1 DEPARTMENT OF MEDICAID SERVICES
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
2 TECHNICAL ADVISORY COMMITTEE

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14 FEBRUARY 6, 2024
9:45 a.m.-11:00 a.m.

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Stefanie Sweet, CVR, RCP-M
24 Certified Verbatim Reporter

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2 A P P E A R A N C E S
3
4 **TAC Members:**
5 Rick Christman, Chair
Melanie Tyner-Wilson
6 Wayne Harvey
Johnny Callebs
7 Christian Stewart
Cheri Ellis-Reeves
8
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1 MR. CHRISTMAN: We still have
2 people in the queue waiting to get in; is
3 that correct?
4 MS. BICKERS: Yes, sir. And it
5 is 9:59, so we will give them that extra
6 minute to get in.
7 MR. CHRISTMAN: Okay.
8 MS. BICKERS: And I will let you
9 know when the waiting room is cleared.
10 MR. CHRISTMAN: Sure, and will
11 you help me count if we have a quorum,
12 too?
13 MS. BICKERS: Absolutely. So
14 far, I see yourself, Wayne, and Johnny,
15 are all that have I seen so far. And with
16 all of our vacancies, we have to have all
17 of our members.
18 MR. CHRISTMAN: Yeah, we need to
19 deal with that.
20 MS. BICKERS: I see Melanie
21 popping in. The only person I didn't see
22 was Cheri, unless she popped in with a
23 bunch of people, or she has a different
24 name on her account when she logged in.
25 MR. CHRISTMAN: Well, she will

1 say something if she is on.

2 MS. BICKERS: It is 10 o'clock

3 and the waiting room is cleared. I can

4 let you know when she pops on, if you'd

5 like, if you want to go ahead and get

6 started.

7 MR. CHRISTMAN: I do.

8 Welcome, everyone. We are one

9 short of a quorum.

10 MS. TYNER-WILSON: This is

11 Melanie. I am here.

12 MR. CHRISTMAN: Okay. We have a

13 quorum; is that correct?

14 MS. BICKERS: No. We still need

15 Cheri. Cheri is not here. Melanie is

16 accounted for, Cheri is not.

17 MR. CHRISTMAN: I want to remind

18 everyone that, you know, if you have a

19 comment, please, raise your hand or

20 certainly you can -- we welcome anyone

21 making a comment or asking a question

22 throughout this.

23 We will skip on approval of the

24 minutes then.

25 Right now, we have how many



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1 vacancies in our membership?

2 MS. BICKERS: I believe it is

3 three or four. I did reach back out to

4 Michaela at the Governor's office

5 concerning Mr. Huff's application.

6 Pardon me, if you are not

7 speaking, do you mind to please, mute?

8 Sorry about that, Rick.

9 MR. CHRISTMAN: Go ahead.

10 MS. BICKERS: I was going to

11 say, I'm not sure what all you heard, but

12 I did follow up with the Governor's office

13 today concerning Mr. Huff's application,

14 and she did apologize for the delay, but

15 said that she hoped to have us some

16 information soon, so I am hoping to have

17 some appointment paperwork for him coming

18 soon, so that was the one more member. So

19 a lot of the vacancies look to be either

20 members on a waiver program in a facility

21 or their representative. We have reached

22 out to a few people and have provided

23 applications to some people who have shown

24 interest, but did not receive those back.

25 Mine and Kelli's goal is to work on TAC



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1 vacancies this year, because we know that
2 it has been a struggle. And Kelli just
3 confirmed there are four vacancies,
4 currently.
5 MR. CHRISTMAN: And one of those
6 vacancies is a representative and I can't
7 think of it off the top of my name, but
8 it's --
9 MS. SHEETS: LeadingAge?
10 MR. CHRISTMAN: Do you have that
11 list of where our representatives need to
12 come from?
13 MS. SHEETS: Yeah, is it
14 LeadingAge Kentucky?
15 MS. BICKERS: I believe that's
16 correct, Kelli, and I have reached out --
17 MR. CHRISTMAN: What is it?
18 MS. BICKERS: LeadingAge.
19 MR. CHRISTMAN: Yeah, I don't
20 know that they exist anymore.
21 MS. BICKERS: I think, if memory
22 serves me, I found a representative and
23 there was a name change and this has been
24 months ago, and I have been back-and-forth
25 with this representative, and he told me

1 that he was working on it, because he's
2 helping to appoint another member for
3 another TAC, and I haven't heard any
4 communication back.
5 MS. SMITH: Erin, have you
6 reached out to Tim? Have you reached out
7 to Tim?
8 MS. BICKERS: Yes, ma'am that's
9 who I have been dealing with. Yes, ma'am.
10 Yes, ma'am, that's my contact.
11 MS. SMITH: Okay. I was just
12 checking to make sure, because that's who
13 I was going to tell you to reach out to if
14 you had somebody different.
15 MS. BICKERS: No, ma'am. I have
16 a very long email chain back-and-forth
17 with Tim. So it's not from a lack of
18 trying.
19 MR. CHRISTMAN: I'm sure.
20 MS. BICKERS: I will promise you
21 that.
22 MR. CHRISTMAN: So we have four
23 vacancies out of what? Nine, total?
24 MS. BICKERS: I'm pulling up my
25 list here.

1 MS. SHEETS: Yes, it's nine
2 total. I have the list in front of me.
3 MS. BICKERS: Thank you, Kelli.
4 MS. SHEETS: You're welcome.
5 MR. CHRISTMAN: So you have to
6 have -- basically, it's going to be a
7 struggle to get a quorum, because we need
8 to have nearly all of our members to make
9 a quorum; is that correct?
10 MS. BICKERS: So currently, as
11 it is, everybody in a position has to be
12 here to have a quorum.
13 MR. CHRISTMAN: And one of those
14 four is from LeadingAge. Do you happen to
15 know what the other three, what their
16 designations are?
17 MS. BICKERS: Kelli, do you mind
18 since you have the list right in front of
19 you. I'm sorry, I should have been better
20 prepared, Rick.
21 MR. CHRISTMAN: So should I.
22 MS. SHEETS: The other three
23 vacancies are a consumer who participates
24 in a nonresidential community Medicaid
25 waiver program. That's two of them, and

1 then the third vacancy is a consumer
2 representative of a family member who
3 participates in a community Medicaid
4 waiver program. So we've got two
5 consumers who participate, one family
6 member of a consumer who participates.
7 MS. BICKERS: Johnny has his
8 hand raised.
9 MR. CHRISTMAN: I think,
10 particularly, we also need someone who
11 participates among those who participate
12 in participant-directed services.
13 Does everyone agree with that?
14 MS. TYNER-WILSON: Yes.
15 MS. BICKERS: I --
16 MR. CHRISTMAN: Does anyone now
17 represent that group? The PDS?
18 MS. BICKERS: Not on this TAC --
19 MR. CHRISTMAN: So we really,
20 really, really need one.
21 MS. BICKERS: That would take, I
22 believe, legislation to change that.
23 MR. CHRISTMAN: Oh, it would?
24 Wouldn't one of those fill in whose
25 receiving a Medicaid service?



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1 MS. BICKERS: I believe that
2 would take legislation change because it
3 was written in through legislation. And
4 Pam, or anyone above me, if that is
5 wrong -- because I had someone else ask
6 about just adding another TAC member to
7 another TAC, and from the way the TACs
8 were established through legislation, to
9 change anything, it has to be done through
10 that process. Now, I can double check
11 that with Veronica.
12 MS. SMITH: Erin, we can look
13 into it. I don't know and don't want to
14 answer off the fly and be wrong -- and I
15 see Johnny has his hand up, but we can
16 take that off-line and we can look into
17 that.
18 MR. CHRISTMAN: Okay. Thank
19 you. Because maybe a person who fits the
20 category could also -- can then also
21 represent PDS. But we'll see.
22 MS. BICKERS: Can I -- Pam --
23 MR. CHRISTMAN: Johnny, do you
24 have a question?
25 MS. BICKERS: Oh, I'm sorry.

