

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

Via Videoconference
June 2, 2026
Commencing at 10 a.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

BOARD MEMBERS:

Wayne Harvey, TAC Chair
Brad Schneider
Johnny Callebs
Corey Nett
Cheri Ellis-Reeves
Doug Hoyt
Melanie Tyner-Wilson
Ann Pierce

1 MS. DAVIS: Good morning, everyone.
2 This is Danni Davis with DMS. The time is
3 9:58. We're still working on clearing the
4 waiting room, as well as for some of the TAC
5 members to join, so let's just give it a
6 moment further.

7 All right. I do have 10 on the
8 clock, and I do see that Mr. Harvey is
9 finding his way here.

10 MR. HARVEY: Danni, I just got a
11 message from Doug. He said he's tied up
12 right now, but he'll log on in just a few
13 minutes. And Brad contacted me earlier and
14 said he's on vacation, and he'll join us if
15 he's able to have signals strong enough or
16 whatever. He may be popping in and out this
17 morning, so.

18 MS. DAVIS: Alrighty. Well, at the
19 moment, I have yourself, Melanie, as well as
20 Johnny Callebs. And Corey Nett is joining
21 now as well.

22 MS. ELLIS-REEVES: I'm on here.
23 Cheri Ellis-Reeves.

24 MS. DAVIS: Oh, there you go. My
25 apologies. Well, you do have quorum with

1 those who are present.

2 MR. HARVEY: Okay, great. We'll go
3 ahead and get started then and other people
4 that join in, you can just let us know as we
5 go.

6 We'll start with the approval of the
7 minutes from the previous meeting. Does any
8 of the committee members that's on the call
9 want to make the motion to get that started?

10 MS. ELLIS-REEVES: I motion.

11 MR. HARVEY: Okay. Thank you, Cheri.
12 Does anybody want to second that?

13 MS. TYNER-WILSON: Second.

14 MR. HARVEY: Thank you, Melanie. Any
15 discussion?

16 (No response)

17 MR. HARVEY: Okay. All committee
18 members in favor of approving the minutes,
19 say "aye."

20 (Aye)

21 MR. HARVEY: Any opposed?

22 (No response)

23 MR. HARVEY: Okay, Danni, let the
24 record reflect that the minutes were
25 approved from the previous meeting. And

1 we'll roll right into the old business.

2 The first thing up is general updates
3 of Medicaid's '26/'27 initiatives. Do we
4 know who's representing the cabinet this
5 morning, Danni?

6 MS. HANCOCK: I'm on.

7 MS. DAVIS: I do believe Carmen will
8 take this.

9 MS. HANCOCK: Yes. I'll take this.

10 MR. HARVEY: Okay. Hey, Carmen. I
11 didn't see you on my screen, so I didn't
12 know whether or not to call you out.

13 MS. HANCOCK: I'm here. Yes, sir.
14 Good morning.

15 MR. HARVEY: Good morning.

16 MS. HANCOCK: Good morning, everyone.
17 Carmen Hancock. I'm the division director
18 for Long-Term Services and Supports here
19 with Medicaid. And I wanted to use this
20 time to come back to the legislative
21 session. During our last TAC meeting, the
22 session hadn't closed. We didn't really
23 know what exactly was going to shake out
24 and, you know, be sort of our directives
25 going forward. So we do have that

1 information now. I wanted to speak to this
2 group specifically about some of the items
3 that impact our waiver populations in
4 particular. A lot of the impacts that we're
5 seeing are coming out of House Bill 2, so
6 I'm just going to go through some of the
7 highlights on those items.

8 So in the body of House Bill 2, we
9 have -- we were required to have a
10 provider's recommendation for waiver
11 services and a provider attestation of
12 primary diagnoses signed by a specific
13 provider, which was a narrow -- a much
14 narrower scope, sort of, than what we were
15 accustomed to previously. This was written
16 really to be effective immediately. So in
17 terms of immediate impacts for anyone who's
18 submitting a waiver application, at the time
19 of application, we are requiring now a
20 specific recommendation for waiver services
21 and a provider attestation to primary
22 diagnosis for anyone applying for any of our
23 waivers. And that provider definition was a
24 physician, a physician's assistant, an
25 advanced practice registered nurse, or a

1 licensed psychologist. And, of course,
2 there were KRS references to what those
3 meant, so again, a narrower scope than what
4 we had before.

5 In addition to the immediate
6 requirement for that provider attestation,
7 we were also directed to go back and
8 essentially revalidate everyone who's on an
9 existing waiting list to ensure that we have
10 that provider attestation on file signed by
11 the correct type of provider for anyone
12 who's on a waiver waiting list. We've been
13 given 12 months to complete that
14 revalidation for everyone on a waiting list.
15 And also in the body of the bill, again,
16 this is House Bill 2, Section 15, we have
17 been directed that if we are unable to
18 obtain that provider attestation with a
19 primary diagnosis signed by an appropriate
20 provider, then certain people should be
21 removed from the waiver waiting lists. So
22 this is a very short turnaround time.
23 Again, we have 12 months from when the
24 legislation passed, which was in April, to
25 complete this revalidation. So that's

1 something that we're working on. There will
2 be letters going out. We're working on the
3 communications right now, but there will be,
4 I would anticipate, a great deal of
5 communication on this topic in particular in
6 all of our meetings going forward. This is
7 -- we want to ensure that people remain on
8 the waiting lists who belong there, but we
9 also have to meet the legislative
10 requirements.

11 So another change by July 1st, 2026,
12 we have been directed to identify,
13 designate, and require the use of a
14 waiver-specific level of care assessment
15 tool for each waiver program. The level of
16 care assessment tools must be nationally
17 recognized, at a minimum, recommend the
18 frequency, duration, and intensity of
19 services needed by the individual, be age
20 appropriate relative to the population
21 served by the waiver program for which it is
22 designed, and there are some other items in
23 here that fleshed that out a bit. But
24 again, this one is an even shorter
25 turnaround time. We've been given to

1 July 1st, so another month, to essentially
2 research, identify, and begin the process of
3 implementation of new waiver level of care
4 assessment tools in each one of the waivers.
5 The reason for that is because of the
6 caveats that were placed into this bill.
7 The assessments that we currently use, aside
8 from SCL -- SCL uses this assessment, which
9 does sort of meet this criteria, but
10 typically functional assessments don't
11 necessarily at a minimum recommend
12 frequency, duration, and intensity of
13 services, and so on and so forth.

14 So we've had to do quite a lot of
15 research on existing nationally recognized
16 tools that meet all of these requirements as
17 specified by the legislator. So again, this
18 is a huge undertaking. This would be,
19 again, a change to the level of care
20 assessment tool in all of our waivers. We
21 have to have that decision made by July 1st,
22 so that's something that we're diligently
23 working on and trying to come to a consensus
24 and agreement so that we can start moving
25 forward with system changes, training,

1 identifying who the assessors are going to
2 be, and so on and so forth.

3 Okay. So let me -- all right.

4 Another update, this is still in Section 15
5 of House Bill 2. We've been instructed to
6 reserve capacity in each waiver program to
7 ensure the availability of waiver slots for
8 individuals determined to have an emergency
9 need status. We're supposed to have this
10 drafted in policy and essentially in action
11 no later than January 1st, 2027. This is
12 the change to every waiver, except for SCL,
13 which already has an emergency, you know,
14 allocation. So we will be looking to -- we
15 are in the midst of developing all of those
16 policies, procedures, plans, amendments.
17 How do we implement this? What does it look
18 like? So that's, again, another short
19 turnaround time that involves changes to all
20 of the waivers.

21 Those are sort of the highlights
22 here. There are some other requirements
23 with regard to presentations that we need to
24 make, and reporting that we're going to
25 prepare and that sort of thing, but that's

1 more internal processes that don't really --
2 you all won't see as participants, you know,
3 community members, advocates, that sort of
4 thing. It's just more internal processes.
5 So that's House Bill 2.

6 In the body of the budget bill, 500,
7 we were allocated new slots for Michelle P.,
8 SCL, and HCB. Michelle P. Waiver was 65
9 slots for 2027, and 45 for 2028. This would
10 be state fiscal year beginning July 1. SCL
11 has 90 for 2027, and 45 for 2028. And the
12 Home and Community-Based Waiver, HCB, 115
13 slots for 2027, and 45 for 2028. Of note
14 there, there was no specific additional
15 funding allocated for those slots, so given
16 the extensive shortfall for the Medicaid
17 budget that was funded by the legislator, we
18 are working very hard to determine how we're
19 going to implement and roll those slots out.

20 Just for general knowledge, just as
21 an indicator overall of the significant
22 impact that underfunding the Medicaid budget
23 has resulted in, we are currently estimating
24 that Medicaid has about a \$270 million
25 shortfall in state funds alone for fiscal

1 year 2027. Once we add in federal funding
2 and look at the entirety of that 2-year
3 budget bill, we have a shortfall anticipated
4 of about 1.2 billion -- that's a B --
5 1.2 billion for the next 2 years in either
6 unfunded or underfunded programs, or new
7 requirements and programs that have been
8 added that did not include any additional
9 funding to support them.

10 MR. HARVEY: Carmen, I noticed, Amy,
11 do you still have your hand up? I thought
12 I've seen it up. Were you wanting to ask a
13 question, or?

14 MS. STAED: I just wanted to note
15 that in the budget bill, the slots do
16 specifically contain both state and federal
17 appropriations to fund them.

18 MS. HANCOCK: Oh, I'm sorry, Amy.
19 You're right. I misspoke on that. You're
20 spot on.

21 MS. DAVIS: And there was also a
22 question in the chat, if QIDP were no longer
23 considered an appropriate provider type for
24 signing the MAP-10s? I think that was the
25 first --

1 MS. HANCOCK: That's exactly right.
2 The provider type who can sign a MAP-10 has
3 now been restricted to a physician, a
4 physician's assistant, an APRN, or a
5 licensed psychologist.

6 MR. HARVEY: Does anybody else have
7 any other questions before I let Carmen
8 continue. I didn't mean to jump in and
9 interrupt you, Carmen.

