DEPARTMENT OF MEDICAID SERVICES
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
TECHNICAL ADVISORY COMMITTEE

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JUNE 4, 2024
10:00 a.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

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

MS. BICKERS: Good morning.

MS. ELLIS-REEVES: Good morning. How are you?

MS. BICKERS: I'm well, and yourself today?

MS. ELLIS-REEVES: I'm good.

MS. BICKERS: It's not quite 10 o'clock.

MR. CHRISTMAN: Erin, do we have a quorum?

MS. BICKERS: We do. It is not quite 10 o'clock, and we are still clearing the waiting room.

MR. CHRISTMAN: Oh, okay.

MS. BICKERS: So if you want to give me just a moment, I will let you know when we are clear.

MR. CHRISTMAN: Thank you.

MS. BICKERS: I have you, Melanie, Cheri, and Doug. So if I missed anybody, or if somebody is logged in under an alternate name, please let me know. Oh Wayne, there you are. I even have a checkmark by your name. Sorry about that.

MR. CHRISTMAN: Hello, Doug.

Hello, Wayne.

MR. HOYT: Hello.

MR. HARVEY: Good morning, Rick.

MR. CHRISTMAN: Hi, Melanie.

MS. TYNER-WILSON: Hi, Rick, how are you?

MR. CHRISTMAN: Cheri, hello.

MS. ELLIS-REEVES: Hello.

MS. BICKERS: Okay. It is 10 o'clock and your waiting room is clear and you do have a quorum.

MR. CHRISTMAN: Okay, thank you.

Welcome to the June 4th meeting of the IDD Technical Advisory Committee. I am Rick Christman.

And our first order of business is the approval of the April 2nd, 2022, minutes which we received. Motion to approve?

MR. HOYT: So moved.

MR. CHRISTMAN: And a second?

MR. HARVEY: I'll second, Rick.

MR. CHRISTMAN: Okay, thanks. All in favor say, aye.

TAC MEMBERS: Aye.

MR. CHRISTMAN: Our next item -- it looks like we've got a little -- it's actually PDS Corrective Action Plan request. Can we get a copy of the PD -- we understand there is a PDS corrective action plan; is that correct?

MS. SMITH: Yes. We are on a corrective action plan with CMS.

MR. CHRISTMAN: Okay. Yeah, my audio is not very good. Is that a yes?

MS. SMITH: Yes.

MR. CHRISTMAN: Okay. Can we receive a copy of that?

MS. SMITH: We do not have the actual -- we've just been having meetings with CMS. We do not have the actual document from CMS.

MR. CHRISTMAN: Okay, so we would request that from CMS?

MS. SMITH: No. I mean, Rick, it's -- you can request information from CMS. You can request information from whomever you want, of course, but we don't have that. I don't have it to share with you, right now, is what I am saying, so.

We are meeting with them. I believe we are working on scheduling a meeting in the next couple of weeks.

MR. CHRISTMAN: Okay. I'm trying to find my volume button here. I'm sorry. It's just that I can't hear very well.

Okay. Is Amy on the line here? Amy Staed?

MS. STAED: I'm here.

MR. CHRISTMAN: Is that what you were looking for? Hi Amy. The PDS Corrective Action Plan request?

MS. STAED: Yeah.

MR. CHRISTMAN: I didn't quite hear what was said, but CMS has it, apparently.

MS. SMITH: CMS issues it, Rick, so, Amy, if you send me what questions you have, we can answer questions, I just don't have a document to be able to send.

MR. CHRISTMAN: Is there a document?

MS. SMITH: There is not a document, and Rick, maybe because you're

having audio issues you were not able to hear me, there is not a document that I am able to Sunday from CMS right now.

MR. CHRISTMAN: CMS does not have a document?

MS. SMITH: CMS has a document they are working on. I do not have the final version to be able to send to you. It is with CMS right now.

MR. CHRISTMAN: So they don't have a final version of the document?

MS. MURPHY: Yes.

MR. CHRISTMAN: They do? Then you saw it on the agenda. Did you see it on the agenda?

MS. STAED: She is saying they don't have a final version of the document that is able to be shared yet.

MR. CHRISTMAN: But does CMS have a final version of the document?

MS. SMITH: No, they do not, Rick.

MR. CHRISTMAN: Okay, I'm sorry.

MS. SMITH: They are working on it. We are meeting with them.

MR. CHRISTMAN: All right.

MS. SMITH: So neither of us have a final version of that document yet.

MR. CHRISTMAN: It does not exist.

MS. SMITH: A final version does not exist that I can share.

MR. CHRISTMAN: Okay. Is there any update on gathering information on gathering regarding involuntary terminations role? Is this something we want to pursue? I think, at the last meeting, there had been like 64 involuntary terminations in the last six months.

MS. SMITH: We are working --

MR. CHRISTMAN: Do we know, like today, how many involuntary terminations there are?

MS. SMITH: We do not. That was not on the agenda, Rick, so we did not gather that data again.

MR. CHRISTMAN: You knew that we were interested in this.

MS. SMITH: You are interested

in a lot of things, but it was not on the agenda, so I did not prepare for that --

MR. CHRISTMAN: I see it right here on the agenda.

MS. SMITH: An update on gathering information regarding involuntary terminations role. I have an update on that.

MR. CHRISTMAN: You do, or don't?

MS. SMITH: I do have an update. I'm sorry. Is everybody having trouble hearing me?

MS. TYNER-WILSON: No. I hear you really well. This is Mel.

MS. SMITH: Okay. This is -- we are working on a survey that is going to be a combination of two things. As you all know, we were awarded several spots in the upcoming budget. We are launching a survey that is going to look at provider capacity, as well as, we are also going to look at the -- we are going to ask questions about involuntary terminations. We are going to do one survey so providers

are not getting inundated with multiple surveys. So we are working on that survey right now. I have the questions that you all had submitted to us, so we are working on -- we are working on that right now, finalizing that survey to go out to providers, but we also want to look at capacity for providers to take on new individuals because as we, you know, have these new slots, we want to make sure -- we want to see, you know, what does our provider network look like? Who is interested in taking on new providers? Who has the capacity to take on new providers -- not providers, new members.

MR. CHRISTMAN: Okay. When the -- do you have any notion as to when that survey will be available or be sent out?

MS. SMITH: It will be -- it will be within the next two weeks.

MR. CHRISTMAN: That is great.

MS. TYNER-WILSON: Yeah.

MR. CHRISTMAN: Thank you.

MS. TYNER-WILSON: Rick, this is

Melanie. Can I ask a question?

MR. CHRISTMAN: Yes.