1 MR. CALLEBS: Sure, a couple of
2 things. Yeah, Rick, what you just said, I
3 don't see any reason why -- I mean, one of
4 the vacancies, for example, was a person
5 in a nonresidential Medicaid program.
6 Whether that could be someone who gets a
7 waiver service and a participant directs
8 it. There is no exclusion for PDS. So a
9 person could, yeah, fill that spot and
10 have a participant directed service. I
11 think we could, yeah, be on the lookout
12 for such a person, but I don't think we
13 would need a legislative change to get
14 that as I see it, but --
15 MS. BICKERS: Well, I was going
16 to ask a question because the waiver world
17 is a little bit above my knowledge. I was
18 going to ask if a PDS participant, are you
19 talking about a waiver participant?
20 MS. SMITH: They are a waiver --
21 Erin, they are a waiver participant. And
22 it's not as much about the regulation,
23 it's about following all the TAC --
24 MS. BICKERS: Can I suggest,
25 then, with those being governor appointed,

1 we can provide the application, have it
2 filled out, send it to the governor's
3 office, letting them know that is the PDS
4 waiver, you know, the participant and that
5 is how they participate in the waiver
6 program and see if -- those positions are
7 all governor appointed so that would be my
8 suggestion, that if we have someone to get
9 them on the application and send them
10 over, and see if we can get them filled.
11 MR. CHRISTMAN: Johnny, would
12 you have any way of finding such a person?
13 MR. CALLEBS: Probably, I'll get
14 my feelers out there and see.
15 MR. CHRISTMAN: That would be
16 great.
17 MR. CALLEBS: Like Mr. Huffman,
18 he is interested, and his application is
19 pending, so we can try to talk to some
20 others as well.
21 MR. CHRISTMAN: And maybe also a
22 consumer? Right?
23 MR. CALLEBS: I'm sorry?
24 MR. CHRISTMAN: And one of the
25 members needs to be a consumer, one or



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1 two? A person with a disability?
2 MR. CALLEBS: And I have a
3 question about the way that we determine
4 the quorum or establish the quorum, so we
5 have vacancies, according to the website,
6 the cabinet's website, there are three
7 vacant spots. So that means there are six
8 seats filled. So when you figure out the
9 quorum, do you just need a quorum of
10 currently filled positions? I mean,
11 because, by definition, none of the -- but
12 the others aren't filled so it's
13 impossible for a person to attend because
14 they are not yet appointed, but we do have
15 six members, so four of the six should be
16 a quorum.
17 MR. CHRISTMAN: So, yeah, the
18 question is: Is a quorum determined by
19 the entire potential membership or just by
20 the current membership?
21 MS. BICKERS: Entire and
22 currently we only have five members.
23 MR. CHRISTMAN: Okay. So that
24 answers our question. So we have to get
25 some more people.

1 MR. CALLEBS: Is that correct,
2 though? I've known it to operate the
3 other way.
4 MS. BICKERS: That is --
5 MR. CALLEBS: You calculate
6 based on filled seats.
7 MS. BICKERS: That is not what I
8 was told and have operated on since I have
9 taken over. That's not how I read it in
10 the bylaws, so I can take that back to my
11 supervisor, but from my understanding,
12 that's how I've always operated, that it
13 is your entire seats and you have to have
14 over half to have a quorum.
15 MR. CHRISTMAN: That has been my
16 understanding as well.
17 Okay.
18 MR. CALLEBS: Okay.
19 MR. CHRISTMAN: Go ahead,
20 Johnny.
21 MR. CALLEBS: I mean, I'm just
22 saying that at some point, you could have
23 enough vacancies that you could never do
24 business or take a vote.
25 MR. CHRISTMAN: Theoretically,

1 yes.
2 MR. CALLEBS: So seats could
3 just never be filled and then the
4 committee could never take any action, so
5 that's why I'm just wondering about how
6 you calculate, you know, establish the
7 quorum.
8 Anyway, my suggestion would be
9 that we get clarification on that so we
10 know going forward how -- what the correct
11 way to establish the quorum is. And I'm
12 not saying I'm right, I'm just saying I
13 would like to know how we go about doing
14 that, going forward.
15 MR. CHRISTMAN: Would any of the
16 members like to take a stab at actually
17 changing the regulation?
18 MS. TYNER-WILSON: I'd like --
19 this is Melanie. I like to, first, go to
20 my groups and see if I can get some
21 individuals to apply for this, because I
22 think it would just be lovely to have an
23 actual individual with IDDD. I think that
24 is one of the required representatives --
25 MS. SMITH: That is one of the

1 required representatives, Melanie, and I
2 think that is an excellent idea. I think
3 that these, as Rick said, these vacancies
4 have been out there for a long time, and I
5 think as the TAC, we can't, as Medicaid,
6 Erin does a great job coordinating
7 information and helping to do things, but
8 this is really your all's technical
9 advisory committee, so really we need the
10 members to reach out -- Johnny you've got
11 great connections within your position,
12 and, Melanie, you have great connections
13 to try and get the vacancies filled. It's
14 not really something that we can do as a
15 Medicaid agency because this is your all's
16 technical advisory committee.
17 MS. TYNER-WILSON: Okay.
18 MR. CHRISTMAN: All right. Well
19 said.
20 MS. TYNER-WILSON: One last
21 question, I apologize. This is Melanie
22 again. If we have somebody who is
23 interested, but maybe is nonverbal or has
24 limited -- could there be accommodations
25 like some kind of -- absolutely. We have



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1 that in other TACs. We have that in other
2 TACs. There can be a -- we have someone
3 who either attends with them, or we've had
4 this in the past with this TAC before,
5 There's also been an individual who had
6 been receiving -- I believe it was the
7 individual who had been receiving
8 residential services, that there had been
9 a staff member that came with them. But
10 in at least one of the other TACs, we have
11 someone who is, essentially, nonverbal and
12 there is someone who either attends with
13 him or there is someone who can always
14 help him to communicate.
15 MS. TYNER-WILSON: And would you
16 mind -- I'm sorry, I promise this is last
17 one. Would you mind to send something out
18 so that I can post on the various groups
19 that I am a part of to help to recruit?
20 MS. SMITH: Erin, can we send
21 out to the TAC, can we just send out a
22 list of the vacancies?
23 MS. BICKERS: Absolutely, and
24 the application.
25 MR. CHRISTMAN: And also the

1 regulation that speaks to that. Like, who
2 they represent.
3 MS. BICKERS: Yes. Kelli and I
4 will gather -- sorry. I'm trying not to
5 talk over anybody for the reporter. My
6 apologies. Kelli and I will work on
7 getting a list of that, and we will also
8 send an application along with it, so
9 there is a link if it is easier for
10 someone to just go to the website and fill
11 that out.
12 MS. TYNER-WILSON: Thank you.
13 MS. BICKERS: You're welcome.
14 And that way, I was telling Rick, that we
15 are trying to make it a goal because this
16 is not the only TAC that has vacancy
17 issues. As Pam was saying, DMS is here to
18 help as best we can, but we do really try
19 to rely on the TACs, because these are --
20 you are in the associations. You guys are
21 out in the field and you know these
22 members and providers and things better
23 than we do, so we do appreciate all your
24 help, and we are here to help. If anyone,
25 Melanie, that reaches out to you has



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1 questions, you are welcome to give them my
2 email address and they can reach out to
3 me, personally, and I will try to help any
4 answer any question that I can.
5 MS. TYNER-WILSON: Thank you.
6 Thank you.
7 MR. CHRISTMAN: Thank you, very
8 much. And I understand Frank Huffman will
9 be submitted to the Governor's office.
10 MS. BICKERS: It has been sent
11 that it twice to the Governor's office.
12 MR. CHRISTMAN: Okay. All
13 right.
14 Let's move on down the agenda
15 then. Thank you. The number of SEL
16 participants who have been involuntary
17 terminated by their current provider by
18 more than six months.
19 MS. SMITH: Okay. So hold on.
20 If you will bear with me for one second, I
21 am just working just off of my laptop
22 screen and I have to switch to where I
23 have a document where I can see it. And
24 forgive me, I am not going to go on camera
25 just because I am switching screens and I



