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

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Via Videoconference
October 7, 2025
Commencing at 10 a.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

**BOARD MEMBERS:**

Wayne Harvey, TAC Chair
Brad Schneider
Johnny Callebs
Frankie Huffman (not present)
Ann Pierce
Cheri Ellis-Reeves
Doug Hoyt
Melanie Tyner-Wilson

MS. WASH: Good morning. It is 9:58, and this is Barbara from the Department of Medicaid Services, and I'm still clearing the waiting room.

So it is 10 a.m. Again, this is Barbara from DMS, and I still have a lot more people in the waiting room. Do you want me to give it a minute or two?

MR. HARVEY: Yes, Barbara, go ahead and give it another minute or two to--

MS. WASH: Okay.

MR. HARVEY: -- try to clear the room completely out.

MS. WASH: Okay, I will do that.

MS. TYNER-WILSON: Good morning.

MR. CALLEBS: Hey, Melanie.

MS. TYNER-WILSON: Hey, Johnny.

MR. HARVEY: We're still clearing the waiting room out right now, so we'll get started here in just a minute or two.

MS. WASH: Okay, this is Barbara again from DMS. It is 10:02, and the waiting room is clear.

MR. HARVEY: Thank you, Barbara. Can you go ahead and confirm that we have a

quorum?

MS. WASH: Yes, you do.

MR. HARVEY: Thank you.

Okay, first thing up on the minutes -- or the agenda I should say, is the approval of the minutes from the previous meeting. Does anyone on the committee want to make that motion?

MS. ELLIS-REEVES: I make a motion.

MR. HARVEY: Thank you, Cheri. Does anybody want to second it?

MR. CALLEBS: I'll second. Johnny.

MR. HARVEY: Thank you, Johnny. Is there any discussion?

(no response)

MR. HARVEY: Okay, all in favor, just give me a thumbs up instead of everybody saying "aye."

(Thumbs up)

MR. HARVEY: Okay. All right, motion carries. Minutes are approved, Barbara.

The next thing on the agenda is old business. Do we have somebody here from the Cabinet, Barbara, that is going to report on the general updates, and then the update of

the impact of recent federal legislation, the first two bullet items?

MS. CLARK: Wayne, it's Alisha. I'm here this morning for Carmen. So I can kind of go through the updates. I know that Carmen gave those last meeting.

And so I know that she had previously talked about Model II and HCB being approved in July. HCB did take effect on 8/1, and Model II, the new application approval is set to take effect on 10/1. And then she had mentioned the HCBS Welcome Packet previously, just wanted to let you all know, we had planned hopefully to have that out the end of September/October-ish. It is in the final review stages, so I'm hopeful that it'll be coming out, you know, in the next month or so. So fingers crossed as we kind of, you know, finish up that review and get that out to you all.

As far as the 1915(c) Child Waiver that we're working on, the team is currently working with CMS to try to get that application approved, working through provider education and training that should

come out late October, early November.

And then I don't know if we have anybody on here from behavioral health that could speak to the 1915(i) RISE. I can tell you, you know, the little bit that I know on that, and they are working through the provider enrollment at this time. So if anybody is on here from behavioral health, just jump in at any point.

MR. HARVEY: I don't think you have any takers, Alisha.

MS. WASH: Yeah.

MS. CLARK: Okay. Well, then we'll just go into the next one. And Wayne, as far as the update on the impact of the recent federal legislation, you know, I don't have anything further at this time. You know, we'll continue to wait on guidance. You know, I am covering for Carmen this morning. There's kind of a standing meeting that all of our executive staff have every so often. So sometimes it does conflict with this meeting, but nobody has provided me anything. So I know Steve, you know, with our budget, everybody is

watching everything closely, so as additional information comes out, we will definitely share that with you all.

MR. HARVEY: Do you have any update on the government shutdown, Alisha? Has that done anything to Kentucky Medicaid or impacted you guys any? I know it has to be difficult to deal with that.

MS. CLARK: I mean, I think there's always the fear from even us that maybe things could be a little bit slower on getting responses from CMS, but, you know, to date, I have not personally had any slowness. I mean, we're still trucking right along with all of our projects, and, you know, I think I even saw an email maybe from CMS, you know, that was questions back to our team on the child waiver. So not experienced any slowdown at this point, but I don't want to say that it hasn't affected Medicaid somehow.