10 MS. HANCOCK: It's okay.

11 MR. HARVEY: I just seen -- when we
12 see a hand up, we try to grab it as we go.

13 MS. GRIBBINS: This is Myra Gribbins.
14 When does the MAP-10 change go in effect?

15 MS. HANCOCK: We put -- we
16 implemented that immediately.

17 MS. GRIBBINS: Is there a new form on
18 the website that we can get, or is it going
19 to be sent out?

20 MS. HANCOCK: That form --

21 MS. GRIBBINS: Because the current
22 one still has the qualified mental health or
23 an IDP can sign.

24 MS. HANCOCK: We will update the
25 form, Myra. There is talk of, you know,

1 developing an alternative form to the
2 MAP-10. Changes in forms like that just do
3 take some time, so it is something that
4 we're aware of in terms of, you know, the
5 content of the form right now doesn't
6 reflect the legislation that was just
7 enacted. So it will be updated and shared.

8 MS. GRIBBINS: So basically, as of
9 June 1st, case managers need to not be
10 signing off if they're an IDP --

11 MS. HANCOCK: That's correct.

12 MS. GRIBBINS: -- for Michelle P. or
13 SCL or any of those. Any of those, yeah.
14 We don't have to for SCL. Okay.

15 MS. HANCOCK: You don't have to for
16 SCL --

17 MS. GRIBBINS: Right.

18 MS. HANCOCK: -- but for Michelle P.
19 and HCB --

20 MS. GRIBBINS: Yes. And --

21 MS. HANCOCK: -- that's correct. And
22 the application reviewers are aware of that
23 change, so they've already been, you know,
24 doing LRIs -- pardon me, LOIs --

25 MS. GRIBBINS: Right. That was my

1 next question. Does Carewise know?

2 MS. HANCOCK: -- that sort of thing.

3 Yep. Yes.

4 MS. GRIBBINS: Okay. Thank you.

5 MS. STAED: Carmen, is this going to
6 all be articulated in a letter so that folks
7 have that guidance?

8 MS. HANCOCK: Yes. So we need to get
9 out a provider letter with regard to the
10 immediate changes to the provider
11 attestation. And then like I said, we're
12 developing the participant letter that would
13 be going out regarding the need for
14 revalidation of those --

15 MS. STAED: The 12-month.

16 MS. HANCOCK: -- provider
17 attestations.

18 MS. STAED: Yeah.

19 MS. HANCOCK: The 12-month. Yes.

20 MS. STAED: Okay. Awesome, thank
21 you.

22 MS. HANCOCK: Yes, ma'am.

23 MS. TYNER-WILSON: Carmen, this is
24 Melanie. Can you hear me?

25 MS. HANCOCK: Yes, ma'am.

1 MS. TYNER-WILSON: I have a question.
2 In regards to the psychologist, it would
3 have to be somebody -- even if they're a
4 Ph.D. school psychologist, the psychologist
5 would have to be functioning within a
6 medical setting; is that correct?

7 MS. HANCOCK: So the verbiage is a
8 licensed psychologist licensed under KRS
9 Chapter 319. So then what we need -- then
10 what we have to do is go to KRS Chapter 319
11 and, you know, determine what the intent was
12 there in the way that that chapter is
13 written. That particular one is
14 interesting. It's a little less -- the KRS
15 Chapter 319 is a little less straightforward
16 in what constitutes a licensed psychologist,
17 as opposed to, say, an APRN is a lot more
18 clear.

19 MS. TYNER-WILSON: Right.

20 MS. HANCOCK: So I don't know the
21 answer to that with regard to school
22 psychologists right off the top of my head.
23 No.

24 MS. TYNER-WILSON: Yeah. I know that
25 there is folks that have the advanced degree

1 that function within the school environment,
2 but just the way it sounds, like, it would
3 just -- they would need to have their role
4 within a medical community. That just seems
5 like that's -- that would be the likelihood
6 that they would be required to come from
7 that kind of environment.

8 MR. HARVEY: I see Corey with his
9 hand up. Go ahead, Corey.

10 MR. NETT: I'm a little confused
11 about why everyone needs to be evaluated
12 again. It sounds like they're trying to
13 narrow down the waiting list because they're
14 only giving them a year, and they only gave
15 us 405 slots for the next -- when the
16 waiting list is 17,000.

17 MS. HANCOCK: I certainly understand
18 that perspective, Corey. Yeah.

19 MR. NETT: It doesn't sound like it
20 was a good faith bill.

21 MS. HANCOCK: And we would -- this is
22 why we encourage you to keep in touch with
23 your representatives.

24 MR. NETT: Thank you.

25 MS. HANCOCK: Yeah.

1 MR. HARVEY: Do we have any other
2 questions or comments for Carmen on that
3 update real quick?

4 MS. DAVIS: There was another
5 question in the chat in regard to the
6 MAP-10. If it was still going to be
7 required annually since Michelle P. was
8 recently changed to being needed only on the
9 initial LOC.

10 MS. HANCOCK: So MAP-10s are required
11 annually at the time of your annual, you
12 know, level of care, plan of care paperwork
13 and all of that. Yes.

14 MS. COOMES: That was my question.
15 This is Cynthia Coomes. I have an email
16 from Karen Griffin, who retired but was at
17 DDID, saying that for Michelle P., they were
18 not required annually anymore, and we
19 haven't been getting them. We continue to
20 get them for level of care for ABI. They
21 don't seem to be required annually for HCB
22 because we only ever get one when we get a
23 new allocation. So I think that it would be
24 helpful as a provider if when the provider
25 letter is drafted, that it clarifies what is

1 needed for what waiver and when because we
2 all just -- you know, we want to do it
3 right.

4 MS. HANCOCK: Thank you, Cynthia.
5 That's really good feedback. We also
6 just -- as another piece of information, you
7 all are likely aware that we've been unable
8 to make a lot of updates to regulations or
9 our waiver applications in recent years
10 based on the public health emergency and
11 ARPA funding and that sort of thing. So now
12 that that has opened up, the sister agencies
13 together, so, you know, Medicaid, Department
14 for Behavioral Health, DDID, Department for
15 Aging and Independent Living, we've taken on
16 a project right now where we are working to
17 rewrite and clean up those inconsistencies
18 and confusing bits of the regulations. At
19 the same time, cleaning up the waiver
20 applications so that we actually have things
21 that match and make sense that are accurate.
22 So this is a good item for feedback that
23 we'll make sure that we look at and clarify,
24 Cynthia. Thank you.

25 MS. COOMES: Thank you.

1 MR. HARVEY: I see Frankie's hand up.
2 Go ahead, Frankie.

3 MR. HUFFMAN: Yes. I just have a
4 quick question about the MAP-10 because I'm
5 on the SCL, so I don't have the HCB or
6 Michelle P. So I don't think they call that
7 on SCL. I said that wrong, I'm sorry. I
8 don't think they call it that on SCL; is
9 that correct?

10 MS. HANCOCK: Frankie, you're exactly
11 right. The MAP-10 is not a requirement for
12 SCL. DBHDID looks for -- and I hope Crystal
13 or someone is on here to keep me honest.
14 They're looking for, like, a full-scale IQ,
15 a psychological, psychosocial evaluation,
16 those sorts of things with that same
17 provider defined signature. That's what
18 they would be using and consider that as the
19 "provider attestation."

20 MR. HUFFMAN: Okay. Can you kind of
21 explain, like, something that's similar on
22 the SCL to me that way I can understand
23 better what the MAP-10 is?

24 MS. HANCOCK: So let's see if I've
25 got --

1 MR. HUFFMAN: Does that make sense?

2 MS. HANCOCK: It does. So the MAP-10
3 is basically a statement from a provider, so
4 it's intended to be like a physician,
5 physician's assistant, those, you know,
6 provider types that we just sort of talked
7 through. And it basically is a statement
8 from a care provider that says that they
9 feel that their patient is in need of waiver
10 services, and we ask them to specify which
11 waivers. And they're essentially making a
12 statement that they feel that their patient
13 needs waiver services because without waiver
14 services they may be at risk for
15 institutionalization. And then they have to
16 verify which waivers they feel like would be
17 appropriate for their patient, and then they
18 have to provide us with the diagnoses, and
19 then we have to have a signature. So it's
20 really just sort of a statement from -- if
21 you think of it sort of like a physician
22 statement confirming diagnoses and then
23 stating that there is a need.

24 MR. HUFFMAN: Okay. That makes sense
25 now.

1 MS. HANCOCK: Okay.

2 MR. HUFFMAN: I just wanted to make
3 sure because, like I said, they don't call
4 it that on SCL. So that's why I asked you
5 to explain it again. Thank you.

6 MS. HANCOCK: You're welcome,
7 Frankie.

8 MR. HARVEY: Thank you, Frankie.
9 We're going to try and move this agenda
10 along because we've gotten stuck here on
11 this.

12 MS. HANCOCK: I'm sorry, Wayne.

13 MR. HARVEY: It's okay. Are you
14 handling the update on the other items for
15 CHFS, too?

16 (Ms. Hancock nods head "yes")

17 MR. HARVEY: Okay. Well, just
18 continue on down the agenda, please.

19 MS. HANCOCK: Okay. So for the CHILD
20 Waiver, we've got -- we received fifty-four
21 participant applications at this time.
22 Fifteen of those have been approved.
23 Twenty-six are in a review status or we've
24 requested additional information from them.
25 We have two people that are waiting on

1 assessments, and then we have a handful that
2 have either been denied or withdrawn. So
3 that's exciting. The CHILD Waiver has a
4 hundred slots. We just went live in
5 January. We've already gotten applications
6 from fifty-four people, so that's
7 tremendous.

8 In terms of providers, we've received
9 fifteen applications; ten of those have been
10 certified and have been moved on to the
11 enrollment process. A handful have already
12 become enrolled and are actively providing
13 services. We have two that are in review,
14 and we have four that have been denied for
15 the CHILD Waiver.

16 So that's what I've got for that,
17 Wayne. And I believe someone else is taking
18 the RISE enrollment process.

19 MR. HARVEY: Okay. Do we have
20 somebody on here to do the RISE update?

21 MS. DAVIS: I do not see the
22 individual that would be reporting on that,
23 so maybe if we move down the agenda, and
24 they may hop on later. I think that'd be a
25 good idea.

1 MR. HARVEY: I'm going to have to
2 move that RISE to the end. It seems like we
3 have a problem every meeting with their
4 update.

