is Becky Downey. I work with NEMT. I work under Eddie Newsome, and we have put together just a little slideshow for you. I'm just going to read it to you.

CHAIR SCHUSTER: That's great. Thank you.

MS. DOWNEY: You're very welcome. Medicaid recipients will now receive NEMT services to narcotic treatment programs. Those places provide methadone treatment to opioid use patients.

CHAIR SCHUSTER: So is that a new -- is that a change, Becky? I'm not familiar with that.

MS. DOWNEY: Yes. Yes.

CHAIR SCHUSTER: Okay.

MS. DOWNEY: Previously, we did not give members transportation to those facilities.

CHAIR SCHUSTER: Okay.

MS. DOWNEY: Those are the ones that I think you have to be there by a certain time, and they only do it a certain amount of -- you have to be there by a certain time, and you only have a certain amount of time during the day to do it.

CHAIR SCHUSTER: Okay.

MS. DOWNEY: So yeah. And it's usually, like, a really quick thing. They run in, they take their medicine, and then they're able to run right back out. So it's not like they have to stay and wait for hours. Some of them do end up having to see a counselor or a doctor, but the majority of them are just an in-and-out situation.

CHAIR SCHUSTER: Okay. That's great. Thank you.

MS. DOWNEY: Yes. You're welcome. Medicaid recipients' eligibility changed from -- before, it was no vehicle in the household and no vehicle -- it's changed to no vehicle in the recipient's name, which means, you know, if -- it didn't matter who lived in the house. If there was a vehicle in there that was operable, that counted as a

vehicle. So now, as long as it's not in the member's name -- it can be in their mother's name, their girlfriend's name, you know, somebody that's living with them. Regardless, if it's not in their name, we do offer the service.

CHAIR SCHUSTER: That's great. Because when we do our road shows, we hear more about that as being a barrier to getting NEMT.

MS. DOWNEY: Yes.

CHAIR SCHUSTER: So that's fantastic.

MS. DOWNEY: Yes, it is.

CHAIR SCHUSTER: Yeah. That's great. Thank you.

MS. DOWNEY: You're welcome.

Recipients with a vehicle in their name may be exempt if they provide a note from the clinician, the school, an employer, a mechanic, or a transportation authority. So, again, that's for the ones that do have a car in their name in the household but, you know, maybe they're not allowed to drive. You know, the doctor says they can't. Maybe they

have seizures. You know, it's broke down. It's inoperable. That's, you know, a lot of times, a mechanic's statement, you know. So it just depends.

CHAIR SCHUSTER: Okay.

MS. DOWNEY: The exemption notes must verify the vehicle is unstable for the recipient. Recipients under 18 will have same vehicle ownership status as parent or legal guardian, and parents may request a two-week exemption for children.

Future changes. We're hoping the Department of Medicaid Services will work with recipients on future changes to increase the quality and access. We want to do everything we can, obviously, to get these members back and forth to their doctors, hospitals, you know, whatever they need to do.

And that's really it. Thanks for letting me share information, and I hope everybody has a great day.

CHAIR SCHUSTER: We've got a couple questions. Don't go away yet.

MS. DOWNEY: Sure. No. No

problem. I'll be right here.

CHAIR SCHUSTER: All right. Beth?

DR. PARTIN: What does -- the two-week exemption, what does that mean?

MS. DOWNEY: I'm pretty sure -- let me make sure I know this correctly. Sometimes the vehicle may be inoperable, but they expect for it to be fixed. You know, let's say that it needs, like, brakes and rotors, something that's not extremely expensive, but they do expect to have it fixed within the next few weeks. That's kind of what that means.

DR. PARTIN: So they can get transportation if the vehicle is going to be fixed in two weeks? I'm not --

MS. DOWNEY: Yes. Yes, ma'am.

DR. PARTIN: Okay. So once it's fixed, then they're not eligible again; right?

MS. DOWNEY: Right. Yes, ma'am.

DR. PARTIN: Okay.

CHAIR SCHUSTER: I guess my question, Becky, is: How are the brokers being told about these changes, and how are

the beneficiaries being told about these really good changes?

MS. DOWNEY: That part I'm not sure about. I know that everything is sent over to the Department for Transportation, which means our contacts over there do let the brokers know. It's also, whenever they're checking for eligibility in the system, it's in the system.

And I'm not really sure -- I'd have to ask Eddie, my supervisor, about how the members know. I'm not sure if things are -- you know, if there are things that are being sent out, mass mailings or anything that are sent out to let them know about that.

CHAIR SCHUSTER: Yeah. I would think that -- I think it would be very important because some of these things have been in place for a lot of years. Like, you know, if there's a vehicle in the family, you just think, well, I can't ever get NEMT.

And that's a huge, huge change, so it feels like we really need -- and probably providers to know. I'm for letting everybody know all the good news, and this is --

MS. DOWNEY: Yes. I will --

CHAIR SCHUSTER: -- a fairly significant change.

MS. DOWNEY: I'll take that back to Eddie and ask him about that.

CHAIR SCHUSTER: Okay. And, Nina, you had a question.

MS. EISNER: I do. One of the things that we often hear is there may be a vehicle; it may even be operable. But they don't have any money for gas. So is inability to fuel the car an exemption?

MS. DOWNEY: No, it is not.

MS. EISNER: Okay.

CHAIR SCHUSTER: But the change would be, Nina, that it only is going to be a problem if the car is in the Medicaid recipient's name?

MS. EISNER: Right.

CHAIR SCHUSTER: Yeah.

MS. EISNER: And that'll help.

CHAIR SCHUSTER: That will help, yeah.

Dr. Theriot?

DR. THERIOT: I was just going to

mention for pediatrics, we're actually really excited about this. Because if you think about it, sometimes a family will have a car that they can drive, but Dad needs it to go to work.

CHAIR SCHUSTER: Right.

DR. THERIOT: And Mom doesn't have access to it to bring the child to the doctor. And this way, they can. Now they can utilize the NEMT service to do that.

MS. DOWNEY: Yes.

DR. THERIOT: I think it really opens things up.

CHAIR SCHUSTER: Yeah. And that scenario, Dr. Theriot, again, we hear -- you know, we take this road show all across Kentucky. And transportation is always -- transportation and housing are the two things that people have the most concerns about getting, and food security as well.

But the -- that particular one where, yeah, you have a car, but if somebody doesn't use it to go to work, then there's no money coming into the family. And somebody else needs to either get to the doctor or take the

child to the doctor. So excellent point.

Any other questions for Becky?

(No response.)

CHAIR SCHUSTER: Becky, I would ask if you have any follow-up information about how some of that -- how this is -- how these changes are being communicated, if you might let Erin know.

MS. DOWNEY: Sure. Yeah.

CHAIR SCHUSTER: So we can let people -- here's a question. If two parents are on the vehicle title and one parent needs the vehicle for transportation?

MS. DOWNEY: I don't know about that one. I do think it excludes them, you know, if they are both on it. But I'd have to ask about that one. I haven't had that question.

CHAIR SCHUSTER: Okay.

MS. DOWNEY: I'll ask about that one, too. I'm writing it down right now.

CHAIR SCHUSTER: Yeah. Thank you. We'll give you a little bit of homework.

MS. DOWNEY: That's fine. Not a problem.

CHAIR SCHUSTER: Yeah. A question here from a provider out in western Kentucky. When do these things go into effect? I've forgotten. The reg has been approved, so they actually are in effect now, I think.

MS. DOWNEY: Yes, they are. I don't know if Jonathan Scott knows that. I'm not sure, but yeah. It's already in effect.

CHAIR SCHUSTER: Yeah.

MR. SCOTT: Yes. The reg has been effective since June.

CHAIR SCHUSTER: Okay. Thank you, Jonathan.

So my final question is: Is anybody, meaning Medicaid or Department of Transportation or anybody, doing kind of a real simple one-pager about these changes? Again, you know, if we're making really great changes at our level but nobody on the ground knows about them, they're really not helpful. And we've just got to get this information out there.

MS. DOWNEY: Right.

CHAIR SCHUSTER: So let me ask my Medicaid folks. I don't know if

Commissioner Lee is still on. Do you have somebody that -- do you have somebody on your staff that kind of turns these things into, you know, communication, one-pager kind of things?

COMMISSIONER LEE: Yeah. We can have our communications office do that.

CHAIR SCHUSTER: And, again, simple to read. You know, put a picture of a car on there and say, "We'll come to pick you up," or something. You know, let's get people's attention. I think that would be really helpful, Commissioner.

COMMISSIONER LEE: We'll work with our Office of Transportation Delivery, too, and we'll see if we can get something out.

CHAIR SCHUSTER: Okay. Great. Well, Becky. Thank you. We don't always get such good news.

MS. DOWNEY: No. No problem. Any other questions, I'll be on here. You just let me know.

CHAIR SCHUSTER: All right. Well, I appreciate Commissioner Lee and Jonathan and all the staff at DMS really going after

and making these changes. This was something Commissioner Lee...

Here's a question in the chat. Let me see if I can get the whole thing. We have trouble locally getting Medicaid transportation to schedule a person who has a vehicle -- oh, if we have problems. That's a good question, Becky.

Here would be another question. If a provider is working with a patient and they're having trouble getting the broker to schedule because they still are saying they've got a vehicle in the home even though it's not in the recipient's name, who do they go to? Who do they take that problem to?

MS. DOWNEY: I would think the Department of Transportation, and I can --

COMMISSIONER LEE: You could get the Office of Transportation Delivery. Jeremy Rogers is our contact over there. And, yeah, Becky looks like she's looking for the telephone number they can put in there.

MS. DOWNEY: Yes.

COMMISSIONER LEE: And if they -- and they're typically very responsive. But

if they cannot get someone at the Office of Transportation Delivery, they can definitely reach out to the Department For Medicaid Services, too.

MS. DOWNEY: Yes.

CHAIR SCHUSTER: Okay. So if somebody could put Jeremy Rogers' -- if it's a phone contact, all the better.

MS. DOWNEY: It is. I'm putting it in the chat right now for you.

CHAIR SCHUSTER: Oh, all right. There you go. NEMT questions or complaints. So that ought to go at the bottom of the one-pager, Commissioner Lee. Not to tell you how to do your business but, you know, just a suggestion.

Oh, and there's phone numbers, too. Wonderful. Super helpful. Great question. And thank you again, Becky. We may have more for you before the end of the meeting but...