MR. HARVEY: Okay. Does any committee members have any questions for Alisha on those updates?

(no response)

MR. HARVEY: Do you see any hands that I'm not seeing, Barbara?

MS. CLARK: Oh, Amy's got one. Amy?

MR. HARVEY: Yeah.

MS. WASH: Amy does.

MS. CLARK: Now, Amy, I knew Amy would ask me a question.

MS. STAED: Well, actually, one, just wanted to add something --

MS. CLARK: Okay.

MS. STAED: -- on top of what Alisha just said about the shutdown. CMS also issued a letter, maybe a week or two ago, just noting that they have sufficient funds to fund Medicare and Medicaid payments through the first quarter of the government fiscal year, which began October 1st, so through the end of calendar year 2025. So all the experts out there aren't really expecting the government shutdown to even last that long. There's sufficient money to fund Medicare and Medicaid.

And then, Alisha, I don't -- I don't want to put you on the spot, so if you don't know any details, totally understand. There

was a letter that came out yesterday about EVV, if you -- I wondered if you could touch on that a little bit, and if you can't, again, totally understand. It wasn't on the agenda, so I get it.

MS. CLARK: No, that's okay. So I'll start, and I might have April on here that can kind of chime in, but, you know, EVV has been a federal requirement, right? And they have expected us to be capturing and making sure that all of the six elements are in place, being captured, and going through that process. So my understanding is recently, we have just now started -- like the pay and list, I don't know, you all -- some providers are probably very familiar with that through other, you know -- it seemed like it used to be a lot back in my other area of where I worked. But pay and list, so it kind of lets you know errors that right now, this is the way that you can monitor that, but come, I believe, January the 1st, that those errors -- you know, if it's not going through the system, then you aren't going to get paid for those claims.

So there has to be, you know, a PA for that visit for them to match up and to get that reimbursement.

So right now, it's kind of like, you know, we've talked about this for a long time. Like, "Hey, this is coming, this is coming." And what we thought would be helpful is to allow providers to see, "Hey, these are my errors," and so, you know, because we have to have KPI reporting to the federal government, and we need to get that where it needs to be.

And I don't know, I will say if April's on here and she wants to add anything or if I got anything wrong, definitely please correct me on that.

MS. LOWERY: So yeah, I'll just add to that, so today, currently, the only real difference is for that visit to be paid, there has to be a visit with the claim. So if you submit a claim today without the EV visit, it's going to pay and list. Moving forward after January 1st of 2026, if that visit is not in the system, that claim is not going to pay.

This also -- this is one of our KPI reporting measures that goes to CMS, and we have already implemented this for the home health care services, which included home health through the MCOs, private duty nursing, and also Model II Waiver providers as of January 1st of 2025, and we've had very little issues with that. So it's just ensuring that for every claim paid that requires an EV visit, that that visit is there in the Therap aggregator.

So there is additional town halls upcoming for providers to attend where they can ask Q&A with Therap. The next one is Thursday at 2:30, this Thursday, October the 9th, and then there is a monthly series up through January for any questions that providers may need to ask, and those trainings will also be recorded. And then DALE is also going to host Therap on the November PDS town -- or it's going to be similar to the town hall deck, so -- on the PDS monthly call.

So is there any additional questions that we can answer related to the upcoming

additions to EVV?

MS. STAED: If people have questions just kind of as we go through this process, not today, what would the best way to submit them be? That HCBS email address? I forget what it is, I'm sorry.

MS. LOWERY: Our 1915(c) Waiver --

MS. STAED: Yeah.

MS. LOWERY: -- Help Desk. Yes, you can submit any questions. Always happy to assist providers along the way with questions, technical assistance, etc. If you get in -- if an agency gets into their pay and list and they've got questions when they receive that, there is a team ready to assist.

MS. STAED: Thank you.

MS. TYNER-WILSON: And --

MR. HARVEY: Okay, does anybody else have any other questions on that?

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

MR. HARVEY: Sure. Yes, absolutely, go ahead, Melanie.