MS. TYNER-WILSON: And thank you. Thanks, Pam for that update. I appreciate that. In the survey that you are putting together for providers, is there -- when somebody accepts -- I know they get the referral packet, and when they -- a provider agency accepts a new client, are there questions that are asked in regards to, you know, capacity, or is that what you are trying to establish with this survey?

MS. SMITH: We want to ask -- so we want to understand exactly what is happening when they -- when case managers reach out, so when they do referrals. Either for new clients, or for clients that are choosing to switch providers or who have had an involuntary termination issue. We want to understand what information is shared, what questions they are asking as a potentially new accepting provider, and what information is being shared by the case manager. And where the

member is in all of this, because, I will tell you, I have been very disappointed lately in several situations that we have had, where the member or their rep, or the member with their authorized representative, have been left out of all of the decisions and all of the discussions. And this is supposed to be a person-centered waiver. They should be at the forefront of these decisions, and they are not being considered a lot of times, and their input is not being gathered.

MS. TYNER-WILSON: And that's awesome. Thank you so much for being thoughtful about that kind of issue, because I think it can only make the system -- it can only improve the system when everybody's at the table, so thank you for that.

MR. CHRISTMAN: Yes, thank you. And thank you for getting that survey put together.

Role of Mobile Crisis units for people with IDD. Is someone going to provide some information on that?

MS. SMITH: I have something. Leslie gave me the information. So the General Assembly did not fund Mobile Crisis in the budget and we are currently evaluating other options.

MS. TYNER-WILSON: Wow. And this is -- can I talk again?

MR. CHRISTMAN: Yeah, go ahead.

MS. TYNER-WILSON: I'm sorry to ask so many questions. Is this something that maybe, might be discussed with the interim legislative committees, you know, would this be a topic that they might have testimony or people talk about, do you think?

MS. SMITH: Potentially, they might.

MS. TYNER-WILSON: Okay.

MS. SMITH: I can't speak to what they will or won't do for sure.

MS. TYNER-WILSON: Sure.

MS. SMITH: But certainly it's something that could happen.

MS. TYNER-WILSON: I didn't realize that that didn't get funded so

that's really too bad, but thank you for the information.

MR. CHRISTMAN: And when we say it didn't get funded, that means for all people right?

MS. SMITH: For all -- Mobile Crisis, in general, did not get funded for any population.

MR. CHRISTMAN: Yeah, that was a surprise.

MS. TYNER-WILSON: Yeah.

MR. CHRISTMAN: I thought it was done. Is there anything to report on the Community Settings Rule?

MS. SMITH: We are currently -- so, CMS offered all states an opportunity to do a cap on Community Settings Rule, just because of COVID, and all of the disruption in the middle of that. So Kentucky did -- we are on a corrective action plan for that, but it was a voluntary -- it wasn't a punitive thing. It was something that all states did. We had to go back and review certain settings that, in the initial review, were deemed

as in the heightened scrutiny bucket, so we have reviewed those settings, are in the process of finishing those settings. Most of them, I believe, have met criteria either -- because the criteria has slightly changed. Some of them have moved. Some of them have very strong risk mitigation plans, and so there's not -- while they may fit in that description of in the heightened scrutiny bucket, they have mitigation plans for the things that make them fit that category, so we actually meet with CMS next week to talk about final rule again, but we are, are largely -- we are in compliance. It was those additional settings that we needed to go back and review.

MR. CHRISTMAN: Will states like Kentucky eventually will get to a point where our compliance with the Community Settings Rule is final, right?

MS. SMITH: Well, we -- our compliance plan, all of that was already done.

MR. CHRISTMAN: Okay.

MS. SMITH: We evaluate -- that is something that is evaluated with every brand-new provider that comes on at every re-cert.

MR. CHRISTMAN: I see.

MS. SMITH: It's not something -- it's a continuous evaluation. It's not something you are ever done with.

MR. CHRISTMAN: That's true. But our plan has been accepted?

MS. SMITH: Our plan was one of the first, if not the first, to be accepted.

MR. CHRISTMAN: I think it was the second or something like that. Yeah, so we did real well.

Melanie, you had a question on critical incident reports, numbers, self injured.

MS. TYNER-WILSON: Yeah, yeah, and this might tie-in really nicely with all of the heightened scrutiny, because a long time ago I got asked to be on a committee that reviewed the heightened.

MS. SMITH: The packets?

MS. TYNER-WILSON: The packets, yeah, I knew it was awhile ago. But the reason I am asking is about critical incidents, because I had gotten a copy of -- I think you send it out, Pam, the instructions for how critical incidents were collected and reported, and I just wanted to get a handle, because the frequency, the kinds of incidences that were reported, I guess they would go to you, or your office, if they are unintentional or intentional, you know, those kinds of injuries. Is there anywhere where that compilation of information is placed?

MS. SMITH: Yeah, so the providers are required to use MWMA, so the Medicaid Waiver Management Application, to report critical incidents as well as noncritical incidents. So if you want to give me, send, you know, specifically what you want, I know what was on the agenda so it does not -- the reporting categories don't go into the level of detail of the number of that are self injury,

necessarily, or injuries by staff. That we get -- we review every critical incident that we get.

MS. TYNER-WILSON: Yeah.

MS. SMITH: So that's something that we capture in reviews, and we look at, we do trending, we look at individuals, we look at the number of incident reports by agency, by individual, we, you know, look at it in multiple of different ways. But I have, by the different categories, I have, you know, illness injury, you know, the abuse neglect exploitation categories, we have -- there is -- do I still have it? Because I was still looking, I think we still have one of them up -- illness to injury is the biggest -- is our biggest bucket, because so much stuff falls in there. We look at medication errors. We look at, you know, if there is suicidal or homicidal ideations, or -- this is a small one I was looking at. This is an ABI one. But we have a lot of data around critical incidents. If you want to reach out with

some more, what you would like to see, I can work on pulling together more of that, more of that information.

MS. TYNER-WILSON: And I appreciate that. I am just trying to get a better handle, because I hear in my world that I reside in, I hear, oftentimes, about scenarios where an individual has been, for whatever reason, injured or treated in a inappropriate way, for a lack of a better way to say it. And I don't know what is true. I know that a long time ago when I worked at KIPRC, I would sit in and hear about the injury fatality review, and I know that that is not a part of this process, but it's just trying to get a better handle in terms of what is going on in our state, and is it something from a safety perspective that we need to focus on more in the future, because a lot of times it came as a result of folks not being trained, or having the capacity of, like you talked about earlier, to meet the needs of some of these unique individuals, so. Anything

that you would be -- a report or something that you would be willing to share, I would be very interested in taking a look at it, so I can better understand and be a better servant on this TAC.

