DEPARTMENT OF MEDICAID SERVICES
INTELLECTUAL & DEVELOPMENTAL DISABILITIES
TECHNICAL ADVISORY COMMITTEE

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APRIL 2, 2024
10:00 A.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Rick Christman, Chair
Melanie Tyner-Wilson
Wayne Harvey
Johnny Callebs
Cheri-Ellis Reeves
Doug Hoyt
Frankie Huffman

MR. CHRISTMAN: Erin?

MS. BICKERS: I am here. I am finally able to hear everyone. Sorry about that. I had to plug and replug my headphones.

MR. CHRISTMAN: Okay, we're glad you're here. Can you tell if we have a quorum?

MS. BICKERS: I am scrolling right now. Give me just a moment. I see yourself, Wayne, Melanie. It looks like Doug has joined us. Rick, Johnny is here. I apologize, I start to scroll and then more people pop into the waiting room and it throws me off track. I do not see our new member, Frankie, logged in yet. I'm not sure if he prefers Frankie or Frank, I've seen both on his email.

MR. CHRISTMAN: Frank Huffman.

MS. BICKERS: Yes, sir.

MR. CHRISTMAN: Is Mr. Hoyt on?

MS. BICKERS: It looks like it. Yes, sir.

MR. CHRISTMAN: Welcome, Mr. Hoyt.

MR. HOYT: Thank you.

MS. BICKERS: It's just now 10 o'clock and the waiting room is clear. I have Rick, Melanie, Wayne, and Johnny all logged in, and Doug. Did I miss anyone else?

MR. CHRISTMAN: Does that give us a quorum?

MS. BICKERS: I believe you are good to go. Yes.

MR. CHRISTMAN: Okay. Thank you. It is past 10 o'clock, so welcome everybody. I am Rick Christman. I am the Chair. There is a number of people on the line and I just want to point out that if anyone wants to ask a question or make a comment, you are welcome to do so.

Our first order of business is approval of the minutes for February 6th, 2024. Would someone like to make that motion?

MS. TYNER WILSON: I move to accept the minutes. This is Melanie Tyner Wilson.

MR. CHRISTMAN: Thank you.

MS. BICKERS: Rick, my apologies, really quick for our new member. When you are voting, your camera must be on. Sorry, I should have mentioned that sooner.

MR. CHRISTMAN: Yes. We want to see your face.

Any second on that motion, please?

MR. CALLEBS: I will second.

MR. CHRISTMAN: Thank you, Johnny.

All in favor say, "aye."

TAC MEMBERS: Aye.

MR. CHRISTMAN: Any opposed, say, "no."

All right. First order of business is new member recruitment and we do have some success there. We have a representative, LeadingAge Kentucky, and that is Doug Hoyt. Doug is the CEO of the Wendell Foster Home, which is great. Anything else you'd like to say, Doug?

MR. HOYT: No. Just glad to be here.

MR. CHRISTMAN: Sounds like you are well-qualified and we are glad to have you.

And Frank Huffman was also approved. He is not on the call yet. That leaves us with still two vacancies; correct, Erin?

MS. BICKERS: Yes, sir.

MR. CHRISTMAN: Is that where a consumer participates in a non-residential community Medicaid waiver program? Or do you know --

MS. BICKERS: Yes, give me half a second and I will pull that up for you. My apologies. I should have had that prepared.

Yes, sir. That leaves the consumer representative of a family member who participates in a community Medicaid waiver program.

MR. CHRISTMAN: Mm-hmm.

MS. BICKERS: And then we also have a consumer who participates in a non-residential community Medicaid waiver program. Those two are still vacant.

MR. CHRISTMAN: Well, those should not be vacant. We should be able to fill those.

Melanie, do you have anybody you could recommend, or Johnny, for the consumer representatives?

MS. TYNER WILSON: I do. I have been attempting to recruit from the world I live in, and I will -- can I get back to you on that? So we have folks, I can get their names and whatnot?

MR. CHRISTMAN: That would be greatly appreciated. Thank you.

MS. BICKERS: Melanie, this is Erin. If anybody has any questions or curious for a little bit more information, you are welcome to provide my email address.

MS. TYNER WILSON: Thank you.

MS. BICKERS: You're welcome. I can provide more information.

MS. TYNER WILSON: There might be some -- someone I'm thinking of would also be possibly using an alternative way of communicating, would be nonverbal;

would that be okay?

MR. CHRISTMAN: Yes.

MS. TYNER WILSON: Okay.

MS. BICKERS: We do have a member on another TAC who has an assistant who helps --

MS. TYNER WILSON: Yeah.

MS. BICKERS: -- while he is on the TAC meetings so yes, we make every accommodation we can.

MS. TYNER WILSON: Okay. I am on that TAC as well. So, yes.

MR. CHRISTMAN: Okay, good. You are the perfect person to do this.

MS. TYNER WILSON: Right. I don't know about that. I will be glad to help because I do think we need to get --

MR. CHRISTMAN: We do.

MS. TYNER WILSON: -- a diverse and inclusive representation.

MR. CHRISTMAN: Absolutely. And we are making progress.

All right. First item of business is use of involuntary terminations. I know there was some

back-and-forth on that. I know, Erin, you are involved with this to somewhat. We brought it up at the MAC meeting which was just here recently, and I know the chairman of the MAC, Dr. Schuster, is also interested in this issue.

So where are we at? I know Erin, were you trying to see if we could get the department to send out a questionnaire?

MS. SMITH: Erin, I can take that if you want me to.

MS. BICKERS: Thank you. Because I was going through my notes, Pam.

MS. SMITH: So we are looking, still, at the best way, whether that's going to be to send out a survey or to work through our -- the QA's and the individuals that work with the providers. There had recently been sent out a bunch of surveys to providers, so we didn't want to inundate providers with surveys, because we do want them to respond. But I do have some additional -- some additional information, because our partners with

BDID worked very hard on getting some additional data for the reasons for currently how many people we have that are being served and some of the current reasons. So I can go ahead, I can share those. As of right now, we have 53 active involuntary terminations, meaning that the voluntary termination notification -- sorry that's a mouthful -- has been presented to the person and/or their guardian. And the organization is still supporting those. Of those, 23 have been in place for longer than six months.

MR. CHRISTMAN: Okay, you have been busy.

MS. SMITH: Yeah, and then --

MR. CHRISTMAN: You were going to say?

MS. SMITH: I'm looking at -- I'm reading my next note. There are 16 providers, so 23 participants.

MR. CHRISTMAN: Mm-hmm.

MS. SMITH: And 16 unique providers serving those 23 participants.

MR. CHRISTMAN: Do you have any

idea how long those providers have been providing services? Is there any, like -- are they recent -- have they recently begun providing services? Can you tell that?

MS. SMITH: We have seen a mix. I don't have it and I can go back and get that, but we have seen a mix where sometimes it is new providers and sometimes it is providers that have been providing services for some time. And then I will -- when I get down to the reasons for involuntary termination you will see that a little bit.

So 23 participants served by -- so 23 unique people served by 16 individual providers. So we have some providers that obviously are serving, you know, more than one person.

Sixty-five SCL participants have been involuntary terminated in the past six months, but 35 of those were resolved through transitions to other agencies.

MR. CHRISTMAN: Would you repeat that again, Pam, I'm sorry.

MS. SMITH: Yes, 65 participants have been terminated in the past six months, but 35 of those were resolved through transition to another agency.

MR. CHRISTMAN: Mm-hmm.

MS. SMITH: Choosing another service type, so they may have decided they wanted to -- Erin, can you help with the --

MS. BICKERS: I'm trying to scroll to see who is not muted.

MS. SMITH: Okay.

MS. BICKERS: I'm sorry.

MS. SMITH: That's okay.

MS. BICKERS: I can't do it fast enough.

MS. SMITH: Thank you.

So they maybe chose to go from receiving residential to living, you know, to going home with a family member; they may have decided to change their service types from traditional to PDS; or they were not able to return to their services, for example, due to a long-term hospitalization or incarceration, so they

had a decline either in, you know, in their health and they needed a higher level of care so they have been hospitalized --

MR. CHRISTMAN: Oh.

MS. SMITH: -- long-term, or they have been incarcerated.

MR. CHRISTMAN: And they are not subject to someone else serving them, I guess, right now.

MS. SMITH: Yes, exactly. They are being served by other people at this point in time, so.

MR. CHRISTMAN: Right. So. So what does that mean? So, so the 16 you said were more than six months, were any of those incarcerated or in the hospital included?