MS. DOWNEY: That's fine. I'll stay on. Not a problem.

CHAIR SCHUSTER: All right. Thank you so much.

MS. DOWNEY: You're welcome.

CHAIR SCHUSTER: And thank you again, Commissioner Lee, because you have taken this on and really done a nice job with it. Big changes. And thanks to all the advocates. I know that we had many advocates that have been pushing on this for years.

Clarification on services that individuals with SMI will be eligible to receive through the reentry waiver. And that's probably you again, Leslie.

MS. HOFFMANN: It is. So this particular reentry application has a limited package until post-release; okay? So the individuals in state prisons and the juveniles in the YDCs are eligible for that case management 60 days' prerelease to identify -- and it covers physical health, behavioral health, which is, you know, mental health and SUD. And it also covers health-related social needs.

So all of that is to try to prepare the individual for leaving and reentering into society. So they developed that care plan based on those needs that they -- that they have identified prior to release to make sure

that the person can go out and be successful.

All the individuals in state prisons and the YDCs are also eligible for that 30-day supply of medication at the time of release, which includes, again, physical health, behavioral health, which is both, and then some over-the-counter. We can cover that as well to make sure that they got their medications the day they leave.

The individuals who have SUD in state prisons and YDCs are eligible for MAT prerelease. Then we've also started working on the jails.

As far as the SMI, the current package for that 60 days is going to be limited because it's just what I just told you. So it's very limited, and we are not allowed to what they call supplant any funds that DOC or DJJ should be covering.

So I did call Commissioner Crews this morning, Dr. Schuster, and she said if any of those needs are identified, that SMI is one of those services that they currently cover. So some of the particular programs that they might have like the SAP and the SOAR, which

is SUD, might only be available in certain areas or certain programs that they have. But she said if that is identified, they do cover those, so everybody has the right to those needs.

So if you need me to get any additional information -- I did call her this morning because I didn't want to speak for her within the jail system. So we meet with her every week. So if there's something specific that you'd like me to reach out, I can.

CHAIR SCHUSTER: And she's with Department of Corrections; right? With the prison system?

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: She is deputy -- yeah, commissioner. Sorry, not deputy. She is a commissioner.

CHAIR SCHUSTER: That's helpful. So, essentially, if the juvenile justice system or the corrections system, whatever services they have available for SMI obviously are going to still be given.

MS. HOFFMANN: Yeah. So I just

wanted to not -- I didn't want to speak for her, but she said yes, that's fine to say. So if there's an identified need, then it should be addressed and covered by those facilities.

CHAIR SCHUSTER: Okay. But they would be hooked up with the case management; right? The SMI folks are going to get the case management.

MS. HOFFMANN: So that -- and I think you're talking about more than just 60 days at the end; right? I think you're kind of looking at person was in for, let's just say, several years. It wouldn't be just that coverage that we're trying to cover at the last 60 days.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: That's what I needed to ask Commissioner Crews about. I can tell you, though, that the -- like, SAP and SOAR and things like that, that's their bigger programs on SUD, I don't think they're across Kentucky yet. They're working on developing those, and I was very pleased to hear what they're doing so far.

So I think these conversations, Dr. Schuster, though, with DOC, DJJ, and Medicaid and all of us sitting at the table has -- you know, it's opened up -- like I said before, the more you know, the more you realize you don't know and the more you need to address; right? So it's just opened up all these opportunities, but she's very open and willing to listen to things that we have to say so got a good relationship there.

CHAIR SCHUSTER: Good. I know some psychologists who have been in that system and, you know, are very dedicated to making sure that while people are being incarcerated and have the symptomatology around SMI, for instance, that they're getting the treatment they need.

MS. HOFFMANN: There has been some confusion that even in that 60 days, that Medicaid is just allowed to cover everything, and we are not. We are not. We have a limited package.

We kept that package, you know, a limited amount and at 60 days due to the fact that CMS said that we along with three other

states could get approved by July 1st, and we got approved July 2nd. They said that we could do that if we did not change our application. So can we build upon that later? Sure.

They are very watchful, though. I'm just going to tell you that. Medicaid is very watchful that they are not duplicating funds that DOC and DJJ should currently have. Does -- and that makes sense. That's in any program. We have to ensure that we don't duplicate.

CHAIR SCHUSTER: Yeah. All right. Any questions? We've talked a lot about the reentry waiver because I think the statistic that you gave us at the BH TAC, Leslie, was that 8,000 people are released each year from the prisons in Kentucky.

MS. HOFFMANN: I believe that's correct. I don't have the number in front of me. Sorry.

CHAIR SCHUSTER: That's a lot of people.

MS. HOFFMANN: That's a lot of people, lot of people in Kentucky.

CHAIR SCHUSTER: And I'm guessing that a high percentage of them have either some mental health or some addiction or a combination of both issues going on.

MS. HOFFMANN: And chronic physical health conditions. I've told you that.

CHAIR SCHUSTER: Yes, chronic physical. Yeah.

MS. HOFFMANN: We've got the epidemic of syphilis, HIV, and Hep C. We've got -- you know, we've got an epidemic again in Kentucky. So that is a big area that if we could figure out how to assist with that, those symptoms and medication before they leave, which we're working strongly with public health and have also -- have met with some folks out in the communities, some FQHCs that are going to have grants related.

And we wrote a support letter. Not that we're connected to that grant. We just wrote support letters to figure out a way how we could partner on those physical chronic conditions.

CHAIR SCHUSTER: Yeah. Any other questions from anybody on the MAC about the

reentry waiver? I will tell you again that the Reentry TAC -- and we'll hear from Steve Shannon -- meets on the second Thursday of every other month at 9:00. And that's -- they were meeting for about two years before the waiver got moved to law. And so now they're really getting busy, and it's exciting. So thank you.

Can we get an update on unwinding Medicaid and flexibilities and the status of children? And I see my friend Veronica Cecil. This is her favorite thing to talk about.

MS. CECIL: It is. Good morning, everyone. Thank you for giving us an opportunity to provide an update. I'm going to share my screen.

CHAIR SCHUSTER: All right.

MS. CECIL: And I, just for the purposes of time, you know, have been kind of condensing this more and more as we move out of unwinding and move into the new normal of eligibility and enrollment processing.

So just a reminder to folks that we have now completed all of the -- what we call the

PHE renewals, those renewals that were on hold for three years. And we restarted with May 2023. We have now come out of those -- a 14-month cycle of distributing those renewals across the 14 months. And we're coming out of what we call that extension period.

So just to remind folks, we still have the flexibility to extend folks one month if they haven't responded to an active renewal notice and up to three months for long-term care and 1915C members.

And then we're also starting to come out of the 90-day reinstatement period which, as a reminder, if somebody is terminated and comes back to -- to provide the information that was requested 90 days following their termination, then they can be automatically reinstated 90 days back as if there's no gap in their coverage.

So that is a flexibility that is also continuing. And by that, I mean CMS, Centers For Medicare and Medicaid Services, have allowed states to continue those types of flexibilities through June of 2025.

I get a lot of questions about the child

renewal. As a reminder, what Kentucky did -- and we were the first state to do this. We requested an automatic 12-month extension for children during the unwinding, and that flexibility remains. We have had to request from CMS to continue it, and they've not provided a response to us. So that -- that request is still pending, but we are allowed to continue until we hear from CMS otherwise.

So we are -- we are automatically extending children 12 months. That doesn't mean we won't get a child termination if the child turns 19, if the child is out of state, or if the child's parent or guardian requests disenrollment for Medicaid.

So you will see some terminations as a result. But otherwise, we are extending 12 months when that child's renewal comes up and then they have continuous coverage because Kentucky adopted a continuous coverage for children. So in that 12-month period, if there is a change of circumstance, that does not get acted on until after the 12 months. And then those termination reasons are still possible if that child turns 19, moves out of

state, or has requested disenrollment.

So -- and the reporting continues with CMS. So every month we continue -- by the 8th of the following month of renewal, we continue to post those on our website, or unwinding website, which I'll provide in a minute. And you can go out there and look to see what's happening at a more in-depth review of each month's renewal.

And then our updated -- which is updated monthly reports are those reports that, at the 90-day period following a month of renewal, we will then update the report based on any pending cases that were processed in that 90 days. So both those reports are on our website if you want additional information.

We are -- we knew about the decline. We knew folks were ineligible when we were going through the unwinding -- through the Public Health Emergency because we were required to keep everyone covered through continuous enrollment.

But as we came through unwinding, and this is from January of last year and to last

month -- sorry, last week, we are at about 1.45 million folks. We've kind of reached a little bit of a plateau. And as we come out of unwinding, I think we'll return back to that normal churn that we saw prior to the Public Health Emergency. People come on and off of Medicaid every month. It's part of the normal churn.

I will say, however, that we adopted a lot of different outreach activities during the Public Health Emergency unwinding, and we're going to maintain those. And those include things like calling folks, reaching them through various modes of communication. So if we have a cell number, we'll try to call them. We'll text them. They always get a written notice.

So, you know, we're trying to -- if somebody has to go through an active renewal, we have lists that we pull down every week, and we're calling those folks to make sure they know. And we're trying to reach them to make sure they know that they have an active renewal. They have0 to take action.

We're still asking our providers to play

a role in supporting our members. If that member is coming into your office and you can check on KYHealth-Net to see when their renewal is, then, you know, maybe ask them: Do you know you're going through a renewal? Have you gotten a notice? If not, maybe they -- encourage them to reach out. So, you know, hoping that providers will continue to support us to make sure that we're reaching everybody where they are.

So just looking at the past three months and looking at August because you've not seen yet July and August from the last MAC meeting. But focused on August, we did have a smaller number. And the result of that is from our redistributions from last year, trying to move the children renewals on into the unwinding period so that we could implement that automatic 12-month extension.

So we had a smaller number in August, 36,136, a really nice, high approval rate. Even though it's a smaller number, it's a high approval rate of 31,823 and then termination of 979. And we only had two pending at the end of August.

That extension is -- the column there that says "extended" is that flexibility I discussed where we can extend folks a month or up to three months of long-term care or 1915C waiver. So we're just reporting out how many were extended at the end of the month because they did not take action.