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1 want to make sure that I can get you all
2 of the information. Okay. So let's see.
3 Let me, first -- so I'll report, Rick, I
4 will give the next three together.
5 Let me caveat this with a few
6 things. One, this, right now, is
7 something that is self-reported. We, a
8 lot of times, get the information that
9 says that we have a provider who wants to
10 voluntarily terminate someone and then we
11 find out a couple months later that maybe
12 it's related to one incident or a couple
13 of incidents and things have been resolved
14 now and they have no problem continuing to
15 serve the person, or they may have
16 transitioned to a different provider and
17 no one notified us. We are working on
18 some system changes to make so we can
19 track this a little bit better, so these
20 numbers are what we have right now that
21 are self-reported, but they may not be --
22 there may be individuals that no longer
23 have that termination letter, and we have
24 not been notified.
25 So right now, the number of

1 participants who have been involuntary
2 terminated by their current provider for
3 more than six months, there are 37
4 individuals that fit into that category.
5 There were 37 involuntary terminations
6 issued to participants listed for six
7 months, or for more than six months. Of
8 those, the number of providers that are
9 currently serving participants who have
10 been involuntarily terminated for more
11 than six months, there are 23 unique
12 providers. And then, of that larger -- of
13 the 37 that have been listed for more than
14 six months, we have an additional 30 that
15 have been terminated in the past six
16 months. I'm sorry I just said that
17 backwards. There were 67 in the past six
18 months. Need to clarify --
19 MR. CHRISTMAN: Sixty seven in
20 the last six months.
21 MS. SMITH: If that is, I need
22 to clarify with BDID, and Elizabeth, I
23 hate to put you on the spot. If that
24 includes, if that 67 also includes the 37
25 that were or above, or is this 67



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1 individuals in the past six months, plus
2 the 37.
3 MR. CHRISTMAN: Yeah, that
4 number 7, I think, the reason we ask for
5 that is to see, okay, let's say it was, is
6 the number trending down? You know, in
7 other words, you know what I am saying,
8 Pam?
9 MS. SMITH: I do.
10 MR. CHRISTMAN: Yeah.
11 MS. SMITH: And like I said --
12 MR. CHRISTMAN: But we don't
13 know exactly what that 67 means.
14 MS. SMITH: It means, so there
15 were 67 participants involuntarily
16 terminated. So a provider contacted us
17 and said that they have issued an
18 involuntary termination in the last six
19 months.
20 MR. CHRISTMAN: Okay. So let's
21 assume it's 67, and it appears that over
22 time, the number tends to be going down if
23 these numbers are representative, however,
24 in my opinion, these numbers are still
25 rather high, and I think it would be good

1 if you could refine these numbers so we
2 can have, as you say, a little more
3 confidence in their accuracy.
4 MS. SMITH: So I am going to ask
5 for your all's help with that in reaching
6 out to providers, and reminding them that
7 they need to also share with us when
8 things have been resolved, when things
9 have been, you know, people have been
10 transitioned. We are working with the
11 BDID staff very closely. Because I will
12 tell you something else we have noticed as
13 a trend, and I think we will get into this
14 with the other agenda items, is that
15 people are agreeing to serve individuals,
16 they are not even going to team meetings.
17 We are getting emails saying, well, I
18 don't know what is on the plan.
19 MR. CHRISTMAN: Yeah.
20 MS. SMITH: That is a problem.
21 MR. CHRISTMAN: It is.
22 MS. SMITH: How do you know if
23 you can serve someone safely and meet
24 their needs, if you're not meeting the
25 person before accepting them, and you are



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1 not at least attending team meetings to
2 know what that person wants, what they
3 desire, what they need.
4 So there is a lot -- we will
5 work on refining the reporting, but I also
6 need providers to work on some of the
7 pieces on their side, as well.
8 MR. CHRISTMAN: Maybe we can
9 work that through CAP to get better
10 numbers.
11 What I suspect, Pam, and I could
12 be wrong, I think if you are a new
13 provider, don't have much experience, and
14 so you accept people because you need the
15 business, okay, and maybe you're not
16 prepared to serve that person.
17 MS. SMITH: We see that
18 happening, and honestly, that is scary
19 because these are people's lives.
20 MR. CHRISTMAN: That's right.
21 MS. SMITH: These are people who
22 have goals and objectives and things that
23 they want to do, and just to take someone
24 on to add to your role without making sure
25 you can sufficiently take care of them is

1 terrifying, honestly. And I would be, you
2 know, ashamed to admit it. We will help
3 any provider out there and provide
4 technical assistance. We have excellent
5 boots on the ground with our QAs in BDID,
6 as well as the help desk, there's many
7 things that we will do to help support a
8 provider to serve individuals.
9 MS. TYNER-WILSON: Pam, this is
10 Melanie. Is it okay if I ask a question?
11 MR. CHRISTMAN: Absolutely.
12 MS. TYNER-WILSON: Can we get
13 just an overall list of the reasons, the
14 reasons why the category specific to the
15 involuntary terminations?
16 MS. SMITH: I'll work on -- we
17 can work on pulling that together based on
18 the information what we have. We will
19 work on pulling that together. I can tell
20 you a lot of them are related to
21 behaviors.
22 MS. TYNER-WILSON: Yeah.
23 MS. SMITH: And what we will see
24 sometimes is a plan where somebody is in
25 residential and so they are going to



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1 residential, they are going to the
2 residential providers ADT, but they may
3 not be getting behavior therapy services.
4 MS. TYNER-WILSON: Okay.
5 MS. SMITH: Through the state
6 plan or through the waiver. But we can
7 work on pulling that together. I think
8 that's a good request, and a way to look
9 at addressing, maybe starting to look at
10 the root cause and addressing.
11 MS. TYNER-WILSON: Thank you.
12 MS. SMITH: I understand there
13 are individuals that are difficult to
14 serve, and we are wanting to work with
15 providers on what kind of education, what
16 kind of additional supports a provider
17 needs to be able to serve, maybe,
18 individuals with challenging behaviors or
19 individuals who may have medical, you
20 know, some medical conditions in addition
21 to their ID diagnosis, and what kinds of
22 wraparound services that are available to
23 support them or how we can just support
24 the provider, in general, in helping them
25 to find training, additional training, or

1 resources, so.
2 MS. TYNER-WILSON: Okay.
3 MS. SMITH: It's all about being
4 a team to serve the individual.
5 MR. CHRISTMAN: Right. And Pam,
6 you know, I've stated this, the way the
7 regulation is written in which you accept
8 someone, then you have trouble terminating
9 them until some other provider is willing
10 to pick them up. It really creates a
11 disincentive to serve people who may be
12 difficult to serve, okay?
13 MS. SMITH: I agree I want you
14 to think about it in the opposite way. If
15 there's not any protection at all in the
16 regulation, we have providers who dump
17 individuals at ERs and they dump them --
18 MR. CHRISTMAN: I know.
19 MS. SMITH: And they become
20 homeless. So it's a double-edged sword.
21 It's a thing -- I know you've reached out
22 to a couple other states and I think
23 there's -- something that needs to be
24 tackled, and I think it's a good topic for
25 this group to look at. You know, what are

1 other states doing and what can we do that
2 is supportive of both the provider
3 population and the participant population?
4 MR. CHRISTMAN: Yes. Or do you
5 remember we used to have a task force,
6 Pam? That was looking at this issue?
7 I don't know, but I'm glad you
8 agree with me that it is a serious
9 problem, and a scary problem.
10 MS. TYNER-WILSON: And Rick,
11 this is Melanie again.
12 Being someone that was a
13 recipient of having a loved one that was a
14 recipient of this whole scenario a long
15 time ago, it is -- it is awful to go
16 through.
17 MR. CHRISTMAN: Yeah.
18 MS. TYNER-WILSON: And what I
19 learned from that journey with my loved
20 one is that the behaviors were created as
21 a result of them not understanding how to
22 interact -- does that make sense -- with
23 my loved one. But on the flip side of it,
24 I basically was asked -- you know, they
25 just kicked us out and it was a horrid