MS. SMITH: No. Those are not. Those are --

MR. CHRISTMAN: Those are being served by someone who we believes they cannot meet their needs.

MS. SMITH: Right. And then let me get into some of the reasons that

people have issued those involuntary terminations. Now, I will say, it can be for any service. The majority of them are for residential services, but it also could be for a different service, so the top reasons that we are seeing are they are unable to meet their needs because there is declining health needs. This is becoming a more frequent reason that we are seeing.

I will say that we've also had -- there is been -- and I have dealt with it more in the brain injury arena, but home health providers can come into residential homes and provide home health services, however, we've had some residential providers who have put up some barriers to that, so we are working through that. So it could be a solution if someone had some health needs that can be met by having some state plan services such as home health. They should be able to get those in the residential home, because that is their home. So we are working through some of those challenges.

So that -- unable to meet needs due to, you know, their declining health has become a more frequent reason.

You know, as we see the population that we are serving age, that I feel like is going to continue to be something that we are going to have to work with.

The second one is unable to treat the person due to frequent aggression due to other individuals in the home, staff, or frequent incidents involving property destruction. So we've seen a lot of agencies that have been trying -- they've worked with other providers and other services to try to handle that before that involuntary termination is issued, but that is the next reason.

And then the next two are similar. One is a voluntary agency closure. So for example, we've had 29 individuals that had an involuntary termination listed or issued in the last six months, were from the same agency that

was closing. So when that happens, we have staff that goes in and help with those transitions and help to make sure that they work with the participants and guardians and their families to offer choice and to help them to transition to a new provider.

The other one is that's similar to a closure, but the provider may not be closing completely, but they are choosing to not provide services in a particular region. And we've seen this when we have staff that, maybe they've been serving a particular region resign, and they choose not to fill that position, they choose not to continue services in that region --

MR. CHRISTMAN: Mm-hmm.

MS. SMITH: -- and so we, you know, again, work with the individual to transition services to a different provider.

Four of the involuntary closures of the past six months were related to that issue. So 33 of the program closures that were issued -- or the involuntary

program closures issued in the last six months, were due to either agency closures or an agency no longer providing services. So about 50 percent of the most recent involuntary terminations that were issued were related to those two causes.

MR. CHRISTMAN: And let me see. How many of those were in the last six months; was it 53?

MS. SMITH: There were 65 --

MR. CHRISTMAN: Oh, 65.

MS. SMITH: -- in the past six months.

MR. CHRISTMAN: Yeah. Let me ask you. How often do you have to deal with agency closures as a challenge? Is that -- it sounds like that happens more than it should.

MS. SMITH: It does -- I don't have the exact numbers and it's been awhile since I have done that with looking at the agency closures, and I don't know if Elizabeth from BDID is still on, if she knows off the top of her had. That may be something that we need to go back and get

you, Rick, we can certainly do that.

MR. CHRISTMAN: Yeah.

MS. SMITH: It depends, one time when I did it, because we monitored it through COVID, we did not have that many agencies that closed, but, you know, it is always -- I will tell you this, for what ever reason, this is very popular for buying and selling each other. So we do, a lot of times, have agencies that they may sell out to another company --

MR. CHRISTMAN: Uh-huh.

MS. SMITH: Or we have a lot of provider changes. But we can get those stats. I don't, I don't have those off the top of my head.

And I think I saw Amy put something in the chat.

MR. CHRISTMAN: Yeah. What does that say?

MS. SMITH: (Reading) Do you have any data regarding how quickly the 35 were resolved and how many of those 35 are served by someone else?

I do not have it here with me,

Amy, but that is something we can dive into. We can get that information.

MS. STAED: Thank you so much, Pam.

MS. TYNER WILSON: This is Melanie. I had a question in regards to where are these agencies located? Are they concentrated on the east, east side of Kentucky? West side? You know, is there a certain county or region that seems to have a clustering of these agencies?

MS. SMITH: I do not have that in front of me right now. That's something I can go back and get. I do not have their locations. You know, if they are concentrated in one part of the state versus another, or if they serve. Sometimes it may be -- we have a lot of agencies that serve across the state, but we can get that information. I just don't have it here in front of me.

MS. TYNER WILSON: And then, the last question I have is in regards to the background, the competency of the staff

that was working. You know, what are their background areas or areas of expertise? Do they have, you know, different kinds of supports in place within the agency that would be able to meet a certain type of special person, you know, that would be within the agency? Like a behavioral therapist or an aging caregiver? I don't know if you understand what I mean.

MS. SMITH: Yeah, I know where you are going. I do. The minimum staff requirements are listed in the regulation, but we, you know, we encourage providers, especially residential providers that are going to be taking on individuals that are, you know, going to be served for the most part 24/7, to look at who they accept and what the qualifications are of the staff. They always can require more, you know, additional trainings of their staff, but we do not have -- we have, you know, who we monitor for the trainings and the requirements that are in the regulation, but anything above and beyond that --

MS. TYNER WILSON: Yeah.

MS. SMITH: -- we do not have that.

MS. TYNER WILSON: Okay. Thank you.

MR. CHRISTMAN: Do you have any estimates of the unable to meet healthcare needs of that 65? Is that a large number, percentage of that?

MS. SMITH: I do not have that number. I can try to get that, but I do not -- I don't have that number.

MR. CHRISTMAN: Do you think that is the long-term solution to this issue that may be growing, is to try and get home health involved? Is that adequate; do you think, Pam?

MS. SMITH: It depends. It really depends on what the individual's needs are going to be.

So, you know, home health certainly can be -- may meet some of those needs, and then there may just be some individuals that their health declines to the point that they -- that them receiving

home health would meet those needs. You know, it's really going to be that individual and the needs that they are having at that point in time. It may be something that they are able to, you know, recover from, and then they are able to function in the community like they were before or with enhanced supports. It may be that their not able to -- their needs may not be able to be safely met in that manner anymore. It really is going to depend on the individual.

MR. CHRISTMAN: What is the outcome then? Skilled-care nursing; you think?

MS. SMITH: It depends on -- it's going to depend on what the individual's needs are.

MR. CHRISTMAN: I know that. Of course. It could be.

MS. SMITH: It could be. That could be what is the best. It truly is, you know, we want individuals to be able to choose their placement. Community is always the best. We want them -- if

that's what they want. But again, you know, it's also going to be up to the individual's choice and where they feel safe and how they want to be served. So it truly is going to be person-driven based on what needs they have at the present time.

MR. CHRISTMAN: You know, under those, because the reason is aggression, I think it would be interesting to know how many different providers have been attempted with some of these people. Are we dealing with a few people making or resulting in a lot of terminations, or -- do you know what I am asking here? Are we really talking about a small group of people that are responsible for most of the terminations? Or --

MS. SMITH: Are you asking on the provider --

MR. CHRISTMAN: Yes.

MS. SMITH: Are you asking on is it the providers are --

MR. CHRISTMAN: No. The individual. Do these individuals go

through a number of providers? I'm trying to determine how big this problem is, and is it being generated by just a few people who are difficult to serve, or is it because we have some agencies or providers who need to improve themselves. Does that make sense?

MS. SMITH: It does. Yes. I don't have an answer.

MR. CHRISTMAN: I'm sure you don't.

MS. SMITH: I know I don't have an answer right now, but I see where you are going. And I honestly think it is going to be a little bit of both, Rick.

MR. CHRISTMAN: Mm-hmm.

MS. SMITH: It really is. Because I have seen, in particular, when we get new providers, they just want to take on --

MR. CHRISTMAN: Yes.

MS. SMITH: -- they take -- they are just taking on individuals without truly looking at what qualifications are going to meet their needs and how am I

best going to serve this individual? And then looking at the mix of people that they are putting in the home together, as well, because, you know, that plays a part in it.

MR. CHRISTMAN: And that's why I asked the question, initially. How long have some of these providers been providing and some of them it has been a short time.

MS. TYNER WILSON: And also, Rick, this is Melanie.

MR. CHRISTMAN: Uh-huh.

MS. TYNER WILSON: I think about all of the things that we experience as a population. You know, where people get cancer, people get COPD, diabetes, all of those kinds of things and would that be a reason, in terms of their eligibility being discontinued? Because the capacity of the individual has been impacted and the current staff doesn't feel comfortable providing that level of care to someone?

MR. CHRISTMAN: Mm-hmm.

MS. TYNER WILSON: Because you

can have intellectual developmental disability and have cancer.