And then that far right is those reinstatements I discussed, that 90-day period following their termination where we can see folks come back in. So as of September 13th in August, we already saw 163 come back in, which is a good number. We're, you know, hoping to always see those increase, meaning we're finding people even if it's after their termination.

So that is just a couple of slides. I will post the unwinding link, unwinding website link in the chat and happy to take any questions.

CHAIR SCHUSTER: Thanks very much, Veronica. It's always good for us to kind of see what the overall enrollment looks like and the issues that are going on.

I think this afternoon, you're having

the Medicaid stakeholders' meeting?

MS. CECIL: Thank you for that plug, Dr. Schuster.

CHAIR SCHUSTER: Yeah. I was looking at my calendar this morning, and I'm like: What is this Medicaid forum? And then I'm like: Oh, yeah.

MS. CECIL: Oh, yes. Which we had to move because we're having in-person forums right now across the state, but yeah. So, normally, our monthly Medicaid virtual stakeholder meeting is on the third Thursday. But this month, it is this afternoon. I'll also post the link to that.

We have shifted. We were holding every month an update on unwinding. But now that we are coming out of unwinding, we kind of now are moving to focus on various updates from the department. So I'll also post the link to that, so I appreciate that plug. It's at 1:30 this afternoon, and it's virtual.

CHAIR SCHUSTER: So in case any of you are not tired of meeting by the time we get to the end of our meeting, you can grab

something to eat and then go to the 1:30 meeting but...

MS. CECIL: And we do record it. So if you want a break, you can find it on our website usually a day or two after if you want to go watch it later.

CHAIR SCHUSTER: Yeah. And I do think I do hear from people that attend these regularly that it is a good way to hear the latest from Medicaid. And, also, I think you conduct them so that people can ask you questions; is that right, Veronica?

MS. CECIL: Absolutely. Yep. We do provide -- yeah. We provide an opportunity for questions.

CHAIR SCHUSTER: All right. Great. Any questions or comments from the MAC members with Veronica about the unwinding? Always glad to see that the children -- the status of children is being protected. We appreciate that.

MS. BICKERS: Dr. Bobrowski has his hand raised.

CHAIR SCHUSTER: Oh, okay. Thank you. I don't have my little screen up.

Garth, go ahead.

DR. BOBROWSKI: Well -- and I'm sorry. I was just -- I need to go back one notch. I was just kind of making sure my notes that I'm taking are correct. But just back on No. G, the waiver relating to incarcerated Kentuckians, was that -- was the number 8,000 people that were released per year as an average? Was that -- did I write that down correct?

CHAIR SCHUSTER: I'll let Leslie answer if she's still on, but I think it --

MS. HOFFMANN: Yeah. Let me double-check that, Dr. Schuster. That sounds right, but I hate to say that that's correct. I'll just double-check with --

CHAIR SCHUSTER: I think that's what you told us at the BH TAC, and I think it was 8,000 in a year, Garth.

MR. SHANNON: Yeah. Dr. Schuster, this is Steve Shannon. That number was reported by Kristin Porter with Corrections at the Reentry TAC as well.

MS. HOFFMANN: Okay.

CHAIR SCHUSTER: So it's 8,000 --

MS. HOFFMANN: But I was going to double-check. Thank you.

CHAIR SCHUSTER: 8,000 in the past year? I guess the question is: Is that -- what's the time frame?

MR. SHANNON: It's a year. 8,000 a year.

CHAIR SCHUSTER: 8,000 a year.

MR. SHANNON: Yeah. She didn't say which -- I think it's close to an average.

CHAIR SCHUSTER: Yeah.

DR. BOBROWSKI: Okay. Yeah. That's fine. Thank you.

MR. SHANNON: It's a lot of people.

DR. BOBROWSKI: Sorry I'm going back on it there.

MS. HOFFMANN: Thank you, Steve.

DR. BOBROWSKI: Thank you.

CHAIR SCHUSTER: No. That's fine. You know, we see a lot of numbers and so forth. So that's a lot of Kentuckians to take care of.

Here's the other thing. You know, Kentucky continues to have -- ranks at the top of a category we don't really want to,

and that is the number of children who have at least one parent, if not both parents, who are currently or have been incarcerated.

And there was actually some testimony about that. I'm not sure what committee that was, but there was really some heartbreaking testimony from a young man, probably a high school student, who talked about the impact of his mom having been incarcerated through a lot of his growing-up years. So something to think about.

Any other questions for Veronica?

(No response.)

CHAIR SCHUSTER: And we'll -- you know, this PowerPoint and so forth will be on the website, and Erin will send it out to us as well. And there's the link to the stakeholder meeting this afternoon. Thank you, Veronica.

MS. HOFFMANN: Dr. Schuster, I was just going to mention something. We're so -- like, so in preliminary stages, I can't, like, hand you something today. But, you know, we've been working on that multisystemic therapy pilot. We went from a

three-year pilot to a five-year pilot. And we added DJJ also in as a provider of those services. And that's a partnership, integrated partnership with the Department of Community Based Services. And they pay for some items that Medicaid cannot cover. So we're partnering with them, with these five providers.

But one of the things that we're seeing, multi- -- for those of you that don't know, multisystemic therapy is to assist a child in diverting totally from a justice system. Because we know once they're in the justice system, then that, you know, just later increases their likelihood to be incarcerated.

But what we're seeing is, is that the siblings of the child that we're involved with and the mom and dad are less likely to have problems while we're working with that kiddo. So I'm just wondering -- I didn't mean to say kiddo, the child.

But I'm just wondering, like, in the future if we'll be able to show some good data about how our involvement with a family

has actually trickled over to other family members. Does that make sense, Dr. Schuster? That's very exciting to me.

CHAIR SCHUSTER: Absolutely.

MS. HOFFMANN: To keep a sibling out of trouble or even a mom and dad because we're involved with one child in the home. That's pretty cool. Like, that's going to be really good. So I'm -- we're just preliminary, but that's kind of what we're seeing right now.

CHAIR SCHUSTER: Yeah. I'm not a family therapist but, you know, the family systems people would tell you that the analogy that they use -- or that they used years ago when I was in graduate school was that if you have a pool of water, whether it's a bathtub or a pond or whatever, and you throw your little rock in, it permeates everything that's in that pool.

So if you think about it that way, every family is a system. You know, that's systems therapy. That's the systems approach. So anything that happens to any member of that family affects the entire system, both

positive and negative.

MS. HOFFMANN: And this has been one of the first evidence-based opportunities that the Cabinet decided for us to pursue, so I've been very excited. You know, I'd love it if Medicaid -- CMS could cover all -- you know, take a look at a lot of evidence-based practices.

But this has been a very exciting, in our partnership with DCBS -- I mean, it couldn't happen if we weren't partnering together right now. So yeah, but I'm just -- I'm excited to see some of those.

I was even more likely to go from a three-year to five-year pilot just so we could get some more data. Because part of that was during COVID, and I didn't feel like it was a good baseline for us so...

CHAIR SCHUSTER: Right. So that's why you -- you know, as the therapist, you always want to -- and I was a child psychologist for 30 years. You always want to involve the -- not only the parents but very often the siblings and the school system.

You know, I mean, all of those systems are affected by the child, and the child is affected by those systems. So that makes all the sense in the world to me and great that you're going to do it for additional years, Leslie. That's exciting.

MS. HOFFMANN: I think July 1 started our third year, I believe, so we still have a couple of years. And we've added in DJJ actually as a provider, which is kind of exciting.

CHAIR SCHUSTER: Right. So our final thing, and this probably is you, is the status of the report that you're required to give to the legislative body about the HCBS waiting list and how it's being managed.

MS. HOFFMANN: So we were successfully able to complete the draft on time. And it is still in current internal review, but it has been completed. So we're excited to have that off of our plates, still in internal review, though.

So yeah, that's -- unless you've got more information that you would want, I would just tell you that we successfully got it

completed. We have a contractor that was assisting with that, GuideHouse, and did get it drafted on time.

CHAIR SCHUSTER: And do I remember that it was going to CMS?

MS. HOFFMANN: No. It goes to -- that one just goes to the legislature. I think it was in the preconference, yeah, section.

CHAIR SCHUSTER: Yes. Yeah. That's where it was. I thought once before, when we asked you about it, that there was something about CMS was going to --

MS. HOFFMANN: Oh, so we have to get -- we have to get CMS approval for the 26 slots based on us submitting that HCB -- House Bill 6 report.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: There was no problem with 25, but we had to -- we're going to have to add those slots in to the waivers.

CHAIR SCHUSTER: Okay. So when will that report be public?

MS. HOFFMANN: I don't know when it will be public. It's got to go through its

process. It's not due to legislators until October 1, I believe.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: But ORLA, I believe, had to have it a month early, something like that.

CHAIR SCHUSTER: Okay. So you'll --

MS. HOFFMANN: It's just a process, yeah, but we did get it drafted on time.

CHAIR SCHUSTER: All right. So you'll make that public when it becomes public.

MS. HOFFMANN: Yeah. That's correct, Dr. Schuster.

CHAIR SCHUSTER: All right. Yeah. All right. Let's turn to our TACs. And, Evan, do you have a second to give your report now?

MR. REINHARDT: I sure can, if that's all right. I didn't want to jump --

CHAIR SCHUSTER: Yeah. If you need to get off, why don't you do that.

MR. REINHARDT: Thank you so much and apologies for having a conflict.

So the Home Health TAC met August 30th. We discussed our ongoing old business with electronic visit verification, chatted on our supply fee schedule, which we're still trying to -- you know, still waiting on a transition there, and then talked through some issues with Availity and authorizations and ESET.

So we did not have any recommendations, and we plan to meet again here on October 8th.

CHAIR SCHUSTER: Okay. So you're staying with the every two-month kind of meeting schedule?

MR. REINHARDT: For now, yes.

CHAIR SCHUSTER: Yeah. Okay. I know that some of the TACs are going to quarterly meetings.

All right. Thank you very much. Appreciate that.

MR. REINHARDT: Thank you.

CHAIR SCHUSTER: All right.

Therapy TAC? It looks like they're meet -- is that they're going to meet, Erin?

MS. BICKERS: They did meet on 9/10.

CHAIR SCHUSTER: Oh, 9. Yeah. What am I thinking? Okay.

MS. BICKERS: I'll put those in parentheses next time to make it a little more clear.

CHAIR SCHUSTER: Well, no. Put a slash.

MS. BICKERS: Okay.