MR. CHRISTMAN: Yeah, thank you. What are the categories, the categories of incident reports?

MS. SMITH: There are -- there are so, just for example, there's a behavior category, death, elopement, an environmental category, illness and injury, medication, public health concerns --

MR. CHRISTMAN: So for example --

MS. SMITH: There's a -- there's a reporting guide that is out on the website for providers that lists -- that has a lot of this information in it.

MR. CHRISTMAN: Good.

MS. TYNER-WILSON: And I had gotten a copy of that. I think I have -- it's from 2021 -- I don't know if that is the most recent one or not, Pam.

MS. SMITH: I believe that is the most recent one. We will be making -- we are evaluating it now, but I believe 2021 is the most recent version of that.

MS. TYNER-WILSON: I remember when I did work at KIPRC, the categories that you all have are very similar to what was used when they reported data for children and youth and adults, you know, so it was helpful to, kind of, see that comparison, but I know it is a unique population that you are having to keep this kind of data on -- for individuals that are receiving services through, like, the waivers and whatnot. I guess children and adults.

So there is probably additional information that you have to capture in your data collection. But it is really interesting to look at what is -- what are the categories are because I think -- I bet there is a correlation between the injuries that you all are seeing at your level, and, kind of, the ongoing concerns about capacity and safety for providers.

So I think it's -- I think having a loved one who falls into some of those categories, I get it. You know, they can be challenging to deal with, but on the flipside, it kind of gives you guidance in terms of, you know, okay, we need to do more training in this area on injury and assault, and that kind of stuff.

So it would help me to know a little bit more about the actual numbers, if it is a critical number of things that are occurring in our state, or if there are only a few.

MR. CHRISTMAN: For example, we would have a report on incidents that would involve injuries right, Pam? So that's great.

I see some hands raised.

Johnny, do you have a question?

MR. CALLEBS: I do, thanks. And good morning.

I had a question back on the Community Settings Rule for Pam.

Pam, do you know how many settings are currently under heightened

scrutiny that you are kind of looking to mitigate or work with?

MS. SMITH: I do not have that on hand, Johnny, but I can get that. A lot of the ones when we went back and looked at the change that came out to the rule, there were several that kind of fell out of that bucket, because there were some that looked at if, you know, they were on the same street. I mean, there were some changes to that. I don't have the number off the top of my head, but I can get that number. If we want to put that on the agenda for next time, I can get that information.

MR. CALLEBS: Yeah, that would be great. I was just curious if it was a lot --

MS. SMITH: No. It is not a big number.

MR. CALLEBS: Is it less than 20?

MS. SMITH: No. It is more than 20, but it is not a number that I -- and especially when you think about

residential, you might have one provider number, but they might have five houses or six houses.

MR. CALLEBS: Sure.

MS. SMITH: So, kind of, you have to think about it in terms of the actual houses or settings that they have, apartments that they have. In that way, you can't do that as a provider to --

MR. CALLEBS: Right.

MS. SMITH: -- you know, setting ratio. But still it was not -- it was not a very -- it was not an alarming number.

MR. CALLEBS: Okay, and --

MS. TYNER-WILSON: And when I sat on that committee, I think there were 26 that were in that category that had heightened scrutiny.

MS. SMITH: That was the first group. So one group got looked at and I think there were three other groups. For whatever reason, that process, you know, it stopped. I think there was a question about feedback from CMS, and then COVID happened. So I think there was just a lot

in the middle of all that.

MR. CALLEBS: Sure.

MS. SMITH: But I think it was -- I don't want to guess the number because I'm going to get it wrong, but I would say that I do not think that we had any providers that we were terribly concerned about. I think that all of our providers had done a great job with having mitigation plans, and there was, you know, access to the greater community and freedom of choice, and there was not a provider, that I can think of, that we thought, gosh we are really concerned about what they are going to do.

MR. CHRISTMAN: All of the settings that are in heightened scrutiny, are they all residential?

MS. SMITH: There was, I think, two adult daycares, maybe --

MR. CHRISTMAN: Oh.

MS. SMITH: -- that were on the site of a nursing facility. And, I believe, one of those has moved and the other one may have closed, but there were

a couple of adult days, but the bulk of them were residential settings.

MR. CHRISTMAN: Thank you.

Amy, I see your hand raised also. Amy?

MS. STAED: I was muted sorry. I forgot to unmute. We've been doing this for years now and I still can't get the hang of it.

MR. CHRISTMAN: I finally got my volume fixed.

MS. STAED: I just -- given Melanie's questions about incidents and things, I just wanted to note something that I thought the group -- that I recently learned about, that I thought the group would be interested in -- actually two things.

Number 1. The state of Pennsylvania has recently contracted with, kind of like a technology provider to do incident reporting tracking, and it is a system that the state uses and providers use to track incidents to keep track of exactly what is happening, but both the

state and individual providers can trend and track their own incidents to see what is happening, what's -- it even kind of dives down to, is there a certain staff that is involved in more incidents than other incidents. But what is also interesting is it fully integrates with the HRST, and what they are finding in Pennsylvania, is that oftentimes certain individuals are having certain incidents or behaviors related to health events, too, and they have been able to look at all of this data that is available and combine it, to really dive down as to why incidents are happening, and they are finding that, obviously, some are health-related, and they were identifying, maybe, some bad apple staff, and it's just really interesting and I thought the group might be interested in that.

2. The CMS has recently released what is being colloquially called, the Medicaid Access Rule, and it's like this giant 1000-page rule that has a lot of stuff in it. A lot of stuff that

doesn't affect waiver services, but a lot that does, and one thing that it mentions is it talks a lot about incident reporting systems, and tracking, and electronic systems, and, obviously, this is all very new and we are all waiting for more guidance, but it is likely that we are going to see some more federal requirements about tracking and data analysis with incident reports that could be very interesting and exciting for the future. So I just thought that you guys would like to hear about that.

MS. SMITH: And we do have, with MWMA, have a lot of those capabilities, as well as, looking at, and it's part of the access rule as you know, there are about eight rules that touch us in some -- touch Medicaid in some shape or fashion, that we are going to, you know, have to review and comply with, but incidents, you know, looking at how -- because an incident report, an incident report data is only as good as the data that gets reported, and you can mandate it, but you always -- you

need to look for ways that you find incidents that potentially are not being reported. So we are looking at that now. How do we look at our claims data to catch potential incidents where something that should have been reported, but wasn't reported. Because I will tell you, the incident reports that we get from individuals in residential, is much better quality and we get, you know, I think, we have a much higher compliance rate than individuals who are in Participant Directed Services, because you don't have a -- many times that is a family member providing services, so things aren't getting back to the case manager, so incidents aren't getting reported as much in those populations.