1 experience to go through as a caregiver.
2 MS. CLARK: I think finding the
3 root cause of the behaviors is the key to
4 success, and that's why I think sometimes
5 we see that things do get resolved --
6 MS. TYNER-WILSON: Yeah.
7 MS. CLARK: -- but we are not
8 ever told on the backend.
9 MS. TYNER-WILSON: Yeah.
10 MS. CLARK: So finding the root
11 cause is very important with these
12 individuals.
13 MR. CHRISTMAN: I'll tell you
14 what, let's refine these numbers and see
15 exactly how big the problem is, okay?
16 We'll start with that.
17 Pam, does that make sense?
18 MS. SMITH: We will try our best
19 to get --
20 MR. CHRISTMAN: Okay.
21 MS. SMITH: I don't know until
22 we --
23 MR. CHRISTMAN: And well, that's
24 what you want us to do, too.
25 MS. SMITH: Well, I think we

1 need to do it at the same time, Rick,
2 because I don't want to waste time. We
3 will certainly take the numbers back and
4 we will certainly work on it, but I don't
5 want to not have forward progress while we
6 are trying to do that.
7 MR. CHRISTMAN: Right.
8 MS. SMITH: And we are working
9 on some system changes and some ways to
10 collect that data differently but, you
11 know, those take some time. They have
12 been in progress, so we are closer, but I
13 don't want to lose time getting to root
14 causes and possible solutions while we are
15 trying to get to numbers.
16 MR. CHRISTMAN: Yeah.
17 MS. SMITH: Because if it is one
18 or if it is 100, it is still a problem.
19 MR. CHRISTMAN: That's right.
20 MS. SMITH: It's still a problem
21 that needs to be addressed regardless of
22 what the end numbers need to be. It may
23 be a severe problem or a less severe
24 problem, but it is still a problem.
25 MR. CHRISTMAN: Is Amy Staed on

1 the line? I'm just thinking that this is
2 something we can work through with CAP.
3 Does anyone agree with me?
4 MS. SMITH: I would encourage
5 you to make sure you are reaching out to
6 all providers, even those that are not
7 members of CAP.
8 MR. CHRISTMAN: And, how do we?
9 MS. SMITH: I would use --
10 Johnny, is there a way that CCDD could
11 potentially help?
12 Or, I mean, I would work with,
13 you know, there is something that we can
14 send out through our distribution list,
15 but I would encourage you not to limit it
16 to a certain group of providers. It
17 really needs to be anyone who is serving
18 this population.
19 MR. CHRISTMAN: Johnny, okay so
20 you think Johnny may have access to such a
21 list of all the --?
22 MR. CALLEBS: I do not. The
23 Council does not. It is more self
24 advocates and families and advocates.
25 MS. SMITH: But through

1 families, Johnny, you could tackle it that
2 way; correct? I mean, you could ask for
3 information just as Melanie shared her
4 story, I think that you need to ask for --
5 it doesn't just need to be the provider's
6 point of view. I think we need to reach
7 out to the individuals being served and
8 the people who advocate for them and their
9 families and supporters. What is their
10 experience? What do they -- this is a
11 multifaceted --
12 MR. CALLEBS: Agree, I can do
13 that part.
14 MS. SMITH: Agree.
15 MR. CALLEBS: I can help with
16 that, but not the provider's side part.
17 But you know, it could be -- I
18 think an easier way to do it is, you know,
19 in the form of a survey -- a Survey Monkey
20 or something, if we have five or six key
21 questions that we want to ask, get
22 responses from, and then we would have
23 data.
24 MS. SMITH: If you all would
25 like to share that and then we can work on

1 sending it out through our distribution
2 list as well because, you know, we have
3 contacts of the providers who are
4 certified, so -- but I want to make sure
5 that we are asking -- you know, I know the
6 questions that I want to ask, but I want
7 to make sure that your all, if there is
8 something that would want to be included
9 in that that I am not thinking of, that
10 that is also included.
11 MS. TYNER-WILSON: Pam, this is
12 Melanie again. Is mediation a part of
13 this whole process? Like, if the agency,
14 the provider, involuntarily terminates as
15 a function of, like, due process, to be
16 really honest, would mediation be
17 something that could be requested so that
18 the two parties could sit down and discuss
19 the issues and concerns around that
20 individual?
21 MS. SMITH: I think that is
22 something that we discussed. I mean,
23 honestly, Melanie, I don't know that
24 anyone has brought that up, but that
25 sounds like something that should be

1 happening today. And I think probably we
2 do work on that. Probably the QAs work
3 with the providers, but making that a more
4 concrete process. It kind of, you know,
5 goes along with the grievance process for
6 individuals, if, you know they have a
7 grievance with the provider, making sure
8 that that is addressed and handled, so.
9 MS. TYNER-WILSON: I'm an old
10 KDE mediator and I saw some pretty --
11 sometimes it didn't work -- but sometimes
12 it -- the staff and families could come
13 together with some possible resolutions,
14 so I don't know if it would work in this
15 situation or not, but I've seen it work in
16 other venues.
17 MR. CHRISTMAN: Yeah, and if
18 nothing, remember, Pam, if we could really
19 know what that 67 number means, too,
20 because if it's actually 30, that is an
21 indication that we are not seeing a lot of
22 movement on the number of people. Does
23 that make sense? That the number of
24 people who have been involuntary --
25 involuntarily terminated, it doesn't go

1 down much in the first six months.
2 MS. SMITH: Right. Like I said,
3 based on those numbers, it looks like it
4 has not went down much, but we have found
5 as we start digging into notes and looking
6 at things, that sometimes those
7 individuals have already transitioned to
8 different services or it has been
9 resolved, so yes, I would agree, yes, we
10 will work on refining those numbers as
11 best as we can.
12 MR. CHRISTMAN: Has anybody
13 else? Wayne Harvey, are you on the line?
14 MR. HARVEY: Yeah, I'm here,
15 Rick.
16 MR. CHRISTMAN: Okay, do you
17 have any thoughts on this?
18 MR. HARVEY: I think we are
19 headed in the right direction. You know,
20 once we get the information together for
21 the survey, let's put it out to everybody
22 and see --
23 MR. CHRISTMAN: I guess that's
24 the question. How do you think we should
25 get the information for the survey?

1 MR. HARVEY: To reach all
2 providers, you had to do it through a
3 mechanism to reach all providers and not
4 all providers are members of CAP. So
5 that's the way to do this. I agree with
6 Pam's assessment and with Johnny's
7 assessment, it has to go to all providers
8 but we have to utilize a mechanism that
9 will reach all providers.
10 MR. CHRISTMAN: And are you
11 familiar with any mechanism that does
12 that?
13 MR. HARVEY: Well, Medicaid can
14 reach all providers. If we create the
15 survey we give it to Medicaid, then they
16 should be able to distribute it for us. I
17 don't know that you can make it a
18 mandatory thing. I think it would
19 probably be something that we are asking
20 providers for voluntary information on.
21 MR. CHRISTMAN: Would that be
22 possible, Pam? That you would distribute
23 the survey?
24 MS. SMITH: Yes, I think that I
25 mentioned earlier that if you all give me



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1 the questions, because I don't want to
2 speak for you all, then we can work on
3 using our channels to distribute.
4 MR. CHRISTMAN: Okay.
5 Next agenda --
6 MR. CALLEBS: Pam, would you
7 also be able to distribute to participants
8 we have a limited -- not everybody --
9 MS. SMITH: We can use our -- we
10 can use our, like, the email where we have
11 participants and advocates sign up for the
12 email distribution list.
13 MR. CALLEBS: Sure.
14 MS. SMITH: It's hard to -- I
15 would say, mail doesn't usually work in
16 this case because there is a -- you would
17 not believe the amount of returned mail --
18 so plug for telling individuals that you
19 support to make sure their addresses are
20 updated with DCBS, because the amount of
21 returned mail. However, we could probably
22 also look at doing something where we
23 create a link, where individuals could go
24 to and we can share that with, like, the
25 case managers and we can share that with,