CHAIR SCHUSTER: I was reading it as 9 or 10, and I'm like: What is this?

Okay. So they met. Is there anybody on from the Therapy TAC?

MS. BICKERS: I'm not seeing anyone. No, ma'am.

CHAIR SCHUSTER: Okay.

Primary Care did not meet; right?

DR. MOORE: We meet next month.

CHAIR SCHUSTER: I'm sorry. I'm hearing somebody.

DR. MOORE: We meet next month.

CHAIR SCHUSTER: Ah. Okay. So you'll have a report for us in November?

DR. MOORE: Yes.

CHAIR SCHUSTER: Okay. Thank you.

Physician's TAC?

DR. GUPTA: This is Dr. Ashima Gupta. We have not met. We will be meeting October 18th.

CHAIR SCHUSTER: Okay. Thank you, Ashima. So you would have a report in November, then, when we meet?

DR. GUPTA: Yes.

CHAIR SCHUSTER: Yeah. Okay. Thank you.

Pharmacy?

MS. BICKERS: I do not see anyone on from pharmacy, Dr. Schuster.

DR. HANNA: I'm here. Can you all hear me?

MS. BICKERS: Oh, my apologies.

CHAIR SCHUSTER: Yeah. Who's that? Cathy?

MS. BICKERS: It is --

DR. HANNA: (Audio glitch.) And they had two recommendations or, you know, action items. The first was they passed a motion for the Department of Medicaid Services to accept pharmacists as providers that are able to order, manage, and bill for community health worker patient

interventions, visits, and encounters.

And they had a second motion that passed for the Kentucky Department of Medicaid to pay pharmacists an administration fee for long-acting, antipsychotic medications. This would reduce the need for an additional office visit, which is a barrier for many, and provide better patient access to care because you've got them there; okay?

This would be medications such as Abilify, Aristada, Zyprexa, Invega, and Risperdal. And these are the injectable forms, obviously, the long-acting. And also, you know, to provide other medications such as B12 injections as well.

CHAIR SCHUSTER: All right. So those are two reports -- or two recommendations. I have to say, as a behavioral health provider, that anything we can do to make the long-acting injectables, psychiatric medications more available really needs to happen, folks. Cathy and I have talked about this, so I am delighted to see that recommendation, Cathy.

Ashima, you have a question?

DR. GUPTA: Can you repeat the first recommendation? There were two; right? I heard the second one, but I didn't --

DR. HANNA: Yeah. There were two. The first one was to accept pharmacists as providers that are able to order, manage, and bill for community health worker patient interventions, visits, and encounters.

DR. GUPTA: So does that one lead into allowing the second resolution to happen?

DR. HANNA: I think they -- you know, it could in some instances. I think that possibly they could, but there are other -- (audio glitch) -- do that pharmacists are active in that -- or pharmacies and their staff are active in those areas, to assisting with, you know, health education and training and all of -- (audio glitch) -- and increase access for patients.

DR. GUPTA: You're kind of breaking up. I couldn't really hear everything that you were saying, but yeah. I'm just interested in more what that would mean.

Does that mean that pharmacists would start treating patients and seeing patients?

DR. HANNA: (Audio glitch) -- providing access to care from another provider, you know, coordination of benefits, this type of thing. So I don't see it as necessarily seeing them.

And on the second one, we are -- you know, if we dispense a product, we can administer that. And that has been done for years, the administration of a product, you know, a long-acting antipsychotic. And so that is -- so they're separate. There are two different recommendations for that reason.

MS. BICKERS: Dr. Hanna, this is Erin. Do you mind to send those recommendations to me in writing? I am not finding where they were sent to me after the meeting in August.

DR. HANNA: I will certainly do that. Thank you.

MS. BICKERS: Thank you so much. And if I missed them, I do apologize.

CHAIR SCHUSTER: All right. Thank

you for those recommendations, Cathy.

Steve, I know you're on. Persons Returning to Society From Incarceration?

MR. SHANNON: Correct. Yeah. We met in July. We had a quorum. So we struggle to get a quorum, but we had one last meeting, approved minutes. Got an update on the reentry waiver. Heard a lot about it today, a lot of the, you know, similar information. Again, we're really excited about how this moves forward and what it looks like.

We always get updates from MCOs and how they're working with reentry already, so I think we're getting ready for that. And, also, the last piece -- one, we have no recommendations. We will have a presentation at our November meeting, if you're interested to learn more about it, from Kristin Porter of the Department of Corrections about their reentry efforts. So we'll all learn more about what it looks like going forward.

And the last piece that I think is invaluable to TACs is I think we've identified someone with lived experience, and

our TAC has a seat for that person. And hopefully it goes through the process pretty quickly, and that individual gets appointed. It's a person with lived experience in terms of being a reentry to society and a Medicaid beneficiary at one time.

CHAIR SCHUSTER: Great. Any questions for Steve?

(No response.)

CHAIR SCHUSTER: All right. Thank you for that, Steve.

Optometric? I think Dr. Compton told me he was not going to be available for this meeting. And they did not meet; right, Erin?

MS. BICKERS: No, ma'am. I believe they meet in October.

CHAIR SCHUSTER: All right.

Nursing Services? It looks like they met in August.

MS. BICKERS: They did, and I am scrolling. I do not see anyone on.

CHAIR SCHUSTER: Okay. Nursing Home Care? Nursing Home Care, I should say.

MS. BICKERS: They have not met all year. I am not sure if they'll meet in

December or not.

CHAIR SCHUSTER: So they haven't met all year?

MS. BICKERS: No, ma'am. From my understanding, I believe they have a task force that they have been working through some of their issues.

CHAIR SCHUSTER: Hmm. Okay. Thank you, Erin.

IDD, Intellectual and Developmental Disabilities?

(No response.)

CHAIR SCHUSTER: And they met in August, it looks like.

MS. BICKERS: They did. They also voted in a new chair, which would be Wayne. I do not see someone on.

CHAIR SCHUSTER: Okay. Are we letting people know, Erin, that we really need for them to show up at this meeting to give a report? I guess I'm -- I'm disappointed if the TACs are meeting and we're not hearing about it. And if they're not meeting or not meeting at all, you know, it feels like we need to get to the bottom of

that, too. Either that -- that part of the provision of services is, you know, not being heard from, which makes me worry about whether the recipients are getting all that they need and the providers as well. So just a thought.

Hospital Care?

MS. EISNER: This is Nina. Russ was not able to be on the phone to deliver his report, so I'll be doing that. The Hospital TAC met on August 27th, and there was a quorum.

There was a lot of discussion around NDC issues. Hospitals report they continue to have issues with multiple denials for invalid NDCs within MCOs and Medicaid when the hospital believes the NDCs billed are accurate and valid numbers.

There was a lot of discussion as to whether or not Medicaid might have a master NDC list or if the MCOs would be able to create their own because it doesn't appear that there's a uniform source of truth around this matter. It was noted by the MCOs that the sources of truth are CMS, APS file, and

Palmetto Medicare file. And it's recommended that there be further discussion with the DMS pharmacy group on this matter.

Though there is no recommendation on this, a meeting was requested by the TAC with DMS pharmacy to explore the issue further, and more examples were requested by DMS to ensure the denials are solely for NDC and not a billing error.

Next discussion was on retro authorizations and altering medical records for payment. There were two letters sent out to clarify DMS policies recently. The first one discussed retro authorizations and split auths and defines and specifies who is responsible for an inpatient stay. That was helpful.

If a member has FFS Medicaid or MCO coverage upon admission, that does not change if coverage is lost during an inpatient stay. And if a member gains Medicaid coverage after admission, fee-for-service or the MCO is responsible at the start date of eligibility. And the second letter sent out discussed DMS not allowing MCOs to require providers to

alter medical records for payment purposes.

Next was discussion on soft denial issues. The discussion was around a tool that the MCOs reported using in a provider form to scrub claims looking for errors in coding, documentation of medical necessity, and sending claims back, which the TAC has questioned if the review was appropriate and fits the definition provided by DMS on prepayment review. So DMS asked the TAC for examples to further the discussion, and that is in process.

Also, several MCOs are using software, mainly the Optum analyzer, to look at ED visits and downgrade the visit denying the initial bill for the hospital and reducing payment or not paying it at all with no reason given and no way to appeal and no letter of communication on why it was denied, only a remit with no recent code.

Incarceration issues. The TAC representatives had a meeting with the Department of Corrections on these issues. It was very productive and led to several items to work on to help alleviate some of

the friction providers are experiencing. Additional work has stalled, and the TAC asked DMS to help restart the discussions and facilitate another meeting.

Skilled nursing facility coverage. Issues concerning MCOs not covering SNF care, and FFS doesn't cover until after one month. So there's a donut hole with no coverage at all and -- no coverage for a month. And hospitals can't transfer the patients without a payment source. This issue has been taken to the long-term care group.

Notification of Medicaid payment rates. Checking to see when the rates are sent out to hospitals after a final rule is established in August and takes effect in October.

And, finally, split authorization guidance. Still waiting on a decision, direction from DMS concerning payment for telehealth services. And although there are many discussions and lots of requests for DMS, there are no recommendations. And the next TAC meeting is October 22nd.

CHAIR SCHUSTER: Very good.

DR. PARTIN: Nina, I have a question. This is Beth Partin.

MS. EISNER: Hi, Beth.

DR. PARTIN: Did you all talk about the -- you were talking about the lookback, I think, on the request for --

MS. EISNER: The retro authorizations?

DR. PARTIN: For money, for payment.

MS. EISNER: Yeah, the retro authorizations. Uh-huh.

DR. PARTIN: So I'm wondering if you all are working on the fact that they can look back three years, but we can only go back 90 days for appealing the request or request for payments. I don't know if I'm saying that right.

MS. EISNER: No. You are. That discussion specifically -- I'm familiar with what you're talking about, but that was not part of the conversation at the most recent TAC meeting. But we can certainly take it back. So the issue, that DMS can look back up to three years, but providers can only

look back 90 days; correct?

DR. PARTIN: Right. And it's a challenge.

MS. EISNER: Yes.

DR. PARTIN: We have no recourse to challenge that three-year lookback.

MS. EISNER: Yes.

DR. PARTIN: So you just have to pay it. I think that's an issue for hospitals and all other providers alike.

MS. EISNER: Yes. I'm making note.