MS. TYNER-WILSON: That's a really good point. And there should be similarity across the board. I mean, I think from a parent perspective or caregiver perspective, I think that is so important. Especially as you look down the road for a time period when the

caregiver is no longer present in that individual's life.

MR. CHRISTMAN: Right. And we might see a relationship between involuntary terminations and incidents too.

MS. TYNER-WILSON: Yeah.

MR. CHRISTMAN: And maybe draw some conclusions from that.

MS. TYNER-WILSON: Because it really is -- I mean, point well taken Rick. It's all about the capacity of staff. You know, when you get to a point where -- I remember when our son was young, there were attempts at, you know, controlling and dealing with his behavior, and then eventually it got to a point where they had no more tools in their toolbox and that's when, you know, the capacity had ended and, oftentimes, things like restraint, or some kind of injury would occur, and I think that is where -- I get it, it is a very challenging thing to deal with, and I can't imagine if you had several clients living in your

residential home that had that kind of behavior. That would be overwhelming.

MR. CHRISTMAN: Right.

Is there any updates on the rate study, Pam?

MS. SMITH: So you can look for information to be coming out soon on that. So. So I don't really have an update to give, other than there is going to be information coming out soon with information about the rates.

MR. CHRISTMAN: Are you trying to get some of this done before the beginning of the next fiscal year? Like the rates, is that possible?

MS. SMITH: So the rates, the rates, any change in the rates will require a modification to the waiver applications, which will require going out for public comment. Are we working on things? Absolutely. We are working on many initiatives right now. We are not just waiting for the start of the new fiscal year.

MR. CHRISTMAN: Okay. So

hopefully very soon then, that's great.

MS. SMITH: There will be information coming out.

MR. CHRISTMAN: Okay, good. And you mentioned there will be new regulations then, too. Anything beyond that, in terms of other regulations other than rates?

MS. SMITH: We are redoing all of the regulations right now. They are out to all of our staff and our sister agencies are reviewing the first draft with comments due, internally, on Friday, and then we will meet to begin consolidating all of those comments and making any modifications and moving those forward through the process, but there are a lot of regs to touch. We are simplifying the regulations, so instead of us having a 50-page regulation, it is going to be much more simple than that. Instead of having rates in the regulations, there is going to be -- we are going to refer to the posted fee schedule like what is out there right now,

so we are doing a lot of work on those right now. We are reviewing any policy manuals that are still existing right now, to update those and change those, as well as any forms. There is a lot of work going on, right now, about updating information.

MR. CHRISTMAN: Among your goals, I understand, is to make the as SCL and Michelle P. more consistent between themselves?

MS. SMITH: It's to make any waiver, all waivers, consistent to where it can be consistent.

MR. CHRISTMAN: Okay.

MS. SMITH: So for example, the definition of personal assistance, in the definition of respite shouldn't be five or six different things. It is to make things easier for providers and for members to understand and to provide services.

MR. CHRISTMAN: Yeah, I think, in particular, I think, in our organization, it's community access, and

CLS, and things like that, if there could be more consistency, or absolute, consistency, that would really be helpful for us.

Amy, you had your hand raised?

MS. STAED: Hi, sorry.

Pam, I wondered, and you might not be able to comment on this and, if so, that's okay. If you have any idea or inclination about whether these will be -- go through the regular reg process, or if we might be seeing some e-regs.

MS. SMITH: I do not know that at this time. Most of them have been going through the regular process, but I don't know. That decision is way above me, so.

MR. CHRISTMAN: Okay, thank you.

Amy, did you have some questions on the PDS follow-up questions? Did you have --

MS. STAED: Yes, I did. Thank you so much. First of all, thank you for the PDS FAQ. That was really helpful.

I did just want to share some

feedback that I have gotten. They are more general concerns than specific concerns, kind of about PDS right now, and maybe these things are being considered as you guys write the regs, and if so that would be wonderful.

Specifically, right now, I think providers are overwhelmingly concerned about what the prevailing -- what our governing document is right now, because providers have gotten several different answers to the tune of: Its in the FAQ, or check the regulation, or look in the waiver. And all of those documents say slightly different things or have slightly different standards related to -- depending on the service that you are looking at, or the answer that you are looking for -- especially when we were comparing the regulations --

MS. SMITH: The regulations and the approve waivers are not going to match. The waiver applications are the governing document right now.

MS. STAED: Sure, okay.

MS. SMITH: The FAQs should match those.

MS. STAED: Perfect.

MS. SMITH: The regulations had things that needed to be changed in them even before we did -- even before these changes. But always, the waiver applications are the ultimate governing authority, because that is the agreement we have, federally, with CMS, so those always -- and then they should -- and this is what we are working towards with the regulation rewrites. They should all be in line, as well as, it should go applications, regs, and then any policy manual FAQ guidance, all of that should be -- you know, it should get more specific as you get down to each level, gets a little more specific, but the waiver applications with CMS are the, right now, the governing and the most up-to-date policy what we are following with the waivers.

MS. STAED: That was my understanding, too. So my second comment

would be, I don't know that that has been communicated to the DALE staff, because they are still sending providers references to the regulation, telling them to check the regulation, which is, obviously, a little concerning when you're getting mixed messaging from different governing bodies within the cabinet, especially, obviously, those answers are more specific to PDS, but additionally, oftentimes when providers write in and ask PDS questions, they are given an HCB regulation answer, when obviously PDS spans the gamut of waivers, and that is, I think, providers have been concerned about that as well.

MS. SMITH: If you could have them send me those examples, because it always helps when I have, you know, the specific examples.

MS. STAED: Perfect.

And then, another specific concern is providers have been instructed that EEF, that employee eligibility form that is on the website is accurate. But

at least -- I have only checked for SCL, so I have not checked for the waivers -- at least for SCL, it is not accurate. It still lists drug screening, and a CPR, and it does not have the sex offender check on there.

MS. SMITH: Okay. Okay.

MS. STAED: So I just wondered.

MS. SMITH: Okay. We have someone, right now, looking at all of these tools.

MS. STAED: Okay.

MS. SMITH: But I will note that one, specifically, since you said you know, for sure, that one.

MS. STAED: And again, you did say that you are updating all of your forms and stuff, so this might be wrapped up in that process, so thank you for that. I think providers will be very happy. Especially the provider manuals, if those are going to be rereleased and updated, I know that back in the day, those provider manuals were like the Bible, basically. So that will be great to see those come

back and be updated. I know that providers will be happy about that.

And then, I guess my last comment is that we are seeing a lot of, like, best-practice language being applied specifically in the PDS realm to different waivers, but those standards aren't in the waivers.

MS. SMITH: Okay. Send me that too, the examples. Ideally, we all want to follow best practices; right, but --

MS. STAED: Yes.

MS. SMITH: But how it's being communicated, I think, is the --

MS. STAED: Yes, exactly. I guess the issue comes, we just need to know what the best practice is.

MS. SMITH: What everybody's view of the best practice is.

MS. STAED: Yes. Exactly.

And then, we've been told that, possibly, there's an updated FAQ coming out. Is that?

MS. SMITH: We are working on -- so there's a couple things with -- and I

was trying to find them on my calendar and why I can't find them at this moment, I do not know.

We have a -- so there's a couple webinars that are coming up, as well as there's going to be, like, a training. So we are going to do a -- I think it's on the 10th, that's Monday the 10th, I think we have a participant and a provider, we should have both a provider and a participant, the LRI webinars. And then, there is another one a little bit closer to when we actually go live on July 1st, and we are doing a -- there it is -- it's the 20th in the 21st. Those are the ones I couldn't find.

So we are going to do -- the 20th we are doing a question and answer session in the evening for the participants at 6:30, and then we are doing the provider one on Friday.

MS. STAED: Okay, perfect. And thank you for those webinars. I've heard a lot of feedback that people are excited for the multiple opportunities to sign up

for that.

And I have one last question and it's a quick clarification, and I have a feeling you are going to tell me my inclination is right. Providers have been told that HCB -- I'm trying to get this right in my head -- HCB case management visits are required face-to-face in the participants home, excuse me, up to three times per year, but the applications say quarterly, so the applications rule in that instance?

MS. SMITH: Yes. And it should be -- and I think there is -- if it hasn't, it may have not gotten added yet, but there is a clarification about the -- the quarterly -- like, we don't want people going six months in between, you know, there being a face-to-face. Because these face-to-face, they are important. There has been some really bad stuff that have happened to individuals that, if there had been case managers in that home, making a home visit, we would have known about. And I can't stress how much CMS

also, that we are fortunate that we can continue having the Telehealth option and having the ability to still do that, but that -- that face-to-face is so important with individuals in their home. And I realize sometimes we see them at other service sites, so we might see them at the adult day, and that's great too, it's all important, and it helps the case manager understand what the members' experience is like, you know, are these really meeting their needs. But that home visit is so critical to the health, safety, and welfare of those individuals that, you know, I can't tell you the bad things that have happened and that if we had had eyes on, potentially, we could have maybe not prevented some of the situations, but we could have stopped things a lot sooner.

MS. STAED: I think COVID made us all realize how important the face-to-face is, but also how important the Telehealth aspect is, and I think you all did a really good job trying to balance those two -- those two different

ideas in the waiver application.

Do you also have any update about the training for the independent case managers to do the HCB and the Michelle P., PDS?

MS. SMITH: HCB has been done, and, I believe, it is out on the website. The Michelle P., I will check on it. We had met with DALE and, really -- so services are slightly different rate, but the concept in what you have to do different if you are doing PD -- if you are doing case management for somebody who is doing Participant Directed Services, that is largely the same regardless of which waiver. I mean, you have to do the same things, regardless of which waiver the person is accessing services in, so we are working on that, and working with DALE on how we can simplify that, but I do know that that they were working on getting that training scheduled for the Michelle P.

MS. STAED: Perfect, thank you. A lot of people were excited to get

started.

MS. SMITH: We certified, I think, we have about eight or ten case management agencies that have went through and have been certified now to do case management for PDS, so.

MS. STAED: Do you know how many are in the queue?

MS. SMITH: I do not know. I haven't gotten that number lately. I can ask, but I don't know, I don't know how many are in the queue. I do know for financial management we are working -- we have been working for about three different people, right now, and they are in various stages of going back for additional information.

MS. STAED: And just to clarify to get certified, you would just communicate with your QA?

MS. SMITH: You go through DALE.

MS. STAED: Oh, you go through DALE?

MS. SMITH: Yes, you go through DALE. You go through DALE, since it is

PDS. Unless it's financial management is, that we are reviewing in Medicaid, so those requests are going through April or myself.

MS. STAED: Do you have a specific person that providers should reach out to at DALE, or is it just a general email?

MS. SMITH: It's that general email. And I will have to see if somebody -- it's horrible. I can't remember what it is. Let me see. I will get somebody to send that to me.

MS. STAED: You are so used to saying medicaidpubliccomment@uk.gov.

MS. SMITH: I know. And honestly, you can never go wrong sending something to there. It will get where it needs to go if it comes there, but let me get the -- let me get the phone number and the email.

MS. STAED: Thank you. That's all -- that's all the PDS question I have. Sorry. That was a lot.

MR. CHRISTMAN: Pam, since we

are on this topic, has there ever been any consideration to having a pretest or some kind of certification for all case managers just to make sure that they understand the regulations and best practices, et cetera?

MS. SMITH: We are looking at additional training and information that can be provided to case managers. We are, you know, we give leeway to providers to, you know, understand who their, we don't want to, necessarily, dictate beyond, kind of, the general qualifications who you can hire, who you can't hire, so we expect that that is something that they, that the agencies do, but we are looking at some additional information that we can put out there that would be resources that providers can use themselves, if they wanted to create, kind of, their own. And I saw, recently, one provider who had as part of their onboarding, they had kind of a testing and a check off for their new -- I saw it both for DSPs and for case managers.

MR. CHRISTMAN: So you are saying you just kind of leave the issue of the qualifications and the knowledge of the case manager to the organization that's doing the case management?

MS. SMITH: We give the outline of the general -- what the requirements are what you have to have as far as education or experience, but we don't want to dictate, we don't want to micromanage for providers, who they can hire, who they -- we give the general guidelines and we, you know, some providers choose to make it more stringent than that.

MR. CHRISTMAN: I was just thinking of something more cut and dry, like understanding the regulations.

MS. SMITH: And, I would hope that, as a provider, as hiring a case manager, that is part of what you are training, you know, the individuals on -- and we offer training opportunities, for example, for new providers and we look at the providers, their policies for training and what they do.

MR. CHRISTMAN: Okay.

MS. SMITH: But we don't get into the day-to-day business of the providers.

MR. CHRISTMAN: Okay.

Let's skip ahead.

MS. TYNER-WILSON: I have one. What is the baseline academic requirements for someone to be a case manager?

MS. SMITH: I do not have that in front of me. I would have to look it up.

MS. TYNER-WILSON: Like an undergraduate degree or Master's degree?

MS. SMITH: I think it is --

MR. CHRISTMAN: Used to be.

MS. SMITH: It's Bachelor's and -- but there's experience, experience can substitute for education. I will be honest, I have been looking at so much, if I quote it off of the top of my head, I am going to get it wrong.