5 MS. DAVIS: All right. My apologies.

6 MR. HARVEY: Update regarding the
7 1915(c) Waiver waitlist.

8 MS. HANCOCK: So I'll just drop a
9 snip in the chat so that you all can
10 actually see the information. So currently,
11 there is no waiting list for ABI Acute, ABI
12 Long-Term Care, our Model II, or the CHILD
13 Waiver. The Home and Community-Based Waiver
14 has 7,960 people on the waiting list.
15 Michelle P. is at 9,776, and SCL is 3,883.
16 That comes out to a total unduplicated count
17 of 18,286 people on waiting lists. And like
18 I said, I'll just take a little snip of this
19 and drop it in the chat so you can refer
20 back to it.

21 MR. HARVEY: Okay, great. Great.

22 PDS update, do we have someone on
23 here to do that?

24 MS. MOUNTJOY: Hi. This is Marnie
25 Mountjoy at the Department for Aging and

1 Independent Living. So for the PDS program,
2 we have 64 agencies that are certified to
3 provide PDS services. There are 13 that are
4 in queue, and of those 13, 3 agencies are
5 being actively worked at this time.

6 MR. HARVEY: Do we have any questions
7 for Marnie on that -- those numbers?

8 (No response)

9 MR. HARVEY: Okay. Do we have
10 somebody on here to do the involuntary
11 termination update summary report?

12 MS. CLOSE: I am doing that today.
13 Elizabeth is off so she sent me the numbers
14 for that. So we have total number of
15 involuntary terminations in the last year
16 for all services was 60. Total number of
17 involuntary terminations in the last year
18 for residential specifically was 45. Of the
19 total involuntary terminations in the last 6
20 months for all services was 31. Total
21 number of involuntary terminations in the
22 last 6 months, specifically for residential,
23 was 22. Total number of involuntary
24 terminations in the last month was 9. Total
25 number of involuntary terminations in the

1 last month for residential-only was 5.
2 Involuntary terminations that transitioned
3 in the last year for all services was 24.
4 And involuntary terminations not
5 transitioned in the last year specifically
6 for residential was 17.

7 MR. HARVEY: Okay. Any questions for
8 Blair on the summary report on terminations?
9 (Ms. Tyner-Wilson speaks while muted)

10 MR. HARVEY: I don't see any.

11 Okay. Let's move on to new business
12 then. We did have --

13 MS. TYNER-WILSON: Wayne, I'm sorry.
14 I had my mute on. Can I ask a question real
15 quick?

16 MR. HARVEY: Sure. Go ahead,
17 Melanie.

18 MS. TYNER-WILSON: Sure. For Blair,
19 last meeting, I think we had a discussion
20 about trying to get the breakout on the
21 involuntary terminations based on their
22 medical diagnosis. Is that something that
23 we can get in the future?

24 MS. CLOSE: Yes. I believe that
25 breakdown was sent at least to DMS. Did you

1 guys receive that initial breakdown and
2 you're wanting it again, or you haven't
3 received the initial breakdown?

4 MS. TYNER-WILSON: Well, it'd be
5 helpful to have as the -- if the voluntary
6 termination summary report is a part of each
7 meeting, if we could have that information
8 added to the summary report.

9 MS. CLOSE: Okay.

10 MS. ADAMS: Wayne, I believe
11 previously that that was discussed and
12 decided not to be included as part of that
13 monthly what was provided. So is that
14 something that needs to come back to your
15 all's committee to vote on whether that you
16 all would like to have that added, or?

17 MR. HARVEY: Yeah. I think anything
18 that we add as a requirement, Melanie, is
19 going to have to be something that's passed
20 through the committee. It can't be
21 something that just a single member asks
22 for. So I think Crystal's absolutely
23 correct in that, that it's going to be
24 something that, you know, we have to take up
25 as committee members when we get to that

1 part of the meeting and determine whether or
2 not we want to add that to the termination
3 summary report, and that be something that's
4 requested through the MAC and makes its way
5 to DMS and the cabinet staff and so forth to
6 have that added to the summary report.

7 Because when we initially got the
8 summary report to become a report that
9 occurs at every meeting, that was something
10 that was done through the process of making
11 a motion and approving the motion and
12 everybody voting and saying "yes" and
13 agreeing on the things that they report on.
14 And it's kind of unfair to the cabinet
15 personnel that are required to, you know,
16 look after this information for each TAC
17 meeting to just arbitrarily add requirements
18 to them as they go and it not be something
19 that's approved through the committee. So
20 --

21 MS. TYNER-WILSON: So to present it,
22 what committee would I present it to for
23 consideration?

24 MR. HARVEY: We can talk about it
25 during this committee --

1 MS. TYNER-WILSON: Okay.

2 MR. HARVEY: -- later on. When we
3 get to the point where I ask if there's any
4 recommendations and so forth, if you want to
5 make a formal recommendation of that --

6 MS. TYNER-WILSON: Okay.

7 MR. HARVEY: -- then please be
8 thinking about what you want that
9 recommendation to be --

10 MS. TYNER-WILSON: Okay.

11 MR. HARVEY: -- as we go throughout
12 this meeting and everything, and present
13 that at that point in time when I ask for --
14 you know, ask the floor basically if there's
15 any recommendations at this point in time.

16 MS. TYNER-WILSON: Okay.

17 MR. HARVEY: Okay?

18 MS. TYNER-WILSON: All right. Thank
19 you.

20 MR. HARVEY: Any other questions for
21 Blair, please? Any members or anything?

22 (No response)

23 MR. HARVEY: Okay. Thank you, Blair.

24 Let's move on to new business, and
25 we've got presentation on adult foster care

1 and family home provider certification
2 process to ensure safety. This has been
3 moved. Melanie, this was the presentation
4 you asked for --

5 MS. TYNER-WILSON: Yeah.

6 MR. HARVEY: -- and we've moved this
7 to the August meeting just because of staff
8 availability to do this presentation from
9 the cabinet side. We had a pre-meeting, I
10 did, with the cabinet staff on the agenda
11 items and so forth, and this was something
12 that we decided during that to move it to
13 the August meeting, because we've still got
14 quite a few things to get through for this
15 meeting.

16 So the next thing, there is the
17 additional clarification on 40-hour limits
18 for HCB and LRIs. Carmen, are you going to
19 address that?

20 MS. HANCOCK: I --

21 MS. STAED: Wayne, would it also be
22 helpful if I -- I know that you had a
23 conversation with Carmen -- just introduce
24 the specific point of clarification?

25 MR. HARVEY: Sure. Go ahead.

1 MS. STAED: Carmen, is that okay with
2 you?

3 MS. HANCOCK: Sure I -- Amy, I have a
4 presentation prepared that sort of goes
5 through --

6 MS. STAED: Perfect.

7 MS. HANCOCK: -- what an LRI is, what
8 the CMS expectations are --

9 MS. STAED: Okay. Yeah.

10 MS. HANCOCK: -- to sort of give some
11 context and lay some -- maybe provide some
12 additional clarification.

13 MS. STAED: Sure. And I can just
14 tell you very specifically --

15 MS. HANCOCK: Yeah.

16 MS. STAED: -- I think the point of
17 clarification that we were looking for when
18 we asked for this agenda item, so you can
19 think about that maybe as you're going
20 through your presentation, which I very much
21 appreciate you putting together, is the 5/12
22 letter that went out, which is the most
23 recent communication. It was a letter of
24 clarification very specifically stated that
25 a PDS worker, which can include an LRI --

1 not all PDS workers are LRIs -- may only
2 work 40 hours if one of the participants
3 that they serve is enrolled in the Home and
4 Community-Based Waiver. And I think the
5 point of clarification that is needed is
6 that can on a non-LRI PDS worker -- so just
7 a PDS worker that does not support someone
8 that they are related to or an LRI for. Can
9 they exceed 40 hours if the people they
10 serve are only enrolled in Michelle P., SCL,
11 ABI, and not enrolled in HCB. I think the
12 confusion with that 5/12 letter related to
13 that language of if one of the individuals
14 is enrolled in the HCB Waiver. And I'll
15 shut up now. Thank you.

16 MS. HANCOCK: So I'm hoping that
17 you'll get that clarity from this because
18 we're going to dig into exactly what's in
19 our waiver applications and why it is
20 slightly different between HCB and the other
21 waivers.

22 Okay. So I'm going to -- I'd like to
23 share my screen, which means I'll -- Danni,
24 you may have to give me the ability to
25 share.

1 MS. DAVIS: Yes, that should be
2 green. Go ahead and give it a try.

3 MS. HANCOCK: Okay.

4 MR. HARVEY: And Corey, I see you.
5 As soon as she gets through with this part
6 of the update, I'll get to you, okay?

7 (Mr. Nett nods head "yes")

8 MS. HANCOCK: Let's try again. There
9 we go. Okay. Can you all see that?

10 MS. DAVIS: Yeah.

11 MS. HANCOCK: An introduction? Okay.
12 Fantastic. Okay. So like you pointed out,
13 Amy, a lot of this conversation does center
14 around that legally responsible individual,
15 or LRI, as participant-directed services
16 employees. So we did prepare a presentation
17 to sort of, again, give a little bit more
18 background, context, definitions, and then
19 kind of look at expectations and what we
20 actually have currently in our waiver
21 applications and regulations. So we're
22 going to go just briefly through these
23 items: What is participant-directed
24 services? Who is a legally responsible
25 individual? How do LRIs -- what are the

1 expectations as PDS employees? Defining
2 extraordinary care. Quick look at the LRI
3 review criteria and process. And then a
4 look at our waivers.

5 So I feel fairly confident that most
6 people on this call know what
7 participant-directed services is, but in the
8 event that we have some folks that aren't --
9 that don't have that information, PDS or
10 participant-directed services is a service
11 delivery option. It's available in five of
12 our seven home and community-based waivers,
13 and those waivers are listed there in that
14 second bullet. Obviously, the intent with
15 PDS is to increase participant choice,
16 flexibility, and control over their supports
17 and services by allowing the participant
18 themselves to find and hire individual
19 employees to provide that non-medical,
20 non-residential waiver-type services. So
21 again, in this scenario, the participant or
22 their representative takes on the role of an
23 employer. So they, you know, find their
24 employees, hire them, ensure that they, you
25 know, have appropriate training, and that

1 sort of thing.

2 So PDS is delivered following a
3 written person-centered plan of care just
4 like any other waiver services. That
5 person-centered service plan is going to
6 detail the services that are being provided,
7 the amount, the frequency, the duration.
8 These would be based on the assessed needs
9 of the participants as well as their
10 preferences, their goals, and other supports
11 that they might have in place. So a very
12 brief summary of PDS.