CHAIR SCHUSTER: Yeah. Garth, you had a question.

DR. BOBROWSKI: Yeah. Just, again, just making sure I heard this right, that, Ms. Nina, you said that the MCOs are asking the -- I guess, the physicians or the assistants, the nurses that put in the notes to go back and change their medical records so that they can get paid.

I mean, that just goes against every course I've been on on the legalities of medical care. I was on the board of dentistry for eight years. So, I mean, that just goes against everything we've ever done.

I don't know. You got any other comments on that? How are the MCOs allowed to do that?

MS. EISNER: I'd have to talk to -- or ask DMS to comment on that, but there was a letter that discussed DMS not allowing MCOs to require providers to alter medical records for payment purposes. So I think that DMS concurs.

Lisa or anybody, you all want to chime in on this?

MS. CECIL: Yeah. It's Veronica. That's correct. I know there's been an industry practice of insurers trying to capture as much information in the medical records as possible because that leads to their HEDIS scores. So, you know, they're trying to ensure a complete record.

We did issue a letter that says it's inappropriate for a Managed Care Organization to alter a record. It may be -- it may be different if they are working with the providers on the completeness of a medical record, but the MCOs should never be --

MS. EISNER: Yes.

MS. CECIL: -- altering a record.

MS. EISNER: Yes. And the TAC was very appreciative of that clarification from DMS. Thanks, Veronica.

MS. CECIL: You're welcome.

CHAIR SCHUSTER: Ashima, do you have your -- do you have a question for Nina?

DR. GUPTA: No. Is my hand still up?

CHAIR SCHUSTER: Yes. It's still up. That's all right.

DR. GUPTA: My gosh. Sorry.

CHAIR SCHUSTER: Nina, you were in the BH TAC, very spirited discussion about MCO audits.

MS. EISNER: Yes.

CHAIR SCHUSTER: And I wonder if your TAC has talked about -- are you all beset with these increasing number of audits on the behavioral health side?

MS. EISNER: No. That hasn't specifically been taken to the Hospital TAC, but it certainly can be.

CHAIR SCHUSTER: Well, I would like -- and, Ashima, I would like for you at the Physician TAC also to ask your behavioral

health providers. Because what's happening -- and I'll have this in my BH TAC report. But, you know, prior authorizations were suspended by Medicaid during the pandemic for all behavioral health services. They were then stored for residential SUD treatment. But everything else in behavioral health, both inpatient and outpatient, does not require a prior authorization.

And so what's happening to providers in behavioral health, at least at the outpatient side -- and Nina was in that meeting -- is that they are being just inundated with requests for hundreds of records at a time with a seven-day turnaround kind of thing. And we're just trying to get a handle on what's appropriate with these audits.

So if you're going to meet, Ashima, you know, before our next MAC meeting, I would like for you to ask your providers or to ask them to check with their -- you know, with the psychiatrists about what their experience has been, if you don't mind.

DR. GUPTA: Sure. Specifically, is the question about the prior authorization

burden?

CHAIR SCHUSTER: No. It's specifically about the audit burden.

DR. GUPTA: Ah. Okay.

CHAIR SCHUSTER: And the reason that the MCOs say that they have to do this is because there is no PA right now on behavioral health services.

DR. GUPTA: Okay. So they're auditing. They're doing a lot of auditing.

CHAIR SCHUSTER: Auditing like crazy.

DR. GUPTA: Okay.

MS. EISNER: Requiring entire medical records, the multiple, multiple cases at a time.

CHAIR SCHUSTER: Right.

MS. EISNER: It really is an egregious practice in that it is very much overly burdensome on the provider, and that is required for payment to be rendered. And so some organizations that are smaller are saying, you know, we don't have the manpower to respond to all these audit requests. And so it was quite the robust discussion.

Which MCO -- I can't remember, Sheila -- was the one who was particularly at center on it?

CHAIR SCHUSTER: WellCare.

MS. EISNER: WellCare.

CHAIR SCHUSTER: Their chief medical officer was on, and it was a -- I'll use the word "spirited." It was a very spirited discussion. So if you -- yeah. If you've got a psychiatrist on there, I would just give him a heads-up maybe to ask, you know, if his psychiatric colleagues are finding this or if their agencies are finding this.

MS. EISNER: Yeah. This is one of those interesting topics that crosses hospital, behavioral health, physicians, and many other providers so...

DR. GUPTA: And is the turnaround request seven days mostly?

CHAIR SCHUSTER: It has been in most of these. And so Medicaid always says, hey, you know, the provider has the absolute right to ask for an extension of that time. But what we're hearing particularly with the

WellCare -- and they have a subsidiary that does this that's called Datavant, I think --

MS. EISNER: Yeah.

CHAIR SCHUSTER: -- is that when the request is made, the most that the providers have been given is another seven or eight days, which, again, if you're being asked to copy 400 records, you know, and nobody has the kind of staff available to do that.

So I'm just trying to get a handle on this. But it's particularly a problem -- although I see where home health just came on and said that they've been audited as well. But I know it's a particular problem in behavioral health because that's where the PAs were suspended.

DR. GUPTA: Okay.

CHAIR SCHUSTER: Okay. Thank you. And, Nina, if you would take it back to the Hospital TAC --

MS. EISNER: I will.

CHAIR SCHUSTER: -- that would be, I think, very helpful.

MS. EISNER: Yeah. And I think,

really, the other thing was, was that -- and I'm sure you'll address it. But they're saying that -- at least this particular MCO CMO was saying that they have to go for all these audits because they don't have an ability to do a PA on behavioral health.

And since the outpatient utilization in particular is nearly the highest in the United States, they have concerns about clinical services being evidence-based and appropriately rendered, which was really offensive, quite frankly, to those of us in the industry.

So thank you. I will take that back to the Hospital TAC.

CHAIR SCHUSTER: Well, I just think that we need to have an answer for that.

MS. EISNER: Yes, ma'am.

CHAIR SCHUSTER: And DME companies are also receiving multiple audit requests from WellCare, again, with a short time frame so...

Let's move on to EMS and that TAC, and they did not meet.

MR. SMITH: Good morning, ma'am.

CHAIR SCHUSTER: Oh. Hi.

MR. SMITH: Hi. This is Keith Smith. We have not met since the last MAC meeting. We went to a quarterly schedule. However, the last meeting we had, I was not able to report out to the MAC because of the scheduling issue.

But we have been dealing with working with Department of Medicaid Services to look at getting our reimbursement rate increased for nonemergency medical transport, using our ambulances when a patient has to go by an ambulance.

Right now, our current reimbursement rate is $55 for the base fee and $2 for a loaded mile. So essentially, every time we take a nonemergent Medicaid patient, our EMS services are losing money, not in theoretical money, in real cash money.

Given the cost of what our staff -- we have to pay our staff, the cost of operating the ambulances, the cost of fuel for the ambulances, the maintenance, the medical equipment on board the ambulance.

And it's getting to a point that -- we

have providers openly stating that they're getting to a point that they're no longer going to do nonemergency medical transport out of an ambulance because they simply cannot afford it.

So we did -- I did have a meeting with Commissioner Lee about this and several others with Medicaid services to bring along what the issues are that we're having. She is committed to working with us to try to find some type of solution going forward.

I will say that we do have some of our services that are getting politically active and going to their representatives in Frankfort to bring the issue up to them. I would much rather have us work as a group through the TAC to get this done, but I understand why some of the services are trying to go the legislative route to get this done.

So we do need to have active discussions on this matter and try to find some way. I know that we're in a non-budget session this coming session, but many of the services are wanting to plant the seed with their

legislators that we have got to have more money dedicated to Medicaid services for EMS services so that we can pay our bills and pay our people.

CHAIR SCHUSTER: Well, and I think we all want you to be able to transport people that need to be transported. So what's the differential, Keith, between your nonemergent rate and your emergency rate?

MR. SMITH: Fantastic question, ma'am. We have a program set up, the GEMT program, to where we have a cost share to be able to pay for -- or to be able to increase the reimbursement for our emergency transports. However, CMS has indicated that it would be illegal for us to use that same type program for nonemergent transports, so we are prohibited from using that type of a program for our nonemergency.

So, really, the only solution that we have been able to come up with is to get additional dollars through DMS in order to compensate the EMS services for the nonemergency transports. Again, we would have loved to have been able to do it through

the GEMT program just like we do the emergency runs, but CMS has said that's a hard no. And we're not allowed to do that program.

CHAIR SCHUSTER: Huh. So the funding would have to come in allocation from the general assembly to Medicaid. So it still gets a federal match, I assume; right?

MR. SMITH: We believe it would. Honestly, when it comes time to the specifics, I'm going to have to defer to the Department of Medicaid staff on how all that works. Those folks know that program much, much better than I do.

But that's the way it looks at this point, is that Medicaid services would have to receive an allotment to be able to use towards the nonemergency transport runs. And we would not be able to do it through a fund-sharing program such as the GEMT program.

CHAIR SCHUSTER: Okay. I just am curious about whether nonemergent transport gets federal -- gets a federal match. So we can look at that.

MR. SMITH: Uh-huh.

CHAIR SCHUSTER: Is somebody from Medicaid on that could answer that question, just out of curiosity?

MS. CECIL: We would -- it's Veronica. We would draw down a federal match for any services. Yeah.

CHAIR SCHUSTER: Yeah. All right. I just wanted to be sure that it wasn't a direct -- you know, it helps with the legislature if you could say, well, you're -- you know, you're putting up 30 cents for us to get a dollars' worth of service from Medicaid, and I just want to be sure that it still gets a match.

All right. Well, that's very helpful, Keith. And, you know, keep us posted. You'll have another meeting where you can report in November, then.

MR. SMITH: Yes, ma'am.

CHAIR SCHUSTER: Yeah. Great. Thank you very much.

MR. SMITH: You're welcome. Thank you.

CHAIR SCHUSTER: Disparity and

Equity?

MS. BICKERS: They meet -- I believe October 16th is their next meeting.

CHAIR SCHUSTER: All right.

Dental?

DR. BOBROWSKI: Yes. This is Dr. Bobrowski. Our TAC met in August. We did have a quorum. We're going through a little transition time where we've gotten a couple of new members, getting them up to speed.

But I want to just briefly just mention a couple of things. One of the things that just came to our attention two days ago -- and I know some other TACs have experienced some issues with the MCOs. I feel like overall, especially the last few years, we've had a good working relationship with MCOs.