MS. TYNER-WILSON: Yeah, and thank

you, April, for that information. Where would caregivers or self-advocates go to get -- to ask those same kind of questions?

MS. LOWERY: Melanie, you can submit those also to the 1915(c) Waiver Help Desk box --

MS. TYNER-WILSON: Okay.

MS. LOWERY: -- and we will respond to those caregiver questions as well there.

MS. TYNER-WILSON: Okay, thank you.

MS. LOWERY: Mm-hmm.

MR. HARVEY: Anyone else have any other questions for April?

(no response)

MR. HARVEY: Do you see anybody else, Barbara?

MS. WASH: I see one question -- let me -- no, there isn't anything else in there, no more questions.

MR. HARVEY: Okay.

All right, moving on then, the next thing is update regarding the 1915(c) Waiver waitlist. Alisha, are you doing that?

MS. CLARK: I was going to say, Wayne, that'll be me again. So this is hot

off the press it looks like. So as of 10/7, and for ABI Acute, ABI Long-Term Care, and Model II, we do not have anybody on the waiting list. For the HCB Waiver, there is 5,284. For Michelle P., there is 9,670. For SCL, there's 3,765. And so the total unduplicated is 16,266.

MR. HARVEY: Okay, does anybody have any questions over the waiting list numbers?

(no response)

MR. HARVEY: Do you see any hands raised, Barbara?

MS. WASH: I see no hands raised.

MR. HARVEY: Okay, thank you.

MS. WASH: Mm-hmm.

MR. HARVEY: Okay, PDS services, are you doing that also?

MS. CLARK: Actually, I have Marnie Mountjoy with the Department for Aging and Independent Living that I believe will be providing the updates for this one.

MR. HARVEY: Okay, great.

MS. MOUNTJOY: Yes, thank you. So we have 71 case management agencies to provide PDS services across the Commonwealth.

That's four additional new ones since I reported this last -- to the last meeting. There is 8 agencies that are in queue to be reviewed, and we have 803 individuals who are on the PDS interest list.

MR. HARVEY: Okay, does anybody have any questions for Marnie while we have her on here?

MS. STAED: Can you repeat the interest list number?

MS. MOUNTJOY: Sure, 803.

MS. STAED: Thank you.

MR. HARVEY: Any other questions?

MS. TYNER-WILSON: Wayne, this is Melanie again. Can I --

MR. HARVEY: Sure, absolutely. Go ahead, Melanie.

MS. TYNER-WILSON: Ms. Marnie, thank you for that information. Can you, for the record, just describe the difference between an independent case management and I guess a dependent case management?

MS. MOUNTJOY: Well, the original traditional PDS case management agencies were the community mental health centers and

the area development districts --

MS. TYNER-WILSON: Okay.

MS. MOUNTJOY: -- so that was -- I believe that totals up to 29 agencies, but we have 71 total, so they could be standalone case management agencies that are certified to provide PDS services.

MS. TYNER-WILSON: Okay, thank you.

MS. LOWERY: Mm-hmm.

MR. HARVEY: Any other questions?

MS. WASH: And there are no questions in the chat box.

MR. HARVEY: Thank you.

Involuntary Termination Summary Report, is Elizabeth doing that?

MS. MARKLE: I am.

MS. CLARK: Yes.

MS. MARKLE: Good morning, everyone.

MR. HARVEY: Hey.

MS. MARKLE: So as of yesterday, we had a total number of involun-terms in the last year for all services was 57. Residential services only was 40. Of the total involuntary terminations in the last 6 months for all services, there were 32. And

of that number was -- for residential only, was 24. And then of the total number of involuntary terminations in the last month, there were five, and of those residential services only were three. Of the total involuntary terminations not transitioned in the last year for all services is 21, 18 of those are residential only, and our number of active involuntary terminations over 1 year has dropped to 10.

I was pleased over the last week as we were collecting information from our field staff to see that there were a handful that actually agencies had rescinded, which tells me that they felt like they were getting different support or had figured some different things out, maybe even created a different living environment or something along those lines that were better suited to the individual's needs. So I'm always excited to see that when a request is rescinded that tells me that they figured out a way to continue to support that person and that that person, most importantly, would not have to be relocated.