13 So who can provide PDS? So
14 participant-directed services can be
15 provided by -- we have a list here; those
16 are suggestions. The answer is anyone.
17 Anyone who the participant or their
18 representative selects to be an employee,
19 but this would be friends, neighbors, family
20 members. Participants are welcome to
21 advertise, you know, on radio, in newspaper,
22 online, word-of-mouth. It might be someone
23 that you find through your, you know, faith
24 community, or at the gym, or, you know,
25 whatever. It is the participant or the

1 representative's choice on how to pursue
2 gaining these employees. Employees have to
3 be at least 18 years old. They do have to
4 submit to a background check just like a
5 traditional employee would.

6 So through a home and community-based
7 waiver, a state can elect, so we can choose
8 to make payments for personal care or
9 similar services that are rendered by
10 legally responsible individuals, or LRIs.
11 So to simplify this statement, a state can
12 choose to allow LRIs to provide certain
13 types of services in the event that they're
14 deemed extraordinary care. So when a state
15 provides payment to an LRI for extraordinary
16 care, we have to meet all of the waiver
17 criteria, or that provider, the PDS
18 employee, still has to meet certain criteria
19 that are laid out in our waiver application.

20 So definition for a legally
21 responsible individual, a legally
22 responsible individual quite simply is
23 defined as any person who has a duty under
24 state law to care for another person. This
25 looks different for minors and adults. So

1 for those under 18, this would be considered
2 a stepparent, a parent, an adoptive parent,
3 or a guardian. Again, there's your KRS
4 definition there that this would be a
5 guardian who has been identified, an
6 individual, an agency who's been appointed
7 by the court to have care, custody, and
8 control of a minor. For adults, an LRI
9 would be considered a spouse or a guardian,
10 very similar, a person appointed by the
11 court to make decisions regarding an adult.
12 So again, a duty under state law to care for
13 another person.

14 There is a caveat down there. This
15 has come up a few times recently. So just
16 for this group, for your knowledge, while a
17 foster parent is considered an LRI, foster
18 parents cannot be paid as PDS employees
19 because they're already receiving a payment
20 from the state for the provision of foster
21 care services.

22 Okay. So having LRIs as PDS
23 employees, those payments -- so payments for
24 services rendered, are intended when the LRI
25 is the most appropriate person to deliver

1 those waiver services, when the services
2 delivered are above and beyond what is
3 typically provided to someone of the same
4 age, and when those services are provided as
5 outlined in their person-centered service
6 plan. Having an LRI as a PDS employee,
7 those payments for services are not intended
8 to be as financial assistance or as a means
9 of income. Again, PDS employees are getting
10 paid to provide a certain set of services as
11 described on a person-centered service plan.
12 They are not intended to be a financial
13 assistance or a means of income. Payment is
14 also not intended to be provided when the
15 services that an LRI is providing that they
16 are already legally obligated to provide.
17 So again, going back to the concept of
18 extraordinary care, which we're going to get
19 into next.

20 These are CMS definitions of
21 extraordinary care. They come straight out
22 of the 1915(c) Technical Guide. So what is
23 extraordinary care? Through an HCBS, so
24 through a home and community-based services
25 waiver, a state may elect to make payment

1 for personal care or similar services that
2 are rendered by legally responsible
3 individuals when such services are deemed
4 extraordinary care so long as the state
5 specify satisfactory criteria for
6 authorizing such payments. By
7 extraordinary, CMS means care exceeding the
8 range of activities that a legally
9 responsible individual would ordinarily
10 perform in the household on behalf of a
11 person without a disability or chronic
12 illness of the same age and which are
13 necessary to assure the health and welfare
14 of the participant and avoid
15 institutionalization.

16 I'm going to go back one slide and
17 address the last sentence of the first
18 paragraph there. So long as the state
19 specify satisfactory criteria for
20 authorizing such payments. So just for
21 information, not all states allow LRIs to be
22 PDS employees. States have the option to do
23 that. Kentucky has selected, you know, has
24 made the choice to allow legally responsible
25 individuals to also be PDS employees. In

1 doing so, we have to specify satisfactory
2 criteria, and we have to meet certain
3 requirements. These are the types of things
4 -- this is straight out of that same
5 technical guide. When a waiver provides for
6 the payment of personal care or similar
7 services to legally responsible individuals
8 for extraordinary care, we have to specify
9 in the waiver how our state is going to
10 essentially prove that this was the best
11 option for the participant and the care
12 that's being provided is extraordinary in
13 nature. So we have to be very clear with
14 the types of LRIs who can be PDS employees,
15 the specific services that can be provided
16 by an LRI, the method the state is going to
17 use to verify that the care that's being
18 provided is considered extraordinary care
19 that exceeds the ordinary care that would be
20 provided to a person without a disability of
21 the same age. We have to set limits on the
22 services that an LRI can provide, and then
23 we have to establish other provisions which
24 I'm going to sort of get into on the next
25 couple of slides.

1 Okay. So these are the extraordinary
2 care LRI review criteria that we have
3 established in our state. So when an LRI
4 wants to be a PDS employee, they actually
5 have to, you know, submit that through the
6 plan of care process, and this is the
7 criteria that we look at to determine
8 whether that person gets approved to provide
9 those services or not. So for minors, we
10 have to have -- we have to meet one in
11 category A and category B. So the child's
12 needs have reduced or eliminated the legally
13 responsible individual's ability to retain
14 paid employment for the last 12 months or
15 longer, and there is not an alternative
16 caregiver who's functionally able to provide
17 care. The LRI can demonstrate attempts
18 within the first 30 days to recruit a
19 qualified provider but cannot find one. And
20 then the minor child has a communication
21 barrier exceeding that of his or her
22 age-matched peers. So we've got to have one
23 from category A, and one from category B.
24 The child's dependency in performing
25 activities of daily living must be directly

1 related to his or her disability and exceeds
2 that of his or her age-matched peers. Or
3 we've got those destructive injurious
4 behaviors that, again, exceed that of their
5 age-matched peers and present a risk of
6 serious injury or death to others.

7 For adults, if we have a legally
8 responsible individual who wants to be a PDS
9 employee for an adult, we only have to meet
10 one of these criteria. They're similar to
11 the criteria A from the child slide, but
12 again, there's a scenario that has made it
13 -- reduced or eliminated the LRI's ability
14 to maintain employment. The LRI has to have
15 demonstrated efforts to find a qualified
16 provider, but they cannot find one. Or
17 there's a communication barrier that impacts
18 the participant's ability to effectively
19 communicate needs and wishes.

20 So these are the criteria that we're
21 looking at as we're doing those reviews to
22 either approve using an LRI as a PDS
23 employee or not. The request is submitted
24 via MWMA. This usually happens, you know,
25 during the course of the plan of care. It's

1 submitted by the case manager. The
2 participant and/or the representative have
3 to sign an attestation that affirms the
4 answers they've submitted are accurate, and
5 then, of course, there's additional
6 documentation that might be requested. So
7 that's sort of the process there. It goes
8 through MWMA. They can be approved, and
9 that approval will go back to the case
10 manager. There might be a lack of
11 information, so we can ask for more
12 information if we don't have enough to make
13 the correct determination, or there could be
14 a denial.

15 If there is a denial of an LRI as a
16 PDS employee, a letter will be sent
17 regarding that decision. The participant
18 can request a reconsideration. There is
19 currently in combination with DAIL, the
20 Department for Aging Independent Living, and
21 Medicaid, we look at those reconsideration
22 requests. If the reconsideration is not
23 acceptable to the participant or the
24 representative, they can request an appeal,
25 and the letter does contain the information

1 on how to request an appeal.

2 Okay. I know there's a lot of words
3 on these slides, but we're almost at the
4 end, I promise. Okay. So Michelle P. and
5 SCL waivers have essentially the same
6 language in the body of the waiver
7 application that targets legally responsible
8 individuals. Again, this is a person who
9 has a duty under state law to care for
10 another person, and except at the option of
11 the state and under extraordinary
12 circumstances specified by the state --
13 which we went through in those LRI review
14 criteria; those are the criteria we have
15 established -- payment may not be made to a
16 legally responsible individual for the
17 provision of personal care or similar
18 services that the legally responsible
19 individual would ordinarily perform or be
20 responsible to perform on behalf of the
21 waiver participant. So this harkens back to
22 that extraordinary care definition. If an
23 LRI would ordinarily be expected to perform
24 certain duties and have a legally -- a legal
25 responsibility, let's say to a minor child,

1 to ensure that they're fed, clothed, they
2 get to school, they're going to doctor's
3 appointments, those are things that an LRI
4 is already legally obligated to do as a
5 parent or a legally responsible individual
6 for a minor child. So again, we're not
7 allowed to pay for services that would
8 ordinarily be performed by an LRI. They
9 have to be extraordinary care.

10 So I'm going to go down to the second
11 bullet there. So again, LRIs -- this PDS
12 option with an LRI is only available in
13 specified extraordinary circumstances
14 exceeding the range of activities that an
15 LRI would ordinarily provide on behalf of a
16 person without a disability of the same age,
17 and which are necessary to assure health and
18 welfare of the person and avoid
19 institutionalization. So this is the way
20 that Michelle P. and SCL are written. That
21 very last line, a legally responsible
22 individual may not be approved to provide
23 more than 40 hours per week of paid services
24 similar to other PDS employees.

25 Here's where things get -- this is

1 the impetus for that clarification letter
2 that you mentioned, Amy. The HCB Waiver
3 defines that first bullet very similarly to
4 the others. Again, that the option of the
5 state and under extraordinary circumstances
6 specified by the state, payment can be made
7 to an LRI for the provision of personal care
8 or similar services. I'm going to jump down
9 to that last bullet. Services provided by a
10 legally responsible individual should not
11 replace the care a participant's natural
12 supports are expected to provide. All PDS
13 employees, including LRIs, are limited to 40
14 hours per week of paid services inclusive of
15 all participants they serve. So the wording
16 in the HCB Waiver is slightly different,
17 which is what triggered that additional
18 clarification letter regarding HCB
19 participants and PDS specifically. It's
20 very clear in our HCB Waiver that all PDS
21 employees, including LRIs, are limited to 40
22 hours per week of paid services inclusive of
23 all participants that they serve.