But the -- one of them is just -- is not backing down on doing extensive prior authorizations for just routine dental work. This list was just sent to Commissioner Lee, I think, Tuesday, so she's got that in her hands. But if she's like me, she may have not read off her emails yet.

But the other thing they're doing is changing the codes of the work that we do to pay a lesser fee. And I've always been told that's illegal, but they're doing it. So that's an issue that's going to have to be worked out, and this one MCO is recouping monies from dental offices with no reason of why. They're told, then, that they've got to pay this money. Then they've got to re-file for the services done.

It's like, folks, what's going on out there? I mean, we're dealing with staff shortages, low reimbursements, administrative time and costs out the wazoo, and our dental supplies are -- you wouldn't believe -- I'm sure some of you would -- how high the supplies are going.

And I just want to give you one example. If I've got a patient that -- Medicaid patient that comes in the door and they need a filling done, well, I look at it. I'll get reimbursed about $50 for that. Well, I pay my receptionist. Say she gets $22 an hour. I pay my assistant 22 to $25 an hour. That's $47 already I'm out, and we get paid $50.

Something is going to have to give, and the dental people are working with the legislators. I get reports from other states, and the latest ones I've gotten this week are from Texas and Louisiana. And they're working with their legislators. I believe it was Louisiana just got an increase from the legislators of 12 to 13 million dollars for dental.

And, you know, some of these other states, they're about like us. Texas hasn't had a Medicaid fee update since 2007. We've been fortunate to work with Commissioner Lee. Some codes through dentistry have been increased, but a lot of them are still hanging around the 2002 fee schedule. And, folks, something is going to have to give.

Practitioners are just having to put seeing Medicaid patients on hold for a while because they've got a business to run. We don't get grants and monies from the Government other than just what we work.

But I'm not going to be a cry baby and keep going on this. But, you know, it's just like the EMTs. That's affecting our

ambulance services here in our county. They're losing money just to make a run. And it's just sad that we've got all kinds of money for certain things, but we don't have money to take care of our people. We don't have money to take care of our providers.

One state -- and I'll hush after this one. But one of the states, I believe it was Louisiana, they were trying to do an incentive thing for practitioners for getting additional payments. I'll give you a couple.

One of them was just to get the patient back in within six to eight months for a follow-up exam and putting fluoride varnish on children's teeth. Another one was to get in patients that are under one year old, you know, to start working out that relationship with, you know, the parents, getting the patients in for their restorative care. You all know that a lot of preventive things, it winds up saving the state a lot of money.

But they're -- and I've been preaching this incentive stuff for years. Some of you may remember 10 or 12 years ago that we were at a meeting, and I said: Where are the

carrots for the practitioners to be able to do more? And I'm still just not seeing a lot out there. I'm sorry.

But, you know, we've got businesses to run and people to take care of, and -- but that's my report. Thank you.

CHAIR SCHUSTER: Thank you, Garth. And I think there are a number of providers that share in your frustrations, but I appreciate your bringing forward those concerns.

Consumer Rights and Client Needs?

MS. BEAUREGARD: Hi, everyone. I hope you can hear me. This is Emily Beauregard. I'm the director of Kentucky Voices for Health and the chair of the Consumer TAC. I am driving back from Alabama right now, so I'm on the road.

And we met -- the Consumer TAC met August 20th. We had a quorum, but we did not make any recommendations. So I hope that being off camera is okay in terms of the rules for this meeting.

I did want to speak to some of the issues that have been discussed on the call

today, what Dr. Bobrowski was just talking about as well as you, Dr. Schuster, related to whether it's low rates negotiated by the MCOs that are perhaps below the fee schedule that Medicaid sets or prior authorizations that are, you know, onerous and sometimes apply to routine services, and then those audits that come when there aren't prior authorizations. And they've become more standard and really common.

I think all of these we need to look at as workforce issues which, in turn, you know, from the consumer perspective is a network adequacy issue. If we have providers that, you know, just can't make the business case for seeing Medicaid patients because it either doesn't, you know, pay the bills or it's too administratively onerous to make it work, that means we have fewer Medicaid providers ultimately seeing patients, which means we have inadequate networks.

And I think that there's a lot of work to be done here to make sure that participating in Medicaid is not more onerous than participating in other commercial plans

and making sure that, you know, providers can see all members of their community, which is just really important. I know providers want to do that, and we need to make it easy for providers to sustain Medicaid. So I'm going to say that. But from a consumer perspective, I really see it as a network adequacy issue, but it does affect our workforce.

And something else I wanted to just briefly touch on. The Beneficiary Advisory TAC, we're looking forward to discussing this further in our October -- during our meeting. Obviously, this is something that we're really excited about. We think people with lived experience, Medicaid members, family members should absolutely be in these roles and providing more input and guidance to Medicaid as they're making decisions, developing services and programs.

And there may also be some overlap with the Consumer TAC, which we need to figure out, you know, exactly what roles we're going to have and how we can also just support this TAC, the new -- I should say the BAC,

Beneficiary Advisory Council, in being successful. So that's a role that I would like the Consumer TAC to play.

And a couple of the other topics that were discussed earlier we also had discussed at our August meeting. Nonemergency medical transportation. I think it's fantastic that Medicaid has updated that regulation and is now allowing more people to be eligible for transportation services.

I do have a concern about -- as Dr. Schuster stated, you know, not -- people not knowing about the changes. Kentucky Voices for Health and our Thrive Kentucky partners have created an explainer about nonemergency medical transportation, and we've updated it since that reg went into effect. I'm in the car, so I can't put it in the chat. But I will share it with Erin Bickers so that she can send it out to everyone.

And one thing it doesn't include -- well, more than one thing. It doesn't include those numbers to call if you have a problem. It also doesn't include any sort of

specifics about what would need to be in a letter in order to get, you know, an attestation from an employer or from a school or from a mechanic to say, you know, that this car isn't functional or is unstable, I think, is the word that Becky used.

And so it would be really, really helpful for us to also get guidance or to see the guidance that the brokers are getting from -- either from Medicaid directly, I would hope, or from the Department of Transportation so that we better understand how they are going to be implementing these changes, what the requirement is going to look like on the consumer side, so we can support that. There's specific language that needs to be in that attestation, you know, exactly what is being asked for us to provide, whatever they're requesting.

And then I also feel like we need to clarify that point about the two-week exemption for parents. Because as I read the regulation -- and, of course, I could have gotten this wrong, so I'd like to clarify it. But as I read it, I thought it was two weeks

that parents had in which they could request transportation for their children and receive that transportation before they had to actually provide any documentation that dealt with a barrier such as the car was being used for work or some other purpose in which the child would need nonemergency medical transportation. So if I understood that, I think it would be good to clarify. But we definitely need to get that kind of information out to families and to Medicaid beneficiaries.

And then language services also came up earlier. That's something we've talked about probably for at least the past year, if not longer, at the Consumer TAC. We've asked for some one-pagers to our different populations that have different types of language service needs such as deaf and hard of hearing versus, you know, speaking another language and people who are nonverbal, of course.

But I want to just caution us that when -- I think it's fantastic that Managed Care Organizations are willing to pay for language services. And it is, you know,

something that they're required to do because they're receiving federal funds. But providers are also receiving federal funds and are also required to provide language services.

If that can happen seamlessly and in almost realtime through the MCOs, I'm all for it. But I -- providers do still need to have something in place for when perhaps they can't get that service to provide it through the MCO in time. It's great if you can, you know, plan ahead and you know that you've got an appointment three weeks out. And you schedule that interpreter, and the MCO can pay for it.

But in the case that you don't have that time, somebody is coming in for, you know, an acute care visit, it's emergency care, whatever the case is, you really need to have your own language line or interpreters, you know, that you can call on to make sure that those patients get services.

And so whatever we end up with -- and I appreciate that the Department for Medicaid Services is looking into how to streamline

this and make it easier for people to access the information and know where to go when they need language services and how to get it, and I think it's great to try to take the burden off providers as much as we can.

But I just want to make sure that providers don't start to assume that MCOs are, you know, wholly responsible for this and that if the MCO doesn't provide it, that they can turn the patient away. So that's just my little note of caution there.

I don't think I have anything else to report, but I do have a meeting coming up in October. I believe it's October 17th, but I don't have it in front of me. So Erin might be able to correct me on that.

CHAIR SCHUSTER: It looks like -- thank you, Emily. It looks like Dr. Gupta has a question for you.

DR. GUPTA: It's not a question, just a comment on the translation services.

CHAIR SCHUSTER: Oh, a comment. Yeah.

DR. GUPTA: Yeah. I understand where you're coming from, and I don't think

that that would ever be an issue. It's just -- like in our practice, you know, we have an online language service, but it really adds up. So if we at least have the MCOs, you know, there to help us. You know, if I have, like, five patients in a morning, I just basically paid them to come see me. It's a total -- like, as far as reimbursement, it's a wash. And maybe I've actually even paid them extra to come to visit me.

So we would never give that up. I don't think any doctor would ever do that because we have to be able to provide that through federal regulation. But if the MCOs can help us out, it would just --

MS. BEAUREGARD: Oh, absolutely.

DR. GUPTA: -- be so much more helpful.

MS. BEAUREGARD: Yeah. And I appreciate what you're saying. I do see that this is a, you know, financial burden on providers. I recognize that. I just want to be cautious of how providers understand, you know, if an MCO is providing services, you

know, that -- in the case when they don't or can't or not soon enough, providers still need to do it. And there are some providers out there who are still resistant to it, unfortunately, although I'm glad to hear that, you know, many are not.

You know, another -- you know, many jobs ago, I worked at Family Health Centers, and I ran our language services department. So I was very familiar with it then. It's been many years.

But this has been something that has taken a long time to really establish as something that providers see as their responsibility and have, you know, the resources and capacity on hand to be able to provide services. And I think we still have some work to do, but I really am grateful that the MCOs are chipping in and trying to cover these services as much as possible.

I still have hope that we can have one single language line, and there would be a screening question. You know, whenever an individual or a provider calls in to ask what MCO -- or whether it's fee-for-service but,

you know, what MCO the patient is enrolled with, and perhaps that can be submitted to them to process on the language line.

Just having one entry access point, I think, is ideal. If that can't happen, then having a one-pager with whatever the number is to call for that MCO service is another option. But I just really hope that we can make it as seamless as possible.