MS. TYNER-WILSON: That's okay.

MS. SMITH: But it is in the waiver applications, or if you want to

send me an email, Melanie, I can send it to you.

MS. TYNER-WILSON: Thank you.

MS. SMITH: Yeah.

MS. TYNER-WILSON: Thank you. There was a group looking at, kind of, increasing the number of case managers and so I know there was some discussion, but I never captured what the baseline academic requirements were, so yes.

MS. SMITH: And we did add experience in there, because what we found is sometimes you have an education or a certain degree, it doesn't necessarily translate into making you a better case manager. There might be different experiences that you had that may translate. So through COVID, we were able to expand that through Appendix K, so we did continue to keep that.

MS. TYNER-WILSON: That's great.

MS. SMITH: Those expanded qualification.

MS. TYNER-WILSON: Okay. Well, thank you.

MR. CHRISTMAN: But again, and I'm sure you agree with me, Pam, there should be some minimum expectations, like in-person meetings, and that sort of thing we are talking about.

MS. SMITH: And that is yes, that is why it is in the application and will be in the regulation.

MR. CHRISTMAN: Okay.

Let's skip ahead to Olmsted Act. Melanie, did you have some questions on that, also?

MS. TYNER-WILSON: Yes. And I didn't mean to add so many things to the agenda.

MR. CHRISTMAN: That's all right.

MS. TYNER-WILSON: But I think the Olmsted Act is in the process, or up for review for being reauthorized, and I'm just curious as to, you know, what is happening in Kentucky around reauthorization. Is there a task force, is there -- you know, if there is a task force are there representatives that or

self-advocates or caregivers that are being included in this effort?

MS. SMITH: There is -- we had the first meeting on May 30th, and it was led by UK, by HDI, Kathy Sheppard-Jones, and Elizabeth Crease, and Johnny -- I'm blanking on his last name -- Collett -- that formed this OCAC, the Olmsted Community Advisory Committee. It is made up of, there are multiple cabinet staff across multiple agencies, there's providers, there's members, there's advocates that are part of that. And I know that they are, we are just getting started, that was kind of the introductory meeting on the 30th, but there's going to be multiple workgroups that come out of that -- that come out of this larger advisory committee, but lots of work already starting to happen on Olmsted, and there's lots of people involved.

MS. TYNER-WILSON: Are those meetings open to the public?

MS. SMITH: I honestly don't know. I don't know why they would not be.

I can ask and see, or if there are people who are interested in being involved, who they would need to contact.

MS. TYNER-WILSON: Yeah, I would be interested in being involved, but I don't know if I met whatever the criteria was to be --

MS. SMITH: And, honestly, I was in invitee, but I can reach out to Kathy.

MS. TYNER-WILSON: Okay, great. Thank you.

MR. CHRISTMAN: Thanks. Was that helpful, Melanie?

MS. TYNER-WILSON: Yes. Yes. Thank you. What is the timeline, too? I don't know if they give you that information, but does it have to be completed within a year's time? Five year's time? Is there, kind of, a time constraint in regards to when things have to be put in place for the reauthorization?

MS. SMITH: I don't know that we got to the timeline, specifically. I'm looking at trying to pull up -- this

initial meeting we really just covered the brief history of it, what the vision and charge was for this group. We kind of met everybody. They did briefly go over the evaluation process and timeline, but I don't have, we haven't got the notes back yet, but I will get you connected with Kathy.

MS. TYNER-WILSON: Okay. All right. That's great.

Because I'm also, this has nothing to do with this group, but the Autism Cares Act is up for reauthorization, and if it is not in compliance, it sunsets in September, so I didn't know if there was the same kind of urgency around the Olmsted Act. I'm guessing that there probably has been something put in place, in terms of when you have to have these things put together, you know, by a certain date, to make sure that they get all of their ducks in a row, so to speak, so I was just curious.

MR. CHRISTMAN: Thank you.

Waiting list is our next agenda item.

MS. SMITH: Okay, so for SCL, currently there are 3,525 people on the waiting list; no emergency category; 67 in the urgent; 3,458 in future planning; HCB, there's 2,035 individuals on the waitlist; and Michelle P., there's 9,125.

And I have a question for this group, or kind of something for this group to see if that's something you all want to take on. Michelle P., so that waitlist continues to grow, however, since 2018, we have been continuously advocating slots, and we have yet to reach even the 10,500 number, or even close to that number. Each time we allocate slots, about 50 percent of those end up not being used -- the person doesn't want it, they are getting services on another waiver, they're happy, they don't know what they signed up for, we can't find them despite -- and I think we have detectives that work on this, honestly, we try anything we can to find these individuals,

but what -- to me, it is very curious that that waitlist continues to grow yet we can't seem to actually get people into services, and it's not because, you know, they get approved and we are waiting on services starting, it's them actually completing the Medicaid process, you know finishing the Medicaid eligibility process, or just completing the -- getting to an assessment. And we even have the CHMCs even get a list of the individuals when we allocate now, and we are not even waiting, necessarily, for the individual to reach out and request an assessment. They are reaching out, you know, to schedule those assessments. So it just seems, it's kind of a mystery that the waitlist continues to grow at the rate that it does, but we don't seem to be getting, you know, that we have a 50 percent -- almost a 50 percent rate of slots going back in to be reallocated each time, so.

MR. CHRISTMAN: And did you say that people are on the waiting list that

have not yet been assessed, or did I get that wrong?

MS. SMITH: The people on the waitlist have not had an assessment.

MS. TYNER-WILSON: Oh, really? How can you? I thought you had to have --

MS. SMITH: No. To go on the waitlist, you have to say, you have to say I have an ID -- for Michelle P. -- I have an ID or a DD, and that's all. It's really more of an interest list than a waitlist, because there are individuals who do not qualify after they get a slot allocated but -- and before, before we had the application process through MWMA, they only had to just fill out a form and just say, I want to be on the waitlist, and I think that we have finally gone through all of those, the timeframe that that was happening and, I think, we finally have gone through all of those individuals, but, you know, my favorite example of an application we got, was the diagnosis was "toothless and skinny," but they wanted to -- they filled out a form and they

wanted to be on the Michelle P. waitlist. So at the beginning, that is why created this list. We had providers that were going out and saying, sign up and fill out this form, and people had no idea what they were even signing up for.

MR. CHRISTMAN: Is there a reason why we don't assess people before they go on the waiting list? Is it really too big of a job or --

MS. SMITH: It was not the process. We are evaluating Waitlist, we may look at how we want to change that. For example, for SCL, there is much more information before you go on that list that you have to provide.