MR. HARVEY: Sure. Does anybody have any questions for Elizabeth on those numbers?

MS. STAED: Elizabeth, for the active over one year, those ten people, do you have any indication of how many of those ten are residential?

MS. MARKLE: I don't, but I certainly can get that.

MS. STAED: It's -- I don't -- yeah, I was just wondering for my own purposes.

MS. MARKLE: I would suspect -- yeah, I would suspect all of them, but I can double check that while we're on the meeting.

MS. STAED: Thank you. That would be greatly appreciated.

MS. MARKLE: No problem.

MR. HARVEY: Does anybody else have any other questions? Go ahead, Ann.

MS. PIERCE: (speaking on mute)

MR. HARVEY: I think you're still muted, Ann.

MS. PIERCE: I said thank you to everybody first. I was wondering, the 18

residential who were not transitioned --

MS. MARKLE: Yes.

MS. PIERCE: -- can we find out -- is it possible to find out what their disability diagnosis is?

MS. MARKLE: I mean, I'm certain that we can gather that information. Is that something the committee would like for us to have ongoing so that we would know to collect that in advance in the future?

MS. PIERCE: That would be great if --

MR. HARVEY: What would be the purpose of gathering that information, Ann, I guess would be the question?

MS. PIERCE: Just to see -- well, that's a fair question. I'm just thinking that people with severe autism have very unique needs, and that if there's a pattern of involuntary evictions for that population, that we might need to address that issue somehow. Does that make sense?

MR. HARVEY: Did you get that, Elizabeth?

MS. STAED: Just to be clear, we're

talking about involuntary terminations.

MS. PIERCE: Correct.

MR. HARVEY: Does anybody else have any other questions?

MS. MARKLE: I have a quick question. So would that data be just for our folks who are still awaiting -- I just want to be clear, like --

MS. PIERCE: The ones that are unable to be transitioned, so can find no other provider who will accept them.

MS. MARKLE: Okay.

MS. PIERCE: Thank you.

MS. MARKLE: You're welcome.

MR. HARVEY: Any other questions for Elizabeth?

MS. WASH: There are no questions in the chat box.

MR. HARVEY: Thank you, Barbara.

Next up is the survey response data regarding involuntary termination. This is going to be put on by Amy Staed. Amy?

MS. STAED: Hi, thank you. First, thank you for giving me the opportunity to speak. Could someone grant me the ability

to share my screen?

MS. WASH: All right, Amy, just give me a minute --

MS. STAED: Yep.

MS. WASH: -- and I will -- I will make you a cohost.

MS. STAED: Oh, that's so much power.

MS. WASH: There you go, you have it.

MS. STAED: Thank you.

MS. WASH: I'm going to stop sharing my screen.

MS. STAED: Okay. Thank you. Hold on just a second. Okay, can everyone see that?

MS. WASH: Yes.

MS. STAED: Okay, good. Thank you so much. And thank you again for allowing me to speak. Just to remind everyone where we started because I know that not everyone gets to tune into all of these TAC meetings, and this is something that we have -- that the IDD TAC has been working on for well over five years, so some of us may have forgotten a little bit of the history.

But again, the IDD TAC has been

working on the issue of involuntary termination of a service, and I really want to be very specific of the language we use here. We're talking about involuntary termination of a service, not the termination of someone's waiver, not evictions, involuntary termination of a service. And while typically we are talking about a residential service, this process applies to every waiver service an individual receives. So if, for example, someone's receiving a nutrition service, and that nutritionist really firmly believes that that individual's needs exceed what they're able to provide, that nutritionist would be able to also utilize the involuntary termination of a service process. So it applies to all services.