1 overall, that big distribution list, too.
2 So I think there are some ways that we can
3 get around that, maybe, and try to reach
4 more individuals.
5 MR. CALLEBS: Yeah, and I agree.
6 Yeah, not send out, you know, paper
7 surveys in the mail, but you know, a quick
8 and easy link to a survey that, you know,
9 folks can go to and answer and then submit
10 and then you get more data that way then
11 we would be able to get, especially to
12 have access to more folks who are signing
13 up for cabinet emails and news.
14 MR. CHRISTMAN: Right.
15 MR. CALLEBS: Okay.
16 MR. CHRISTMAN: Okay, care wise,
17 prior authorization, letters of intent --
18 MS. SMITH: So I need some help
19 with that.
20 MR. CHRISTMAN: Well, this
21 was --
22 MS. SMITH: Is this supposed to
23 be lack of information?
24 MR. CHRISTMAN: Well, I asked
25 Amy Staed if she had some ideas for the

1 agenda and she listed several and I'm
2 disappointed that she's not on this call
3 to help with these.
4 MS. SMITH: So we can -- maybe
5 we need to get clarification from her.
6 One thing I will say on this before we
7 move on on this one, is if it's related to
8 lack of information, I will tell you
9 that -- there have been several lack of
10 information letters going back to
11 providers, but one of the things that --
12 and I mentioned it earlier, we would talk
13 about it later, is we are getting plans of
14 care where servicing providers, the goals
15 and objectives are very generic. They are
16 asking for the max amount of units, we are
17 asking for justification and support, and
18 what we are getting back from the
19 providers is, I don't know, I've never met
20 them. I didn't go to the team meeting. I
21 have no idea. So let's get clarification
22 from Amy, and then we will look into that.
23 We have at least weekly meetings with
24 Carewise, the staff that are reviewing the
25 waiver reviews. We do quality reviews on

1 the back end. I will tell you that, so
2 far we have been very pleased. Carewise
3 took this -- when we handed the waiver
4 back to them, we took that as doing it
5 from scratch. We trained them from the
6 very beginning. There were no assumptions
7 about what they knew or what they thought
8 they knew. They said to us and we to
9 them, we want this to be like we have
10 never done this work before. We built
11 extensive resources for them. So I just
12 need some information and, you know, if
13 there is someone who needs to be
14 retrained, whether that is on a submitter
15 side or a reviewer side, we will address
16 that when we get that information. And if
17 she meant letters of intent, I'm not sure
18 what that is.
19 MR. CHRISTMAN: Okay. I just
20 got a message from Amy. She is at the
21 hospital. Apparently there is a family
22 emergency, so that explains that.
23 MS. SMITH: Oh, goodness.
24 MR. CHRISTMAN: So maybe several
25 of these will have to --



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1 MS. SMITH: Move to the next
2 meeting.
3 MR. CHRISTMAN: Table. Unless
4 there's something that you want to comment
5 on. Like, 10, 11, 12, 13.
6 MS. SMITH: Yeah, let me --
7 Rick, can I tell you some things that I
8 need?
9 MR. CHRISTMAN: Yeah.
10 MS. SMITH: So 11, I need to
11 know -- not 11. Nine, the Carewise
12 audits. I need more context about what
13 that question is. And then did the 10,
14 11, 12, 13, that also come from Amy?
15 MR. CHRISTMAN: Yeah.
16 MS. SMITH: Thirteen, I also
17 need clarification because I'm not sure if
18 she meant FMA fiscal management agency
19 applications, which is related to PDS or
20 if she is talking about Medicaid
21 applications. So I need clarification
22 about what that agenda item actually was
23 looking to be addressed.
24 MR. CHRISTMAN: Okay, number 14.
25 We know that the house has allocated some

1 money -- I think it was $92 million for
2 rate increases for the redesign. I guess
3 you can't comment and any of this; can you
4 Pam? Well, tell us again, what kind of
5 timeline we are on for redesign and rate
6 study and waiver regulation? Is there
7 anything to report?
8 MS. SMITH: Well, let me tell
9 you the things I can tell you. The waiver
10 redesign. So the first group, you know,
11 of the amended applications went to CMS so
12 they are in review. That was the one that
13 made changes that were in appendix K,
14 permanent, that also made the temporary
15 rate increases permanent.
16 MR. CHRISTMAN: Right.
17 MS. SMITH: So those are with
18 CMS right now. We've received official
19 approval back on model 2, and we had a
20 request for information and had some
21 questions back on the others, and those
22 have been answered, and those are back
23 with CMS, again.
24 Regulations, we are starting to
25 work on changes to the regulations, so we

1 are working on that right now, and you're
2 right, as far as the rate study and the
3 budget, the budget is not final yet,
4 anybody who has been part of that process
5 before, knows that there's a whole lot
6 more that happens before we really know
7 what our final budget looks like, so
8 there's nothing, really, that we can
9 comment on about any of the versions of
10 the budget. But there is still a plan for
11 us to -- the rates that were put in
12 through appendix K were temporary and the
13 plan is still that we will get to a
14 finalized rate based on the rate study,
15 but I don't have a timeline for that.
16 MR. CHRISTMAN: Right, and if
17 I'm correct, I may have heard you at the
18 MAC meeting, among, or before, among the
19 goals of the redesign is to bring more
20 consistency between the SEL and Michelle
21 P. Waiver.
22 MS. SMITH: It's to bring
23 consistency among all of the waivers when
24 all of the waivers.
25 MS. SMITH: So we don't have a

1 service like Respite have five different
2 definitions or be called -- you have
3 attending care that service, and have it
4 be called four different names. So that
5 is about -- is still one of the
6 fundamental goals of redesign. There's a
7 lot that went into -- and we with
8 participant direction and expanding that
9 but a lot of making it consistent among
10 the waivers where it can be. Now we
11 realize that each waiver serves a unique
12 population so there will be things that
13 you don't make consistent, but where we
14 can have consistency, the goal is to have
15 consistency so that it is less burdensome
16 for the providers and the providers who
17 desire to serve more than one population
18 are able to do that.
19 MR. CHRISTMAN: Well, let me
20 make sure I am understanding this. The
21 public comment for waiver redesign, do you
22 have a goal for that, in terms of time.
23 MS. SMITH: So what will happen
24 is -- when we do the regulations, when we
25 redo the regulations, there will be public

1 comment associated with that. There will
2 be public comment associated with --
3 because we will have to do redo the waiver
4 applications, again, to make the rates
5 permanent. To make any -- we couldn't
6 make a lot of changes. For example, the
7 service names, we couldn't change this
8 time because we are still under the
9 maintenance of effort until all of the
10 F-met funds are expended. So there will
11 be changes to those that have to happen
12 again, and there will be public comment
13 attached to that.
14 As we begin to work on the
15 waitlist, there will be opportunities for
16 public comment, for things around that.
17 As we look at, you know, we are wrapping
18 up the children's feasibility study.
19 There will be opportunity to review that
20 final document and make comments about
21 that.
22 So there will be many more
23 opportunities for comment as we continue
24 through this process.
25 MR. CHRISTMAN: Well, let me ask



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1 you this. Waiver redesign and rate study,
2 do those have to be done simultaneously?
3 Does one depend on the other? Do they
4 have to done separately?
5 MS. SMITH: No. Waiver -- when
6 we talk about redesign, it's really by
7 continuous quality improvement of the
8 waivers. It's something we should be
9 striving for and we do, continuously, look
10 at the waivers and to make changes and to
11 make improvements. Rates are a component
12 of that.
13 MR. CHRISTMAN: Yeah.
14 MS. SMITH: So will they be done
15 at the same time? No, they will not.
16 MR. CHRISTMAN: So will they be
17 done in one package or will they be
18 tackled separately?
19 MS. SMITH: So we will make --
20 we will strive to make as many changes to
21 the applications at one time that we can,
22 so anything that requires a change to the
23 waiver application. So there will be
24 pieces, but like I said, the waivers, it's
25 continuous quality improvement. We will

1 always look at ways to make the waivers
2 better. So it will be ongoing. So yes,
3 we will do as much as we can at the same
4 time, but we are not going to delay one
5 for the other.
6 MR. CHRISTMAN: Okay. That's
7 it. So, for example.
8 MS. SMITH: I think that's what
9 you wanted right?
10 MR. CHRISTMAN: So, for example,
11 to bring more consistency among the
12 definition.
13 MS. SMITH: That's a change that
14 can happen easily, that, you know, we have
15 already done a lot of work on.
16 MR. CHRISTMAN: So we should see
17 public comment on that coming.
18 MS. SMITH: That would be when
19 the waivers -- that would have to be in
20 the waiver application, so you will see
21 that, yes. As well as we will see that in
22 the regulations, because they are defined
23 in the regulations.
24 MR. CHRISTMAN: And tell me when
25 that would be.