MR. CHRISTMAN: That's right.

MS. TYNER WILSON: So I think that is the whole journey, because we have individuals who are ancient like me, that, you know, get all of the issues and concerns of it, and other people get as they get older.

MR. CHRISTMAN: What's the -- what is your feeling, Pam, and also members of this committee, about developing some kind of questionnaire that would drill down on some of these questions?

What do you think, Pam? Do you think -- could, if we don't -- there's some things we don't know. Would a questionnaire help us learn those things?

MS. SMITH: If you get a good response and people filling it out, that's gonna be your --

MR. CHRISTMAN: Right. Yeah. What is your personal opinion? Should we do one?

MS. SMITH: I mean, it is truly up to you all.

MR. CHRISTMAN: Yeah.

MS. SMITH: As the TAC.

MR. CHRISTMAN: I know you had some questions, too, at our last meeting, or concerns about, you know, providers not attending Plan of Care meetings and case managers. I don't know.

What do the other members of the committee think? What -- do we have a problem here? Is it something we need to know more about? Is it something that we need to make recommendations? Anyone?

MR. CALLEBS: Hey, Rick. I'll jump in. I think it would be good to know more about, even though this group of people may be small in number, still, you know, we want to do whatever we can to ensure that whoever needs services gets them.

I have been told that there are a growing number of people stuck in psychiatric hospitals who have waiver funding, but for one reason or another,

they are in a psychiatric hospital, in a psychiatric setting, and no longer need to be there, but can't find a provider, so they are kind of in limbo and they are kind of stuck. So, I think, that is a problem and I don't necessarily have a solution, but, I think, maybe we need to look at, you know, how do we get folks out of an institutional setting that they no longer have to be in.

MR. CHRISTMAN: Pam, those people that are in psychiatric hospitals, would they fall into the category of unable to meet their healthcare needs?

MS. SMITH: It truly all really depends, Rick, on what the individual -- on the individual. It could be that they --

MR. CHRISTMAN: It could be.

MS. SMITH: It could be. I don't know. I don't know what that, you know, what those individuals -- I don't know what the needs were that placed them in the hospital or where they are now.

MS. TYNER WILSON: And Pam, this

is Melanie. Along those same lines, you can have someone that has, maybe, their wisdom teeth coming in or a toothache, but is nonverbal and has aggressive behavior as a result of internal pain that they might be experiencing, so it's so hard in some situations to be able to, kind of, hone in on exactly the -- why is the behavior occurring.

MS. SMITH: Mm-hmm.

MR. CHRISTMAN: That is absolutely right.

Well, I don't know. I know a few years ago this seemed like a hugely critical problem.

Do you recall that, Pam? Just a lot of providers who were concerned about this issue. I don't know if it has gotten better or worse.

MR. HARVEY: Rick?

MR. CHRISTMAN: Yes.

MR. HARVEY: I don't think the concern has gone away. I think providers still consider it an issue. I think finding, you know, the information that

helps us solve the issue is something that is of concern to this committee, anyway. Whether that is done through a survey, or some other means, maybe that is what we should be talking about.

MR. CHRISTMAN: That is what we are talking about.

So what is your opinion, Wayne?

MR. HARVEY: Well, I think we started out to do a survey. I don't know why we don't go ahead and follow through with that and obtain, you know, the numbers that Pam gave us today, just looking at those, it's quite concerning. I think we follow through with the survey. And I know providers, you know, feel like they are overwhelmed already with surveys coming at them left and right.

MS. TYNER WILSON: It's true.

MR. HARVEY: But if it's explaining the importance of this particular survey, then I think they won't mind filling it out.

MR. CHRISTMAN: But there is still a concern that many won't, I guess.

So the ones that are having a problem probably may not. Well, I agree with you, Wayne. I think we should send out a survey.

And Pam, do you think enough time has passed that a survey would be responded to?

MS. SMITH: Yeah, I have the question list that you all had sent, so we can work on.

MR. CHRISTMAN: Okay.

MS. SMITH: We can work on getting that issued.

MR. CHRISTMAN: So why don't you and I go back and forth and we can finalize that survey.

MS. SMITH: Okay.

MR. CHRISTMAN: How about that? And we'll try to get it submitted before our next meeting.

(Audio interruption.)

Does that sound reasonable, Pam?

MS. SMITH: That is fine, Rick.

MR. CHRISTMAN: Okay, thank you.

MS. BICKERS: I'm sorry, Rick.

This is Erin. Can I, but in for just a moment?

I'd like to make another request. If you are not talking, stay muted. There is a lot of feedback and a lot of noise going on. And it makes it hard for the court reporter with the minutes.

MR. CHRISTMAN: I agree. We are hearing a lot of noise in the background.

Okay. Let's move on to the next agenda item, then. Number 6. CareWise prior authorization letters of intent.

Amy, did you have something?

MS. STAED: Hi. Yeah. Thank you so much, Rick. Thank you. When I put LOI in my request, it was actually to mean lack of information request, and not letter of intent.

MR. CHRISTMAN: Oh, I'm sorry.

MS. STAED: You are fine. It's okay.

Pam, I know that you talked about this earlier in the year and now we are, kind of, in April and I know that you

all have been working really diligently with the people at CareWise to, kind of, get those prior authorizations running smoothly and updating the processes, et cetera. I am still receiving feedback that some are taking over 30 days, and I just wondered if due to -- primarily what I am hearing is LOIs that providers/case managers are receiving, and one of the top complaints that I have received feedback on, is the folks over at CareWise are asking for documents to be emailed that already exist within MWMA and, maybe, they just don't know where to find them, and I don't know if you have any updates about all of this, and how that is going, et cetera.

MS. SMITH: I need those sent to me and the examples and who it is, so that I can address it. I do know that I had -- I am working with a provider and I am working with CareWise on an issue that we previously addressed with them asking for second identifiers on pages, and so I have been addressing that with CareWise, but

unless the provider tells me and sends me the example so I can address it with CareWise, I don't know what to address. There shouldn't be any request for anything to be emailed, because the documentation needs to be in MWMA, so I really need to know about those, but we can't address that with them if I don't get the examples. And it really helps if we get the cases so that we can identify, you know, if there is a particular person maybe, that just needs some retraining.

MR. CHRISTMAN: For the benefit --

MS. SMITH: Thank you so much.

MR. CHRISTMAN: Oh, I'm sorry.

MS. STAED: Oh, I was just going to say thank you so much, Pam. For you, specifically, would the easiest way be for providers to email you directly, submit a case to the help desk --

MS. SMITH: Either one.

MS. STAED: -- which would you prefer?

MS. SMITH: Either one.

MS. STAED: Okay.

MR. CHRISTMAN: For just the benefit of everybody else on this call, Amy, would you like to explain what CareWise does, what their role is?

MS. STAED: I can.

MR. CHRISTMAN: Yeah.

MS. STAED: Sure.

MS. SMITH: Amy, do you want me to do it since they're actually our contractor?

MR. CHRISTMAN: Yes, Pam. Thank you.

MS. STAED: It might be better for Pam to do that.

MR. CHRISTMAN: I'm sorry. Go ahead, Pam.

MS. SMITH: So CareWise is a subcontractor with Gainwell. They are our utilization management contractor, so they review for, you know, this group, what's relevant to this group, is they review the waiver level of care and Plan of Care reviews on behalf of Medicaid.

MR. CHRISTMAN: Right. And so

they may have issue with some of the billings, I suppose, if they don't have all of the required properties?

MS. SMITH: Well, it would be for the Plan of Care, so if there's not all of the required documents. Or it could be the level of care, all of the required documents. And once Amy gets me the examples, then we can dive into that little bit more to see if there is a pattern or what's going on, so we'll figure it out.

MR. CHRISTMAN: We'll do that. Thank you.

Did you still want to speak about audits, Amy? The CareWise audits?

MS. STAED: Sure. A provider letter was sent out -- goodness, at the beginning of January, I'm not going to remember the exact date -- but regarding the new CareWise function of billing audits --

MS. SMITH: Mm-hmm.

MS. STAED: And I don't know if anyone has reached out to me and told me

they've had a billing audit yet, but I just want to know if we could walk through that, if there have been any changes in the billing audit process, and if anything has been done in previous years.

MS. SMITH: It is the same audit that the state staff or, you know, one of the sister agencies were doing, whether it be DAIL or BDID. It's the exact same billing audit. So it's looking at, I believe, this year, let's see, we are in '24, I think they're looking at last year. We give -- no, we're looking at '22, because we give a full year of timely filing. So since we just started in '24, we are not looking at '23 yet. So it would be looking at billing that occurred in for services provided in 2022, and possibly, they may go back just a little bit further, if there were some -- if there were audits that hadn't been done, but the provider will be notified of the timeframe we are looking. It is the same process where it is done by either us or BDID or DAIL, and it's looking at, you

know, now we also look at the EVV records, it's looking at the billing, compared to the authorization and the service documentation. So it's the same audits, just being done by CareWise versus state staff.

MS. STAED: Can you talk a little about, obviously, particularly, '22, that time period we are dealing with. We are obviously operating under Appendix K. That was a period of time where Appendix K guidance changed several times. How is that being accounted for in the audit process to ensure that providers aren't facing potential recoupments for, you know, just an auditor looking at the wrong guidance from the wrong -- comparing the wrong date of service, et cetera.

MS. SMITH: So all of that documents, they have that as part of their audit tools, but in addition, there will not be any recoupments issued without -- there will be -- my staff will or BDID or DAIL, some of the cabinet staff will look at those before any final decisions are

made if there are anything that is identified as a recoupment.

MS. STAED: Okay. Perfect. I think that's all I have.

MS. SMITH: And so we realize that there was a lot of stuff, there are limits, the limits weren't in place or, you know, there was some overtime. What we are really looking at is where there is no documentation at all of the visit happening. And, like I said, EVV plays a huge part in this; right? Because it's so much easier as far as the documentation in capturing the visit. But, you know, we are really focusing, also, on providing a lot of technical assistance when we see, kind of, the outcome of that. Because we realize the whole, you know, '22 -- '20 through '22 -- or through '23 were crazy, and things changed frequently, and we also had two natural disasters through all of that, so all of that is going to be taken into consideration.

MS. STAED: And is CareWise doing the PDS audits?

MS. SMITH: I do not know the answer to that.

MS. STAED: Or just traditional?

MS. SMITH: Right now, I know they are just doing traditional. There is a lot going on with PDS, right now. So right now, they are just doing the traditional audits, but they may also be doing the PDS. I would need to ask someone on my team because, for some reason, that answer has totally escaped me at the moment.

MS. STAED: Awesome. And just an FYI, when we get to the PDS agenda items on the agenda, I will probably be talking about them in bulk, and just for Pam's information, too.

MR. CHRISTMAN: Yes. That is what I was going to ask you. And before we get into that, another point that I was just thinking of, is there will be some regulation changes coming up and, you know, PDS is just growing in its importance, and we don't, specifically, have someone on this committee

representing someone who receives PDS, either as an individual or their family. Could we, at some point, through the regulation, add a representative for PDS on this committee? What would be required to do that? Or should we do that?

MS. BICKERS: I --

MR. CALLEBS: Rick --

MS. BICKERS: Oh, I'm sorry, Johnny, go ahead.

MR. CALLEBS: Well, I was just going to say, Frank Huffman has now joined and Frank, I will let you --

MR. CHRISTMAN: Okay.

MR. CALLEBS: -- confirm, but I think Frank is also a PDS participant.

MR. CHRISTMAN: He happens to be a PDS participant.

MR. CALLEBS: He happens to be, yeah.

MR. CHRISTMAN: But we don't officially have a PDS representative.

MR. CALLEBS: You are talking about adding it as a required number?

MR. CHRISTMAN: Yes. Yes.

MR. CALLEBS: Not just by chance. I see.

MS. BICKERS: Rick, this is Erin.

Johnny, you beat me to it in the chat. I was waiting for Pam and Amy to finish up so I could let Rick know our new member was on.

So welcome, Frank, our new member, or Frankie, I'm not sure which you prefer.

But to add a member, we will have to have a regulation change and I would honestly have to figure out, I would have to reach out to the Governor's office. Since I have been on, we have not added anyone, we have just appointed. This is one of the few TACs that has Governor-appointed members, as well, so I would probably have to get higher up clarification on that process, but I believe it would be, like, a statute regulation change.

MR. CHRISTMAN: Oh, a statue regulation -- do mean a law? A law would

have to be passed?

MS. BICKERS: Some of them are brought about by statute and some by regulation, so honestly, I'd have to do some digging, because this one does have some Governor-appointed members, so I'd have to refresh myself on everything, but I think it's more than just finding a member and having them appointed. I think there would be some legwork that would probably take several months to do. At least several months.

MR. CHRISTMAN: What is the feeling of the committee? Is that something where we would like to go through that process to officially add a PDS representative? Any feeling? Any opinions on that?

(No response.)

No. Okay, that's why we rely on this committee for guidance.

MS. TYNER WILSON: This is Melanie. I think that's a great idea. And to have -- it could be -- to be honest, it could be an individual that

personally oversees their PDS program, as well as, maybe, someone who maybe has different level of needs, and maybe a caregiver or family member that is overseeing their PDS plan.

MR. CHRISTMAN: Okay. Well, I will put --

MS. BICKERS: Sorry. I was going to mention too, these are public meetings, so you are welcome to invite and they can reach out to you if they have agenda items, so if you know someone who would be willing to come and speak and bring some of these issues, that is always an option, too, for now, if you are looking for a voice, because they are public meetings and they're welcome to anybody who would like to join.

MR. CHRISTMAN: Well, I think that is what we've done with Frank. But I just wonder if we would want to go beyond that. Why don't you, Erin, look at how much rigmarole we are talking about here.

MS. BICKERS: Will do.

MR. CHRISTMAN: Thank you.

With that said, Amy, if you would like to help us with these next four agenda items, that would be great.

MS. STAED: Thank you. And I'm going to practice this with Pam. I don't necessarily expect you to have very specific answers to these. I'm just going to talk about these things broadly.

Over the past two years, obviously, we have seen an increased need and desire for PDS, which is wonderful. We have or are in the process of expanding who can be a PDS case manager for both the home and community-based waiver, and the Michelle P. waiver, which is great and wonderful, but with these great and wonderful changes, we have also seen a really tremendous increase in issues. And really, this is, kind of, what I am hearing the chief complaints are.

Number 1, and I think this is something that we can work out by a reg, et cetera, just things to think about as we move forward.

The roles in PDS related to case

manager, the individual, the individuals family, the FMA, et cetera, they are not very well-defined. And depending on where you are in the state, or which providers you use, or which team you are on, it can change, and I think it creates a lot of confusion about who is supposed to be doing want. And, I think in order for the system to function really well, those roles and responsibilities, you know, who is responsible for doing what need to be honed in and well-defined. And I think along with that, there is a really strong need for family member education for PDS, or the individual education, exactly what their roles and responsibilities are, when it comes to being the employer.

Because right now, we hear, of course, from case managers who are being asked to do things that they really should not be doing. FMA is being asked to do things that they really should not be doing, and there is just a lot of confusion out there. And guidance coming from, you know, different agencies that

have hands in PDS, whether that be DAIL or BDID, none of the guidance is incorrect, but it does differ depending on what waiver we are talking about. And again, it just creates a lot of confusion. The standards seem to be different depending on what waiver we are in, et cetera, and I think, as we move through this year, as we move towards creating new regulations, kind of streamlining a lot of different things, that standardizing the process across the waivers, creating strong, or really specifically outlining everyone's roles, would just be a tremendous benefit to everyone, and really improve the PDS service for everyone involved.

MR. CHRISTMAN: I see a hand raised. Frankie, did you have a question or wish to make a comment?

MR. HUFFMAN: Yeah, I didn't know if I should mention, not only do I do PDS and SCL, but I am also a representative, so I oversee, like, the people I hire and things like that.

MR. CHRISTMAN: Yeah, and we are

happy with that because that makes you a good representative for PDS. I guess I was just trying to get more formalized in the regulation.

Did you have any other questions right now, Frankie? Or comments regarding PDS?

MR. HUFFMAN: I also wanted to mention that I do agree with what you guys are saying, as well, about there needs to be more training on what the case managers do, when it comes to PDS and what the representative does, because there's a lot of people that don't understand that. Excuse me, as well. So.

MR. CHRISTMAN: Yeah, thank you.

Amy, would you like to continue?

MS. STAED: Sure. And again, I think that, and obviously, I have encouraged various members of teams, case managers, individuals, et cetera, to really write into that Medicaid public comment email, because I do know, again, we will see changes to waivers and changes in how to make that system better and what

the pitfalls are, you know, the points of tension, et cetera, and I do know that you all check that very frequently so, hopefully, you are still getting some feedback.

Are there -- can you please provide us an update on the process of the expanded case management for both HCB and SCL? Are those active -- can people actively apply to start that now?

MS. SMITH: Yeah, so for SCL, it didn't really change because it already was open the way --

MS. STAED: I'm sorry, I meant Michelle P.

MS. SMITH: Yeah -- we are changing -- I thought you probably did. No, we are changing all of the other waivers, so the other four: Michelle P., HCB, and both ABIs. It is open, PDS case management is open. We have actually, or DAIL on our behalf, has certified nine new agencies to certify case management. We've received three applications for providers wanting to be financial

management agencies. So far, unfortunately, we are still struggling with those and really struggling with people understanding what the financial management agency's responsibilities are, so, you know, for example, we have an application and their staffing plan was a nurse and two CNAs. I mean, this is somebody who is going to have to have tax knowledge, know payroll, because that's, you know, what they're going to do. They are going to have to do all that on behalf of the individual.

We are actively drafting the RFP to have a statewide, or possibly up to three statewide FMAs, so that is coming soon. We are under a corrective action plan with CMS right now about our PDS. Or, for the court reporter, I don't think we have ever mentioned. It is Participant Directed Services, so we've all said PDS, and have not ever spelled it out, so for how PDS is functioning in Kentucky right now. I will tell you, we have identified lots of opportunities for improvement, we

are working on education, we have seen a lot of case managers that are doing things as part of the participant, or their representatives responsibilities, for example. They felt like it was their responsibility to approve or set the rate for the employee, and that is not the case. And, you know, if you are participant directing your services as the participant or with the help of your representative, you get to set the rate for your employee, based on what you feel like they need. You have the guide rails of it cannot be lower than minimum wage or higher than the max allowable, but it is up to you to decide what you want. It is up to you to decide the services that you need. So we are really starting to work on some education about that, how we can, kind of, revamp the whole -- this whole service delivery method so it is better understood.

We are going to roll out -- we did an employer responsibilities tool, we developed that several years ago. We are

looking at that, again, now, and going to roll that out to be voluntary use in the beginning. But it really goes through all of the different points with the participant and their family, or their guardian, or who they choose to help them, if they choose to do so with Participant Directed Services.

It outlines, here is what your responsibilities are. Can you do this yourself, or do you need think you need help with that? And if you need help with that, that is okay, but how do you get the help so that you can do that. But really making sure that if somebody elects to participant direct their services, that they understand what that means, and that we don't have, you know, families that say, I just need my $30,000, and not understanding that it is tied to a Plan of Care, and really that participant has goals and objectives, and that is what is important to them and this is what they want to do. Maybe they want to be more involved with the community so that is

going to involved in their employer helping them facilitate that, maybe learning the bus stop, or learning travel, or helping them to join groups, or going with them. It's really all about the participant and that individual's participants needs, not just somebody saying, I want to provide 40 hours of care. Obviously, if the person needs 40 hours, that is awesome and that is great, but if they don't, and the person is like I really don't want you in my face or in my house, that is okay too. So we are really trying to look at participant direction and making that better.

And Amy, you hit on a lot of the points that we are working on to really try and make it better. We were fortunate enough to go to the Applied Self-direction National Conference a couple weeks -- I guess now it has been a couple weeks ago. And we presented, basically, on where we are in Kentucky with participant direction and in particularly, legally-responsible individuals and, kind of, how our plan

went off the tracks a little bit and how we are revamping that, and received a lot of good feedback, and it was a fabulous conference, so we brought a lot to apply as we revamp Participant Directed Services, because it is an important delivery. It's an important delivery method for a lot of people. You know, nothing wrong, if you choose you want to get your services through a traditional provider, but if you choose participant direction for all of them are even some of them, that is great too, so we want to make sure that we are serving the individuals to the best of our abilities and that we are giving them the opportunity to get the most out of their services.

MR. CHRISTMAN: Pam, you mentioned something about having two or three intermediaries developed? Was -- is that the idea to replace the area development districts?

MS. SMITH: This will be -- this will no longer be -- FMA will no longer be

a service. It will be something that we have at least one, probably no more than three, I know we are in the process of writing that RFP right now. So I am hesitant, I don't want to talk a whole lot about that, because I don't want to exclude anybody who may want to participate in that process when we get further down the line, but, yes. It will replace -- this is how most other states function. They have, you know, either 1 or 2, sometimes 3, depending on how big the state is and how it is set up, fiscal management vendors that do that function for participant direction.

MR. CHRISTMAN: You know, that strikes me as a good idea to have organizations that are just more focused on that role as opposed to the area development districts that have lots of different responsibilities, so.

MS. SMITH: There are several -- there are a lot of different agencies that that is their whole and their sole focus on.

MR. CHRISTMAN: In other parts of the United States, you mean.

MS. SMITH: Yes. Uh-huh.

MR. CHRISTMAN: Yes, I think that is a good idea, personally. That is good to know.

MS. SMITH: It is a hard job. There is a lot to it. There is a lot to do with tax and labor and that I just don't even claim to know enough about to speak intelligently about it, so.

MR. CHRISTMAN: Yes, it is very complicated.

Amy, is there anything else?

MS. STAED: No. But can I just give a shout out? Again, I know I shouted out that Medicaid public email address, they really do read it pretty frequently. So if anyone is on here and has thoughts or ways to improve the PDS system or, like, very specific issues they've identified, that Medicaid public comment email address is a good place to send those things.

MR. CHRISTMAN: The next item

has been kind of a standing one. Timeline for implementing rate study, waiver design, and Children's Waiver. Pam, can you give lightness on that?

MS. SMITH: I am waiting on our final budget.

MR. CHRISTMAN: Okay.

MS. SMITH: As soon we get the green light on what that final budget is, then I think we will be able to start speaking about that and outlining those timelines. I will tell you, waiver redesign has really not stopped and this will -- as we've talked about 13 and 15, you will kind of hear, work that there is still work going on. We are still doing a lot of things. It is not that we are not doing any work pending the budget, but I can't give you, like, any timelines or any plans until, you know, we know where we are going.

MR. CHRISTMAN: That leads me to a motion or recommendation I would like this committee to make to the MAC and I'll read it off:

(Reading.) As a biennium budget is essentially known, in the beginning of the new budget here, it is only two-and-a-half months away, the IDD TAC recommends the Department for Medicaid Services release its current plan for the implementation of the various provisions of the biennium budget as soon as possible. The department should also provide opportunities for input from providers before associated regulation changes are released for public comment.

If someone would like to second that, we can have some discussion. That is a formal motion I would like to make, that I have made.

MS. STAED: Rick, would it be helpful if I gave members of the TAC an update about what is currently in the budget?

MR. CHRISTMAN: Sure.

MS. STAED: Okay.

MR. CHRISTMAN: Maybe then we can get them to respond after this. I don't know.

MS. STAED: As Pam noted, the budget isn't finally final yet, but essentially it is the House and the Senate conference committees have passed it and it has now gone to the Governor's desk where he has line item veto power. After the Governor looks at it and may or may not make any sort of vetoes to the budget, that is yet to be seen, the legislature has a few legislative days where they can come back and override those vetoes if they choose.

So currently, the budget, as the budget stands, there are 750 Michelle P. Waiver slots over the two-year budget; 375 SCL slots; 750 HCB waiver slots; 50 ABI long-term care slots; funding for a serious mental illness waiver; funding for a substance use disorder waiver; $94 million in general fund dollars with associated federal funds too, which I think is over 100 million in each fiscal year to fund the 1915(c) rate study; funding -- a little bit of funding to get us to the next budget to help establish

the Children's Waiver; and there was language inserted in the budget that would require the Cabinet for Health and Family Services to conduct an analysis and assessment of the waitlists for all of the waiver programs and present that information by October, 2024. So that is where the budget currently stands for anyone interested.

DEP. COMM. HOFFMAN: This is Leslie Hoffman, Deputy Commissioner. Of course, as of today, we are not able to make any comments related to the budget until it is completely finalize, but thank you, Amy.

MR. CHRISTMAN: Right. And so, I guess, the intent of the motion is to get this information released as soon possible, and I understand from the Assistant Commissioner that that will happen as soon as, I guess, the legislative session is over. It also contains -- this motion contains -- a provision that we have provider input before any regulations are proposed to the

public.

I am still looking for a second to that motion.

(No response.)

Which dies, because there is no second.

And we will move on to the next agenda item.

How are we coming along with the eligibility assessment tool for children?

MS. SMITH: We have a work group that is comprised of multiple people from the cabinet, so it's from Medicaid, BDID, DAIL, that we are looking at, not just the functional assessment tool for children, but looking, in general, the functional assessment tool we use across all populations.

MR. CHRISTMAN: Thank you. Have you narrowed it down to some?

MS. SMITH: No, we have not. We are in the process of talking with other states and looking at what other states use and have found to be successful.

MR. CHRISTMAN: Are there quite

a few different examples out there; would you say? That you know of?

MS. SMITH: Everybody does things a little bit different.

MR. CHRISTMAN: Okay.

MS. SMITH: There are some that are more, I think, more prevalent. It really depends on, kind of, the population that you are serving --

MR. CHRISTMAN: Mm-hmm.

MS. SMITH: And the waiver programs, what you provide, so.

MR. CHRISTMAN: Okay.

We talked, last time, about perhaps having a presentation on Mobile Crisis units. Do we have someone available?

DEP. COMM. HOFFMAN: Rick, this is Leslie Hoffman. I'm going to give you an update. I feel like I repeat myself a lot. Just forgive me, because I have the Behavioral Health TAC, and the MACs, and I'm asked to present a lot on reentry, so just bear with me. But I do have a presentation I can share with you after

today, or today, and that way you that information. And I am going to share screen.

Erin, can you double check if I can share screen? It says one at a time. And it looks like it's going to let me. Just a second, I am getting there.

So again, Rick, this is probably more than what you want, and it's probably a repeat of what you have heard before, but I didn't want to leave you empty-handed this morning --

MR. CHRISTMAN: Well, I think above all, we are interested, does this affect people with intellectual and developmental disabilities?

It does. And so let me go -- I'm just going to skip through this really quick. Of course, I want to go over this with you real quick. It's an all-inclusive model for Kentucky. That means it does cover waiver clients. Now depending on where they live, and I will get there in just a second. It's to ensure that behavioral crisis for any

person, any resident, anywhere, anytime, no wrong door. We assessed Kentucky's needs for behavioral health crisis and we evaluated those in our current landscape.

If you are wanting to know where we started, it was based on SAMHSA's National Best Practice Guidelines. And again, I'm moving through this very quickly, but I'm going to send this to you for you to have today, and if you have questions, absolutely contact me. This is just how we got started.

MS. BICKERS: Commissioner?

DEP. COMM. HOFFMAN: Yes, ma'am?

MS. BICKERS: Your screen is not sharing.

DEP. COMM. HOFFMAN: Oh, I'm so sorry.

MS. BICKERS: It's okay.

DEP. COMM. HOFFMAN: Let me try again.

MR. CHRISTMAN: It did there for a minute.

DEP. COMM. HOFFMAN: Hang on just a second. I'm getting ready to get a

storm here in this area. Let me see. I'm so sorry. Hang on just a second. Can you see it now?

MR. CHRISTMAN: Yes.

DEP. COMM. HOFFMAN: Oh, sorry. I've definitely got a delay here. So just bear with me. I'm getting ready to go into storm, storm soon.

This was just the beginning of how we started with Mobile and the Planning Grant and all of the folks that were involved and how we drove every decision we made.

So if you can see my screen, this Click Here will take you to a 258-page Needs Assessment. There's about 20-page Executive Summary if you wanted to just go to it, and kind of a look over the summary that helps for folks to know how and why we went the direction that we did.

Again, I'm just going through this really quickly. This is to develop our assessment in findings, and what we needed to do here was not really a project management change, we had to do a change

management -- or not a project management -- we did a change management approach where we evaluate what we currently have in Kentucky, how we can leverage all of the good work and the bits and pieces that we have across Kentucky, and how we can move forward and leverage those as we go.

This is just how, kind of, have our gaps and meeting our aims and our goals. I think I was asked on another committee just recently, how are your goals looking? And so far we are doing well.

In Kentucky, you might already know this, that we decided based on that needs assessment that we needed to have two models: One here in Kentucky, that the federal government that put out in the show letter, that we would have a two-person team who would be on that two-person team, available 24/7/365, and that if we met that criteria, they would give us 12 quarters of enhanced funding. But we also realized in very rural

Kentucky, we are 112 counties of 120. As a rule, that we needed to develop something else, so that's when we developed our Community Co-response Grant Program that would go out to primarily 911 dispatches where local municipalities would be involved. So the governor allowed us to roll out, if you have heard him announce, roll out grants, the first round of the grants went out to these folks, which was the Boyle County Fiscal Court, Christian County Fiscal Court, Cynthiana Police Department, Lexington-Fayette Urban County Government, Maysville Police Department, Perry County Ambulance, and Warren County Sheriff's Department. And this allows us to help them, give them technical assistance, startup money, and understand the mission and values of what we want to go on here in Kentucky.

So we know that, although we want to minimize law enforcement involvement, we know that it's going to happen in our rural Kentucky, and how can

we help these folks to maybe bring on, for example, social workers. If you all have seen lately, there are several, I think in Boyle County, and maybe one other in Maysville, both have licensed clinical social worker positions posted out there to bring on to their groups. So I'm very proud of these groups, because it is very humbling to see a Boyle County or a Maysville Police Department wanting to help their local community and their neighbors next door, and to do it in a way that is to fidelity and to help these folks in a way that meets their diagnosis and their exact need.

You have heard me say before that a person with a mental illness or a person with depression and anxiety in the LGBTQ community is not the same response as we want with an elderly person that's maybe having a behavioral health crisis and maybe having an episode of dementia.

Just going over this real quick. You've heard me say this before. This is kind of where we wanted to go, someone to

call; someone to respond; and a place to go.

This one lays it out a little bit easier for you. If you heard me speak at health and welfare, it gives, kind of, a definition of one of these items so it is a laid out a little bit different.

These are the goals that we have met so far. I won't go over those but you have them. Sorry. I apologize. I am moving through this fast.

The administrative service organization is Carelon. We put out an RFP. Their expected go-live date is June 1, but that is subject to change.

Our current activities, and this is where I wanted to go with you today, were really right now in the contract and provider network phase. We have met with all of the CMHCs, all the CCBHCs, we met with all of the MCOs, a couple of BHSOs at this point. We started out with our safety net, the CMHCs first, and now we are also starting to meet with other interested providers that meet the

qualifications, and again, I can go through that later.

So what does that mean for SCL or other, like the brain injury waivers that have the residential components? CMS has allowed us to include a community residential setting such as a three-person home that you may have in the ABI Waiver or the SCL Waiver as a qualifiable location that we would need to assist. When you get into group homes, that is a little bit different, because it is a licensed facility. It cannot go into nursing homes and it cannot go into licensed facilities. So I just wanted to let you know that I was actually pleasantly pleased that CMS would allow that. It also would cover folks who live on their own, independent, shared living, I need to check on the family foster care, but I believe it would allow for that as well. So just wanted to let you know that if it is a residential setting that's in the community and there is a crisis that is called, and it truly has to be a

behavioral health crisis, then we are able to see this.

Rick, now, there is a lot more to come on this, right now we are really trying to establish those contracts that I told you about, the introductions, the collaborations in meetings. So in the next three months, I'm guessing, that you might want to have me or one of my staff come back and to come back --

MR. CHRISTMAN: Yes.

DEP. COMM. HOFFMAN: -- and start explaining where we are. But really until June, probably is going to be, like, a lot of behind-the-scenes stuff going on, that the public is not seeing, because it is contract-related. We did come up with -- Dr. Schuster asked for some service definitions the other day. Erin, I don't know if -- has that been shared with you from Lee or Eric? The service definitions for the Behavioral Health TAC? If not, I will send those to you.

MS. BICKERS: Not off of the top of my head, but I can go back because that

was a few weeks ago.

DEP. COMM. HOFFMAN: No, you are fine. I believe Lee may have sent those directly to Dr. Schuster. So I can get those out. We are sending those out with any contracts that we have so folks can better understand with the service definitions are and what they look like. And I think everybody, right now, has a fear of the unknown. With any new program, it is the fear of the unknown, and we are trying to close down any gaps. We will have growing pains. I'm telling this community right now, we will have growing pains and we will have gaps that we identify. This program is of such magnitude that there is no way that we can't have growing pains. So we will.