CHAIR SCHUSTER: All right. Thank you very much, Emily. Drive safely and get home before the remnants of the -- or the forbearer of the hurricane hit us hard here.

MS. BEAUREGARD: Yeah. Thank you. I think we managed to do it. We got out just in time. And the sun has come out now, so we're out of the rain. Thank you all.

CHAIR SCHUSTER: All right. Watch those tornados coming up I-65. You know, that comes along with the hurricane so...

Children's Health?

MS. BICKERS: They meet on the 9th of October. Emily, your all's next meeting is October 15th.

CHAIR SCHUSTER: Okay. We've not

had a report from Children's Health in some time, it doesn't feel like. Erin, is that right? Do you remember? I'll have to go back and look. It doesn't feel like we've had any kind of report from them in months and months.

MS. BICKERS: I believe you're correct. I'm not sure if they've had a representative on in the past several meetings.

CHAIR SCHUSTER: Yeah. Okay. Thank you.

So the Behavioral Health TAC met on September 12th. All seven of our members were present. We did get a response. We had asked DMS to provide some guidance for providers about how to deal with audits, and they did send us some information from the contract with the MCOs. But we may want to come back and ask for something a little bit more direct.

As I mentioned earlier, we had a very spirited 45-minute discussion about the audits, that some of the Children's Alliance members -- just as a sample, 9 of their

members received 53 audits with a request for 1,744 client records. We had one CMHC that had a request for 400 records and another that had a request for 600 records with the initial request being seven or eight days.

So that gives you some sense of, you know, the kind of volume of this. And as I said earlier, the complaint from the MCO was that because there's no PA, they don't really know what kind of services are being provided. You know, again, I'm not sure that that's accurate.

We've had an ongoing study in -- going on on rates. It's a multistate rate study that the Office of Data Analytics is doing on behalf of Medicaid. So we've had a first iteration of it, and Victoria Smith with that office has been great to work with.

We've had some very robust discussions about what some of the data means and what, you know, some states like Missouri and Illinois -- she apologized that she didn't realize that they were contiguous states to Kentucky. So she's going to go back and add them in.

There were about six other codes that she's going to complete in that phase one and then we had asked for her to also add the rates on IOP, partial hospitalization, and some of the ABA codes. And so that first part of the study is going to be finished.

The second part is, in some ways, I think, going to be more meaningful. Because what they're going to try to do -- and they're going to come with a proposal to our November meeting.

There were four questions that we asked right off the bat, about, you know, what's the importance of rates, and they're going to try to look at the rates and see what they can come up with in terms of accessibility to services, the quality of services, the diversity and availability of the workforce, and then how rates impact specialized services for populations that are with more intense needs.

And so those four things are going to be kind of the pillars around which the phase two is going to be developed. And so we -- I've reached out to everybody who comes to

the BH TAC meetings to say if you've got some ideas or some specifics or some population variables like age or something that you think would be really helpful to have, to please let me know.

We got an update from Ann Hollen, who used to be with Medicaid and has now been reassigned as a special advisor over at Behavioral Health, Developmental and Intellectual Disabilities. DBH is going to be kind of monitoring the day-to-day rollout of this SPA once it gets approved.

We're set back a little bit. We were hoping it was going to be approved by CMS in September, but they came back with some specific questions, which have now been answered. But that starts the clock again for them, so it's an additional 90 days, that we're hoping for approval by the end of the year and implementation to start in July.

That's the waiver that would give supported housing and supported employment, among other specialized services. Would offer for the first time respite to the families of people with severe mental

illness, which they have never had. And believe me, if there's a population of family members or caretakers that could use some respite, I would nominate them. So we're excited about that.

You heard about the reentry waiver. We always get an update on that.

We had an issue come up -- and I would also be interested in some of the other provider TACs. We've got some of our providers getting letters from an MCO that says we're cutting your rates by ten percent. Boom. And if you don't like it, then, you know, you can -- we'll just break the contract with you.

And so Veronica was on and gave us some helpful hints in terms of, you know, what providers can do and so forth and the fact that MCOs have to notify DMS if a provider is no longer in contract with them. You know, if we really think about what we're all about, folks, it's really about people getting services.

And I really worry, at a time when it's so hard to find licensed mental health

professionals in all of the different professions and to find them available across the state -- obviously, telehealth is helping. But I really -- I worry about particularly one of the larger MCOs in terms of numbers of covered lives kind of walking around with this kind of ultimatum. So I would be real interested if other provider TACs could look at that issue as well.

We got an update on the 1915C waiver waiting lists. And, actually, they were down by a few people in each of the categories. But we've got over 14,000 people on that waiting list. And while we were excited that 1,925 new slots were approved for the next two years, think about that in terms of 14,000 plus people on the waiting list and growing.

We did ask about the wait time to get the PDS. That's the person directed services where a person or their family can hire their own caregivers under the waiver. And, you know, it varies, but it's out there to be talked about.

We've had some issues with the ABI

waiver with therapy services going to the state plan, and the rates are lower. And so they're losing some of their -- or would lose some of their more experienced providers of services like OT, PT, speech. The behavioral health services are going to stay with the waiver and not go to the state plan.

Veronica gave her usual excellent report, although we were really out of time this meeting, on Medicaid unwinding. We had no recommendations.

Nina brought up a need for provider guidance from DMS for delivery and billing of IOP and PHP via telehealth and also described a problem with EPSDT rates, which we may come back with a specific recommendation for the next MAC meeting.

There also was a question or an issue brought up about how IOP is -- has to be provided and billed for. So if it's a three-hour-a-day, three-days-a-week service and something happens and the only patient only gets to it two days a week, those two days are not paid for because the complete service has not been provided.

And Nina was helpful in clarifying that it's a rolling seven-day period, not a Sunday through Saturday, so that may help. But I think that's an issue also that the Hospital TAC is looking at.

I guess I'm feeling like so many of these issues that are provider-wide -- and I think we talked about this with the audits. I'd really like to see us -- see the TACs share more information across TACs and, you know, work together on solutions for some of these things.

I mean, Behavioral Health, for instance, which is obviously what I'm about, is our TAC, but it's also the Children's TAC. It's also the Physician TAC. It's also the Nursing TAC. It's also the Hospital TAC. Certainly, it's the Pharmacy TAC. We've had those discussions. And I think there are some of these things that -- so, you know, we need to think crossways as well as within our own silos.

Our next meeting will be November 14th. And, again, we had no recommendations for the MAC.

Nina, it looks like you have a question.

MS. EISNER: Actually, a comment. Just as you said that these issues permeate providers across the continuum of our TACs, I did get confirmation back from the Hospital TAC while I was on -- while we were continuing. Hospitals are indeed as well receiving an inordinate amount of requests for record reviews and from a particular MCO.

CHAIR SCHUSTER: Yeah. So I think --

MS. EISNER: Not just behavioral.

CHAIR SCHUSTER: Yes. Oh, not just behavioral.

MS. EISNER: Not just behavioral. Correct.

CHAIR SCHUSTER: Oh, interesting. Okay. Well, that's helpful, not positive but helpful.

Garth?

DR. BOBROWSKI: Well, I appreciate your comments, and I've just got to get this off my chest. It's just, you know, a lot of us are just out here just working, and we're not the gazillion-dollar dental offices. You

know, we're just trying to help people in our communities.

But some of the MCOs did do that 10 percent reduction to dentistry, also, several years ago. And I just flat out told one them, I said, "Look, you cut me ten percent, I'm cutting you." And they cut me ten percent. I cut them. I just said, you know, I'm done with you. And I'm so sad that I had to do that because -- but, you know, we have bills to pay. I'm like the EMTs. You know, you can't keep doing this and go in the hole every day you work it. And I don't know.

It's just I think DMS has got to seriously look at these contracts with the MCOs. It's all weighted for their profit. It was in the *Courier-Journal* years ago that some of the MCOs in the state of Kentucky made record profits nationally. Folks, we've got to look at these contracts or something because our people are just not getting seen.

They're -- I mean, I've got dentist friends over an hour drive from here, up in Owensboro two hours away, and they're getting people driving from one side of the state to

the other side of the state just to be seen, you know, in a dental office. Is that what Kentucky is about?

I mean, I'm not saying that -- well, the MCOs, they've got that in their contracts of a certain amount of profit, but there's no contract between me and the MCO on what my profit margin can be. They've got it in their contract that they can make a -- what is that, that loss ratio?

CHAIR SCHUSTER: Medical loss ratio.

DR. BOBROWSKI: Yeah. That's in their contract, but it's not in mine. So I'll be quiet. It's just so frustrating that, you know, you work your butt off, and you look back at your quarterly profit and loss. Well, you're in the hole. We can't keep doing that. Thank you.

CHAIR SCHUSTER: Yeah. Well, and I -- you know, there's so many of the behavioral health providers that are still a cottage industry. I was in a meeting with some legislators, and they want everybody to have an electronic health record. And I

said, you know, that's fine for your agencies or your hospitals or whatever. But you're still talking about psychologists and social workers and counselors that are in one-person offices or two-people offices. And to have the wherewithal and the money to invest in an electronic health record, you know, may put them out of business.

And I feel like -- I feel that way about the dental offices as well, Garth. I mean, I'm sure there are bigger offices and clinics and so forth. But, you know, a lot of Kentucky providers are still in that cottage industry without a whole lot of leeway here.

So could I -- yeah. I'm getting a lot of agreement in the chat about, you know, looking at some of these things across -- across TACs, across providers and professions. And I think that's one of the advantages of us all being on here together, so let's kind of think about that going forward.

We may change our format a little bit to talk about topics as opposed to having each TAC report or something. Maybe we can think

of some ways to change things up a little bit to get more -- with always the, you know, provision of quality services to our people.

So you're getting a lot of support in the chat, Garth. I hope that makes you feel better. You're not alone for sure. So thank you for speaking up.

I would entertain a motion from one of the members of the MAC to accept the TAC recommendations and send them on to DMS.

DR. GUPTA: Dr. Schuster?

CHAIR SCHUSTER: Yes.

DR. GUPTA: May I make a request that we vote on the recommendations separately?

CHAIR SCHUSTER: So the only -- I think the only ones we have are the pharmacy recommendations; right? Is that what you're --

DR. GUPTA: Yeah. May we vote on the two separately?