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1 MS. SMITH: I don't have a
2 timeline right now, Rick.
3 MR. CHRISTMAN: All right.
4 Okay. Okay.
5 January MAC meeting report. I
6 attended. One of the things that occurred
7 was that there was a description of the
8 1915c waivers, because they talk about
9 that a lot at these meetings, and people
10 didn't understand what they were, and Pam
11 and the Commissioner explained what FCL
12 was and all of these other waivers, so
13 that was good.
14 The unwinding of Medicaid, I
15 believe she said that the number of
16 denials had decreased to 1200 a month.
17 Does anyone out there have
18 issues with the Medicaid denials as part
19 of this changeover? We have about four
20 people that are pending. Does anybody
21 else have a comment on that? It seems to
22 be going okay. Johnny's got his hands up.
23 MR. CALLEBS: Hey, Rick. It's
24 actually just a question about the
25 previous -- not the unwinding, but the

1 previous one, the rate study.
2 MR. CHRISTMAN: Okay. Sorry.
3 MR. CALLEBS: I was just going
4 to ask. That's okay. I was going to ask.
5 It's a question for Pam.
6 Pam, it's my understanding the
7 rate study has been completed and the
8 cabinet is -- there is a weight or
9 decisions to be made about what to --
10 MS. SMITH: It is with
11 executives staff way above me.
12 MR. CALLEBS: With the
13 recommendations.
14 MS. SMITH: Correct.
15 MR. CALLEBS: But it is, the
16 study itself has been completed, so my
17 question is: Can that be made public?
18 You know, understanding decisions have yet
19 to be made on the data and the report, but
20 it is complete. So is there a way that
21 this committee or we can see the study?
22 MS. SMITH: I can ask, but it is
23 beyond my decision to be able to
24 release -- whether I can release it or
25 not, but I will follow-up.

1 MR. CALLEBS: Sure. There's
2 just a lot of questions are around it and
3 it ties into access to services and
4 provider capacity. I think everyone is
5 excited about the prospect of increased
6 funding for waiver slots and this, you
7 know, budget bill, but there's also
8 growing concern about, okay, the waiver
9 slots are going to be increased and more
10 people are going to get services, but, you
11 know, from who? And providers are
12 closing, providers can't keep staff, and I
13 am hearing more and more buzz about that.
14 So that's why I'm just asking -- not to
15 bug you about it, but the rate study, you
16 know, is important and if it's going to be
17 used to implement rate adjustments, higher
18 reimbursement rates, which will presumably
19 allow providers to, you know, stabilize
20 workforce and recruit and hire and retain
21 more workers, I guess that's the
22 importance of it. That's the reason I'm
23 asking.
24 MR. CHRISTMAN: Well, I can tell
25 you, Johnny, that the chair of the MAC --

1 Dr. Sheila Schuster, is also interested in
2 the question that you just posed. So I
3 will bring it up at the next MAC meeting
4 as well.
5 MR. CALLEBS: Thank you. And I
6 understand, Pam, that you are not
7 authorized to share information about it.
8 But if you don't mind asking could the
9 completed study be made public,
10 understanding decisions have not been
11 made?
12 MS. SMITH: I will put in that
13 request, Johnny.
14 MR. CALLEBS: All right. Thank
15 you very much.
16 MR. CHRISTMAN: And then another
17 agenda item at the MAC meeting was mobile
18 crisis development.
19 Pam, is that going to be
20 strictly for people with behavioral health
21 issues or does that include our
22 population, as well?
23 MS. SMITH: It is individuals
24 that have -- that have those diagnoses,
25 but it could include -- it could serve our

1 individuals -- any of our individuals that
2 have mental illness and have some of those
3 services. But I don't have -- since it
4 wasn't on the agenda, we don't have the
5 right people here to -- that is outside of
6 my realm --
7 MR. CHRISTMAN: Right.
8 MS. SMITH: -- of really,
9 haven't worked on it a lot and so we would
10 need -- if you want to add that to the
11 agenda for next time, I can make sure that
12 we have someone here to speak to it.
13 MR. CHRISTMAN: Yes. I will do
14 that. I will do that, because that's a
15 resource that we need to know about.
16 Waiting lists.
17 MS. SMITH: Okay.
18 MR. CHRISTMAN: Do you have that
19 info?
20 MS. SMITH: Yes, I do. Let me
21 bring it up so that I can look at it, and
22 we actually have some -- Erin, can I
23 share? Erin, can you let me screen share?
24 MS. BICKERS: Yes. Give me just
25 a second. You should now be a cohost.

1 MS. SMITH: Okay.
2 When you are used to working on
3 multiple screens, going to a laptop is
4 just hard. Just a laptop screen is
5 difficult.
6 Are you all seeing the
7 presentation?
8 MR. CHRISTMAN: Yes.
9 MS. SMITH: Okay, so I want to,
10 and we can share this, but I want to --
11 this is more detailed information than we
12 would usually get, but it is really good
13 information, though.
14 So these are numbers as of 2/1.
15 There are 8,839 people on the Michelle P.
16 waiting list. There are 3,410 on SCL.
17 You can see in the overlap that there are
18 2,102 that are both on the SCL and the
19 Michelle P. waiting list.
20 We have some individuals that --
21 so 299 individuals on the SCL waiting list
22 are already receiving -- are on the
23 Michelle P. waiting list are already
24 receiving SCL services.
25 There's 2,200 -- a little over

1 2,200 who are receiving HCB services that
2 are on the Michelle P. waiting list. So
3 of the 8,839 that are on this list,
4 5,183 -- they may be eligible in receiving
5 other services, such as state plan and
6 EPSDT. So the waiting list doesn't mean
7 they are not getting any type of service.
8 MR. CHRISTMAN: Right.
9 MS. SMITH: Same thing with SCL.
10 There are, you know, a little over 1,600
11 of those individuals who are getting
12 Michelle P. services. There are a little
13 over 400 who are getting HCB services. So
14 if you look at, there are 10,829
15 unduplicated individuals on both lists
16 together. 4,685 of those are getting
17 services in another waiver. So 43 percent
18 of those individuals are getting services
19 on another waiver, while they remain on
20 the waitlist.
21 When you look at the breakdown,
22 the children break down, so for Michelle
23 P., again, that under 21, or up to the age
24 of 21, we look at that because they can
25 receive EPSDT services with the EPSDT

1 benefit if they are medically necessary in
2 the child. There are 70 percent of the
3 individuals who are on the Michelle P.
4 waitlist that fall into that bucket.
5 27 percent are over 21 so, for SCL, you
6 will see the flip-flop of that. Most of
7 these, if not all of these individuals
8 that are in the younger age groups on SCL
9 are on that future planning list. So, you
10 know, those individuals who have just
11 signed up, because they are getting
12 everything they need right now, they are
13 not asking for services, they just want to
14 say, put me on this list for later. I
15 know that services are going to be needed
16 later. So if you look at the breakout
17 between the two waivers, 22 percent are
18 under the age of 18, and 77 percent are
19 over 18.
20 MR. CHRISTMAN: Can we go back
21 to the first slide, Pam?
22 MS. SMITH: Yes.
23 MR. CHRISTMAN: Wow, is that
24 helpful.
25 MS. SMITH: Yes. And I will



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1 thank our colleagues --

2 MR. CHRISTMAN: Good for you.

3 MS. SMITH: Particularly, Cathy

4 Lerza. I know she couldn't attend today.

5 MR. CHRISTMAN: Yeah.

6 MS. SMITH: She has put this

7 together for us so, we have been taking a

8 very intent look at the waitlist. I know

9 that BDID has been specifically really

10 looking at the urgent number on the SCL

11 waitlist and that number, I don't have

12 that called out here, but that number has

13 gone down, as well, so we have been really

14 focusing on these.

15 I will get to the -- let me go

16 on down and talk about the reallocation.

17 So right now there are 4,491 slots

18 approved for SCL. There are 100

19 additional slots that are pending SCL

20 approval. So that is in the waiver

21 applications we are waiting on CMS to

22 approve. So that will take us up to

23 4,591.

24 And again, allocation is done

25 based on urgency of need and that is

1 outlined in the regulation for SCL. So
2 when emergency criteria is met, that is
3 why we hold on to those slots. That's why
4 we have available slots and you still see
5 individuals on the waiting list. We want
6 to make sure that those individuals that
7 are maybe aging out of DCBS care, or have
8 had a catastrophic event and they lose
9 their caregivers, that we have a slot that
10 they can go into.
11 For Michelle P., so there is an
12 additional 100 slots so that will take us
13 up to 10,600 who are pending final CMS
14 approval. We are making allocations
15 monthly. We recently transitioned the
16 management of the waitlist to BDID, and so
17 we had been allocating every 90 days and
18 we had discussions and changed that to
19 allocating monthly, and that allows for
20 the CMHCs to be able to plan better so
21 that they can do those assessments. It's
22 not such an influx of individuals all at
23 one time.
24 But I will tell you, out of the
25 number that we allocate every month, at

1 least 50 percent of those never go on to
2 receive services because, either we can't
3 find them, or they don't know what
4 Michelle P. is, have no desire for
5 Michelle P., don't know how they got on
6 the waitlist.
7 So it takes -- even with
8 allocating monthly, so 75 a month, and the
9 allocations that we have done in years
10 prior, since 2018, we have been allocating
11 every 90 days to six months of Michelle P.
12 and we've not gotten up to our full
13 capacity, yet. And that is largely
14 because each time we allocate, only about
15 50 percent of those individuals go on to
16 actually receive services.
17 MR. CHRISTMAN: Yeah, I remember
18 back a few years ago when we had a huge
19 backlog on the allocations. I think,
20 maybe, one out of ten was actually
21 interested and eligible, but 50 percent
22 said -- so it takes you a good bit of time
23 to determine their eligibility and whether
24 they really want the service and if they
25 are eligible; correct?



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1 MS. SMITH: Well, a lot of that
2 time is on the individual actually taking
3 the steps then they need to request the
4 assessment. So we made some changes in
5 how we are doing that, and we reach out to
6 the CMHCs so the CMHCs know sooner who the
7 person is, so instead of waiting for the
8 person to get the letter and reach out to
9 them, they contact the individual to
10 schedule the assessment. But sometimes
11 its taking them multiple attempts to
12 either get in contact with the individual
13 or actually do the assessment, because the
14 individual says they will put it off or
15 they will cancel last minute. And, you
16 know, things happen but some of these
17 individuals are canceling three or four or
18 five times, so we have available slots in
19 both of the waivers and for SCL we are
20 allocating on that emergency basis for
21 Michelle P., we are allocating every month
22 75 individuals, but you will see we are
23 still not getting up to our full capacity
24 number.
25 MR. CHRISTMAN: Well, what

1 you've got going there with SCL, I think,
2 is working very well. That you never have
3 anybody on the wait -- on the emergency
4 list. That's great.
5 MS. SMITH: And we are reviewing
6 the waitlist processing. That's part of
7 the whole something that we have been
8 talking about that we want to review how
9 that is done to make it consistent so that
10 there is a process for individuals,
11 regardless of what type of waitlist you
12 might be on that, there is a process that
13 if you or somebody who needs services
14 urgently, maybe you are not getting
15 services at all and you need them, you
16 know, your situation changes and you need
17 those sooner versus, maybe, a child who
18 has parents who are able to care for them
19 and maybe has other instruments, there's
20 different situations. So we are looking
21 at how do we make the waitlist process
22 better as well, right now. And we're
23 looking at modeling it more like what we
24 do with SCL because that does -- that
25 works very well. We are able to ensure



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1 individuals who have those catastrophic
2 needs and are getting those services.
3 And we are also getting an
4 analysis of diving deeper into the
5 individuals that are on the waitlist to
6 see, okay, why are you not accessing these
7 other state plan services that are
8 available to you? What is the barrier?
9 What can we do to take away that? Because
10 it may be that that meets their needs, at
11 least at the moment that may meet that
12 need, so we are really taking a holistic
13 look at the waitlist and the individuals
14 that are currently on the waitlist.
15 MR. CHRISTMAN: So, if I
16 understand you correctly, on the Michelle
17 P. waiting list, you are thinking about, I
18 guess, creating categories of the most
19 need, rather than chronologically?
20 MS. SMITH: Right. As of right
21 now, SCL is the only one that has -- brain
22 injury has a slightly different process,
23 but it is not exactly like SCL, but HCP
24 and Michelle P., for example, it is
25 chronological order. So we are looking

1 at -- we are looking at what other states
2 are doing, would make that process better
3 so that we can ensure that the individuals
4 that have the highest need are able to
5 access those services, and also looking at
6 the individuals to understand what is
7 available to them, that it is not just the
8 waiver services.
9 And I think, Johnny, has his
10 hand up again, I think.
11 MR. CHRISTMAN: And when you
12 draft something, obviously, you will share
13 that with us?
14 MS. SMITH: Exactly. That's one
15 of the things that we talked about that
16 will be shared that people will be able to
17 comment on. Correct.
18 MR. CHRISTMAN: That. I think
19 that is a really great idea. Let's go
20 back to the first slide one more time.
21 I really suggest you share that
22 with the MAC.
23 MS. SMITH: We are going to. We
24 did not have -- that will be the next
25 time. We will share that and Erin I will

1 get this over to you and Kelli so that
2 this can be shared as well. But this is
3 how we are going to begin reporting the
4 waitlist information because I think it
5 just has a lot of value -- there's a lot
6 of valuable information there. Because
7 when you hear -- the numbers are still
8 shocking. Don't hear me saying that, that
9 they are not, they are still shocking, but
10 when you look at it in full picture of
11 what -- that there are some individuals
12 who maybe on a waitlist, but they are
13 being served. The next piece, the next
14 layer that we are looking at is Medicaid
15 eligibility as well as the individuals
16 that also have third-party insurance
17 coverage available.
18 So it's not just that someone is
19 on a waitlist --
20 MR. CHRISTMAN: I see.
21 MS. SMITH: -- not receiving or
22 not able to receive any type of services.
23 MR. CHRISTMAN: The fact that
24 there are 299 people with the SCL waiver
25 who are -- okay -- but they are still

1 wanting --

2 MS. SMITH: There is something

3 mystical about Michelle P. waiver. I have

4 yet to figure it out, but there is

5 something about it. Because we will reach

6 out to those individuals and say, do you

7 want to remain on the waiting list?

8 Because for most people, the

9 goal is either -- their goals are

10 consistently met on Michelle P., and they

11 don't want to leave Michelle P. And

12 that's fine. If their needs are met on

13 Michelle P. then obviously they do not

14 need to change, but most people, it is

15 meant as a transition to SCL, or meant to

16 meet the needs while they are waiting on

17 SCL. Maybe they haven't got to that

18 emergency, that category yet. They are

19 being served. But their main goal is to

20 get on SCL. These individuals, we've

21 reached out to them and they do not want

22 to be removed from the waitlist. So we

23 will not take someone off the waitlist if

24 they don't request to be removed.