Again, we've been working on -- the IDD TAC, excuse me, has been working on this issue for at least five years, probably longer, but I can only talk about at least five years. Earlier this year, the IDD TAC submitted recommendations based upon that five years of work to the MAC, which then

submitted that information to Medicaid. And Medicaid -- Kentucky Medicaid responded with a letter, and in that letter, Kentucky Medicaid said that it supported the implementation of structured and consistent time frames, or a structured and consistent 60-day time frame for involuntary terminations. In that response, Medicaid requested that the IDD TAC gather critical information to help inform -- to help inform Medicaid's policy decisions related to this. So I just want to be really clear. Medicaid asked that the IDD TAC gather information, submit ideas related to the information, but again, just so everyone knows, this IDD TAC has absolutely no ability to form policy, the MAC does not form policy. We discuss things and submit those ideas to Medicaid so that it can consider them as it considers changes to any policy, not just this policy.

So Medicaid asked that the IDD TAC look at a few areas as we consider this -- the involuntary termination policies. They asked that we, the IDD TAC, create, talk about exceptions for critical safety

concerns, so to develop a proposed criteria that would allow for expedited termination in cases where continued support would present a verified and immediate threat to the individual or others; define transition requirement -- transition planning requirements, meaning that providers require that providers submit a transition plan detailing interim supports, referral efforts, and coordination with case management during the 60-day involuntary termination of a service process; implement provider support measures, so assess options for enhanced technical assistance, crisis intervention support, and temporary funding solutions to help providers manage high-risk transitions; and then conduct stakeholder engagement, which is what's happening right now. And again, these -- this all comes directly from the letter from Medicaid. These are not my words, I just kind of cut and pasted from that letter.

So one of the things that we discussed as we talk about stakeholder support -- or stakeholder engagement related

to the involuntary termination of a service process was to really do a survey of providers to see -- to get a handle and get data about what exactly we're talking about, how widespread is the issue, what is the impact, things like that. And that's kind of where I come in. Obviously, I am the CEO of the Kentucky Association of Private Providers. We are Kentucky's association for 1915(c) Waiver service providers, so in my position, I have access to a lot of providers that I can quickly get a survey out to, and so that's what we did. We surveyed residential Level 1 and Level 2 providers, so staffed residences, and family home providers, residential providers, and then case managers. And we did this because while, again, we said that every service provider type, so behaviorists, nutritionists, therapists can engage with the involuntary termination process if they feel like they can no longer support an individual, and they do, that does happen, the majority of involuntary termination of a service notices we see are for residential

services. And so for the purposes of this survey, that's what we focused on, and again, I do not want to diminish at all the fact that other services do engage with this process when necessary. And then obviously, we also surveyed case managers because they see this from a completely different perspective, they have a different view, and they case manage lots of different types of people with lots of different diagnoses, and then they can offer a unique perspective.

So our response was we had 62 individual provider agencies that provide residential services respond to this, which is quite a lot. And then 69 independent case managers, which is also quite a lot. So we can confidently say that well over two-thirds of our members responded to this survey and offered input. And again, so that's just a little baseline of what we're -- of who responded and what we're talking about.

Hold on, let me fix my screen so I can actually read what's on the page. So we asked both case managers and residential

providers: Do you think the current involuntary termination process works well? So for residential providers, 74 percent of them responded that it does not work well when the participant has a history of aggressive or violent behaviors, a history of law enforcement encounters, or intense support needs, including medical supports. And it is important to note that medical supports are often a reason for initiating the involuntary termination of a service process. Twenty-five percent of residential providers said it never works well, that process never works well. Case managers, 85 percent said that it does not work well when that participant has that history of aggressive or violent behaviors, etc. Thirteen percent of case managers said that it never works well, and then one case manager, just one, said that it works well all the time. So I'm glad that they believe that it does work well all the time.

Then we decided to ask both residential providers and case managers if they'd ever -- residential providers if

they'd ever had to issue an involuntary termination notice, and then case managers if they'd ever case managed someone -- if they'd ever had someone on their case role that had received an involuntary termination of the service notice. So 90 percent of residential providers have issued an involuntary termination notice, 10 percent -- about 10 percent -- I'll round sometimes in this conversation -- about 10 percent have not. And case managers, 72 percent have case managed someone who has received a notice of involuntary termination of a service from a Residential I or Residential II provider, and about 28 percent have not.

We asked residential providers, on a scale of 1 to 10, how much strain does the current involuntary termination of a service policy place on an agency when an individual remains after that initial 30-day period. And 67 percent of providers said that -- rated it a 10, tremendous strain. So that's obviously not great. No provider rated it under a six, so that's -- you know, that's

not great, that's not really where we want to be.