For brain injury, when we have brain injury, when we, you know, we don't currently have a brain injury waitlist, but that is similar to SCL, and there is much more information that has to be provided.

HCB is similar to Michelle P. You just have to be at least 65 or over or have a physical disability. Now again,

like I said, these really are interest lists, because they are not necessarily -- you don't know that everybody on that list is really waiting for services, because they may not qualify for services.

MR. CHRISTMAN: Yeah, and that is really misleading; isn't it?

MS. SMITH: It is misleading, yes. So I think as we continue to work through the assessment that we have to do as part of House Bill 6, that was in, you know, that was in part of the actions that we have to take, we'll be looking, we'll be looking at that, and there are several things that we have to report back, as well as just, in general, we have a work group, that is working on -- working on Waitlist. And we've talked to several other states that have eliminated their waitlist, or that have done other things, so we are looking at that as well, but again, I will say when you look at HCB and Michelle P., it is more of an interest list. It is somebody who said: Hey, I have this diagnosis and I would like

services. It doesn't mean they even know what services they want to get, so.

MR. CHRISTMAN: Right. Right. That's interesting.

Amy, you had your hand raised.

MS. STAED: Yeah, thank you.

Just anecdotally, Pam, something that we have seen. Obviously, some of these individuals who are on the Michelle P. waitlist, are currently getting services through the HCB waiver, which does, you know, allow them to have a paid caregiver of some sort, et cetera, and that's wonderful, and that's really helping a lot of families, and I think some of this may be a little bit of an educational piece, at least, some of these individuals, or families of individuals, may not realize the range of services that an individual will likely have access to on the Michelle P. waiver, if they so qualify, you know, behavioral supports, et cetera. Another thing that we have anecdotally seen in some instances, and again, this is not an across-the-board

characterization at all, but we've seen a reluctance of some paid caregivers to approve additional services that may reduce their paid hours. Thereby, you know, a reluctance to engage in additional kinds of support, other than caregiving service, so that might be something else going on that's definitely related to that.

MS. SMITH: And, I will also say, that these individuals have access to state plan services, and for the most part what we see, is they don't access the state plan services, they don't access the -- even when they are on Michelle P. and have access to behavior services, they do not access those services, and so the services that they are getting in HCB, are really the exact same services that they are going to access on Michelle P., so it's very interesting, looking at -- and we are doing a lot of, you know, looking right now, at the service utilization, and what services outside of the waiver, because there's a lot of state plan

behavioral health services that some of these -- especially the children with the EPSDT benefit, there's even more, you know, it's even more open for them, for things that are medically necessary, for them, as well as the adults, but we are not seeing as much utilization in the children population.

MS. STAED: Again, I just would caution us to think critically, kind of, about that utilization, because, again, there is that push and pull of reducing caregiving services when we engage with those other things, and sometimes that comes into play.

MS. SMITH: But if you do it through state plan, if you access it through state plan, it does not affect the waiver hours at all.

MS. STAED: Sure. Absolutely.

MS. TYNER-WILSON: One of the things -- this is Melanie again -- one of the things that I found when I was trying to, when I used to work in developmental peds, in terms of trying to access EPSDT

services like home health agencies, I could get -- oftentimes I couldn't get the whole -- I could get, maybe, OT or PT, but I couldn't get speech for the individual, or behavioral therapy services, so sometimes that might have made -- influence decisions that were being made for individuals who were seeking a very specific type of service.

MR. CHRISTMAN: Thank you.

Let's see, Johnny, did you have your hand raised, also?

MR. CALLEBS: Yeah, thank you, Rick.

A couple questions, Pam, about the waitlist. So HCB, 2,035 people are on the HCB waiver waitlist. Will, I guess, will those be allocated at the start of the fiscal year?

MS. SMITH: We actually, we have slots now, and we were allocating, like, we can't allocate them all at one time because then that just creates a separate problem. We have people just waiting to get their assessment, waiting to find

their provider, so we allocate slots every week for HCB. I don't know -- we already do have the slots for 7/1, so for start of fiscal year '25, we have the slots have already approved by CMS, so they will already be there beginning July 1, but we can't jump them all in at one time because that creates a separate problem because the providers can't keep up with it.

MR. CALLEBS: Okay. How many per week -- do you have an average or something you shoot for to allocate per week HCB, or?

MS. SMITH: I think they allocate about between 50 and 75, I think, I'll have to check on that for sure.

MR. CALLEBS: Okay. And then, is there a projected date that the HCB waitlist would be eliminated with this periodic --

MS. SMITH: No, because we are -- we add -- at the rate that we add to that waitlist, let's see, we were getting 250 slots and we have -- we don't have enough right now with the slots that

we received, plus what we have available to wipe out the waitlist, so there would still be a waiting list even after we allocate all of the slots.

MR. CALLEBS: Okay, thank you. And then a question about the SCL waitlist. So 67 -- I think you said 67 people are in the urgent category for SCL, so with this newly-funded slots, will people in the urgent category --

MS. SMITH: Will they be allocated?

MR. CALLEBS: Right.

MS. SMITH: We are talking through that, and we are working through that. They've done an excellent job with everybody who was on that urgent list in kind of cleaning up that category.

MR. CALLEBS: Okay.

MS. SMITH: But we are -- we have -- and I don't remember exactly when it is scheduled, but we are meeting with them soon to talk through how many slots we have now with what's coming in July, plus what we have gotten in the previous

budget year that is now approved in the waiver, so we are looking at that to see what the best plan is. Something else that we did with SCL, is we moved -- Money Follows the Person -- we are moving a few slots, I think, we decided five slots, maybe, that we are going to reserve for transitions using Money Follows the Person. That had moved out. It had been done exclusively in the waiver, which was problematic for someone -- because there are transition dollars, but if you are not on the waiver, and you need help getting back into the community, you can't access those. So we have reinstituted transitioning, using Money Follows the Person for individuals going to SCL, so we will reserve a few of those slots. Like I said, 5, 10, at the max, that we have reserved for transition for Follow the Person.

MR. CALLEBS: Okay, so all of the new slots plus what you have already, will, potentially, be used or be allocated to folks in the urgent category and not

held in reserve for emergencies only?

MS. SMITH: We still will have to hold some in reserve for emergencies, but if not, what can happen, is we will have people in dire need of services that don't have a spot, so there will be some slots that will be held in reserve for emergency, we just haven't looked at what that number needs to be. There's a lot of analysis that goes into that. We looked at how close did we get each year, at the end of the waiver year to having a waitlist? What is the trend rate of how many emergencies that we were getting that get approved each year, so we want to -- it's a very fine balancing act. We don't want people waiting when we have slots, but we do want to have a reserve amount of slots for those individuals who truly, something catastrophic happens and they need, you know, they need services immediately, and we want to be able to meet those needs as well.