CHAIR SCHUSTER: Yes. I don't know that we've -- we don't typically have -- I guess it's all right. Is there any reason, Erin, that we can't do that or shouldn't do

that? I can't think. We've never done it that way, but I guess --

MS. BICKERS: Veronica, do you know if there's any rule against that? There's -- I'm not sure, Dr. Schuster, to be honest. I'm going to have to refer to Veronica, if she's still on.

MS. CECIL: So the Chair can make the decision as to how they want to vote on the recommendations. Just remember that this is kind of really just -- I mean, we accept the recommendations. You know, even if there's not a quorum to vote on them, we accept them anyway just based on the bylaws. So -- but that's up to you, Dr. Schuster. Not to put you in the situation. But, really, you can make the call.

DR. GUPTA: It's fine either way, Dr. Schuster. It's only two recommendations. That's fine.

CHAIR SCHUSTER: Yeah. I'm just -- I'm trying to think what a vote -- I need to think just for a second about: What does our vote really do? Our vote is not a vote of agreement --

MS. CECIL: Correct.

CHAIR SCHUSTER: -- with the content of the recommendation.

MS. CECIL: That is correct.

CHAIR SCHUSTER: If that makes sense.

MS. CECIL: It is just --

CHAIR SCHUSTER: It is literally a process.

MS. CECIL: That is correct.

CHAIR SCHUSTER: A recommendation cannot get from a TAC to DMS unless it comes through the MAC.

DR. ROBERTS: I think the only reason that we would not recommend something is if it was a procedural issue or if it was something that was inappropriate for the MAC to recommend. I think otherwise, as you said, we're simply -- we're not -- we are simply accepting the recommendation. So I don't think there's any merit to voting on them separately unless there is something that the MAC is divided on from a procedural standpoint.

DR. GUPTA: Okay. So, like, if I

don't agree with something, I can still vote for it to go to DMS, for DMS to do their further investigation?

CHAIR SCHUSTER: Exactly.

DR. ROBERTS: Right. If it was -- perhaps if it was something that -- if we were making recommendations for the Department -- if one of the TACs made recommendations for the Department of Justice, that would be an out-of-order recommendation. And so in that instance, there may be some divisiveness or a lack of agreement on the MAC on whether that -- you know, that recommendation should flow through our committee.

In this case, that's -- you know, this is not a procedural thing. These are merely the recommendations that have come from the TAC, and we are accepting them.

DR. GUPTA: Okay. Got it. Thank you for that clarification.

DR. PARTIN: I would like to make a comment, if that's okay, Sheila.

CHAIR SCHUSTER: Sure. You have a lot more experience than I do in this job so

opine away.

DR. PARTIN: Yeah. And this is just my opinion. We do -- we are just passing through the recommendations to DMS. However, I think that if a member of the MAC has a comment that they want to make or provide some of their opinion regarding any of the recommendations, I think that that is totally acceptable.

It's not that we're not going to pass through the recommendation, but I think that it's worthwhile and appropriate that we allow MAC members to make any comment they want to on the recommendation.

DR. ROBERTS: And I think in the past, Beth, we've had issues where a recommendation was brought forth, and we sent it back to the TAC just for clarification or to address an additional component.

DR. PARTIN: Right.

DR. ROBERTS: But I think in this case, that's probably not applicable.

DR. GUPTA: May I make a comment, then --

CHAIR SCHUSTER: Yes. Certainly.

DR. GUPTA: -- on a recommendation that I'm just a little bit concerned about? It was the first recommendation by pharmacy. It -- to me, it feels like expansion of scope of practice, and I -- yeah. I simply just didn't want it to, like, be passed and then accepted. You know, I'm sure that -- I know that wouldn't happen. But any kind of expansion of scope of practice, I feel like, needs a thorough, like, process and investigation before that happens. That's all I wanted to say.

DR. HANNA: Sorry. This is Cathy Hanna. I don't think that is the intent in any way. Many of these, you know, things that community health workers are doing, they are trained as community health workers. That's already been done. Other states are doing it.

It's not an expansion of scope of practice. It's just a mechanism by which to be paid for those services like any other, you know, community health worker would be doing if they were offered by another provider. So it's not an expansion in any

way.

A good example is smoking cessation. We already have that ability within our scope. And just to be paid for that extra service so that a -- you know, a Medicaid beneficiary would be able to utilize it.

So it's not intended to be an expansion. It's just a payment for the services that could be provided already within that scope. Does that make sense?

DR. GUPTA: Yes. Thank you.

DR. HANNA: I don't think they were asking for that. It was just to be paid. You know, so to -- (audio glitch).

CHAIR SCHUSTER: We're losing you, Cathy.

DR. GUPTA: Yeah. But I think I got the point.

DR. HANNA: Okay. Gotcha. Thank you.

CHAIR SCHUSTER: All right. But a good discussion. And I'm, you know, new enough at being the chair, I just couldn't remember.

So may I have a motion to accept the TAC

recommendations and send them on to DMS?

DR. PARTIN: I'll make a motion.

MS. EISNER: This is Nina. I'll make a --

DR. BOBROWSKI: Second.

CHAIR SCHUSTER: I think I heard Beth. Nina, you want to be a second?

MS. EISNER: Yeah. Sure. I think someone else seconded, too. We're all so anxious.

CHAIR SCHUSTER: We're almost ready to give you a few minutes of your day back. All those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed and abstentions?

(No response.)

CHAIR SCHUSTER: All right. We will send those along.

Any new business? Anything that we haven't talked about? This has been a great meeting for some discussion. I love it. Anything?

MR. MARTIN: Hey, Sheila, this is Barry.

CHAIR SCHUSTER: Yeah.

MR. MARTIN: I would like to recommend or suggest that, you know, we get back to an era of feeling like we're partners in the care of our state population. I think that will help both the MCOs and the providers and DMS.

I think right now, we feel like the providers are always -- always the last ditch effort, you know. And I really feel like if we could start feeling like providers are more included in some of the decisions and some of the options. Like, if they're having a bad year, you know, the first thing is to start cutting. I think if, you know, us as providers, we could see where maybe we could help and if they would kind of get our input, if we could kind of sit at the table with DMS, MCOs, and providers, it would work a lot better. And we would feel like we're not being unjustly done whenever there's a knee-jerk reaction.

And I'm not being negative about anything. I'm just saying that it would be a lot more efficient and productive if we -- if

we did act like we're truly partners in making some of these decisions and helping with where there's shortfalls, and how can we get around that. And the same token. Whenever we're experiencing shortfalls, it would be nice.

CHAIR SCHUSTER: I --

MR. MARTIN: I know that's self-evident. But I think sometimes we forget that we need to be partners, that DMS and the MCOs, I mean, they do have, I guess, the upper hand because they're our paymasters. But in the same token, they've got to have us because we're the ones getting the work done as well. So sometimes we need to feel more like partners than subservients.

CHAIR SCHUSTER: Yeah. I think that's true, Barry. And I think that, again, you know, the consumer voice needs to be a part of that partnership as well.

MR. MARTIN: Yes.

CHAIR SCHUSTER: We're still talking about people in the third -- you know, in the third person. And I think CMS is trying to address that by creating this

BAC. And, remember, over a period of years -- I don't remember what it is, but half the membership, or 51 percent of the membership of the MAC will be made up of consumers of services. So think about that.

MR. MARTIN: Yeah. Sounds good.

CHAIR SCHUSTER: And that's why we went into the professions that we went into. That's why we went into the businesses that we went into. That's what Medicaid is all about.

I do feel like we have a really strong communication and working relationship with Medicaid, which has not always been the case. Some of you may remember other administrations, other Medicaid commissioners. We had a commissioner one time that refused to come to the table when we were still meeting in person, you know, to make a statement to the MAC because he didn't agree with having a MAC.

So -- but your point is well taken, I think, Barry, and we --

MR. MARTIN: And I agree. We have a really good relationship with Medicaid.

Medicaid is very responsive. Like I said, I just think maybe we can keep, you know, keeping it at the forefront that, you know, if we can keep all three of us or four of us --

CHAIR SCHUSTER: Yeah.

MR. MARTIN: -- at the table, we can help each other when we need to instead of making just arbitrary decisions that kind of cuts everybody or whatever.

CHAIR SCHUSTER: Right. Well, thank you --

MR. MARTIN: Just my two cents.

CHAIR SCHUSTER: Yeah. Thank you for that input.

So our next meeting will be Thursday, the 21st. Is that -- is that Thanksgiving, or is Thanksgiving the 28th? Surely we didn't do that.

DR. ROBERTS: No. It should be the week before.

DR. PARTIN: Yeah. It's the week before.

CHAIR SCHUSTER: Okay.

MS. BICKERS: I thought you guys

might want to spend turkey day with me, Sheila. Just joking. No. I moved it to the week before.

CHAIR SCHUSTER: Actually, if you're cooking, you know, I'm not --

MS. BICKERS: I do.

CHAIR SCHUSTER: I love turkey, but it turns out that none of my family does. So I'm always looking for a turkey dinner someplace so...

Anyway, thank you all very much. We'll see you in November. And I'll send out a couple of things to the TACs in particular to get them kind of thinking about these cross TAC issues that we've talked about today.

MR. MARTIN: So the next MAC meeting will be at Erin's house.

MS. BICKERS: Yes, with turkey.

MR. MARTIN: With turkey.

MS. BICKERS: I did just want to let everybody know -- this is a good place for me to get a plug in for all the TACs. I am working on the 2025 calendar, so I will start getting that out in the next couple of weeks to all the TACs to approve their dates,

same with the MAC. So I just wanted to let you guys know that'll be out in the next couple of weeks. I've already started working on those dates.

CHAIR SCHUSTER: Okay. Thank you.

MS. EISNER: Thank you.

CHAIR SCHUSTER: Yeah. And thank you, Erin, for -- whether you cook dinner for us or not on Thanksgiving, we appreciate all of your help. We could not function without you.

So you all have a good rest of your day and stay safe. I think we're going to get a ton of rain here. All of the Friday night football games here in Louisville have been rescheduled, or most of them, to Thursday night. So, you know, we're concerned about the deluge that's coming.

So be safe and thank you all very much, and we'll see you in two months. Bye-bye.

(Meeting concluded at 12:18 p.m.)

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C E R T I F I C A T E

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

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

Dated this 30th day of September, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR