CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
February 4, 2025
Commencing at 10 a.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Wayne Harvey, TAC Chair

Brad Schneider

Melanie Tyner-Wilson

Johnny Callebs

Frankie Huffman (Not present).

Ann Pierce

Cheri Ellis-Reeves

Doug Hoyt

MS. BICKERS: Good morning. This is Erin with the Department of Medicaid. It's not quite 10 o'clock and we are still clearing out the waiting room. We'll give it just a moment before we get started.

It is now 10 o'clock and the waiting room is cleared. I have Wayne, Melanie, Johnny, Doug, Cheri, and Ann. If I missed any TAC members -- oh, and Brad is currently logging in. If I missed anyone else, please let me know.

MR. HARVEY: Erin, does that establish a quorum for us?

MS. BICKERS: Yes, sir, it does.

MR. HARVEY: Thank you.

MS. BICKERS: I'll hand it over to you. You're welcome.

MR. HARVEY: All right. The first thing on the agenda today -- and we've got a lengthy agenda, so everybody that's logged into the call, bear with us as we work our way through it. The first thing on the agenda is the approval of minutes from the previous meeting. Do I have a motion from any of the committee members to approve the

minutes?

MR. HOYT: Move to approve.

MR. HARVEY: Do I have a second?

MR. SCHNEIDER: I'll second.

MR. HARVEY: Okay. Is there any further discussion?

(No response).

MR. HARVEY: All right. All committee members, please, if you're in favor of approving the minutes, say aye.

(Aye).

MR. HARVEY: Any opposed?

(No response).

MR. HARVEY: Okay, Erin, that's got the minutes approved for us. We will move into old business. The first thing on the agenda is a general children's waiver update. Do we have someone from the cabinet to report in regards to that, Erin?

MS. HOFFMANN: This is Leslie. I'm on, Wayne. How are you?

MR. HARVEY: Doing fine, Leslie. Good to see you again.

MS. HOFFMANN: Good to see you. Give me just a second. I am transferring from a

downstairs meeting, and I've got a little -- a couple of power -- just a few slides on a PowerPoint to show you, if that's okay, for the children's waiver. Just a second.

MR. HARVEY: Sounds wonderful.

MS. BICKERS: Leslie, I made you a co-host, you should be able to share.

MS. HOFFMANN: Oh, thank you. Give me just a second. I'm sorry. I was coming up from downstairs, just a second.

I'll tell you what I'm going to do -- I can't find it real quick. I'm so sorry. I can just read off -- I took a picture of the slides when I was downstairs, just a second. And I can send this through Erin. So I was just going -- I thought you might like to have a little bit of an update as to where we were with working with the children's waiver.

So if you remember, there is a budget allocation for a child's waiver in -- starting state fiscal year '26. So that -- we didn't get '25. It was state fiscal year '26. And the children's waiver has actually morphed into something much larger. The

secretary has been very diligent in working on a bigger scale picture than -- not just a waiver. So it has become part of a larger scale initiative where many of our sister agencies, and even agencies outside of our cabinet, like Department of Juvenile Justice. Those folks are even involved with us as well.

The initiative right now is called -- they just changed it last week, and so I'm going to say that this is a draft. And it's tentative because it may change again. We're calling it the Families First Initiative. So families, plural. Families First, and it has nothing to do with the Family First Grant we have here in Kentucky. It's called Families First. And it has become a larger multidisciplinary system that we're working on. And I'm just going to tell you some things that are included before I go into what actually the children's waiver we're doing right now.

So it's a much larger comprehensive, multiyear initiative enhancing the existing care for Kentucky's children and youth. One

of the initiatives -- of course, you probably have already heard about it. We have SHINE Kentucky, which is a grant that we applied for to help school-based children -- or school-based services for Medicaid and CHIP eligible enrolled students. So that's just one piece of it.

Then we have the reentry 1115. If you've heard about that, that is for children that are in DJJ custody and we're trying to improve their lives as they are coming back out into the community. We also started an initiative -- and I know this is a lot for you all. I'll send the slides. It's called Child Mapping. It's the children's health initiatives or innovation mapping tool, and it is to bring all programs that we have here in Kentucky, whether it be Medicaid, DBH, you know, public health into one tracking tool so that we know who's held accountable for it and what those programs are doing related to children's health, so that we're not overlapping, but that we can integrate and actually leverage each other to provide a

more universal or a more inclusive tool or product here in Kentucky.

We also are looking at targeted case management and unbundling, the restructuring of Medicaid payments for medically necessary treatment and services. Sorry, Erin, can you let them know I'll send the slides. I wasn't able to pull them up quick enough, sorry -- in the chat.

And then also, we are looking at high need service delivery for those children that are very high need. If you've heard folks say that sometimes unfortunately, they're too acute for acute, we've got a lot of programs that are trying to take a look at hard-to-place children right now here in Kentucky. And the service is designed to meet the child centric care support service, whether that be housing, custody, placement, and any other health-related social needs.

So right in center of all those things that I'm telling you about is the children's waiver. So we're not sure yet. It might be a "children's waiver," and it might be a "state plan amendment." It could

be an I. So I don't want to give you anything for sure right now, whether that's going to be a C, an I, or anything else. There also probably needs to be adjustments in our eligibility which will be additional state plan amendments.

So I don't know if you all have heard of the Katie Beckett waiver in other states. We're also looking at the eligibility piece out of the Katie Beckett, kind of mixing all the things together as to what Kentucky needs.

So Family First seeks -- I just wanted to read this because the secretary has been very involved with this. "Families First seeks to create a unified, integrated, and child-centered care framework to address the diverse needs of Kentucky's young population by enhancing the coordination across health, education, social services, and any other key sector or factors that aim to ensure that every child and youth receive the necessary support to achieve their full potential." So again, this waiver is going to become a much bigger initiative.

Generally, the things that we're working on right now are identifying behavioral health service gaps, assessments for mapping. We have an advisory work group that's in progress right now. We are looking at trying to complete this within 18 months, and we are about -- let's see, I think December would be around our marking for the 18 months. We're also doing environmental scans.

Some other things are exploration of child-related program transformation initiatives, emerging trends, innovation and challenges of service access, policy considerations around the implementation of new programs, identification of barriers to access of services, an emphasis on equity and inclusion service delivery, a recognition of identified risk in the current system, development of mitigation strategies to address all risk that we might have here in Kentucky, and an examination of pathways to Medicaid eligibility. Kind of what I was telling you.

Not -- nothing's for sure. This is

all a draft, and when you get the slides, it says "draft" because it changes. It's a work in progress of how that eligibility might work. So we're kind of looking at some things. If you are, like I said before, familiar with the Katie Beckett waiver, we're looking at just the eligibility piece and how that has been approved through CMS.

So of course, we're looking at all kinds of assessment tools that we might be able to utilize and leverage, and how we can get this up and going as quickly as possible. There is a huge group that is working on this, like I said, and we do have a contractor that is assigned, which is Myers and Stauffer. So just sharing that information with you.

And I'm sure there'll be more to come, Wayne, as we move towards coming into this time period that folks expect us to be working on. What was called a waiver in the state budget, there were some meetings held last year that God House actually held related to what folks would like to see. We

do have that information. It is now under Myers and Stauffer contractor.

Let's see, the rate study implementation timeline for 100 percent implementation was what was listed on -- oh, is it okay, Wayne, if I just go through your list here?

MR. HARVEY: Sure --

MS. HOFFMANN: I didn't mean to get ahead of you.

MR. HARVEY: -- I do want to ask --

MS. HOFFMANN: I'm sorry.

MR. HARVEY: -- did anybody have any questions --

MS. HOFFMANN: Sorry.

MR. HARVEY: -- about the children's waiver update?

MS. STAED: Wayne, I had a follow-up, Leslie, if that's okay?

MS. HOFFMANN: Yes, ma'am.

MS. STAED: If you'll note on there, it talks about -- in the December meeting, I think it was you. I don't know if it was you, so if it wasn't you that mentioned this, I'm sorry. It's -- the holidays are a

blur, but there was a mention of creating a January workgroup. Is that still moving forward? Is that a stakeholder group?

MS. HOFFMANN: Yeah. Let -- I'll ask about that for the -- we've changed some directions, not for the bad, for the good.

MS. STAED: Yeah, yeah.

MS. HOFFMANN: We're adding more things and so let me just double check on the January workgroups that we thought were coming.

MS. STAED: Sure. And then, can you, to the extent that you're able, talk a little bit about -- this sounds great. This like kind of comprehensive approach.

MS. HOFFMANN: Yeah.

MS. STAED: And it also sounds like there may be a shift towards a more funding-heavy model, to a model where we're making systems changes so the systems function better to address the needs of children --

MS. HOFFMANN: Mm-hmm.

MS. STAED: -- including kids with IDD that do currently -- that are currently

served in the waivers. So can you talk a little bit about -- it sounds like maybe that's where you all are heading. So could you talk a little bit about that, if possible?

MS. HOFFMANN: Yeah, and I'm -- I don't want to get too far ahead because it's the presentation that I had that Myers and Stauffer had developed from our conversations. But, you know, this administration has been awesome, wonderfully awesome in allowing us to integrate with our sister agencies to lever the -- leverage some programs.

We've really done a lot of environmental scanning, trying to figure out where the problem is and how can that be picked up. And literally, if I can't fill the gap, can DBH fill the gap? Can DALE fill the gap? I'm just saying. Can DJJ fill the gap? How can we make it a more smooth transition or a smooth course of continuum, right, for the children here in Kentucky?

And I was just giving you a lot of

lists that have been floating around in our head. We've got all kinds of things going on for children right now that we're trying to address. I mean, we're all aware that -- I can't remember. We've been doing this for years. We have an 8:15 every morning call, and I think we even did it through -- Thanksgiving before last, I think we were even on there on Thanksgiving. 8:15 every morning to discuss children that might be out of placement in the future. We're trying to be proactive, so we're addressing the needs of children that might not have a placement, and we've been doing that all through COVID, I think since 2020, meeting as a team, like I said, integrated.

So there's a lot of things going on. You all probably heard about that, that we've got a crisis for children who have exceptional needs right now. And just -- this is kind of like just fit in at the time that we want to like try to make it an integrated effort. Does that make sense?

So yes, will there be systems changes? Probably. Is there going to be

integrations between sister agencies? Probably, yes. Will there need to be new assessments that are more capable of addressing these needs? Sure. But I think it's a very positive -- we've been wanting something like this for honestly 25, 30 years. So it's really good that we're trying to move forward.

The other thing is, is that we've got money in the budget to move forward, and we are trying to look at a December date. Now, if you all will allow me, as we have the IDD TACs, I'll come back and give you more updates as to where we are in that process.

MR. HARVEY: Absolutely. Thank you, Leslie.

MS. HOFFMANN: Absolutely.

MR. HARVEY: Any other questions for the children's waiver update?

MR. CALLEBS: Wayne, I have one.

MR. HARVEY: Sure, go ahead.

MR. CALLEBS: Leslie, the funding that you do have for '26, is that funding for kind of development of waiver and services, or for actually service provision,

or both?

MS. HOFFMANN: It was for service, and it starts fiscal year '26.

MR. CALLEBS: Okay. And how much -- can you -- I know you've said this before, but can you refresh my memory? Do you know how much it is?

MS. HOFFMANN: I can't remember.

MR. CALLEBS: Just curious.

MS. HOFFMANN: I'll have to look. I'm so sorry.

MR. CALLEBS: That's okay.

MS. HOFFMANN: I did not -- I should've pulled that --

MR. CALLEBS: I can't remember either.

MS. HOFFMANN: Oh, I should've pulled that for you today in case you asked.

MR. CALLEBS: Yeah, no. No problem. I know you've said it before and I forgot as well, but --

MS. HOFFMANN: We were pleased that we at least got it in on fiscal year '26, so that was a very positive -- a positive thing that happened with the budget.

MR. CALLEBS: Okay, thank you.

MS. HOFFMANN: Mm-hmm.

MR. HARVEY: And, Leslie, if you don't mind, can you tell some of the callers that might not be familiar with what a fiscal year for the state is?

MS. HOFFMANN: Oh, July. Sorry.

MR. HARVEY: What that means when you say, "fiscal year '26."

MS. HOFFMANN: Yeah, July 1. So --

MR. HARVEY: July 1st, 2025.

MS. HOFFMANN: -- it was a two-year budget, right? It was a two-year budget, but we didn't get funds for it until fiscal year '26, which would be July 1 of 2025. I know that's confusing. Federal years run different. We've got all kinds of good old years, so yeah, just bear with me. I forget sometimes that -- and I talk in acronyms. I'm so sorry. If there's no more questions, I will just move on.

There was a list on here about rate study implementation. Timeline for 100 percent, and plan for inflation adjustment related to 100 percent. So all

the changes that were planned to be made have already been made and active January the 1st of 2025. All other financial changes, of course, you all already know this, we would need additional appropriations to be able to do that, which would include -- I'm guessing that's a cost-of-living plan for inflation. I'm guessing that's cost-of-living. So we've gotten done what we were supposed to do at this time. So just wanted to mention that.

So --

MR. HARVEY: Any questions --

MS. HOFFMANN: -- yeah.

MR. HARVEY: -- on the rate study implementation update?

MS. TYNER WILSON: Wayne, this is Melanie.

MR. HARVEY: Sure.

MS. TYNER WILSON: Good morning. Can I go back and ask a question about the previous thing that Leslie talked about?

MR. HARVEY: Sure, absolutely.

MS. TYNER WILSON: Thank you. Thank you so much. I'm guessing that you're kind

of focusing on children in out-of-home care. Are you also -- is it -- am I correct in that assumption?

MS. HOFFMANN: It's not -- it's all children that might fit this category.

MS. TYNER WILSON: Oh.

MS. HOFFMANN: And I don't want to talk about the eligibility just yet because it --

MS. TYNER WILSON: Oh, no, that's fine.

MS. HOFFMANN: -- Melanie, it tends to grow every time we get together because you can imagine --

MS. TYNER WILSON: Yes.

MS. HOFFMANN: -- the meetings that we have, there's enough experience in all of our sister agencies and Medicaid, we've got all kinds of wish lists that we want to throw in there. So just hang tight with us.

And I've asked, as we get a little farther each couple of months, I'll try to go back and get updates. We work -- like I said, we work very closely with the secretary. This is kind of something he's

wanted literally for 25 or 30 years. So --

MS. TYNER WILSON: Yeah, I think it's wonderful. I just was hoping that fictives, or relatives, grandparents, I wanted to know if that population was also included as a -- I wear that hat.

MS. HOFFMANN: Okay.

MS. TYNER WILSON: And so if there's an interest in having someone like me be a member of the workgroup, I'd be happy to.

MS. HOFFMANN: On the workgroup, okay. Okay.

MS. TYNER WILSON: Thank you. Thanks, Wayne.

MS. HOFFMANN: Thank you.

MR. HARVEY: You're welcome. Any other questions regarding the children's waiver or the rate study implementation update that Leslie gave?

MS. STAED: Hey, Wayne, I had a question.

MR. HARVEY: Sure.

MS. STAED: And, Leslie, you may not be able to answer this. I think that providers are a little bit frankly baffled

as to why we spent, you know, tens of millions of dollars creating a rate study, and then The Cabinet for Health and Family Services asking for an appropriation that's 30 percent under the rates that an independent body said were enough to support the continuation of provision of frankly, lifesaving services. And so I think providers are really looking for The Cabinet's plan to get to 100 percent implementation since they thought that 70 was, you know, where we needed to be right now.

MS. HOFFMANN: Mm-hmm. So the rate study was combined with lots of things, not just what we needed here to sustain, but what our other sister states were doing and what CMS would agree to and approve for us to move forward, so we went with the 70 percent.

I do want to remind everybody though that after that rate study came out many, many rates, per CMS, were supposed to reduce and we didn't reduce any. So if you just go from the 70 study to a 100 study, you have

to remember that there were many, many rates -- I'm -- I can't remember for sure, but probably 56 across the board that were supposed to be reduced that we left -- we left the rates as is and did not reduce them. So I don't want to get into that either, Amy. The fact is, is that that's where we landed. That's where we are. That's what CMS has approved. Anything more than that we're going to need more appropriations. And I'm just sharing that with you because I know you all are all advocates for Kentucky services and programs, so.

MR. HOYT: Mr. Chairman, I think that conversation that Amy brought up is very important for all of us as providers. I'd like to make a motion that the IDD TAC recommends and requests that CHFS provide a written guidance or guideline that outlines the implementation of the completed rate study to 100 percent implementation that includes specific timeframes and implementation dates.

MR. HARVEY: Doug, let's hold that

motion. They've given me a strict agenda to follow now, and we have to wait until we get to the part of the meeting where there is a call for recommendations --

MR. HOYT: Okay.

MR. HARVEY: -- before we can present any motions. So just hold that thought, and we'll come back to it when we get down to it on the agenda. Okay?

MR. HOYT: Sure.

MR. HARVEY: Thank you, Doug.

MR. HOYT: Just don't want to lose sight of it.

MR. HARVEY: Okay.

MS. BICKERS: Wayne?

MR. HARVEY: Yes?

MS. BICKERS: This is Erin. If you'd like, you guys can go ahead and make a motion since he just read it in full. That's okay.

MR. HARVEY: Okay. All right.

MR. SCHNEIDER: And I'll second.

MR. HARVEY: You guys give me a strict agenda format to follow, I was going to follow it.

MS. HOFFMANN: We appreciate that.

MS. BICKERS: We have a little wiggle room, but I don't want Doug to have to repeat all of that again.

MR. HARVEY: Okay, great. Good.

MR. SCHNEIDER: I'll second that motion.

MR. HARVEY: There's a motion on the floor that was made by Doug. It has been seconded by Brad. Any discussion regarding the motion that Doug stated?

MR. CALLEBS: Can you please repeat the motion?

MS. TYNER WILSON: Yes, please repeat.

MR. HOYT: The motion is --

MR. HARVEY: You want me to repeat it?

MR. HOYT: Yeah, the motion is that the IDD TAC recommends and requests that CHFS provide a written guideline that outlines the implementation of the completed rate study to 100 percent implementation and to include specific timeframes and implementation dates.

MR. HARVEY: Okay, any discussion regarding the motion? Does anybody need it read again?

MR. CALLEBS: No. I do have a question though.

MR. HARVEY: Sure.

MR. CALLEBS: So to let -- and I know -- yeah, this rate study has gone on for a lengthy period. And to Leslie's concern about implementation at 100 percent would require additional appropriation. So I guess my question is if this motion passes as a recommendation, and goes onto Medicaid and The Cabinet through the MAC, then if the money isn't there, the funding isn't there, then, you know, how do you get to 100 percent? Or is that going to involve a legislative request for additional appropriations to -- in order to put together a plan or a timeline to get to 100 percent. Did I -- I kind of rambled a bit, but.

MS. HOFFMANN: Brian, that's correct. We would need additional appropriations to Medicaid. And I know it's hard for folks to

understand, but it's always a lot more money than folks think about, right? It's a huge amount of money. We're not talking about thousands or hundreds of thousands. We're talking about millions. So, yeah, we would have to have additional appropriations.

But again, Johnny, Wayne, I was mentioning this earlier, don't forget from the 70 percent that we gave when all -- many, many codes across the board were supposed to reduce, we did not. So if you went to the 100 percent of what's currently out there, those things that we didn't allow to go down may reduce. I'm just -- I want you to understand that. I'm just sharing that information. That's why it would be better to have appropriations for something like this.

MR. HARVEY: I understand what you're saying, Leslie. I think there is some different numbers and stuff that's floating out there amongst the --

MS. HOFFMANN: Yeah.

MR. HARVEY: -- legislators versus The Cabinet personnel --

MS. HOFFMANN: Yeah.

MR. HARVEY: -- and so forth and so on. I think what Doug's motion is more about, if I understand it correctly, is, you know, getting a clear picture from The Cabinet each and every time as to where we're at on that. Because if we're completing a rate study and we spend the time and everything to do that, I don't understand why you wouldn't work towards 100 percent completion of that.

MR. HOYT: And, Wayne, thank you for that clarification. That's exactly what the motion is intended to do is to -- it's difficult for us, as providers, to hit a moving target. And I understand that in life, the target moves on a regular basis, but we're trying to get at baseline so that we're able to know where we are because candidly, each and every provider is losing money every day that they participate in these programs. And it's very difficult for us to continue to support the individuals we support and convince our boards that it's appropriate to do so while losing hundreds

of thousands of dollars every year.

MS. HOFFMANN: Again, I just want to go back, hear me, this is what I'm saying: I just want to remind everybody that after the 70 percent, right, which we had the rate study report that backs that up that CMS approved, right? And remember how long we were on hold and still needed to do lots of work because they were waiting for a rate methodology. Look how long that's been. And the waiver redesign and all of those things that we were looking on that's been on hold to get these rates to where CMS would approve, but that's not where I'm going with this.

Where I'm going with this is we did 70 percent, but because of that, we also allowed a lot of codes that were supposed to be reduced, to stay where they were. So you're not really at 70 percent. You're probably higher than that. Does that make sense?

So if you go back to the 100 percent of that original rate study, right, it's going to be -- I'm just saying -- okay, I'll

go ahead -- I'll handle the recommendation.

MR. HARVEY: Well, I have a follow-up question. And -- well, I see Johnny with his hand up. Go ahead, Johnny, ask your question and then I'll ask mine.

MR. CALLEBS: Well, I was just going to ask if, I mean, is there -- is it -- are all of the services only funded at 70 percent of the recommended --

MS. HOFFMANN: So we did the 70 --

MR. CALLEBS: -- rate?

MS. HOFFMANN: We did the 70 percent, plus I think there was 56 of 77 codes across the board that were supposed to be reduced, and we did not reduce them after that. So you got the 70 plus we had this whole group of services that should have reduced across the board, that we didn't reduce. I'm just saying, you're probably -- if you go back and compare all of that, you're probably above 70 percent. Does that make sense?

MR. CALLEBS: And -- yes.

MS. HOFFMANN: So if you go back and ask for 100 percent of that 70 percent, you've got all of those allowances that we

made afterwards. Just throwing that out there.

MR. CALLEBS: And is there an example of a --

MS. TYNER WILSON: Code.

MR. CALLEBS: -- service rate that's come out?

MS. HOFFMANN: Yeah, I -- so, Johnny, just -- this was just 15 minutes before I came up here, I talked to Steve Bechtel just for a few minutes, and we thought maybe we could get you some information together with God House's assistance and see if I can come up with an answer. And just -- that's what I want to do is I want to maybe come up with a little better answer for you because I don't think folks realize that 56 of 77 codes that were supposed to reduce did not, so.

MS. STAED: And I think --

MS. HOFFMANN: And in the 100 percent -- for the 100 percent, 12 of those codes would need to reduce. So we made allowances after the fact. I just want to share that with you.

MS. STAED: And, Leslie, I respect your position, and I respect --

MS. HOFFMANN: I know. It's hard.

MS. STAED: -- you're put in a tough place right now. I don't think anyone's asking The Cabinet to implement the rate study right now. I think everybody's asking for a little bit of clarity about what that looks like moving forward. Obviously, whenever we do get to 100 percent implementation, there will need to be cost-of-living adjustments, etc., which will likely cover some of the gaps in those things. But, you know, frankly, because I've gone through the rates and hand gone through them, only 18 percent of our services are funded at 100 percent of the rate study. Which is hard, right?

So, you know, some of the rates you're referring to -- and we're incredibly thankful that those were preserved because providers rely on them, you know, to do our -- some of those temporary 50 percent that have to -- with the pass-through requirement, which are so important for

employees to be able to --

MS. HOFFMANN: Right.

MS. STAED: -- make higher wages, but unfortunately, those aren't even available to new providers. So new providers are at a disadvantage that they can't even bill that.

So, you know, only a handful of providers are getting to bill those rates. It's -- you know, it's a tough situation, and I think everyone -- I think the point of the motion is that everyone's just asking for a little clarity regarding the targets and the timeline. You know, no one's asking The Cabinet to do anything today. Just so we -- because everything's just so up in the air, and no one really knows what's happening.

And I understand that you all don't know what's happening given some questions about federal funds and things like that. And I think everybody's just asking for a little clarity. Not for you to --

MS. HOFFMANN: Amy, did you just say -- sorry, I haven't even -- like, except for my meeting just a few minutes ago with

Steve, did you say that you did some calculations and 18 percent of the codes are at 100 percent?

MS. STAED: Yes.

MS. HOFFMANN: Is that what you just said?

MS. STAED: Yes. And now, that does not include the optional pass-throughs. Those were not included in our calculations because those are optional and they're not available to providers anymore if you were not in business at the time --

MS. HOFFMANN: COVID, yeah.

MS. STAED: -- of the attestation.

MS. HOFFMANN: Okay. Okay, so send the recommendation, we'll see what we can do.

MS. TYNER WILSON: And --

MS. HOFFMANN: And again --

MR. HARVEY: Melanie, go ahead.

MS. HOFFMANN: There are plenty of advocates on here. Appropriations is what's going to be needed.

MR. HARVEY: Melanie, you had a question. Go ahead.

MS. TYNER WILSON: Yes. And I wasn't privy to the workgroup that did the rate study, so I'm trying to catch up. Can I share a list of the codes that you all are referring to just to kind of help me understand? And would all of this also be accessible to individuals that use services through the PDS system?

MS. HOFFMANN: Alisha, are you on? Can you send -- or, Erin, can you send the rate study to Melanie? I think we've sent it to this group before. It's still online.

MS. TYNER WILSON: No, yeah. I've read that, but I do have questions about the codes that you're --

MS. HOFFMANN: I'll have to go back and look. I don't have those in front of me.

MS. TYNER WILSON: Oh, okay.

MS. HOFFMANN: I was just asking Steve a few minutes before that, and he said around 56 of the 77 across the board, and in the 100 percent, another 12 of the 77. So -- and that means nothing to you all right now, I know. I'll go back and work on

it.

MS. TYNER WILSON: Okay, thank you.

MS. BICKERS: And, Melanie, just to make sure I get the take-back right, you're looking for the codes that were included in the rate study?

MS. TYNER WILSON: Well, what Leslie is referring to now about certain things -- certain codes were funded at a certain percentage and certain number of codes --

MS. BICKERS: Okay.

MS. TYNER WILSON: -- were funded at 100 percent. I'm just trying to seek -- I'm seeking clarity.

MS. BICKERS: Thank you. I just want to make sure I get the take-back correct.

MS. TYNER WILSON: All right, thank you.

MR. HARVEY: And, Leslie, I just wanted to confirm --

MS. HOFFMANN: And, Wayne, I think HealthTech is going to --

MR. HARVEY: Who?

(No response).

MR. HARVEY: Was somebody asking a

question?

MS. BICKERS: Leslie, I think you froze.

MS. HOFFMANN: Oh.

MS. BICKERS: I heard "health," and then you froze.

MS. HOFFMANN: Can you hear me?

MS. BICKERS: I can now, yes, ma'am.

MS. HOFFMANN: I'm sorry. I believe HealthTech Solutions are going to give you an update on the MAC and BAC changes.

MR. HARVEY: Okay. I have one more question about the --

MS. HOFFMANN: Yes, go ahead.

MR. HARVEY: -- about the rate study information. And that is it's my understanding when we were working with The Cabinet to complete the rate study that the state of Kentucky was utilizing the rate study as a rate methodology to validate the rates and so forth requested from CMS; is that correct?

MS. HOFFMANN: That's correct. And it's finally been approved. And if you remember, we've had tons of things over the

years that have been on hold, right, that we need to work through because CMS was waiting for us to come up with a rate methodology that they would approve. So that's been a long time coming within the waiver redesign and CMS requirements. So for a long time we were on extensions because they were waiting for this rate study. So they finally approved it.

MR. HARVEY: Okay, now I need to go back to the motion itself. There's been a lot of discussion back and forth with Leslie in regards to information around that. Does anybody else have any other discussion in relation to the motion that Doug made before we put it forward to the committee members for a vote?

(No response).

MR. HARVEY: Okay. On the motion that Doug made, all in favor, say aye.

(Aye).

MR. HARVEY: Any opposed?

(No response).

MR. HARVEY: Okay, the motion passes. We'll go ahead and pick up with the

general updates that you started into, Leslie, and I interrupted you and I'm sorry. Your voice is cut out again, Leslie.

MS. HOFFMANN: Can you hear me okay? I'm sorry.

MR. HARVEY: Yes, now we can. Thank you.

MS. HOFFMANN: I believe HealthTech Solutions is going to give you an update on the MAC and BAC changes. And I don't know if it's Marie Matthews or one of her other staff.

MS. COMEAUX: Hi, Dr. Hoffmann. It's Nicole Comeaux.

MS. HOFFMANN: Thank you, Nicole.

MS. COMEAUX: I am a partner at Mercer, and we work in partnership with HTS to support DMS on this effort around implementing a set of final rules. So I'm going to talk y'all through a set of slides here. I am going to share my screen, if that's all right. I think somebody has the screen.

MS. BICKERS: You're now a cohost.

MS. COMEAUX: Okay. Give me one

second here and I'll put this in the right view. Okay, can you all see my slide?

(No audible response).

MS. COMEAUX: Okay, great. Okay. Well, thank you for giving us time today. I heard that there was a strict agenda. Do you want to give me a time estimate for how long you all want me to take here to run through these? I can be faster or slower. There's about 18 slides.

MS. BICKERS: In the interest of time --

MS. COMEAUX: Yep.

MS. BICKERS: -- if you could go through them somewhat quickly.

MS. COMEAUX: Okay. I'll try and stick to it. Do you want us to use about like ten minutes, Erin?

MR. HARVEY: That'd be good.

MS. COMEAUX: Okay, all right. I'm going to go a little quickly then, but we are going to send this deck to DMS, and then they'll be able to distribute it accordingly for folks who want to reference it later and ask any follow-up questions.

So again, real briefly, my name's Nicole Comeaux. I'm a partner at Mercer, but in my prior life, I was the state Medicaid director in New Mexico and worked at CMS, and I was also the deputy director at Kynect, so I spent a couple of years down with you all in Kentucky. I'm really happy to be working with you guys.

So we were hired to support the state in the implementation of a broad set of federal rules that came out last year. And as part of those rules, there's a requirement that states implement kind of updated versions of what were previously called MCACs or Medicaid Advisory Committees. But now, they'll be called Medicaid Advisory Committees, and also as part of that, they'll be required to implement Beneficiary Advisory Councils.

So we're going to go through kind of some work that we did to gather input from important external parties to help support the state as they develop these new communities in accordance with those federal rules. So in the deck, we have kind of an

overview of the information that went out publicly. A survey went out following those forums to get feedback from folks. I think a number of you were there, so thanks for your participation. We'll talk about the survey results, and what we saw come in that's information that now the state will take to incorporate as they go ahead and put their plans in place to get these committees going. And then, I have a little bit of time for questions, but I'll leave that to you all if you need me to save that time and let you move forward with the agenda.

Okay, that's up. Okay. So as you can see on the slide, there is a requirement that these committees be in place and in compliance with the federal rules -- looks like somebody's trying to get in there -- by July of this year. So we've been working to get that public information, and towards the end of last year, in December, two forums were held to go through the information that we thought that would be important to folks to consider. That included the federal requirements, and then also, to seek public

input on key decision points, and make sure that we got the information that the state will need to put in place these new committees.

You can see that on the first meeting, we had 400 folks register, about 200 actually attended. And for the second meeting, 300 registered and 152 attended. For those of you who attended the webinars or watched the recordings, we hope that you'd agree that the topic resulted in really thoughtful discussion, and that we heard from a pretty diverse set of voices, including the individuals who spoke, and then as you'll see, the individuals who responded to the survey. The webinars included a QR code at the end that linked folks to the survey, and the QR code was also sent out to folks following the forum.

Okay. These are the kind of high-level results from the survey. So in addition to posting the link on DMS -- for participation I should say. In addition to posting the survey link on DMS's website, the invitation was sent to over 500,000

individuals and posted on social media. We received 668 submissions of the survey, and about 502 of those provided, you know, concrete feedback to at least one survey question. As to be expected and as is common in these kind of engagements, other folks responded with kind of individual circumstances or issues that they wanted to bring up to the state's attention. So that's why that count is a little different.

On social media, you can see that the forums received almost 900 views and some engagements. That's where they like clicked through to see what additional information was included on the post.

So you can see here kind of the representation of folks who actually participated in the survey. The survey asked individuals to provide their affiliation so we could get a sense of participation. The self-reported affiliation is presented on the slide, but the information might not be reflective of all of the forum attendees as many submissions had multiple selections.

However, based on the responses we received and the participation we heard, we do feel confident that those with lived Medicaid experience were prevalent in their responses. You can see there, 338 of the total responses self-reported a Medicaid member affiliation.

Okay. So let's get into the substance a little bit more here. The rules outline a set of requirements for the MAC and BAC that the states must follow. We covered this information in the forums, and for the sake of time, I'm not going to review these requirements where the state has no discretion, but we wanted to provide it here for your reference in the future.

The survey questions and the forum questions instead focused on those areas where the states do have some discretion and have the ability to mold these committees as they see fit. So the forums targeted questions about a key set of areas where they do have that space, and you can see those seven areas listed on the right-hand of the slide. As we go through the

following slides, we'll give the feedback on each of those specific areas.

Okay. So the slides are broken up into recommendations that were given for the MAC and the BAC. Again, as a reminder, the MAC will be structured similar to kind of that MAC structure that you're familiar with now with a lot of broad stakeholder representation -- or, I'm sorry, external partners. And the BAC is actually intended to be filled with representatives with real Medicaid lived experience. So the recommendations that came back were either for the MAC and the BAC separately, or for the MAC and the BAC together. So you'll see that broken down on the slides.

So you can see here that there was a desire to expand MAC representation to providers including FQHCs, federally qualified health clinics and rural health clinics, community mental health centers, chiropractors, dialysis providers, and the list goes on. There's also some desire to include legal aid services, and quite a bit of feedback about the importance of

representation for behavioral health.

On the BAC, there were suggestions about the split between Medicaid members and their caregivers. So for example, a 50/50 split, 60/40. They also provided a lot of response around ensuring that there was representation based on gender, age, and geography, those with waiver experience and other different Medicaid program experiences, dual eligibles, and then children with special health care needs.

On the MAC and BAC size, there was quite a bit of information that folks provided about feeling concerned about it getting too large and the difficulty in maintaining operations if size gets too large, but in general, recommendations ranged from 15 to 30 members on the MAC. And many said the current size works well. On the BAC, recommendations, again, ranged from 13 to 19.

When folks give us information about the length of the appointment, so this is how long somebody who's appointed to each committee can serve, the desired period of

time ranged from two to six years. And feedback also noted that it was sometimes really hard to get your hands around, you know, all of the pieces of Medicaid and how it works. And so giving folks enough time to really kind of learn the ins and outs of Medicaid so they can feel like they're giving meaningful participation in that role requires at least some period of time, and not shorter than two years.

When folks gave feedback about the selection and appointment process, they stated that the current process for the MAC works well with advocacy groups and provider groups giving recommendations that the commissioner then selects from. On the BAC, there was a recommendation -- or numerous recommendations for applications that were available in multiple formats, and support for folks to complete those applications as well.

When it came to additional subject matter expertise, we heard that subcommittees might be a great way to comply with the new federal rules and help focus on

specific topics. That might mean a change from the current structure with TACs, and that this is an alternative approach that's adopted by many states to help support, still making sure all of those voices are heard. One individual suggested a refocus of subcommittees into five broad areas of focus, like regulatory reimbursement, many of the things you all are talking about on your meeting today, advocacy, education, and access as these areas impact the entire system.

Sorry I'm talking so fast, y'all, just trying to get through it. The meeting frequency and format: We heard that frequency, folks had suggestions that they meet monthly, maybe every other month, as needed by the department, on an urgency needed to convene basis, or quarterly. However, the majority of respondents felt that the current cadence, every other month for the MAC, was appropriate. We wanted to note for you all that keeping the cadence of meetings every other month for the MAC would require -- remember that slide where I said

the federal government put requirements on some things that were nonnegotiable for the states? One of those requirements is that the BAC must meet before the MAC every time it gets together to ensure that those folks have an opportunity kind of coalesce around the voice they want to bring to the MAC meetings. So if the MAC were to meet every other month, that would require BAC members to meet every -- basically twice within a month to meet those federal requirements, which may feel burdensome to some. So we wanted to highlight that for you all as a consideration.

Timing: There were a lot of comments from folks that it's hard to meet during working hours, both on the MAC and the BAC side. Hard for folks who are working from the member perspective, and also for providers -- busy providers to get out of their schedules to make it to the meetings. So recommendations that there's a consideration for meetings outside of normal hours. Three hours was long when folks talked about the duration, but most

respondents felt like there was a lot of information that they needed to hear. And so those meetings might still need to be fairly lengthy.

Finally, for participation, lots of requests to continue to allow Zoom and phone access, and if meetings were held in person to also make sure that there was transportation. And you'll see more of those member supports here in a moment.

Okay. And that is this last slide of feedback. So the last area, bucket No. 7, was for supports, for both the MAC and BAC. So you can see the left column is shared supports for both committees. Folks wanted orientation and training around Medicaid, kind of like a Medicaid 101. Supports prior to the first meeting -- Amy, I see your hand. I'll grab you as soon as I get through this slide. And then supports -- sorry, supports prior to the first meeting: Sharing agendas and information in advance of those meetings so folks can get familiar, holding pre and post meetings possibly to provide context or answer questions, and

dedicated policy staff on the BAC. These would be for BAC members only. A lot of additional supports, things like monetary supports around stipends, transportation, childcare. There's a lot of considerations that we wanted to flag there, making sure that those don't impact eligibility.

And then also we heard from members who responded that they wanted to make sure it also didn't impact their waiver budgets depending how things were structured. And then some others there that you can see around meeting transcripts, webinars, virtual meetings.

Okay, last slide. Just some other feedback that came, not in the bucket areas, but were really common themes. Just a lot of desire to engage, which is great I think for Medicaid agencies. They want to hear from their members, and I know DMS is certainly representative of that kind of desire. So wanting to make sure that folks have publicly available information was a lot of that feedback, and also a desire for kind of two way communication. So not just

the agency pushing information out, but also an opportunity for them to engage. So folks liked having surveys, or opportunities to convene, online forums, and talk to each other, and engage in that way.

And with that, I will stop sharing so I can see everybody. And I saw a hand go up there. I think, Amy, that was you?

MS. STAED: Yeah, that's me. This is more of a general comment than a specific comment to your presentation. Thank you so much for being here. We really appreciate it. I know you've been --

MS. COMEAUX: Sure.

MS. STAED: -- talking about this a lot lately.

MS. COMEAUX: Yeah. Apologies for those of you who've had to hear me multiple times.

MS. STAED: But I really appreciate it. I just wanted to note for the record that members of the Kentucky Association of Private Providers, and frankly, waiver providers in general are tremendously concerned about the notion of potentially

getting rid of the TAC structure and creating subcommittees, for a number of reasons that were noted. I was on those calls. A number of reasons that were noted on the calls: One, it doesn't sound as important. But I think it's vitally important that we continue to have specifically this TAC. While I realize that it's the IDD TAC, we really talk about, you know, issues that face providers and recipients of all 1915C waiver services. It's just kind of turned into that.

And like, for example, the rural health clinics and the federally qualified health centers have their own representation on the MAC because they are a very unique provider-type who experience --

MS. COMEAUX: Mm-hmm.

MS. STAED: -- very unique audit issues, very unique reimbursement issues.

The same goes for 1915C waiver providers. 1915C waiver providers are audited completely differently than any other Medicaid provider. Our reimbursement is very different. Our set of rules and

standards that we have to abide by are completely different. I mean, to be frank, you know, there are some behavioral health providers who also provide waiver services, and the way they have to provide, document, and account for the provision of those services is completely different under waiver reimbursed services and Medicaid services.

MS. COMEAUX: Mm-hmm.

MS. STAED: And we believe that it's vitally important to preserve this forum that is outlined in statute, for these issues to be discussed.

MS. COMEAUX: Okay. Thank you for that feedback, Amy. We've got folks taking notes, and we'll make sure to take that back to the folks on the state side. And, Dr. Hoffmann, feel free to jump in, of course, or any other representatives from the state.

I talked so fast y'all. I really apologize. But we will send the slides, and I think overall, there was really great and thoughtful feedback. I think some of those

ideas about how committees could be structured and the supports that can be provided are great.

I will say from the privilege of getting to have some national perspective, that the way that you all operate currently and the way that the state engages with the members is pretty incredible. There's a lot of really, like you said, Amy, specific groups, and I think there's a desire to make sure that folks still hear voices, but also a desire to make sure that they could do that in a way that's effective.

You know, there's a point where there's so many different engagements and not enough resources. So how do they balance, you know, kind of that desire to engage, and also to get work done in between? So I think they're hearing that loud and clear, and we will take that back.

Any other questions?

(No response)

MS. COMEAUX: And again, we'll share the slides, but I know y'all will continue to hear from the state on this as things

move forward. If not, I'll give it back to the strict agenda. Thanks for your time.

MR. HARVEY: Any other questions for Nicole?

(No response).

MR. HARVEY: Okay. PDS corrective action plan is the next thing on the agenda. Is Leslie still with us?

MS. HOFFMANN: I'm on, Wayne. Did -- am I missing one? Was there a question about regulations? Did I just totally miss that? Do you see that? Oh, general updates --

MS. BICKERS: It's on the back, Leslie.

MR. HARVEY: Oh, yeah. General updates, yeah.

MS. HOFFMANN: Sorry. Did you want me to give an update on the regulations? I was just --

MR. HARVEY: Yes, please.

MS. HOFFMANN: -- going to say that the e-reg, of course, was sent in along -- so that's the emergency reg for those that haven't been through the process. And then

the o-regs were filed -- that's ordinary regs -- were submitted at the same time. The e-regs are effective and we are currently going through the o-reg process.

One of the things that I just want to remind everybody again, is that we had to ensure that we could get these regulations through very quickly for the rates. And so we only amended -- we amended the existing regs as an emergency, and only enhanced the rate part of what we've done for waiver redesign, which is the rate study. We'll need to do some larger changes later in the year and address some things that have kind of been on hold for a long time that don't -- you all are aware, we've got things that we need to kind of match up and make sure that everything is consistent between regs and waiver language, so additional policy changes.

That's it. I just wanted to let you know that that was specifically just to get the rates approved, and we didn't want to add in a lot of things that may delay those getting approved.

And then --

MR. HARVEY: Okay. Any questions on that?

MS. STAED: Leslie, are you still planning to potentially reamend the waivers and submit -- and promulgate new regs just to be -- so that everything conforms to existing practices later this year?

MS. HOFFMANN: Yes. If everything goes okay and we're, you know, approved to move forward and all those things, but there are things in the waiver application that need to be updated to reflect regs and things in the regs that need to be updated to reflect the waivers. I do not have a list of those. I do know we have several things though that need to be addressed.

Just -- it's just for timing and the way things have all played out with us on hold with waiver redesign and that rate methodology. So we need to go back and correct some of those things, right?

MR. HARVEY: Any other questions before we move on?

(No response).

MR. HARVEY: Okay, the next thing up is PDS corrective action plan.

MS. HOFFMANN: Okay. So we meet with CMS on a regular basis, I may have told you all this last time. There is no official KAPP. We've just been meeting with them on a regular basis. So we meet again with them on the 21st, and this is always on our informal meetings. So I do not have an official plan or KAPP from as -- and as soon as we do, I've let folks know that I will plan on releasing that, but I do not have one as of right now.

There was some language on here, too, about getting statewide vendors and things like that. Of course, we can't discuss anything like that at this time in case we, you know, had an RFP in the future. We just can't discuss any of that on the public forum.

We do meet with CMS monthly. We do give additional, you know, information back and forth, and we will -- it will be posted on their website as well as ours as soon as the KAPP is released.

MR. HARVEY: Okay. Any questions in regards to that? And I apologize if anybody's on the call that don't speak acronym language. We -- people that -- I know Leslie does --

MS. HOFFMANN: Right.

MR. HARVEY: -- and cabinet personnel, and obviously, providers and so forth have spoke acronym language for a long time.

MS. HOFFMANN: Sorry.

MR. HARVEY: So if somebody has a question about an acronym that we reference during this committee meeting or anything, just put it in the chat and we will clarify what that acronym stands for.

MS. HOFFMANN: I apologize.

MR. HARVEY: The last thing there underneath the old business part, is update regarding the 1915C waiver waitlist.

MS. HOFFMANN: Waitlist. And, Steve, there's -- Wayne, down at the bottom, too, there was another request, and we can talk about that later, that's kind of a repeat.

MR. HARVEY: Mm-hmm.

MS. HOFFMANN: If you want this information, I give this to other TACs on a regular basis. We can do it every month if you want to. It can just be a standing report if you need it.

Currently, right now -- let me explain this before we -- while I'm going through it. We have total unduplicated individuals is 14,054, but we have many, many of those that are receiving services in other waivers or have other funding streams. So there might be somebody that's on Michelle P., but on the waiting list for SCL. Does that make sense? Or maybe they're in the HCB waiver, but really, they want SCL or they want to go to Michelle P. I just wanted to share that information. So the current list right now is 2,846 for the HCB waiver, 9,480 for Michelle P., and 3,530 for SCL.

MS. STAED: Are those unduplicated, those numbers you just read, or are they potentially duplicated?

MS. HOFFMANN: 9, 10, 11, 12, 13, 14. Those are unduplicated.

MS. LERZA: If you add that all up --

MS. HOFFMANN: Thank you, Catherine.

MS. LERZA: -- it's going to be more than the 14,000. It's because it includes the -- so there are 1,802 people who are on more than one waiting list.

MR. HARVEY: Any other questions?

MS. TYNER WILSON: Wayne, this is Melanie. Can I ask a question?

MR. HARVEY: Sure, go ahead.

MS. TYNER WILSON: At the Kentucky Voices for Health meeting, Commissioner Lee spoke, and there was a question asked of their -- of how the revision or the modification of people that are on the waiting lists, like Michelle P., is going to be revised. Because I guess, right now, anybody can just go on it, but they are looking at having more of a criteria-based -- or they already have it -- criteria-based eligibility. And is that in place? Is there regulations on it, or statutes or modification -- whatever the term of art is? Is any of that in place as of now? I've tried to get the answer to it, but I -- go

ahead.

MS. HOFFMANN: Cathy or Alisha, I'm not aware of any changes that we've made so far.

MS. CLARK: No, there's no changes as of yet, but we are working with Cathy and her team, and also with our Department for Independent -- DAIL, The Department for Independent Aging and Independent Living, there we go. See, I was trying to not speak in acronyms and then I got confused.

But, no, we are all meeting and looking at different recommendations that we can make to our commissioner's level, and also, the secretary's office because, Melanie, yes, we understand that there needs to be some updates --

MS. TYNER WILSON: Yeah.

MS. CLARK: -- because --

MS. TYNER WILSON: I just wanted to be able to invite somebody in to talk to caregivers or individuals that might be interested in applying for the waivers. And I wasn't quite sure if it was at a point that, you know, I'd be -- there'd be

somebody available that could speak to that. So I'm -- they're just very interested in increasing the understanding of folks out in the Kentucky world that are interested in applying but don't not quite know all of this, so.

MR. HARVEY: Any other questions?

MR. CALLEBS: Wayne, I don't have a question, but I just have a comment. Thank you, Leslie, for the updated numbers. I just wanted to point out for the record that, you know, despite record appropriations for new slots during the last budget session, we're still -- the waiting list seems to only grow. It never decreases. So, you know, again, not the fault of Medicaid or anybody else. It's just a lack of funding for people on the waiting list.

So again, just an observation or comment, not a question.

MS. HOFFMANN: When the budget was approved and we had those slots to be able to offer the opportunities out to folks, it -- and I don't have anything in front of me,

but it felt like the waiting list grew even quicker than it normally is because folks knew we had those slots. But unfortunately, those slots weren't going to reach new folks just coming -- unfortunately, new folks just coming on the list.

MR. CALLEBS: Good point. All right, thank you.

MR. HARVEY: Any other questions or comments before we move on?

MS. PIERCE: I have a concern.

MR. HARVEY: Go ahead, Ann.

MS. PIERCE: I think the people -- the people -- thank you. The people on the waiting list, I mean, they have serious issues they're dealing with, and I understand that they have to wait, but I'm wondering, I mean, is there some other way we can help them aside from the waiver? Does that make sense?

MS. HOFFMANN: Yeah, again, I don't have the information with me. I see Alisha's coming off, too, but a couple things: Just a reminder, as we mentioned before, there is over 1,802 that are on more

than one waiting list. So we have to -- so we would reduce that down -- I believe, down to about 8,615. A large majority of those have state plans, so they can get access to any services that we have in straight Medicaid while they're on the waiting list because they have not started the waiver.

Alisha, did you want to see anything else, or was that what you were going to say?

MS. CLARK: No, that's what I was going to say. And I was going to say, actually, Cathy might have the specific numbers. I think it was around 80 percent that had Medicaid funding possibly. And like you said, a lot of these people that are on some of these waiver waiting lists, they do have funding in another waiver, or they're Medicaid eligible and can get, you know, a lot of services -- any service that's through state plan already. So I don't know if Cathy had anything to add.

MS. LERZA: Yeah, I don't have the overall Medicaid information, but 37 percent of the people of the unduplicated number of

people on the waiting lists, are -- already have funding within a different waiver then -- so they are receiving services in one waiver while they're on the waiting list of another waiver.

MS. HOFFMANN: Kind of what I said before. As you all are aware, the HCB waiver was the last one to fill up, so many folks on the HCB waiver may not prefer or want that waiver, but that's the waiver that they ended up on. And so they're on a waiting list for another waiver, like SCL or Michelle P. Does that make sense?

MS. PIERCE: Yeah.

MS. HOFFMANN: As long as they can meet the criteria, of course.

MS. CLARK: And, Leslie, there is also, I think, some different types of grants and stuff through -- for our aging population, like heart supported living --

MS. HOFFMANN: Sure.

MS. CLARK: -- and some other things through them that people might --

MS. HOFFMANN: Mm-hmm.

MS. CLARK: -- be able to get as

well.

MR. HARVEY: Go ahead, Ann.

MS. PIERCE: Thank you, Wayne. Is there a way -- because I'm thinking of specific people, it just breaks my heart -- that are -- need help and can't get it, and can't even -- well, anyway, is there some way to make them aware of these other programs you're talking about, like heart-assisted?

I mean, word-of-mouth is one thing, and I can tell them what I've heard today, but is -- there's all the ones that I don't know, right? So how do we let them know about these things? Can there -- I just -- I don't know. It seems like something needs to be done though because they're crying, and --

MS. ADAMS: The community mental health centers can assist with that. They have an access and referral service that we utilize for individuals with intellectual and developmental disabilities. The purpose of that service is to help folks apply for the waivers, and also connect them to any

other funding, as well as some small, limited resources that we have available and funding directly with the community mental health centers to provide supports to individuals.

So I would encourage them to reach out to the community mental health center in their area and ask for the access and referral service for individuals with intellectual and developmental disabilities, and they can assist them with all of that and walk them through every step of it and explain it.

MS. PIERCE: Yes, good. And then that's another good source, right? And I appreciate that, but how do we let them know about this -- these things?

MS. ADAMS: Each of the community mental health centers do outreach and education in their areas to attempt to make people aware of the services. But certainly, if you're aware of individuals personally, if they -- they can call the community mental health center directly. If they're not sure how to do that, then we can

provide a listing of the ones for their area and how to contact them.

MS. PIERCE: So again, yes, but, I mean, is there a way, like, maybe when someone first receives a diagnosis of a disability, maybe they can be given a list of places they can call for help. Is that happening? I'm just running into people that aren't aware of what to do.

MS. ADAMS: Well, that would depend on the provider who provides the diagnosis. Like I said, we do outreach and education in the areas with, you know, all the different providers that we're aware of to give them information that they can share. But since we don't have any direct oversight over all of the individual physicians or psychologists who may be the ones providing that initial diagnosis to an individual, we can't set into place an automatic process for that to happen. But anyone is always welcome to reach out to the division if they have any questions, and we'll be happy to connect them to the correct folks in their area to get that moving.

MS. PIERCE: So what I'm hearing is there's nothing we can do then to get the word out, right?

MS. ADAMS: If you --

MS. BICKERS: Ann -- go ahead, Crystal.

MS. ADAMS: Go ahead.

MS. BICKERS: I was just going to let her know there was a resource PDF dropped in the chat I can email her after the meeting.

MS. PIERCE: Yes, but it's not about -- it's about all these other people who don't know, and I know these things you're saying. I know what you're talking about, and I tell them, but what that means to me is there's other people out there that I don't know who don't know what to do.

MS. TYNER WILSON: Mm-hmm.

MS. PIERCE: It just seems like there should be some way -- I just think that's something we need to think about, about how to get the word out of what's available in the state for help while you're waiting for your waiver. Does that make sense?

MS. TYNER WILSON: Yeah. Yes, and,

Ann, can I speak? Is that okay?

MR. HARVEY: Sure, go ahead, Melanie.

MS. TYNER WILSON: I used to work for Developmental Pediatrics at UK, and these were the itty-bitties, so, you know, when they -- when a child 2 to 18 months to 6 was identified as having some kind of medical diagnosis, oftentimes my job was to make sure they received information. And we would fill -- you know, the doctors would fill out the MAP tens and I would send them to the powers that be to help them get on the waiting list.

But your question is great because there's a lot of people that are older that get some kind of -- have been identified, you know, with some kind of medical diagnosis or disability that need information, and I think that is harder to access. I mean, your point is a good one, and sometimes you have to kind of search through the weeds in order to be able to find that out.

In my life, with the Autism Society and the ARC, we have -- we try very hard to

keep that information on the website, but it doesn't always get to the, you know, people that probably need it right at the moment in time. So we could always do better.

MS. PIERCE: Well, it was just a concern. Thank you.

MS. TYNER WILSON: Yeah.

MS. STAED: And I just wanted to note that ultimately, if your question is in regards to doctors who make diagnoses making information available to people, that would definitely be an issue to take up with the Kentucky Board of Medical Licensure, who regulates physician licensure and has oversight over their continuing education, and would be able to make, you know, physicians all over the state of Kentucky aware of programs that exist out there. Whereas not all physicians participate in the Medicaid program and wouldn't -- and Medicaid does not have the resources to necessarily reach all of them with the information.

MS. PIERCE: So that's a great idea, Amy. And -- but that -- are you saying --

is that something this committee can make happen?

MS. STAED: The Kentucky Board of Medical Licensure is an independent body.

MS. PIERCE: So how do we make that happen with them? Does that -- are you saying I need to call them and tell them? Is this not a committee concern?

MS. STAED: That would likely be something you would have to pursue on your own.

MS. PIERCE: I have to pursue that on my own. Okay.

MR. HARVEY: Are there any other comments or questions? We really need to move down the agenda. We've still got a number of things to cover here.

The next thing up on the agenda is new business, and the first thing up is financial management service, the future of the service, CMS concerns about conflicts, the search for a statewide vendor. We still have Leslie on with us?

MS. HOFFMANN: Yeah, Wayne, it's Leslie. So this is what I said earlier. I

knew there was another comment on here. I can't -- other than telling you I don't have an official KAPP right now, and I can't discuss anything about statewide vendors and those kind of things right now. Sorry.

MR. HARVEY: Okay.

MS. TYNER WILSON: Well, what is a statewide vendor? Can you give us just a definition.

MS. HOFFMANN: We don't have a statewide vendor, so we would have to procure one.

MS. TYNER WILSON: Oh, okay.

MS. HOFFMANN: That's what I'm saying. Just -- I can't get into those conversations on a public meeting, please.

MS. TYNER WILSON: Okay.

MR. HARVEY: Okay, noted. The next agenda item is MPW respite changes. I think there were some concerns related to the switching of that particular service from the way it's calculated and everything. Leslie, are you speaking to that one, also?

MS. HOFFMANN: I asked Alisha she would assist with -- I've got a couple other

folks that I'm turning some of these over to that have been kind of deeper in the weeds. Alisha, would you mind to address the Michelle P. waiver respite changes?

MS. CLARK: Absolutely. So, yes, during the waiver amendments that we actually -- I think we put those out for public comments on -- I can't remember if it was September the 13th, or maybe it was August the 13th. But anyway, those were sent out for public comment, and we included summaries. That is one thing that was done to make this and Michelle P. waiver, the service, more like all the other waivers that had units instead of just the dollar amount. But one thing that was great to see in this, instead of around $4,800, now an individual can get up to $7,700 and some change of services. So their services actually increased, but this also goes to be consistent with the other waivers.

So I know that we actually put out a letter on December the 23rd, and then there were some additional questions from some folks. So we tried to assist and put out

additional guidance on that on January the 16th. So, you know, if somebody used $4,000 during or -- I'm just saying 4,000 just to keep it simple math for me. But say they use $4,000 before 12/31 of 2024, then they're going to have up to the 7,700 and whatever it is, I don't have it right in front of me, but -- so it will take a little bit of math, but you can see how much you have for the rest of your plan of care year. And then once your new plan of care year starts, then it'll be super easy.

And I see Kelly put it in the chat for me of the public comment. I thought I wrote it down, and I wrote it down wrong. So that's why when I went to read it, I was like, wait a minute, this isn't right. So thank you, Kelly, for that. But is there any specific questions that you have? I just kind of wanted to kind of give an overview of what we've done.

MR. HARVEY: Any other questions?

MS. CLARK: Thank you all so much.

MR. HARVEY: Okay. The next one is a big one. It's a question in regards to

medical marijuana: Clarification of the rules related to medical marijuana hiring and firing of staff, medical marijuana prescribed to individuals receiving Medicare funded waiver services. Leslie, are you the one addressing that, as well?

MS. HOFFMANN: Yeah. So unfortunately, I'm not going to have you an answer today. We've reached out to a couple of other states. We reached out to Colorado. Of course, they're a much more progressive state than we are right now with some of the things that they have there. We also -- I've reached out to the Cannabis Task Force here in Kentucky, but of course, there's a learning curve. Just because they're the task force of Kentucky, they don't necessarily understand waivers and these kinds of programs. So we've got some additional things that we've got to work on there.

So I don't have you an answer to this right now. Hopefully I will soon. I hope it doesn't take as long for me to get answers back on this as some of the

telehealth questions back in the day, so I'm -- just bear with me. We are -- because we want to know. We have things that come up on a regular basis with some of our clients especially, so we do want to know how this is going to roll out and what will be considered legal and not legal considering these are federally -- have federal funds -- programs have federal funds going to them.

So just wanted to let you know that I don't have an answer for you today.

MS. STAED: Hey, Leslie. And this -- to be clear, we put this on there knowing that you would not be able to give us an answer today.

MS. HOFFMANN: I want to know, though. I do want to know.

MS. STAED: But we just ask that you think about this on two fronts. From an employer's standpoint, obviously, drug tests and so on and so forth are required. So No. 1, can an employee, if they have a prescription, test positive for medical marijuana? Is that allowable?

MS. HOFFMANN: Yeah.

MS. STAED: Is that fireable, not fireable? And then, 2, you know, if it's fireable, it's fireable, and then we just move on. But if it's allowable, then how do providers document and handle the drug testing portion of that?

MS. HOFFMANN: Okay.

MS. STAED: So that's specifically the guidance.

And then the other front is from a participant standpoint. If an individual who receives waiver services is prescribed medical marijuana for one of the --

MS. HOFFMANN: Yeah.

MS. STAED: -- I can't remember. Is it like ten listed reasons? Is that allowable or not allowable?

MS. HOFFMANN: Yeah.

MS. STAED: If it is allowable, how -- are staff allowed to administer since they are federally funded services. Is that it has to be documented by the MAR, you know, kind of all of that progression of thinking after that, if it becomes allowable.

MS. HOFFMANN: Right, yeah. I do understand. And we met twice yesterday, and we work closely with our sister agencies on this one, too, and just trying to talk through it.

I did get some additional names for the Cannabis Task Force, but I just feel like they're going to be unknowing, I think, unless they can give me some general guidelines about what's allowed in federally funding buildings. And, you know, I bring this up sometimes you might have your conceal and carry, but we all have signs, right, that say no fire weapons and things like that are allowed in the federally funded buildings.

So I'm just throwing that out there. I don't even know if that's in the same realm, but, you know, just because you can, doesn't mean you can in a federal building. But I might be told that I'm wrong, so we just -- we're going to have to wait on that one, okay?

MS. STAED: Thank you. I just wanted to flag that for you.

MS. HOFFMANN: Oh, that's fine. You can keep it on here, but I don't know if I'll have an answer for a while. So this was like when I was working in the telehealth stuff trying to wait for what was going to be an allowable platform, right? This was miserable for a while. I just don't think that they have -- they're prepared to give answers just yet to states.

MR. HARVEY: Okay, any other questions on that?

MS. STAED: Actually, I have one more -- I have one more comment. In the meantime, I think if The Cabinet could come up with guidance until there's guidance. For example, you know, if someone does have an employee that is subject to a -- that has a prescription right now and is subject to a random drug test, what do we do in the interim while we're waiting for guidance? That kind of thing. And it may be just reach out on a case-by-case basis, but I think that would be helpful.

MS. HOFFMANN: Yeah. I mean, I can ask, Amy, but I don't know if they'll make a

decision just yet. That might end up in some kind of legality down the road if somebody got fired or didn't get fired or -- I don't know if I can get an answer just yet, but I'll bring it up, okay? I will.

MS. STAED: Yeah. I just don't want anyone to get in trouble for like not firing someone who tests positive because per the regulation.

MS. HOFFMANN: I know, I got you.

MR. HARVEY: Okay. The next agenda item is the right to appeal an HRC decision. Ann brought this to the agenda. Ann, are you prepared to speak on this?

MS. BICKERS: Ann, you're muted.

MR. HARVEY: I was going to say, I didn't hear her.

MS. PIERCE: I speak softly. But I carry a big stick, right? It's just what it says that it's part of due process, the right to appeal, and I think it should be included. So I don't know what CHFS response is that you have there.

MS. HOFFMANN: Crystal, can you speak to the next two there -- bullets for me?

MS. ADAMS: Certainly. So an HRC decision is not per se like a denial of service so it doesn't fall under the same category that we're familiar with when we think of the administrative appeals associated with Medicaid programs. Because it is a restriction on rights, it follows more in line with the processes that we have for other restrictive measures, such as involuntary hospitalizations and things of that nature. And in those situations, when the criteria is not met, the process is just to reapply and provide additional information, and then it can go through the process again. And there's no limitation on how many times that it can be reviewed.

MS. PIERCE: So what about having it reapply to a different committee?

MS. ADAMS: The process at this time is to reapply through the same committee and just provide additional information.

MS. PIERCE: Yes, I understand that because I've been through it. So it needs to go to a different committee if it can't be appealed.

MR. HARVEY: Is there any other questions or feedback, Ann, that you want to provide around that particular issue?

MS. PIERCE: I'm just thinking of people with disabilities, and they have concerns and their guardians have concerns and they're not being addressed.

MR. HARVEY: I understand that.

MS. PIERCE: I understand --

MR. HARVEY: Crystal, do you --

MS. PIERCE: Yeah.

MR. HARVEY: Go ahead, Ann.

MS. PIERCE: I understand that Secretary Friedman -- Friedman; is that right?

MS. ADAMS: Friedlander.

MS. PIERCE: Friedlander is considering changing the makeup of the HRC committee to include more guardians, so maybe that will help. But as it stands, people with disabilities are at the mercy of primary provider membership, so I just --

MR. HARVEY: Crystal, do you have the reg in front of you that has the HRC makeup? Because I think it's several different

entities there that make up an HRC.

MS. PIERCE: It is.

MS. ADAMS: Right now -- yeah, there's also a PowerPoint on our website that is used as the training for HRC committees that can be accessed and googled, and it goes through the specific makeup. It's in the specific waiver regs at this point, so for SCL, it's the 907 KAR 12:010, and I could look and find you the exact section it's in.

MS. PIERCE: Yeah. I'm pretty sure I have it memorized. But --

MS. ADAMS: Thank you, Amy, Section 7.

MS. PIERCE: Anyway, it's -- what I'm telling you is from a lived experience. It's a problem, and people with disabilities aren't getting a fair shake.

So I don't know, can we make a recommendation of that? I'm new, so I don't know how y'all word things. You all obviously know a lot more than I do. All I know is what I've lived. And if I'm living it then other people are too. So I need

y'all's guidance on how to proceed with this to get some fairness. I mean, Doug, you're so good at --

MR. HARVEY: I don't think we've received enough information to really make a formal recommendation in reference to changing the HRC because there just really hasn't been anything presented to do that, Ann.

MS. PIERCE: Like what information do you need, Wayne?

MR. HARVEY: Well, if you wanted to propose a change then what do you propose to change it to? And, you know, why are those reasons? I mean, you've not presented anything that relates to, you know, trying to initiate any kind of system change here.

MS. PIERCE: How do I explain to make y'all understand? So Crystal is saying that there is -- that we have no right to appeal. That it doesn't apply to HRC committees; is that correct?

MS. ADAMS: The administrative appeal process that comes with the denial of service does not relate to this process

because it's not a denial of service. The process for rereview is just to submit a new review at this time.

MS. PIERCE: What if it is a denial of service? What if a participant wants to waive the right to something and the committee doesn't let them?

MS. ADAMS: Those are federal requirements, and we have to follow those as part of our administration of the waiver.

MS. PIERCE: So it's not person-centered then, which is also a federal requirement, correct? It just seems like there should be an appeal of some sort available.

MS. ADAMS: Well --

MS. PIERCE: I've said my piece. Wayne, I'm not sure what it is you want to hear. I know that what's going on is wrong and it's hurting people.

MR. HARVEY: It's not about what I want to hear. It's --

MS. PIERCE: Well, you're saying I'm not presenting it in a way that you understand and I'm not sure what it is that

you need to hear as a group. As a group, not just you.

MR. HARVEY: Well, I don't know that any committee members understand exactly, you know, what you're asking for us to do here in relation to regulation. I mean, we -- you know, we're forced with following regulation. We -- I just don't understand what you're asking for. Go ahead, Johnny.

MS. PIERCE: Thank you, Johnny.

MR. CALLEBS: Hi. I was just going to point out that I just took a quick look at the regulation for human rights committees for SCL, and, you know, it prescribes the required makeup of a human rights committee, but the language, it says, "at least these members." So it can include more. So if a particular human -- as I read it, if a particular human rights committee wanted to include members in addition to those that are prescribed in the regulation, then that seems to me to be, you know, permitted as long as the committee has members -- membership as prescribed in the regulation. So it says, "at least these

members."

So I don't know if anyone else reads it that way. So there's already -- there's some leeway for having additional voting members of the HRC if the HRC wishes to structure itself that way. I just want to throw it out.

MS. PIERCE: Yes, I --

MR. HARVEY: Crystal, does The Cabinet view it that way, or --

MS. ADAMS: What's listed in the regulation is the minimum requirements. So it's certainly not the exact makeup that is required for review as long as the additional members meet the other requirements to be part of -- part of the committee, then, yes, he would -- he's correct in what he's saying.

MS. PIERCE: Yes, he is correct because in our district the committee is made up of 24 people, and they are all provider representatives of some sort. So it's --

MS. BICKERS: Crystal, this is Erin with Medicaid. Is it possible maybe offline

you can touch base with me on who oversees that committee, and I can maybe pass that information along to Ann since that committee is not overseen by Medicaid?

MS. ADAMS: Yeah, we can -- I can provide you some additional information offline to provide --

MS. BICKERS: Thank you.

MS. PIERCE: Thank you, Erin.

MR. HARVEY: Okay, the next agenda item is discussion of current incident reporting requirements and plan of care amendment within the SCL waiver program. Ann, I'm going to turn things back over to you. This was your issue.

MS. PIERCE: Okay, thank you. So here we are again with -- it's an SCL regulatory thing, correct? So are we going to meet up with the same problem we had with right to appeal? Is it going to be the same?

MS. ADAMS: I'm not sure what your question is yet.

MS. PIERCE: Well, it has to do with -- has to do with the waiver

regulations. So on incident reporting -- what do you have on there? Oh, okay. So incident reporting, as it is now, those are reported by residential providers or case managers. That's been my lived experience; is that correct?

MS. ADAMS: All providers can and do submit incident reports.

MS. PIERCE: Okay. So unfortunately, they're not always accurate, and individuals do have a right to accuracy -- accurate information written about them. Injuries are minimized/unreported, or just plain old false information.

So I don't know, how do we fix this? Is there a way for -- and this is -- I mean, even the -- what? Office of Inspector General and department of -- they came out with a big joint report saying what I just told you. So it's not just me saying it. It's not just my personal experience, but there seems that there should be a way to fix this. And I know that participants can call APS, but they can't file a report.

And I also know that there is an area

on the risk mitigation section that asks for guardian participant recommendations. But then again, that is submitted after the fact and things change and there is inaccurate information, again, reported by -- the potential to be reported incorrectly by residential providers or whoever the provider is reporting.

Is there a way maybe for the participant to also submit their own incident report? Does it have to go through provider?

MS. ADAMS: So the incident reporting process is designed for the individual who discovers the problem, the provider to submit the incident report, but they are mandatory reporters. If there's a concern that a provider is not following the regulation guidance, then the method of response would be to reach out and file a complaint with our division and we would look into them.

MS. PIERCE: And is that happening, Crystal?

MS. ADAMS: I'm not sure if -- do

people contact us when they have concerns? Yes.

MS. PIERCE: And are y'all addressing it because I'm hearing that that's not always happening. So that's a problem, too. Is it possible --

MS. ADAMS: We address every complaint that we receive, yes.

MS. PIERCE: Oh. Oh, Crystal. Okay. I have not had all of my complaints addressed.

MR. HARVEY: Well, if it's --

MS. ADAMS: To the satisfaction of the complainer is not necessarily --

MR. HARVEY: If it's a personal complaint issue, we don't need to air that out in this committee meeting.

MS. PIERCE: That's right. You're right. And that -- I'm just saying --

MR. HARVEY: Ann, why don't you just contact Crystal after this meeting's over with and relate that information to her, and maybe we can get it addressed that way.

MS. PIERCE: Okay. Again, this is not about me. This is about my lived

experience and how it has been well documented by federal agencies that incident reporting is seriously lacking in all states. It's a national problem. So it's not being addressed, and why is it possible -- is it possible for participants to file their own report? Why is that not possible?

MS. STAED: Crystal?

MS. PIERCE: Why are they not allowed to speak for themselves if they're capable of decision-making? And if they're not, they have guardians to do it for them. It's their right. It's part of living in a community independently as possible. Why are they being denied that?

MS. STAED: Crystal, correct me if I'm wrong, but let's just talk about a hypothetical scenario in which an allegation of abuse or neglect is reported by a residential provider in their program. If that person -- if any participant, you know, speaks to their case manager, and anything differs about the incident and anything differs in that report, the case manager is

then required to file an additional incident report listing the discrepancies or the additional details, etc.

MS. ADAMS: That is correct.

MS. STAED: And an individual may contact their case manager or any other provider on the person-centered team at any point in time, report an incident, which would then be required to be reported; is that not correct?

MS. ADAMS: That is correct.

MS. LERZA: And just to add to that, for any incident that is reported, the case manager is to review it and sign off on it. So they are seeing whatever is reported by any of the providers.

MS. PIERCE: You guys, I wish you could come and live just one day in my shoes. And you would understand that you obviously do not have boots on the ground and understand what's going on. And that's I guess my purpose on this committee is to bring that lived experience to the forefront because there's no way for y'all to possibly know. I mean you're -- I know I'm telling

you what's going on, and I'm telling you that people with disabilities are not getting accurate information written about them. They have no -- Erin Bicker's screen went dead.

Okay, so let's see, Amy wrote, "All providers are mandatory reporters and must report incidents when they become -- " Yes, that's true.

MR. HARVEY: Ann, we've got a long agenda today. And I'm going to ask if you're done presenting information on these items, if -- because, you know, you've not presented anything that really we could move forward on. I mean, you've made a lot of allegations yourself. And I really think those were probably better served if they were taken up directly with DDID or the appropriate entity there rather than in this committee meeting, but I --

MS. PIERCE: Wayne, I understand. And, no, they are appropriate for Medicaid. It is huge. We're talking about the safety of the people that we are paid -- that you are paid to serve.

MR. HARVEY: Well, we understand that, Ann. And, Ann, there's a whole regulation that is pages, upon pages, upon pages that have a continuous --

MS. PIERCE: And --

MR. HARVEY: -- number of requirements in them that all providers have to meet.

MS. PIERCE: And they are lacking.

MR. HARVEY: And I don't think that there's something that providers are out there in mass ignoring these regulations. Those regulations are in place for a reason to, you know, keep people safe and those type of things. We're going to move on with the agenda because this is becoming counterproductive here.

The next thing up for discussion is also your item, Ann, and it's a discussion around family councils and whether they are needed within waiver programs and ICFs.

I'm not, myself, familiar with family councils. You indicated to me when you asked for this to be placed on the agenda that this was something that nursing homes

used. So the floor is yours. Please enlighten us about the family councils.

MS. PIERCE: Okay. So the family councils, yes, they are in nursing homes and there's also resident councils, both. And they can -- they're not a requirement, but they are optional. If people want to have one, then they can. And they just get together and talk about the need -- it's just an extra safety measure for the people in the care, in long-term care. And I think it should be extended to people in waiver services.

MR. HARVEY: Do you know of anybody that could possibly come to a future meeting and speak specifically to, you know, how these are organized and how you go about creating family councils and so forth, Ann? I just thought we would want to receive a little more information.

MS. PIERCE: Yes, I do. Or I can just do what y'all do and just put up links to look it up. You can just go to the long-term care ombudsman. It's on their website. And it's probably -- is Doug Hoyt

still here?

(No response).

MS. PIERCE: It's probably in the IDD regs. I mean, the -- what's it called? What's it called? What's the acronym for where Doug works?

MR. HARVEY: Are you talking about ICF?

MR. HOYT: Are you referring to the ICF?

MS. PIERCE: ICF, yeah. Is it in the ICF regs, family councils? Can you speak about family councils?

MR. HOYT: I'm not aware that it's in the ICF regs. I haven't read that.

MS. PIERCE: So I guess it's just in the nursing home regs. But there's a lot of people with IDD in nursing homes, so -- and on waivers. But anyway, I think it would be an extra safety measure for people with IDD. And so, Doug, you're so good at making your motion, I don't know how to do that, make a motion, but I would like to move that we create that, whatever the wording should be.

MS. STAED: Hey, Ann, I think the

reason -- and I won't speak on behalf of Wayne, but I think the reason he asked why if you knew anyone that could come present, because historically the TAC has -- when they want to learn more about something, has asked subject matter experts, like maybe someone from the Nursing Home Association, or we've had people come and talk about how other states -- from other states about how they do things. And they'll take those presentations, and then the TAC will work together to form a recommendation based upon the presentation made that then goes to the MAC.

And what the MAC can do is just recommend that The Cabinet for Health and Family Services look into something. So the TACs and the MACs can't actually order The Cabinet for Health and Family Services or Medicaid to act on anything, but they can make recommendations about what they think they should look into.

So maybe if you know someone at a nursing home, it would be great to have them come talk about how they operate their

family councils and what they do and how they work, so that the TAC could become more familiar with that process and then make an informed recommendation to the MAC.

MS. ADAMS: And also to provide clarity on what the difference is between the role of those and the already existing TACs, the BAC that we are working on establishing the Consumer Rights TAC, and how that would be differentiated from their work.

MS. PIERCE: Oh, yeah, these are like on a region-by-region basis, or even a provider by provider basis. So, yeah, that was a good question, though, Crystal and Amy. Thank you. I will contact my person to speak at the next meeting.

And I wish I understood how these meetings worked better, but I guess it just takes time. So I appreciate your all's patience with me. Sorry to have taken up so much time.

MR. HARVEY: Okay. The next agenda item is a call for recommendations. And the one that we had listed out is simply

following up on a response that we had received from the Medicaid Commissioner Lee herself, and it's basically establishing these reports during the TAC meeting ongoing, and you guys can read it there. It's specifically spelled out.

We also threw in on the end of it, the Michelle P., SCL waiver, and HCB waiver waitlists data. We always ask for that every meeting anyway, so we just included that within this particular recommendation so that, you know, that would always be a standing agenda item. Do I have anyone that wants to make the recommendation that we move forward with this motion?

MR. SCHNEIDER: I'll make the motion.

MR. HARVEY: Brad makes the motion. Do I have a second?

MR. HOYT: I'll second it.

MR. HARVEY: Doug seconds it. All right, discussion. Anybody have any discussion about -- this is specifically speaking to the involuntary termination information that we --

MS. ADAMS: I have a question for

clarification just because it's saying 30, 60, and 90 days. And so where this TAC doesn't meet monthly, are you only wanting it presented like, you know, as of right before that time? Is it something you want monthly even if we only see it, you know, two months at a time? How do you all want us to provide that to you?

MR. HARVEY: I think gathering it and presenting it for that particular meeting would be fine, Crystal.

MS. ADAMS: Okay, thank you.

MS. PIERCE: Is there any way we can include if they have severe autism or a severe disability or high-support needs? Those are the ones being evicted. I mean, I assume that's why.

MS. STAED: I think everyone who's enrolled in the SCL waiver, which this would for the most part apply to, has a severe disability and high-support needs. That's how they get on the waiver.

MS. PIERCE: Oh, yes, but some of them have aggressive behaviors. And I'm wondering if -- maybe that's what I

should've said, the ones with behaviors. Can we include that to see if that's what's going on because if it is, then we'll need to figure out how to help them.

MR. HARVEY: Where do you want to add that into the recommendation at, Ann?

MS. PIERCE: Where would you add it?

MR. HARVEY: Well, I wouldn't add it to the recommendation because I think it's not as relevant as the information that the commissioner asked us to continue to monitor. But if you're wanting it added then, you know, you --

MS. PIERCE: Well, maybe add it after number of outstanding -- well, add it -- see how there's the little circle that's -- not the bullet point, but the one that's open, add it under each one of those. How many have had aggressive -- were terminated because of aggressive behaviors.

MS. STAED: Crystal, does a provider have to list the reason for an involuntary termination?

MS. PIERCE: Yes.

MS. ADAMS: They do list a reason.

I'm -- Elizabeth, I know you're on here. You've looked at some of that as far as how that's being collected currently. I don't know that we have a specific category or things like that, that would indicate aggressive behavior, correct?

MS. MARKLE: Typically, it's behavioral needs. Some do go on to provide more information. It generally falls into two categories -- well, probably three, but, you know, we've talked about that before. Agencies' voluntary closing will trigger an involuntary termination. Behavioral needs that have come to a point where the agency feels they can no longer support them perhaps in the same way they had previously. And then health needs that occur that maybe have come over time. So when they originally started supporting them, as the person has aged, that may also be a category that we would see.

MR. HARVEY: What I'm going to say is that this particular recommendation is built around the information that we know DDID can assemble and has assembled for us because

they reported on it during the last meeting.

MS. TYNER WILSON: Mm-hmm.

MR. HARVEY: I move to make the motion stand as it's written, you know, without any further additions. You know, that's the motion that I make.

MS. PIERCE: And I think that's fine, Wayne, because I think Crystal and Elizabeth both verified what I suspected, so we know that's why. So we just have to figure out what to do about it, but it has nothing to do with this motion, so.

MR. HARVEY: Is there any further discussion? Any other committee member have any comments or discussion on the matter?

MS. TYNER WILSON: This is Melanie. Can I speak?

MR. HARVEY: Sure, go ahead.

MS. TYNER WILSON: Just trying to wrap my head around this because this is a pretty big deal. When that involuntary termination request is made, is there -- as a part of a procedural, is there a response from The Cabinet to give guidance or recommendations as to, you know, things to

consider as a possibility prior to the involuntary termination to occur? Or is it just -- you know, it just happens, and then it basically it's what's done is done?

MS. ADAMS: It varies from situation to situation, but we provide a lot of ongoing training and technical assistance --

MS. TYNER WILSON: Assistance.

MS. ADAMS: -- to providers and encourage them to utilize our CMHC crisis services if there is someone that they feel that as a team they're struggling to understand how to support or have concerns about how to access additional resources. We also frequently connect them with our specialty clinics to get additional resources there. If they reach out to us as our QAs at any time prior to completing the involuntary termination, of course they'll follow up and provide information, or again, try to connect them with other resources in The Cabinet.

Once the involuntary termination is issued, the quality administrators assigned to that agency are following up on these

cases. And that's where we're actually gathering the information from. And, Elizabeth, you can comment if there's anything additional.

MS. MARKLE: No, you said it perfectly. We tend to know in advance, you know? These are agencies that generally are working on and have been working with those agencies around a particular person, you know, before it actually gets there. And then there's continued follow-up on that individual in terms of the processes and how that's going until that person is transitioned.

MS. TYNER WILSON: And I appreciate the challenges that can be presented as a result of someone -- someone I care very much about was -- it was a long time ago, but we went through that same experience with our loved one, and it's very difficult. So I'm not minimizing the challenges that you all go through, but it is a -- I just was curious as to what all the -- what all efforts were put in place to be able to provide support, either for the individual

or the caregiver guardian that's involved in that person's life. It's tough.

MS. PIERCE: It's tough, and really, I just have to tell you all, Crystal Adams is wonderful when she recommended the crisis -- the specialty clinic. Because they were amazing, and, Crystal, you need to like, whatever it is, pat them on the back because -- patting you on the back because that was a lifesaver for us, although we're still terminated. We're still terminated but at least we have a hope for a few smiles now and then. So those are a good thing, and we need more of those, more and more and more of those.

MR. HARVEY: Okay. Any other discussion before I put the motion to vote?

(No response).

MR. HARVEY: All right. All in favor of the motion as it's written, all committee members say aye.

(Aye).

MR. HARVEY: Any opposed?

(No response).

MR. HARVEY: Okay, the motion passes.

Any other calls for recommendations?

(No response).

MR. HARVEY: Okay. MAC meeting representation: The next MAC meeting will be March the 27th from 9:30 to 12:30 p.m. eastern time. I will be in attendance at that meeting to forward the recommendations that have passed this particular TAC meeting.

The next meeting date will be April the first, 2025, 10 a.m. via Zoom. Any other questions before we adjourn this particular meeting today?

(No response).

MR. HARVEY: Okay. I want to thank all of The Cabinet representatives that were here, and also the lady that presented on the BAC committee. Her name is escaping me right now because we've had so much discussion back and forth. I thank all of those representatives for being on the call with us and the information you provided. We will adjourn. Thank you.

(Meeting adjourned at 12:01 p.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim 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 10th day of February, 2025

Tiffany Felts, CVR