We did partner with the Department of Behavioral Health, we are connected to their 9-8-8 call center, and then our ASO picks up where deployment needs to be made so the CMHC 9-8-8 call centers will take a call, triage, and then decide whether deployment needs to occur,

and that will all go through our administrative service organization that we are collaboratively working on together.

Again, that's probably more than you wanted, but I will send it out and then if you have questions later, feel free to reach back out to me.

I think -- I'm sorry, I am jumping around here. I did put -- so we have a specific, KYMOBILECRISIS@KY.GOV, that's picked up everyday and there is my personal email. Just make sure that you can label it that it's related to Mobile Crisis or that it's related to the IDD TAC, so that I can get the answers to your questions efficiently.

That is it, Rick.

MR. CHRISTMAN: Well, Leslie, you have a lot going on there.

DEP. COMM. HOFFMAN: I do.

MR. CHRISTMAN: That is very impressive. You just heard us speak earlier, you know, about involuntary terminations and people being served, you

know, by organizations that really don't feel that they're capable of doing so, and some of this is related to aggressive behavior. So would this be something that would be appropriate for a Mobile Crisis unit to help deal with?

DEP. COMM. HOFFMAN: So, Rick, I'll have to work with Pam on this. We'll probably have some parameters that we will need to let folks know. There are some situations where a provider would be expected to handle; correct? And then there will be some that are outside danger of self and others that we will have to identify. I will tell you, though, that we absolutely want to be able to respond to the IDD population as well as the ABI population and what their specific needs are. You are aware that I used to be in Pam's position, so I know quite a bit about the waivers and the populations that we serve, and we want to make sure that we meet that need. Now the other piece of this is absolute diversion from hospitals, EDs, the emergency department, the

psychiatric facilities, and jails -- I'm getting some feedback sorry. So those are things that we would all want to work on, but Pam and I will have to come up with some parameters the closer we get as to what would warrant a behavioral health crisis; right?

MR. CHRISTMAN: Right.

DEP. COMM. HOFFMAN: A lot of folks I'm aware of, too, have dual diagnosis, so we'll have to work through that as well. But I don't want to speak too much for Pam, because we will have to work on this together along with our sister agencies, including the Department of Aging and Independent Living.

MR. CHRISTMAN: And the plan also includes places to go. How many places to go?

DEP. COMM. HOFFMAN: That is correct. So currently, right now, we are working on expanded Mobile Crisis Stabilization Unit and we are also working on a 23-hour facility. Now that is not one facility. We are hoping that lots of

partners will come on and that is part of the contracting and service definitions that we are talking about we are trying to develop. I don't know if anybody is familiar with the old living room model that used to be in Louisville Kentucky and, I think, it is no longer there due to funding.

We are trying to develop something that would look like a 23-hour -- as you are aware -- sometimes we just need to remove the audience sometimes, or isolate the situation for the member, and especially with younger adults, that might just mean that the families need to be apart, you know, for seven or eight hours of the day; right? So the 24-hour would truly be 23-hour or less time away and/or we also are going to work on a residential crisis stabilization expansion where people can stay a little bit longer, but since day one it has been our desire to eliminate, as much as we can, law enforcement -- unnecessary law enforcement -- now there's going to be

some situations where it is necessary. Unnecessary law enforcement, and then diversions from all those types of facilities that we told you about.

But again, Rick, I think after June you might want to ask us to come back and give another presentation.

MR. CHRISTMAN: Yes. We will do that. And I do agree that sometimes just changing the environment magically can change a whole situation so this sounds like a great idea.

It was mentioned last time, if I understood you correctly, that you are going to look at, you know, how the SCL is prioritize based on urgency of need, and did I understand you that you are working on the same thing for Michelle P.?

MS. SMITH: We have an entire work stream that is working on waitlist in total. So it is looking on how SCL does it today, it's looking how Michelle P. is set up today, how other states have structured their waitlists. So it is not to say that it is going to be just like

SCL. We may find we things we want to change with SCL, but there is a plan to go away from just having the general waitlist where it is allocated just in chronological order. We are looking at options for that. But there is a collaborative team that have been looking into that.

MR. CHRISTMAN: That's great. I think that's a great idea.

And then you also mentioned, are you still working on plans to try and eliminate -- not to eliminate the category, but I know, like, emergency always has, like, zero and you are trying to make urgent a zero, too; is that correct?

MS. SMITH: And right now, we are down to only 38 individuals in the urgent category on the SCL waitlist. There are 3,477 individuals on the SCL waitlist. We have 38 in urgent in the balance and future planning, so 34 and 39 in future planning.

MR. CHRISTMAN: Would that

involve keeping some of the newer slots open for that purpose? The new slots that have been coming from the General Assembly?

MS. SMITH: It depends on what that final count is.

MR. CHRISTMAN: Yes.

MR. HARVEY: And that is something that we are reviewing. And you know, and again, I want to remind anybody at any point in time can request emergency funding, whether they are on a future planning list or an urgent list. And, but we have been working very diligently, as you can see, the numbers on urgent have gone down, considerably. We are at 38 right now, so.

MR. CHRISTMAN: But that depends on do you have the slots to do it?

MS. SMITH: Correct, because we always want to make sure that we have enough slots so that we don't ever have anyone who needs emergency services on a waitlist. And we have been able to manage that very well for the last several years,

and so it is always looking at that to determine how many --

MR. CHRISTMAN: Yes.

MS. SMITH: -- how many slots we save for emergencies you have for those emergency allocations, but I do believe that we will be able to allocate more individuals who are in the urgent category.

MR. CHRISTMAN: Just personally I think it's important to reserve slots for the purpose.

Another item that came up subsequent to sending out this agenda, Frankie had a question regarding the use of nonemergency transportation funds from Medicaid, which I realize comes from the Department of Transportation, but it is Medicaid dollars for other kinds of activities.

Frankie, would you like to expand on that?

MR. HUFFMAN: Yes, if you don't mind, thank you.

Me and my caregiver have sent

Governor Beshear an email, because the way that it works right now in Kentucky, whatever the Department of Medicaid paid for the nonemergency medical, they pay the transportation rate to make sure that they find the company that can support the need. And right now, the way the cabinet's got it, they're getting a huge amount for the number of people that's on Medicaid, so they hand a huge amount to the companies then they just make everybody on Medicaid gets a ride. But if you have a vehicle, you are not able to use it.

I'm wondering, if they get paid either way, from the salary that they give these companies, and it doesn't cost any more, if we can make it to where we can use it for activities as well. I don't know if that makes sense.

MR. CHRISTMAN: Yes. Yes, it makes sense and I think what you are referring to are the transportation brokers; correct? These companies that get the money on a per capita basis;

right? Is that probably what you are referring to? Like, it's federated transportation.

MR. HUFFMAN: Yes, sir. Like, for example, they'll let you volunteer, but they won't take you to, like, work, or to, like, Walmart or anything like that. So they'll only take you to volunteer, state programs, and the doctor. But, like, for example, I don't volunteer today, so they get that money out of that lump sum, but just in case I needed. So I'm just basically wondering if we might be able to change that to where, since they get the money anyway, why we wouldn't be able to use it for nonmedical events.

MR. CHRISTMAN: Right. You are referring to surplus funds that the broker might have?

MR. HUFFMAN: Yeah, right.

MR. CHRISTMAN: To use for other purposes. I suspect they want to keep it for themselves, but I could be wrong.

Does anyone from Medicaid want to comment on that? Are there

restrictions that would prevent that from happening, what Frankie is suggesting?

MS. SMITH: So I think, Rick, what needs to happen, is we will need to postpone this till the next --

MS. BICKERS: Pam, Becky is on.

MS. SMITH: Oh, is Becky? I didn't know if you had known ahead of time enough to get somebody on, and I didn't see that Becky was on. Okay.

MS. BICKERS: No worries. I received the Governor's email about a week ago and we had reached out. Sorry about that. I didn't mean to cut you off.

MR. CHRISTMAN: So we have someone to speak on that?

MS. DOWNEY: Yes, hey. This is Becky Downey. How is everybody?

MR. CHRISTMAN: Thank you, good.

MS. DOWNEY: As of right now, from what I have been told, Medicaid does not pay to transport anybody to other activities. You know, they take them to the doctor, I do think, sometimes, they can take them to the pharmacy, because

usually that is a need along with the doctor's office. But as of right now, Medicaid doesn't cover to take them, you know, like, to the grocery, Walmart, or, you know, to drop them off at somebody's house or something, you know. As of right now, we don't do that.

MR. CHRISTMAN: Right.