24 And the ABI waivers, again, the
25 initial verbiage here is very similar.

1 Specified extraordinary circumstances
2 exceeding the range of activities that the
3 legally responsible individual would
4 ordinarily provide on behalf of the person
5 without a disability of the same age and so
6 forth. In ABI and ABI Long-Term Care, a
7 legally responsible individual may not be
8 approved to provide more than 40 hours per
9 week of paid services similar to other PDS
10 employees. So it's very similar to Michelle
11 P. and SCL.

12 That might be the last sort of
13 informational slide. Here are resources
14 that we pulled from to put together this
15 presentation. Obviously, we've got our FAQs
16 up there. The help desk is always
17 available. We have our PDS website, our
18 LTSS website. There's a link here to the
19 actual state Medicaid manual that guides
20 some of this information. And then the link
21 to the CMS Waiver Technical Guide that
22 really defines a lot of the terms that were
23 used.

24 So sort of in summary, I want to go
25 back to that conversation about 40 hours.

1 In general, right now, that 40 hours
2 inclusive of all participants, as you all
3 saw, is in HCB only. You will likely see
4 that language starting to be mirrored in the
5 other waivers that offer PDS services.
6 There is tremendous -- I'll just -- I'll end
7 this and stop sharing. Let's see if I can
8 -- if it will let me stop sharing. Okay. I
9 think I did it. There we go.

10 So there is, as you all have all
11 likely heard, a tremendous push at the
12 federal level to investigate and target
13 instances of fraud, waste, and abuse. At a
14 national level, the participant-directed
15 services programs in general are ones that
16 have been highly scrutinized for fraud,
17 waste, and abuse, and the 40-hour limit on
18 LRIs, again, sort of at a national level, is
19 a rule that is being implemented more and
20 more. I do hope that the presentation has
21 helped to sort of clarify that we are only
22 supposed to approve LRIs to provide
23 extraordinary care. That is stated many,
24 many times within the CMS technical guides,
25 within the state manuals, within any

1 correspondence that we receive that involves
2 participant-directed services. So as a
3 state, we have to make those efforts to
4 ensure that we're managing and overseeing
5 the waivers appropriately in the way that
6 we've stated that we would and in the way
7 that the Centers for Medicare and Medicaid
8 Services requires.

9 MR. HARVEY: Okay. Thank you,
10 Carmen, for that update -- or that
11 presentation. It was very informative.

12 Corey, you've had your hand up for
13 quite a while now, so I'm going to go ahead
14 and get your question in here. Hopefully
15 you've not forgotten what you were going to
16 ask.

17 MR. NETT: I have two or three, if
18 that's okay. I've been on the Michelle P.
19 Waiver for over a decade. When I started,
20 you could roll over the hours from week to
21 week. So some weeks you may need more hours
22 than others, and they could just roll over
23 as long as you -- and that would be okay as
24 long as you stay within your budget. I'm
25 not sure why that ever changed because most

1 people, disabilities change from week to
2 week. We might feel better one week and not
3 the next, so we might need more care.

4 MS. HANCOCK: Corey, that's a good
5 question. I'm likely going to have to lean
6 on my BDID counterparts for the history on
7 that. I know that there was a shift, and I
8 don't know when because I'll be honest, it
9 was pre-me, away from budgets. When PDS --
10 when it was CDO, Consumer-Directed Option
11 way, way back when, obviously it was
12 budget-based. It's no longer budget-based
13 and I'm not sure when that change occurred.
14 So I've gotta rely on my BDID folks for
15 that, or it's something that -- we might
16 have to take it back.

17 MS. ADAMS: Yeah. We may have to do
18 that. I don't believe any of us currently
19 on the meeting were in those positions when
20 that occurred. So we'll have to research it
21 and get a little additional information on
22 when that changeover occurred.

23 MR. NETT: My other question. And
24 did I hear you correctly, if an aide is
25 caring for two different individuals, does

1 that limit them to just 40 hours a week?

2 MS. HANCOCK: So the limits that
3 we're talking about, if we're -- Corey, it's
4 Michelle P., right? You said Michelle P.
5 Waiver?

6 MR. NETT: Yeah.

7 MS. HANCOCK: So that 40-hour limit
8 that we're talking about right now is for
9 LRIs.

10 MR. NETT: Okay.

11 MS. HANCOCK: But the Michelle P.
12 Waiver in general is going to be limited to
13 40 hours a week anyway, so.

14 MR. NETT: So if they work for two
15 different people, is 40 the total, or would
16 it be 40 for each person?

17 MS. HANCOCK: So we probably want to
18 take these. Wayne, I don't know if you can
19 support taking these individual, like,
20 specific scenarios offline maybe for
21 discussion.

22 MR. HARVEY: Yeah. The situations
23 that are specific and individualized, we
24 just need to send an email into Medicaid and
25 ask that specific question. I think she's

1 got the gist of what you're asking right
2 now, Corey, and I think she could respond to
3 you via email with a more specific answer
4 right now rather than continuing to tie a
5 lot of time up in regards to researching and
6 answering while we're in the middle of the
7 meeting. So is that okay?

8 MR. NETT: Yes. Thank you.

9 MR. HARVEY: Okay.

10 MS. GRIBBINS: Wayne, this is Myra.
11 One comment on that.

12 MR. HARVEY: Amy's had her hand for a
13 while.

14 MS. GRIBBINS: Okay. Well, I can't
15 get my hand up.

16 MR. HARVEY: So let's get to her
17 first, and then I'll get to you, okay, Myra?

18 MS. GRIBBINS: Okay.

19 MS. STAED: Sorry. Let me lower my
20 hand. Carmen, and again just circling back
21 to my original question. I think often when
22 we have these conversations, they are often
23 framed as looking at it from the perspective
24 of the individual who is enrolled in the
25 waiver, and that's -- and again, that's the

1 appropriate frame of reference. But I would
2 simply ask that the cabinet also look at it
3 at another direction and look at it from the
4 individual PDS worker's perspective. So if
5 I, Amy Staed, want to engage with, you know,
6 and provide PDS care for multiple
7 individuals -- let's take the HCB Waiver out
8 of this because we know that the HCB has a
9 limit of 40 hours for the participant, for
10 the individual worker, no matter if you're
11 an LRI or not. But if I, Amy Staed, want to
12 provide non -- and I'm not an LRI for
13 anybody -- want to provide support services
14 to individuals enrolled in the, let's just
15 say Michelle P. and SCL waivers, how many
16 hours can I work? Is that unlimited? You
17 know?

18 MS. HANCOCK: Right now, there's
19 nothing that restricts a scenario like that.

20 MS. STAED: Okay. And I would -- and
21 we would just ask, because obviously,
22 there's a tremendous amount of changes
23 coming from the federal government --

24 MS. HANCOCK: Yes.

25 MS. STAED: -- and DMS doesn't -- you

1 all don't always have control over that,
2 right? So as we think through changes that
3 may be coming down from a federal level
4 regarding these services, regarding workers,
5 etc., the only -- we would just ask that you
6 think through the individuals who may have
7 exceptional supports who are enrolled in PDS
8 services. We would just hope that they
9 would not have to find -- if there is a
10 limit, you know, to let's say, I'm only, as
11 a worker, allowed to work 40 hours, that
12 hopefully exceptions could be made for
13 exceptional supports so individuals would
14 not have to go out and find another PDS
15 worker just to fulfill those hours. And
16 again, I know that there's lots changing and
17 you all are kind of thinking through all of
18 this.

19 MS. HANCOCK: Yes.

20 MS. STAED: Just an item to note as
21 you kind of think through those changes in
22 the future.

23 MS. HANCOCK: That's a great -- it's
24 a fantastic point, Amy. And you're right.
25 And I appreciate you saying there are larger

1 things happening that we sometimes have no
2 control over. We have to, you know,
3 interpret and implement in the best way
4 possible. And obviously, in the instruction
5 that we always get, consistently get from
6 executive leadership from the commissioner's
7 office, from the secretary's office, is that
8 when we're making decisions, when we're
9 interpreting, you know, legislation and
10 final rules and that sort of thing, that we
11 always act in the best interest of the
12 participant. We're always going to take the
13 stance that's in the best interest of the
14 participant or the member who's receiving
15 services. But yes, we are placed in
16 situations where we don't have a lot of
17 choice.

18 The other just food for thought that
19 I would want to throw out there is
20 especially for someone, let's say, who's on
21 the SCL Waiver who does have, you know,
22 exceptional supports, we also have to come
23 from the perspective of not just the
24 provider as a PDS employee but the provider
25 as a caregiver, and acknowledge that there's

1 caregiver burnout, and acknowledge that one
2 person is -- it's -- can one person be
3 responsible for 80 hours a week of direct
4 one-on-one services and be able to provide
5 that with high quality without themselves
6 being exhausted and that sort of thing? So,
7 you know, that's the thought as well as we
8 have this conversation.

9 MR. HARVEY: Okay. Myra, you had a
10 question. Go ahead.

11 MS. GRIBBINS: Amy pretty much
12 answered it because, you know, we do have
13 situations where the Michelle P. Waiver, SCL
14 PDS employees work with more than one
15 client. And so that's what I was wanting to
16 hear from because, you know, the rumor mill
17 is that they can -- have to limit how many
18 participants they work with and how many
19 hours. So that's where the questions we're
20 getting from the field. Again, I know
21 there's only 168 hours in a week, so
22 feasibly, you know, who can work, like you
23 said, 80 hours a week and maintain their own
24 mental and physical health.

25 MS. HANCOCK: Yes.

1 MR. HARVEY: Okay. Any other
2 questions on the LRI update?

3 (No response)

4 MR. HARVEY: I don't see any other
5 hands. Danni, do you see any that I can't
6 see?

7 MS. DAVIS: I do not see any other
8 hands. I think there was a few questions in
9 the chat a while back. Is there a plan for
10 the new assessment for HCB and Michelle P.
11 to have a separate component for children?
12 Right now, it is at the discretion of the
13 team. Unless this has already been
14 answered.

15 MS. HANCOCK: I don't believe I saw
16 it answered in the chat, Danni. The answer
17 is yes; we are actually having -- we have
18 actually identified assessment tools that
19 are appropriate for each age range and each
20 potential set of qualifications on each
21 waiver. So for instance, I think we've
22 identified three -- it's either three or
23 four assessment tools that would be used in
24 Michelle P. So this has been a very intense
25 process, and we've had to consider the

1 legislation, which specifically said, you
2 know, age-appropriate tools and that sort of
3 thing. So yes, there is a separate
4 assessment tool in each waiver, but if they
5 serve children and adults, there's a
6 different tool for children and adults.