25 MR. CHRISTMAN: Well, it's good



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1 to see the numbers.

2 MS. SHEETS: If they don't

3 request to be removed, we will not remove

4 them from the waitlist. But, yes, there

5 is something there about -- I think that

6 says something. It's -- you know, why?

7 But we have to get through just to

8 understand, so even these, you know, all

9 of these individuals who are currently

10 receiving services, so we still have to

11 get through those allocations, so it maybe

12 we allocate and they decide no, I don't

13 want services anymore, but that process

14 still takes the full amount of time

15 because we have to give them the

16 opportunity if they are allocated a slot.

17 MR. CHRISTMAN: Right. But

18 again, that gives us a more accurate

19 picture of who is really on the Michelle

20 P. waiting list.

21 MS. SMITH: Yes.

22 MR. CHRISTMAN: So right. So

23 that is helpful.

24 So to summarize, I think we are

25 going to try to find some more members of

1 the MAC and, Johnny, you thought that you
2 could help with that? And Melanie?
3 Correct?
4 MS. TYNER-WILSON: Yes.
5 MR. CHRISTMAN: Particularly
6 look for people to do the person-directed.
7 On these, we are going to work
8 on a survey to get more information about
9 people who have been terminated, and send
10 that out to all providers and that survey,
11 I suppose, I can work on and maybe involve
12 Amy as well, or anyone else and, let's
13 see. It seemed like there was one other
14 thing. Oh, and then put mobile crisis on
15 the agenda for next time.
16 MS. BICKERS: And Rick.
17 MR. CHRISTMAN: Yes?
18 MS. BICKERS: Johnny and Melanie
19 both have their hands raised. I wasn't
20 sure whose hand went up first, though.
21 MS. TYNER-WILSON: Johnny's did.
22 MR. CALLEBS: Okay, thank you.
23 I just have a question about waitlists,
24 Pam.
25 The people who are on the SCL

1 waitlist in the urgent category, would
2 they -- you know, it is good that we don't
3 have an emergency waitlist, but people who
4 are deemed to be in urgent need of
5 services still wait and hang on until
6 something tragic occurs -- a death of a
7 caregiver, a homelessness, you know, on
8 the verge of institutionalization.
9 Something horrible has to happen, still,
10 before the person is getting allocated,
11 you know, waiver funding.
12 So I guess my question is: If
13 the budget, expanded slots in the budget,
14 250 a year for SCL, for example, would
15 those slots be used or be allocated to
16 people in the urgent category?
17 MS. SMITH: We are looking at
18 that. We are having discussions about
19 that. We have talked about that. I will
20 tell you most of the individuals in that
21 urgent category are receiving services
22 through a different waiver, but we are
23 looking -- we are looking at that, and you
24 know, depending on what the final numbers
25 look like, you know, it's really, it's

1 honestly this big balancing game to make
2 sure that we don't lose -- it's what
3 number is the right number two say for
4 emergencies versus you want to serve as
5 many people as you can, but we are
6 talking -- we are talking about that and
7 looking at that to see, you know, when we
8 get the final approved number of slots, is
9 there a certain number? Can we allocate
10 all of them? Is there a certain number
11 that we can allocate, and it will just,
12 you know.
13 We are also looking at previous
14 years and are we trending up the number of
15 emergencies that we've had, because the
16 last thing we want to do is have a
17 waitlist and have somebody who has a
18 catastrophic event not have a slot, but we
19 also don't want to be holding on to slots
20 when we can be serving people. So we are
21 going to add a lot of data and talking
22 through that with BDID on what the numbers
23 look like. But our goal will be to try
24 and serve some of those individuals.
25 MR. CALLEBS: Thank you. And

1 also into the equation. The new approach
2 where you can -- the cabinet can allocate
3 vacant slots when a participant passes
4 away.
5 MS. SMITH: And that's already,
6 that's been -- that has been in place for
7 several months. We have been doing that.
8 So now, immediately, when a participant
9 passes away, that slot is reallocated and
10 it goes into that bucket to be
11 reallocated.
12 MR. CALLEBS: Thank you. Hats
13 off to you for doing that.
14 MS. TYNER-WILSON: Yeah.
15 MR. CALLEBS: I think that's
16 great. That would be, you know, helpful
17 too in your equation to figure out how
18 many spots to hold in reserve knowing that
19 there will be some added on throughout the
20 course of a waiver here due to unfortunate
21 deaths.
22 Thank you. I just wanted to ask
23 that question about folks in the urgent
24 category.
25 MR. CHRISTMAN: Melanie?

1 MS. TYNER-WILSON: Yes, and
2 thank you, Pam. This is amazing, and I
3 bet it's a hard job to compete. But,
4 thank you and thank you for sharing it
5 with us.
6 The one thing I had when I
7 worked in developmental PEDS at UK, we had
8 one of our older patients, the mother died
9 and the father was not capable of caring
10 for them, and it was my first experience
11 with trying to put them on the emergency
12 list or get help, and I had to reach out
13 to the community mental health centers and
14 I was -- it was -- I had to eventually
15 reach out to a person by the name of April
16 Proctor. I think she is someone up in
17 your all's world, but it was very
18 difficult to get in contact with someone
19 to say, help me to navigate this to be
20 able to get the individual to the next
21 step because, clearly, the individual had
22 significant intellectual disability and
23 was living in not a very healthy
24 situation, and receiving services on the
25 Michelle P., but was really needing to go

1 to a different kind of waiver service, and
2 it was really difficult to get that
3 through, and I didn't know if their job
4 descriptions had been revised, because it
5 was really difficult to get in contact
6 with somebody to get the support that this
7 individual needed.
8 MS. SMITH: We are working -- I
9 will tell you the team that we work with
10 right now has been phenomenal. If
11 somebody reaches out to us and says, you
12 know, because I know, Melanie, you have
13 done that before, too, we immediately send
14 something to them and I know they are
15 great at reaching out immediately, but we
16 are also working on some more of those. I
17 think you've heard us refer to them as,
18 what does this mean to me, or those one
19 pager documents that are actually three or
20 four pages? But really, they can be out
21 there for individuals that I think this
22 has happened to me, now what? Or I had
23 this question is about, now what? So they
24 really will guide individuals through what
25 they need to do and it's very easy a

1 step-by-step of this is who you call. We
2 continually work on the who to call list
3 which, I believe, is posted on our website
4 that we really try to add to that and
5 refine that and so you can look at
6 individuals, and it is categorized by
7 eligibility questions or service questions
8 so that you have a question, I need
9 services immediately, or I have to renew
10 my eligibility, who do I call? Really
11 trying to get individuals directly --
12 linked directly to the individuals that
13 they need to call so that there's not this
14 kind of -- I hate, and my team knows this,
15 and I have a phenomenal team that does
16 this -- the ping-pong game. I don't want
17 individuals to call somebody and say oh,
18 you need to call this person. So we are
19 really trying to work on how do we make
20 those connections in how we help
21 individuals get those contacts so they are
22 able to make that connection the first
23 time and not have to go through two or
24 three different people.
25 MS. TYNER-WILSON: Yeah. Thank

1 you and I appreciate that. Some of these
2 families are very -- have a limited
3 ability to navigate a sometimes very
4 complex system.
5 MS. SMITH: It is a very complex
6 system. I would agree. So we want to try
7 and cut down on any complexity as much as
8 we can and provide those resources while
9 also trying to promote independence of the
10 individuals and a feeling of control of
11 what is going on in their life and what
12 they want to see for their life.
13 MS. TYNER-WILSON: Yeah. Us
14 too. Thank you.
15 MR. CHRISTMAN: Okay. Any other
16 comments or new business? I thought that
17 was a very good meeting. Thank you, Pam,
18 for all of the good information. And if
19 not, we are adjourned. Thank you.
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C E R T I F I C A T E

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

Dated this 20th day of February, 2024

___/s/ Stefanie Sweet_____

Stefanie Sweet, CVR, RCP-M