MS. DOWNEY: And I don't know, I haven't heard anything about that changing.

MR. CHRISTMAN: Yeah. Well, that would require regulation -- is it possible from a federal point of view, is it something we could address with a regulation? It seems like these brokers, they might have, like, a fleet of buses, and they might be sitting idle, and the driver's sitting idle, and maybe they can address some of these needs.

Is that kind of what you had in mind, Frankie?

MR. HUFFMAN: Sorry, it took me a minute to get off of mute. But that's sort of what I had in mind, because me and

my caregiver did an Open Records Request to see how much they pay. We're not supposed to share that information, but it is a good amount, and I've been wondering, like, from where, if you have a vehicle and you can't use it, I'm assuming there's money left over.

MR. CHRISTMAN: Yeah.

MR. HUFFMAN: They still get that money just in case. So when you have a vehicle you can't use it, so it sounds like there is money left over, the brokers could use.

MR. CHRISTMAN: Or even from employment purposes, right?

MS. SMITH: Rick, there's also --

MR. CHRISTMAN: Well, unfortunately, the General Assembly is closing. I think this might be -- require a law change, and it's something that, perhaps, we can speak to legislators about what you are saying, Frankie, and see if that is possible.

Was there another comment out

there? Did you say something, Becky? Did I cut you off?

MS. DOWNEY: No, no. You are fine.

MR. CHRISTMAN: Did anybody else want to comment on this issue?

MR. CALLEBS: In terms --

MR. CHRISTMAN: It could also be brought to Waiver Services, yes. But there are a lot of people disabilities who don't have Waiver. But I do understand that, Pam, thank you.

Anyway, it's something you may want to work, Frankie, with some other advocates and see if maybe some legislation could be put together that would address that.

MR. CALLEBS: Rick, I was going to -- can I say something about it?

MR. CHRISTMAN: Mm-hmm.

MR. CALLEBS: It just seems like the fundamental question is, in EMT service, does each State Medicaid Agency determine the parameter of those, so is it a Medicaid decision about what trips can

be provided or covered under EMT, or, you know, again, does it require something more, like a federal approval, or.

MR. CHRISTMAN: Yeah, that's what I was getting at. I don't know if it requires the federal government to waive, or --

MR. CALLEBS: Or is it a change in statute or is it simply what Medicaid puts in its transportation plan or state plan or whichever one of those areas governs it. And I don't know the answer.

MS. DOWNEY: I don't know that either. That is a question I'd have to take back to upper management for you.

MR. HUFFMAN: I can make a quick comment on that, real quick, if you don't mind. It's Frank by the way.

MR. CHRISTMAN: Mm-hmm.

MR. HUFFMAN: A problem is what they had told me, but the way she was telling me it is a federal law that it has to be provided for, like, medical trips, but each state gets to decide, like, what trips they want to provide and what trips

they don't want to provide.

MR. CHRISTMAN: Well, maybe this is something that the DD Council and ARC and some other organizations can look into and take up and see if there is legislation that could be created here in the state that would help with this issue.

MS. BICKERS: Rick, this is Erin.

MR. CHRISTMAN: Because I think it would -- it would take some sort of legislative change, I'm sure.

Yes, someone commented here?

MS. BICKERS: This is Erin. Kelli and I are also the SPA coordinators. The State Plan Amendment coordinators, so anything that would -- and, of course, I would have to do a little research and rely on Becky as well, but if there was anything in the state plan that would need to be amended for the EMT, it would require CMS federal approval.

MR. CHRISTMAN: It requires CMS federal approval?

MS. BICKERS: Yes. CMS, I

always say federal approval after I say CMS, for some reason. So if there were any changes that had to be made to the state plan, that does require a change. So through CMS, an approval. I do know that. Now whether or not what is being asked is laid out and where, I would have to get with Becky and we would have to do some research and get back to you.

MR. CHRISTMAN: So we would have to jump through that hoop first.

DEP. COMM. HOFFMAN: Rick, this is Leslie. I was just going to mention, too, for the most part, I think if it is listed on the Plan of Care, if it is a specific item, even if it looks social in nature, but it might be related to a specific goal and task that they are out working on, when it is included on the Plan of Care, right, it is usually covered, but Erin is totally right. If we go outside of the norm of what CMS would allow us to do, then we have to ask for either a SPA change to be approved or a waiver to do that. I think SCL does

have -- doesn't SCL have transportation in it too, now?

MS. SMITH: Yes. It does have a transportation service. And just to clarify, when you are speaking if it's on the Plan of Care, that's related to Waiver, not necessarily to EMT.

MR. CHRISTMAN: So you may be able to get the transportation in a plan, but, right now, it doesn't -- we don't compel the nonemergency transportation providers for providing that transportation.

DEP. COMM. HOFFMAN: Right.

MS. SMITH: They would not be providing it. It would be the waiver provider.

MR. CHRISTMAN: Right. Right. Right.

DEP. COMM. HOFFMAN: Sorry if I made that sound I'm confusing, too. When I think about a particular service that might be going out into the community and working on something that may be social in nature, that is what I meant. As long as

it is on the Plan of Care. I'm sorry if I misspoke.

MR. CHRISTMAN: Well, I don't know. I think there has been, like, some significant increases in reimbursement rates for nonemergency transportation. Maybe, I don't know. Maybe something can be done to apply some of these, maybe, excess monies for other good things.

But we will keep an eye on that as we go along, okay Frankie?

MR. HUFFMAN: Okay. And then, if you don't mind, can I ask one more quick question?

MR. CHRISTMAN: Sure.

MR. HUFFMAN: For Pam. I just want to make sure I understood it correctly. Because this is the way that I understood it as well. Like, if it's in the plan because the NAMI can take me to volunteer in the plan, but let's say I wanted to go to Walmart, something like that, but the caregiver would have to provide that and not the Medicaid.

MR. CHRISTMAN: That's what I am

getting, yes.

MS. SMITH: Yeah, it would be that, yeah, your caregiver could provide that and it's part of that -- because it's part of that. So I think, Frankie, probably under the personal assistance service, that is part of the services that they can provide. So under your Plan of Care you have, you know, that you want to do your own grocery shopping or you want to, you know, have something in your goals and objectives, then that is absolutely covered for your caregiver to transport you to do those types of things. As well as if you want to, you know, for when you volunteer.

MR. CHRISTMAN: Right. Well, Frankie, like everyone on this committee, you are, I will send out a notice about meetings and I asked for suggestions for topics to discuss and as things go along, if you want to bring this up again, you are very welcome to do so; okay?

MR. HUFFMAN: Okay. Thank you.

MR. CHRISTMAN: Sure. Is there

any other business?

MR. CALLEBS: Rick, can I just point out --

MR. CHRISTMAN: Yes. You mentioned about waiting lists. I noticed on the website, if you scroll down, the waiver capacity and waiting list is on the IDD Task Force or IDD Technical Advisory Committee website.

The one that posted there now, Pam, is that fairly up-to-date?

MS. SMITH: I'm assuming. I'm not on that website right now, but it's probably from the last -- it probably was from the last time it was updated.

MR. CHRISTMAN: Okay. So anyway, it contains that visual presentation about how big the waiting lists are. I think that is an excellent tool to figure out what's going on with waiting lists. But you are not sure if there has been any updates to that?

MS. SMITH: I don't think that has been updated. And I don't have the current. We can get that updated, but I

don't have the current. We want to get that up on the screen right now. I'm just looking at the dashboard right now. So I can give the numbers to you.

MR. CHRISTMAN: Okay, go ahead.

MS. SMITH: And then we can --

MR. CHRISTMAN: Okay, go ahead.

MS. SMITH: Okay for ABI, long-term care, there are 5 individuals on the waitlist. SCL, I gave that a little bit earlier, but there are a total of 3,477; 38 in the urgent category; 3,439 in future planning. For HCB, there's 1,945 individuals on the waitlist; and Michelle P., there are 9,009 individuals on the waitlist. I don't have the counts of the child versus adult, but it is holding steady at right about that, I'm sorry, 70 percent that are under 21.

MR. CHRISTMAN: Yeah, and I would encourage everyone to look on the website. This is a really excellent thing that the department has done that kind of puts that waiting list in perspective. I think it's very helpful.

If there's not anything else, we are adjourned. Thank you.

(Meeting concluded at 11:39 a.m)

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C E R T I F I C A T E

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

Dated this date th/st/nd of MONTH/YEAR

_____

Stefanie Sweet, CVR, RCP-M