7 MS. DAVIS: And then to follow up
8 with that, will DMS be providing criteria
9 such as a rubric of some sort to providers
10 to assist with determining how much care an
11 LRI may provide for a given individual?
12 Just having items from DMS in writing would
13 be helpful.

14 MS. HANCOCK: Completely understand
15 that. This is something that is in the
16 works. This is the longer-term plan, so I
17 don't know that there's much that we can
18 really get into in depth right now. But the
19 general answer would be that the intent is
20 that, especially with the new functional
21 assessments, if there is a firmer outcome
22 that specifies frequency, duration, you
23 know, acuity of need, that that would be a
24 great benefit to case managers, which I
25 think it was the perspective that that

1 question was coming from.

2 MS. DAVIS: And lastly, does DMS have
3 any plans to restrict LRI PDS employee hours
4 similar to the HCB Waiver limitation?

5 MS. HANCOCK: It certainly is
6 possible that something like that could
7 happen in the future. I don't have a
8 timeline or any firm plan on that, but I
9 think Amy said it's safe to assume that that
10 might be something that we're looking at.
11 And again, those considerations are stemming
12 from, you know, external sources and calls
13 for action, especially within the PDS
14 program at a federal level.

15 MR. HARVEY: Okay. Well, that was
16 very informative. Thank you, Carmen, on
17 that.

18 The next agenda item is the new HCBS
19 option under Section 1915(c)(11), and you
20 can see the bullets there. Are you
21 addressing that also, Carmen?

22 MS. HANCOCK: I am. And I'm flipping
23 through my notes here trying to find -- so
24 there was a brief meeting with -- that CMS
25 hosted last week. We thought we were going

1 to get some additional information on these
2 1915(c)(11)s. We did not, but they did
3 announce that there is going to be -- on the
4 (c)(11), there's going to be a fundamentals
5 presentation and a learning series that's
6 kicking off in July. So we have not gotten
7 a lot of information about this 1915(c)(11)
8 option other than what you all -- what we
9 all sort of saw in -- when, you know, that
10 was released; I think it was H.R. 1. So I
11 can't comment much on the other bullets.
12 Again, they have announced informational
13 sessions starting in July, so we should have
14 more information after that.

15 MR. HARVEY: Do you have any other
16 questions about that, Johnny? I know that
17 was your agenda item.

18 MR. CALLEBS: Oh, thanks. I thought
19 maybe it might be a bit early to get any
20 specific information, but thank you, Carmen.
21 I would just like for, you know, us, as a
22 committee, to keep an eye on that, or I
23 suggest that we do because it is a way -- a
24 new authority given to states to expand what
25 we might think of as traditional waiver

1 services for people who don't meet level of
2 care for one of the waivers. And so that's
3 the big difference, and I know there's some
4 money allocated in the federal budget. I
5 think they said 50 million to CMS to kind of
6 get this organized and rolled out, and then
7 another 70 million or 75 million to states
8 to do the same thing.

9 So anyway, hopefully it's just a way
10 that we could provide, you know, waiver
11 services or waiver-type services to people
12 on the waitlist while they're waiting if
13 they need those services. And then other
14 folks who would not meet level of care but
15 could stay in the community longer with
16 support and some services. So again, I
17 think it's a promising development that we
18 should keep monitoring. So thanks, Carmen.

19 MS. HANCOCK: Sure.

20 MR. HARVEY: Frankie, go ahead with
21 your question.

22 MR. HUFFMAN: My question was --
23 sorry, I was having trouble getting my hand
24 raised when we were on that subject. When
25 you guys were talking about on some waivers

1 being able to go over 40 hours, you have to
2 have an exceptional budget for that.

3 MR. HARVEY: Did you get that
4 question, Carmen?

5 (Ms. Hancock speaks while muted)

6 MS. CLARK: Carmen, you're on mute.

7 MS. HANCOCK: I'm so sorry. Thank
8 you, Alisha. Alisha and I are right next
9 door, so she heard me talking in the office
10 but not on the computer. I didn't get the
11 end of it, Frankie. I caught a budget, but
12 I didn't catch what that was tied to.

13 MR. HUFFMAN: Oh, I'm sorry.

14 MS. HANCOCK: That's okay.

15 MR. HUFFMAN: I'm having trouble with
16 my phone. When you guys said on some of the
17 waivers the employee can go over 40 hours,
18 do you have to have, like, an exceptional
19 budget, or can anybody do that?

20 MS. HANCOCK: So really, we were
21 talking about those -- the legally
22 responsible individuals as PDS employees
23 being limited to 40 hours, especially in --
24 well, currently in the SCL Waiver, we do
25 have that option for exceptional supports.

1 So I know that that consideration has been
2 made for many participants in cases where
3 their needs exceed that limit that an LRI
4 can provide. Again, those same stringent
5 types of limitations, they're not
6 necessarily in place right now for PDS
7 employees who aren't LRIs. I hope that
8 makes sense.

9 MR. HARVEY: Okay. Amy, go ahead.
10 You've got your hand up.

11 MS. STAED: I -- Melanie asked me to
12 verbalize what I put in the chat, and just
13 for those listening; Johnny touched on this
14 a bit. H.R. 1, which is the One Big,
15 Beautiful Bill, contained a provision that
16 would allow states to implement new kinds of
17 1915(c) waivers, which is what our SCL,
18 Michelle P., ABI, and HCB waivers are, that
19 specifically is 1915(c) Section 11, that's a
20 citation to the federal code, that would
21 allow states to create 1915(c) waivers for
22 individuals who do not meet institutional
23 level of care.

24 I do want to reiterate that this has
25 always been available through the 1915(i)

1 process. States have always had the ability
2 to provide HCBS type services to individuals
3 who do not meet institutional level of care,
4 and actually, Kentucky does this through the
5 RISE initiative, which is our 1915(i). The
6 difference between the two types of approval
7 mechanisms, I will call them, or the path to
8 approval that they seek from the federal
9 government is that the 1915(i) is continuous
10 enrollment, meaning that there are no
11 waitlists. If you qualify under the
12 1915(i), you get the services. 1915(c)s are
13 funded with slots, meaning that there can be
14 waitlists if the need exceeds the number of
15 funded slots. So those are the differences
16 between those two approval mechanisms. But
17 states have always had the ability to
18 provide HCBS to individuals who do not meet
19 institutional level care. This is kind of
20 just a new -- another pathway to do that.

21 MS. HANCOCK: And Amy, to piggyback
22 on that, in the (i), sort of that
23 qualification process, do you meet the
24 requirements, is a level of need, as opposed
25 to in a 1915(c) we're looking at a level of

1 care, which equates, again, to an
2 "institutional level of care" currently. So
3 that's also a difference in terms of how you
4 think about, again, that continuous
5 enrollment, no waiting list, no slots. If
6 you qualify, if you meet a certain level of
7 need for a 1915(i), that's the bar there as
8 opposed to a level of care.

9 MR. HARVEY: Okay. Any other
10 questions on that particular agenda item?

11 (No response)

12 MR. HARVEY: Okay. The next one is
13 basically asking for comment in reference to
14 an article. Are you going to do that,
15 Carmen?

16 MS. HANCOCK: I am, Wayne. Okay. So
17 I did go back and take a look at this
18 article that was referenced here. And
19 really just sort of a summary of what this
20 is referring to, so there are federal final
21 rules out there. There's an access rule
22 that we've been working on for quite some
23 time to meet numerous new federal
24 requirements that have timelines on them.
25 And this particular article was related to

1 the federal final rule that had to do with
2 the grievance processes in our states.

3 So when the access rule first came
4 out, the date for compliance with the
5 grievance process requirements in the access
6 rule, the date for compliance was originally
7 July of this year, July 9 of 2026.
8 Additional guidance was released which
9 extended that compliance deadline out to the
10 end of December of 2027. So this article
11 was sort of expressing some concern about
12 the need for the grievance processes as
13 described within the access rule and
14 concerns with how extending the deadline for
15 compliance could impact really participants,
16 you know, communities, advocates, families,
17 specifically.

18 So going back to -- the cabinet's
19 been doing work on these access rules for
20 quite some time at this point. We have
21 actually already completed a full, like,
22 review of our state's grievance processes.
23 We did this in conjunction with all of our
24 sister agencies again, and took a look at
25 how each agency, each department, each

1 division handles grievances, what those
2 processes are, what correspondences look
3 like, you know, how clear communications
4 are, and that sort of thing. So we already
5 have a gap analysis and full report on our
6 state's grievance process.

7 So for the most part, we already look
8 pretty good. We have a grievance process in
9 place that's been in place, you know, for
10 years in practice. The way that we handle
11 our grievances and route our grievances is
12 fairly well aligned already with what's
13 required in the access rule. What we are
14 looking at in terms of this access rule --
15 this grievance piece specifically, is we
16 need to update some correspondence language,
17 we need to update some FAQ language, and
18 we're also working on some updates and
19 clarifications to a regulation that will
20 address grievances specifically. There's
21 also a requirement to implement some
22 electronic systems that we kind of have in
23 place, but they're not fully fleshed out.

24 So we are already doing the work on
25 this. The extension through to December of

1 2027 has not slowed or faltered or changed
2 our work and our efforts on this. So we're
3 already, again, just in those final stages
4 of correcting correspondences, updating
5 FAQs, realigning regulations, and that sort
6 of thing. So thankfully, in our state this
7 should not be alarming. And I hope that
8 helps or answers that point.

9 MS. TYNER-WILSON: Wayne, this is --
10 Carmen, this is Melanie. I'm the one that
11 submitted and thank you for that. That was
12 helpful to have as a part of the meeting.
13 Will the -- in your work to update, revise,
14 will there be plain language added so that a
15 whole continuum of individuals will
16 understand the impact and what is being said
17 and done? Does that make sense?

18 MS. HANCOCK: Yes, ma'am. Yes, of
19 course. In that -- that has been a focus --

20 MS. TYNER-WILSON: Yeah.

21 MS. HANCOCK: -- is making sure that
22 our -- the correspondence that we send out,
23 the communications that we send out are
24 plain language that people understand where
25 we're targeting those at, like, a fifth or

1 sixth grade reading level. So yes, the
2 intent is for it to -- those communications
3 to be very easy to understand. And that is
4 also a push, just for information, from the
5 secretary's office.