MR. CALLEBS: Sure. Thank you for the clarification. I just wanted

to -- I know in many previous years, just like, all slots were held for emergencies because it took all of them to.

MS. SMITH: Right.

MR. CALLEBS: -- handle that.

MS. SMITH: Right. But now we've been given more of a buffer.

MR. CALLEBS: Okay.

MS. SMITH: Because we were running right up to -- at the end of the waiver year we were very close. We managed to still not have a waitlist, but we were, you know, very close a couple times, but now we have a little more -- we do have a little more of a buffer with the slots that we have been given, so.

MR. CALLEBS: Okay. And one last question. We were on a call yesterday about the waitlist recommendations and concerns, and it was a little unclear about whether or not DMS is allocating vacant slots upon their vacancy --

MS. SMITH: We allocate --

MR. CALLEBS: -- or waiting on a

plan from CMS or waiting on approval, or is that actively underway?

MS. SMITH: We allocate immediately upon when individuals vacate a slot due to death. That's been in process now for over six months that we have been doing that. We are not reallocating immediately, because for the others slots, and we talked to CMS about this, we have so many that come back to their slots.

MR. CALLEBS: Sure.

MS. SMITH: That, if we do that, we will have people that had been getting services, like maybe they fell and broke their leg -- something happened and they were out of service for 60 days, and they -- if we give away that slot and then they come back and they need those services, and then we don't have that slot to get back to them. So we have not moved to do that yet, because we have had so many situations where we give the slot back to the individual that vacated the slot. But we have been, for individuals where the reason is death, we have been

reallocating those immediately, and that has been going on for over six months, now.

MR. CALLEBS: Okay. Thanks for clarifying. I thought that was the case, but there was some confusion about it yesterday on the call. So thank you.

MR. CHRISTMAN: Okay, I'm sorry, go ahead.

MS. STAED: I just want -- may I ask a question about the vacating of slots, Pam?

MS. SMITH: Yes.

MS. STAED: Would it be possible, and obviously, I know that this is not the norm at all, but would it be possible to create a voluntary relinquishment form, if someone does just choose to leave the waiver, would it be possible to create a form that they can sign saying: I'm leaving and not coming back. So we can reallocate that slot.

MS. SMITH: I think that's something that we can -- I can take that to the group that's looking at waitlists,

because we can bundle that kind of research and see if any other states do that with that research.

MS. STAED: Thanks.

MR. CHRISTMAN: I just want to comment. I think you all have done a very good job of keeping that emergency list to zero for the longest time, and I just so I understand, how many slots do you reserve, then, at, I guess, the beginning of the fiscal year for emergencies? Would there be a certain number?

MS. SMITH: Previously what has been done, is any open slots are reserved for emergencies. But again, that was before we, kind of, had an influx of slots so it looked like -- usually it was between about 100 or maybe 125 slots that we would have, and so that would have to last, you know, the entire year for any emergencies, and that includes kids who are aging out that had maybe been in DCBS custody, they're aging out and transitioning into SCL residential, so that is what we are trying to figure out

right now, what that number -- based on historic allocations, what that number needs to look like, and when we can go ahead and allocate.

MR. CHRISTMAN: For the purpose of keeping both the urgent and emergency to zero.

MS. SMITH: Let me -- and we are looking at, do we even still have -- because there's really, honestly there's no difference between -- I know in the regulation there's different criteria between urgent and future planning, as far as how soon services are needed. However, most of the individuals that are in the urgent category are receiving services in another waiver, and don't want SCL right now, and they don't want residential right now. And anybody, regardless of whether you are on the waitlist right now, you are in the urgent category or you are in the future planning category, you go through the same process request emergency funding. So we are also looking at that, too. There's people -- there are people

that have been on the urgent list for several years, and again, they are receiving services, they are happy, they don't want services right now for SCL, they want to continue receiving the services that they are receiving and their needs are being met.

So it's a little bit misleading when you think about the categories, so we are looking at that, too, when we look at the waitlist, and also looking at for Michelle P. and HCB, looking at an emergency process. So if something happens and you have somebody who is further down on the waitlist that has an emergent need, looking for a process -- so again, this goes to consistency, right, and how we manage things across waivers, so if there is an emergency need for somebody, regardless of where they are on the waitlist, that they have a mechanism or they have a path to go to be able to get to those services, versus somebody who may be having all of their needs are being met right now.

MR. CHRISTMAN: So the more you think about it, there may not actually be a need to eliminate the urgent list.

MS. SMITH: I don't know -- well, we are going to look at -- we still have to talk. We are going to look at the individuals who are on that list, but there may not be truly an urgent list anymore, if that makes sense. It's really just a waitlist so, you know, there is a lot of work that's going into looking at it, and we are doing this very carefully and very thoughtfully, because we do not want to cause anyone to not, you know, be able to get services that are going to need them, but we also don't want to have funding that we are not using, so we were putting a lot of work into this, and very thoughtfully considering how we -- how we move forward with this, but we want to serve the maximum amount of people that we can serve. And we also -- this goes into our provider capacity too, and how do we grow our providers, and who has the capacity to serve individuals. We don't

want to, you know, allocate a bunch of slots and then have people not have anybody that can serve them, so it's really taking a holistic view of everything, and how do we do this in the most efficient manner, but also the way that ensures the individuals get services.

MR. CHRISTMAN: Well, very good. Are there any other comments or issues?

I have one. I am -- and I have discussed this with Amy, but I am going to leave this TAC, and Amy, I think, has someone to take my place who would represent CAP in the nonprofit category. That would still leave this group having to elect or choose a chair. So how would we like to go about that?

MS. BICKERS: Rick, we will probably need to wait till your replacement is there, so we have a full TAC, and then on that agenda we can put it on the agenda under new business. Someone can nominate themselves or another member and then vote on it in the next meeting.

MR. CHRISTMAN: That would

probably be the first order of business, then, I suppose.

MS. BICKERS: Yes.

MR. CHRISTMAN: Particularly, if I don't attend the next meeting.

MS. BICKERS: I can always call the meeting to order and that.

MR. CHRISTMAN: Okay. All right.

And, of course, anyone who wants to have this job, they are also obligated to participate in the MAC meetings, too, and give a report. So keep that in mind.

Anyway, I would like to thank both Pam and Erin, you have been really great to work with, and just thank you.

So if there is no other business, our meeting is adjourned.

MS. BICKERS: Thank you.

(Meeting adjourned.)

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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 13th of June, 2024

/s/ Stefanie Sweet

Stefanie Sweet, CVR, RCP-M