We also asked both residential and case managers about their typical annual utilization of this involuntary termination of a service process. So first, residential providers, 69 percent said that they rarely have to use this process, so less than once a year, which is wonderful. And 24 percent said that they occasionally have to use it, which is 1 to 3 times per year. So about 74 percent of residential providers need to use this process less than 3 times a year, which is good. We don't want people over utilizing this process, so, you know, less than 3 times a year at 74 percent is good. No residential providers said that they needed to use it more than three times per year, and several said that they had never needed to use it.

Case managers, 72, 73 percent said that they have a participant, 1 to 3 participants per year that they case manage that receive a notice of involuntary termination from a Residential I or

Residential II provider, and 20 percent said 0, so that's great as well. And what this shows us is that this is not happening super frequently, and that's -- we don't want it happening super frequently. And so this is kind of in line with, you know, ideas and beliefs that we had about how much it was being utilized, but it's good to see the data behind it.

We asked case managers what -- in their view, what they saw the most common reason for involuntary termination notices, again, when we're talking about residential services. Overwhelmingly, 57 percent said behavioral challenges; 23 percent -- and this was a "select all that apply" question, so you didn't have to just select one reason -- 23 percent said safety concerns for the participant or others, that other could be participant's roommates, staff, etc.; 4 percent said lack of appropriate staffing or resources at the provider agency, and a lot of times, that can have to do with medical needs. The provider agency doesn't have, for example, someone who is able to

issue sliding scale insulin, things like that, G-tubes, things like that. Now, 3 percent said the participant's medical needs, again, what we just talked about, and then 13 percent kind of selected everything, a mix of all of these things or the all of the above. But again, overwhelmingly, it had to do with behavioral challenges and safety concerns.

We asked case managers how long -- the average time that it took to get a new residential placement after a notice of involuntary termination of a service was issued, and we asked them in two ways. We asked them for how long it took for participants without significant behavioral challenges or criminal history, and then we asked them how long it took for participants with significant behavioral challenges or criminal history, and the results are very interesting. So for participants without significant behavioral challenges or criminal history, 25 percent said 1 to 3 months; 25 percent said 3 to 6 months; and 22 percent said 6 months to 1 year; and then

19 percent said over a year. Now, if you compare that to participants with significant behavioral challenges or criminal history, 42 percent at 1 plus year; 31 percent said 6 months to 1 year. So when you compare these, it is very clear that participants with significant behavioral challenges or criminal history on average take much longer to find a new residential placement. Again, this is something that we suspected and that we kind of anecdotally knew, but it's very interesting to see the data comparison on this issue.

We asked residential providers and case managers, and this one is very interesting, about their willingness to accept a referral for a participant within intense support needs if a true 60-day period of involuntary termination of a service was enforced. Overwhelmingly, nearly 100 percent, 97 percent of residential providers said, yes, they would absolutely accept someone. Now, what's interesting is that case managers are a little bit more skeptical, and they said

that -- only 70 percent of them said that they believe that a residential provider would be willing to do this. And this is really interesting because residential providers are saying, "Yes, we would do this, we would do this," and case managers, you know, I think just are a little bit more skeptical. But this -- I think this really demonstrates, again, something we anecdotally hear about a lot is lots of misunderstanding on person-centered teams between members of the team, and not -- just not quite understanding where each other are coming from on how these teams operate. And I think this is a data point that just really does indicate the lack of understanding sometimes on person-centered teams, just different perspectives, and how that can create tension in person-centered teams sometime. But this one was definitely some -- an interesting result.

We asked residential providers what they -- this was, again, one of those select all that apply questions -- what challenges they faced in finding alternative placements

after issuing that involuntary termination of a service notice. And so 98 percent said one of the biggest challenges was just finding another willing or available provider; 77 percent said difficulty matching the participant needs with available services; 55 percent said insufficient funding for alternative placement; and then 63 percent said participant or family resistance, which was very interesting.

So we asked the same question to case managers. Again, this is a select all that would apply question: 90 percent said lack of willing or available providers; 64 percent said difficulty matching participant needs; 44 percent said funding for alternative placement; and then 26 percent said participant or family resistance.