6 MS. TYNER-WILSON: Yeah.

7 MS. HANCOCK: Secretary Stack is very
8 adamant about clear is kind. Plain
9 language. Write things the way that people
10 will understand them. Yes.

11 MS. TYNER-WILSON: Thank you.

12 MS. HANCOCK: Yes, ma'am.

13 MR. HARVEY: Okay. The next item up
14 is an update for PDS workgroup regarding
15 current activity and any proposed policy
16 changes that would affect self-advocates and
17 caregivers. It's referencing specifically a
18 memo sent regarding PDS transition. Is that
19 you also, Carmen?

20 MS. HANCOCK: Yes, sir. Okay. So
21 this memo was sent, and this is regarding
22 the decision that was made at the cabinet
23 level to split out the responsibility for
24 PDS service delivery to its operating
25 agency.

1 So for many years, let's say that you
2 were a Michelle P. Waiver or SCL Waiver
3 participate and you receive PDS services,
4 there would be sort of this disconnect
5 because DBHDID actually is the operating
6 agency for Michelle P. and SCL, but DAIL has
7 been overseeing PDS services. So we're
8 cleaning that up and moving that
9 responsibility for PDS oversight back to the
10 operating agency that actually is overseeing
11 each waiver.

12 So that memo was sent just notifying
13 folks that that was going to be happening.
14 And I'm hoping April, or Marnie, or Crystal
15 can help me out with this one. So some of
16 these changes are going to be effective
17 July 1. Now, all of this being said that if
18 the question is policy changes that would
19 impact self-advocates and caregivers, I
20 don't know that you're going to see a lot of
21 impact there. This is really more
22 operational, like internal operational flow.
23 So really streamlining communications for
24 case managers, who they would reach out to
25 with questions or concerns and that sort of

1 thing. But there are duties that are sort
2 of going to be shifting over the next year
3 with a big chunk of those starting on
4 July 1st.

5 And again, if April, or Marnie, or
6 Crystal wants to comment, I know that
7 legally responsible individual reviews are
8 one of the items that's going to shift on
9 July 1. What are some of the others, team?

10 MS. MOUNTJOY: Well, I was thinking
11 -- when I saw the agenda, I was thinking it
12 was more around the PDS consortium that
13 meets monthly.

14 MS. HANCOCK: Oh, okay.

15 MS. MOUNTJOY: And how we use that
16 group for those activities. So I'm not sure
17 who posed this question and if that was what
18 the request was. But it's DAIL's intent
19 that we would just continue those meetings,
20 and we would partner and host those meetings
21 along with our friends at BDID and DMS to
22 continue the PDS consortium and the work
23 that's been going on.

24 MS. HANCOCK: Well, thank you for
25 that, Marnie.

1 MS. LOWERY: So Carmen, just to add,
2 so the Legally Responsible Individual Review
3 Task will be going on August 1st --

4 MS. HANCOCK: Okay.

5 MS. LOWERY: -- to the different
6 sister agencies. The Critical Incident Task
7 will go July 1. So there will be a
8 different -- same process on the end-user
9 side. It'll just come to a different
10 reviewer based on the waiver program.

11 MS. HANCOCK: Thank you, April. So
12 again, we're -- the intent is that the
13 impact for self-advocates and caregivers
14 would be that they see that we've
15 maintained, you know -- they shouldn't see a
16 difference on their end.

17 MS. TYNER-WILSON: This is Melanie
18 again. I'm the one that posed the question.
19 Will any information that you all send out
20 also be done in plain language so a whole
21 continuum of individuals would be able to --
22 and their caregivers would be able to access
23 this?

24 MS. MOUNTJOY: So I think that's why
25 we use the PDS consortium to review

1 materials so that we can make sure that it
2 is in plain language. I see that somebody
3 entered into the chat, when is the
4 consortium and how do we participate? So
5 you're more than welcome to send that to me
6 and I'll pass that along to our staff person
7 who coordinates those activities. I'll put
8 my email address in the chat.

9 MR. HARVEY: Okay. Any other
10 question on the PDS stuff?

11 (No response)

12 MR. HARVEY: Okay. The next item is
13 update on the federal provider revalidation
14 announcement, overview of Kentucky's
15 compliance plan and information about
16 categories of high-risk providers. I'm
17 assuming, Carmen, that you're taking that
18 one.

19 MS. STAED: And just to give Carmen a
20 break if I -- so I can -- I'm happy to,
21 like, introduce the issue just so everybody
22 on the call knows what I'm talking about
23 because that's a lot of kind of
24 scary-sounding words, if that's okay.

25 So on April 23rd, Dr. Oz, who is the

1 head of CMS, who -- CMS is the federal
2 oversight agency for all state Medicaid
3 programs -- sent a letter to every state's
4 Medicaid director related to concerns about
5 Medicaid fraud and how provider revalidation
6 is a really key component to preventing
7 Medicaid fraud. So in that letter, Dr. Oz
8 asked all states to develop and submit a
9 comprehensive two-year provider revalidation
10 strategy. And in that letter, it also -- it
11 very specifically asked every single state
12 to outline how it would increase oversight
13 of "high-risk" provider types.
14 Additionally, it would ask states to
15 specifically identify how it would handle
16 revalidation and continued oversight and
17 monitoring of providers who do not have
18 NPIs.

19 Now, the reason that we have brought
20 this -- asked that it be brought up in the
21 TAC meeting is because nationally, there has
22 been a tremendous amount of conversation,
23 number one, about what types of providers
24 fall in the high-risk category, and number
25 two, specifically there's been a lot of

1 national confusion about providers without
2 NPIs and if PDS workers fall into the
3 category of a provider that does not have an
4 NPI. And so we were hoping that Medicaid
5 would be able to share its plan that it
6 submitted to federal regulators about this
7 provider revalidation regarding the
8 frequency, and if they had -- and again, I
9 know that the provider without NPI issue has
10 been a big topic nationally about whether
11 that does cover PDS employees, you know, how
12 that relates. And if you all have gotten
13 any clarity on that because I know a lot of
14 states have been asking a similar question.
15 And just what providers and individuals who
16 receive waiver services should expect in the
17 coming years related to provider
18 revalidation efforts.

19 MS. DUDINSKIE: This is Jennifer
20 Dudinskie. I am the division director for
21 the Division of Program Integrity. So I can
22 take this one because this one falls under
23 my purview.

24 I can't give you a lot of specific
25 details about the plan. The plan is not due

1 to CMS until Friday. So we are currently
2 drafting the plan. It will be submitted
3 timely. But I can give you some general
4 information that might help you to
5 understand the situation.

6 In regard to high-risk providers,
7 right now, providers in the high-risk
8 category are as follows: nursing
9 facilities, home health agencies, hospice
10 providers, DME providers, and then providers
11 who have had a credible allegation of fraud
12 within the past 10 years, and also providers
13 who have been excluded as a provider through
14 either HHSOIG or another state's Medicaid
15 program. So those are technically who are
16 considered high-risk providers in that tier
17 that you were speaking of. Those are the --
18 what we designate as a high-risk provider.

19 In regard to atypical providers, so
20 atypical providers are those providers who
21 do not have an NPI number. And we are being
22 asked to revalidate those providers in the
23 same category as the high-risk. So that
24 doesn't mean that they will be evaluated
25 necessarily in the same manner as a

1 high-risk provider, but they're asking us to
2 do a priority revalidation on those
3 providers.

4 So in regard to your question about
5 PDS employees, PDS employees are not
6 technically considered Medicaid-enrolled
7 providers. So at this time, those providers
8 do not fall into the atypical category or
9 any other category. However, you referenced
10 discussions about PDS nationwide. I will
11 tell you that I do anticipate, because of
12 some of those conversations and the
13 conversation surrounding fraud, waste, and
14 abuse, that we may get information from CMS
15 soon that addresses the PDS population and
16 the PDS employee population. But as of
17 today, we have not received anything
18 specific to address those employees. Now, I
19 do believe some other states may enroll
20 those employees, so that may be applicable
21 in other states who do that. But in
22 Kentucky, we do not, so they do not have to
23 be included in our tiered response to CMS.
24 Does that help answer your question?

25 MS. STAED: It does. Thank you so

1 much. And I appreciate you shedding light
2 on the submission timeline because there was
3 a lot of --

4 MS. DUDINSKIE: Yes.

5 MS. STAED: -- there were a lot of
6 dates in there -- in that letter.

7 MS. DUDINSKIE: Yes. Yeah.

8 MS. STAED: When it is submitted,
9 will that be made public?

10 MS. DUDINSKIE: Well, I don't know
11 that the plan itself will be made public,
12 but we will be issuing communications
13 regarding what our next steps are.

14 MS. STAED: Perfect.

15 MS. DUDINSKIE: So there will be a
16 series of different provider letters that
17 will go out explaining what is happening and
18 what for that specific provider is -- you
19 know, what that means for that specific
20 provider. So we will be doing a lot of
21 communication around this, but I don't know
22 that the plan itself will be made public.

23 MS. STAED: Perfect. Thank you. I
24 appreciate that.

25 MS. DUDINSKIE: Sure.

1 MS. STAED: And then do you have --
2 you don't have to give me an extensive list,
3 but do you have a quick example of what, in
4 Kentucky, are currently atypical providers
5 that don't use NPIs?

6 MS. DUDINSKIE: Well, it's just --
7 there's -- it's not like a listing.

8 MS. STAED: Okay. I'm sorry.

9 MS. DUDINSKIE: It's just any
10 provider that does not have an NPI.

11 MS. STAED: Okay.

12 MS. DUDINSKIE: So yeah, we do have
13 some categories of those. Like, one example
14 would be, like, any of our governmental
15 agencies that have a Medicaid provider
16 number that provide services. So a
17 governmental agency would have an atypical
18 provider number.

19 MS. STAED: Okay.

20 MS. DUDINSKIE: The MCOs are
21 considered atypical. Does that kind of help
22 give you a picture of what they are?

23 MS. STAED: Yes. Yeah, thank you.

24 MS. DUDINSKIE: Sure. Somebody else
25 has a hand up, I think.

1 MR. HARVEY: Johnny? Johnny had a
2 hand up, and then we'll get to Corey. Go
3 ahead, Johnny.

4 MR. CALLEBS: No, Amy asked the
5 question I was going to and got it answered,
6 so thank you.

7 MS. DUDINSKIE: Sure.

8 MR. HARVEY: Go ahead, Corey.

9 MR. NETT: I know there's a lot of
10 talk about fraud right now, and I was
11 wondering if in the last five years, what
12 the percentage of fraud has been found in
13 Kentucky's Medicaid?

14 MS. DUDINSKIE: I don't have those
15 numbers, like, in front of me right now to
16 be able to give you numbers that are
17 actually correct, but if that is something
18 you all would like for us to report back, if
19 somebody would submit that to us, we'd be
20 more than happy to try to address any type
21 of questions surrounding that topic.

22 MR. NETT: The reason I ask is I know
23 it occurs, but I don't think it's as common
24 as they want us to think it is. For
25 example, when Johnny Callebs and I met with

1 that senator, he said, "Do you know how many
2 illegals are on the waiting lists?" In my
3 mind, I was like, "You don't know that
4 answer because it would be a HIPAA
5 violation." Thank you.

6 MR. HARVEY: Thank you, Corey. Fraud
7 is something that I think anybody could
8 speak hours on any given day. So thanks for
9 that update, Jennifer. We really appreciate
10 it as a lot of useful information.

11 The next agenda item that's up for
12 discussion today is one that Ann brought to
13 the committee. It's in regards to autism
14 services involving aggressive behaviors
15 regarding the gaps and so forth between
16 CHILD Waiver services and school system
17 services and stuff that's led to shortages
18 in service provision. Ann, do you want to
19 speak to any, kind of frame it up for our
20 discussion here?

21 MS. PIERCE: Yes. Thank you, Wayne.
22 Just briefly since we're short on time
23 because I would really like to hear from
24 y'all. And actually, I think the CHILD
25 Waiver will be helpful if we can get --

1 it's -- what brought it to my attention most
2 recently, not that I'm not living with it on
3 a daily basis, but a friend of mine quit her
4 position as a special ed teacher in our
5 local county school because she was tired of
6 getting beat up. So I don't know how
7 prevalent that is in our state, but she's
8 been doing it a long time, and she just
9 couldn't take it anymore. So what that
10 tells me is the school or teachers or what
11 they're being taught in colleges is not
12 addressing this issue, and it bleeds over
13 then into as they grow up, they become
14 adults, there out of the school system.
15 Oftentimes, even before they're adults, they
16 are placed in institutional care while
17 they're still in school.

18 So it's just -- and I know people
19 with empty waivers because they can't get
20 providers to serve them as adults; hopefully
21 the CHILD Waiver will help the children with
22 this. Good work on that. And then there's
23 long-term care issue, which is huge, and
24 it's going to be more and more and more. I
25 had a statistic somewhere: 74 percent of

1 people with profound autism are still living
2 in their family home. And what this means
3 for families is if they do have behaviors,
4 they're trapped. They're trapped in their
5 home, they're depressed, they can't go to
6 church, they have no friends anymore because
7 they can't socialize. And then another
8 number is 79 percent are told that they're
9 too severe for services. That's a lot. So
10 there are a few providers, obviously, that
11 are willing to, but I would just like some
12 discussion on this and what can we do to get
13 -- this day to figure this out because it's
14 going to get worse and worse.

15 Do you want that statistic? I think
16 everybody knows that the CDC data from '24,
17 1 in 31 8-year-olds were diagnosed with
18 autism, and 1 in 4 of these had profound
19 autism. So that was 2 years ago. So it's
20 just going to keep growing exponentially.
21 It gets worse every time they do the data.

22 Anyway, I would love to hear your
23 all's thoughts on that. Thank you for
24 letting me speak.

25 MR. HARVEY: Okay. I see Starr has

1 got her hand up. Go ahead, Starr.

2 MS. LYNNE: Hi, you guys. So I'm
3 going to introduce myself as I have a child
4 that's severely autistic and he will be 18
5 soon. With that, I'm also with the Kentucky
6 chapter of the National Council on Severe
7 Autism and I continue to hear parents talk
8 about the gaps within the system of when a
9 parent -- when the children turn into
10 adults. And now that my child is turning
11 into an adult, I guess I fully didn't
12 understand there is such a big gap in
13 services, like stabilization, crisis, and
14 housing.

15 And, you know, we are seeing that,
16 like, I think over 50 percent of the
17 caregivers are going to be 50 or older, so
18 we're going to be coming up on a national
19 crisis with all of these individuals and
20 having to place these individuals. And I do
21 know that there is a big gap. I've actually
22 even reached out to, like, Amy. So this is
23 a known issue, and I just wanted to bring it
24 to the table to make sure that it's still up
25 there, and wonder if, like, any of the

1 things that have been recommended, like a
2 task force and such, have those gone on, and
3 where we are in those kinds of processes.

4 MR. HARVEY: Okay. Good feedback.
5 You know, this is a tough subject. I've
6 been around forever, and it's -- you know,
7 this is a tough one. Have you spoken with
8 anybody at the Department of Education, Ann,
9 about, you know, the different things that
10 they may have to combat and work with us on
11 this particular issue?

12 MS. PIERCE: No, I have not, but
13 that's a great idea. It's a great idea. So
14 we could include that. How do we make that
15 happen?

16 MR. HARVEY: Well, I think our good
17 friends at Medicaid may have a contact
18 number or two for us that we may be able to
19 utilize and make contact with the Department
20 of Education that way and set up a meeting
21 and see if we can't get some traction.

22 MS. TYNER-WILSON: Wayne and Ann,
23 your timing is excellent because right now,
24 Kentucky Department of Ed is having ongoing
25 conversation about restraint and seclusion

1 within the school environment. And Starr,
2 your point was excellent because it's huge.
3 I remember years ago, it was really very
4 difficult to get what we call applied
5 behavior analysis, ABA therapists to come in
6 our state, and it slowly has grown over the
7 years. But we still need lots more of those
8 types of providers in the schools as well as
9 out of -- in the waiver provider kind of
10 spaces. So with the incidence rates that
11 Ann gave being so high, we're definitely --
12 timing is -- would be very important to have
13 those kind of discussions with Kentucky
14 Department of Ed.

15 MR. HARVEY: Okay. I think what else
16 I can do, Ann, to help you on this
17 particular matter is I can send an email out
18 to each committee member individually and
19 ask if they've gotten any further ideas, you
20 know, after this meeting is over with and so
21 forth, that could assist us in looking at
22 different avenues for you to approach this.
23 You got a question?

24 MS. PIERCE: Not a question, just
25 another comment. And I appreciate you

1 offering to send out that email and I hope
2 people will respond. We can compile a list,
3 and maybe the state chapter of the NCSA can
4 approach, or DMS, or whoever, someone.

5 It begins in the schools. It begins
6 there. And that's where it needs to be
7 fixed because then they grow up and it
8 doesn't go away. So if we can fix it while
9 they're still young, then we won't have as
10 severe a problem when they're older. So
11 thank you for giving us time to talk.
12 Appreciate it.

13 MS. TYNER-WILSON: And if I could
14 jump in real quick. Behavior is
15 communication.

16 MS. PIERCE: Yes.

17 MS. LYNNE: And I would like to just
18 jump in as well as this is something that we
19 had talked about with the CHILD waivers, and
20 I was on one of those studies. And
21 something that I had made sure I told the
22 state, and I think the state's aware of
23 this, too, but unfortunately, like, when
24 what Ann's talking about is the behaviors.
25 If we can get the behaviors down when

1 they're younger, we're not going to see this
2 crisis epidemic and having to go in, like,
3 to residential facilities, hopefully it's
4 not always the case. But currently, the way
5 the services are set up is once we get a
6 diagnosis, then we have to go on to a waiver
7 waitlist. The waiver waitlists are like 10
8 years, and that's -- we can't really get any
9 of these behavior services in the home until
10 we can get some of these waivers in place.
11 And so I feel like that's a big gap also
12 because if we could get the help when
13 they're younger, like, early intervention is
14 so critical, and right now, the way the
15 system is set up with Kentucky, it's
16 impossible to access those services. A lot
17 of private insurances are not paying for ABA
18 services, and if they are, the deductible is
19 out of reach for a lot of families.

20 MR. HARVEY: Okay. Thank you for
21 that feedback. We are really short on time
22 here, so I am going to press forward.

23 The next item on the agenda is call
24 for recommendations. And what I would like
25 to do here is, Melanie, I know you had the

1 issue around information specific to the
2 termination summary report. Can we deal
3 with that with an offline email between all
4 the committee members and so forth between
5 this meeting and the next meeting? And that
6 way we'll get good feedback and decide
7 whether or not we want to pursue asking for
8 any further information there instead of
9 going through the process of recommendation
10 and everything.

11 MS. TYNER-WILSON: Of course. That's
12 fine.

13 MR. HARVEY: Okay. Thank you. Thank
14 you.

15 The MAC meeting representation, the
16 next MAC meeting -- we haven't had one since
17 our last IDD TAC meeting. Actually, the
18 next one is scheduled for this Thursday.
19 It's the weird schedule that the IDD TAC and
20 the MAC are on together. We meet the first
21 Tuesday of every other month and they meet
22 the first Thursday. So unfortunately, the
23 MAC meeting came before our meeting the last
24 time we had a meeting. So we will be
25 present at the MAC meeting on Thursday, and

1 I'll present the recommendation that we had
2 from the previous meeting at that particular
3 meeting.

4 The next meeting date for the IDD TAC
5 is August the 4th, 2026, 10 a.m. via Zoom.
6 Do we have any other comment or question or
7 anything before we adjourned today's
8 meeting?

9 MS. PIERCE: Wayne?

10 MR. HARVEY: Thank you all --

11 MS. PIERCE: I'm sorry. I think
12 Melanie wanted to make a recommendation
13 about --

14 MR. HARVEY: No. We discussed that,
15 Ann, and we decided we would handle that via
16 email between the committee members and
17 stuff between this --

18 MS. PIERCE: I'm sorry. I'm a little
19 stressed right now.

20 MR. HARVEY: That's okay.

21 MS. PIERCE: I'm in crisis myself.
22 So thank you.

23 MR. HARVEY: I understand.
24 Understand. Any other questions or anything
25 before we adjourn the meeting?

(No response)

MR. HARVEY: Okay. Thank you all for
your patience and everything. I know we ran
over just a couple of minutes or so, but
thank you, and we'll see you at the August
meeting.

(Meeting adjourns at 12:03 p.m. Eastern Time)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, 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 8th day of June, 2026.


Tiffany Felts, CVR

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