We also asked what -- both residential providers and case managers, what resources would be most beneficial to them to help manage the needs of an individual after an involuntary termination

of a service notice has been issued. Both residential providers and case managers overwhelmingly said active involvement from state officials, 79 percent and 81 percent. And I think that this indicates that they really would like to see individuals from the Cabinet, whether that be, you know, DDID or Medicaid -- we didn't ask specifically what department, we just kind of asked generally -- to see them be more hands-on with this process to help. They also noted, 73 percent of residential providers and 64 percent of case managers, financial assistance for extended support services, whether that be crisis, things like that, but definitely more funding for those things, which wouldn't we all like to get more funding for those things if we could -- if we could just find the money? Residential providers said -- 71 percent said dedicated case management for transition planning, and that would be, you know, like a third party that comes in and really helps everybody involved manage the situation, whether that be someone from the

state, or a type of case management that's just dedicated to these kinds of unique situations with someone who has very intense support needs.

Case managers said -- 64 percent of case managers said increased access to crisis services; 58 percent of residential providers said increased access to crisis services; and then -- sorry -- 90 percent of case managers wanted additional professional development and training from, you know, Medicaid, from the Cabinet on identifying alternative placement resources. And they asked that this be ongoing because obviously, resources and things like that do change. You know, new things become available, but they did ask for ongoing professional development or training on those items.

So we asked case managers to rate the level of support they felt that they received from the state -- again, we just termed it "the state," we didn't identify any particular agency or department or anything like that -- during the involuntary

termination process: 40 percent of them said 0 support, and again, this is on a scale of 1 to 5, 5 being just unlimited, overwhelming support; 29 percent rated it a 2; and 24 percent rated it a 3, which would be, you know, medium support.

Okay, so those are -- we have more survey results, but they start to go into a slightly different topic. So those are just the general survey results about the general involuntary termination process. Again, referring back to the letter, the Cabinet for Health and Family Services also asked about -- talked about creating criteria for critical safety concerns, so emergency situations, to create criteria for emergency situations in which, you know, the 60-day time period would not suffice. You know, this was a critical area, you know, a truly emergent situation, so we also did add survey questions kind of addressing that topic area where we asked -- so our task, again, was the Cabinet very specifically said, "Develop criteria that would allow for the expedited termination in cases where

continued support would present a verified and immediate threat to the individual or others."

So we asked residential providers -- and case managers, but first, I'll talk about the residential providers -- what criteria that they would consider warranting expedited termination, so prior to the termination within that 60 days -- excuse me, before that 60 days expired: 95 percent said -- and again, this was a select all that apply kind of question -- 95 percent said injuries have occurred to the individual, the individual's roommate, or staff supporting the individual since the termination notice was issued; 96 percent said the individual supported has exhibited sustained criminal behavior; 90 percent said the provider is unable to maintain/hire trained staff who are willing to work in a residential setting with a participant exhibiting severe behavioral challenges; 85 percent said the individual is demonstrating consistent and/or increasing aggression towards staff or others without

any effective behavioral modifications; and 89 percent said the individual supported is destructive and causes excessive property damage; 85 percent said a report from a licensed medical mental health professional indicating that harm is imminent to the individual supported or those present in his/her current environment.

So then we asked case managers, "What criteria do you consider warranting this expedited termination?" 71 percent said injuries have occurred, and then 78 percent said the individual supported has sustained -- exhibited sustained criminal behavior.

So again, taking that and remembering sort of the charge of the letter that Medicaid issued to the TAC, we thought a lot about what these -- what this criteria would look like and sound like, and based off of the survey results we received, we developed suggested for discussion criteria. And so that criteria would be that a provider may request expedited involuntary termination of a service after it has issued the general

notice of involuntary termination in accordance with the SCL regulation. We said that a criteria should be that a provider may request expedited involuntary termination when the health, safety, or welfare of the individual enrolled in the waiver, other individuals in that setting, or provider staff at risk of a verified -- are at risk of a verified and immediate threat.

And I want to be clear here that we consulted with colleagues in other states, looked at other state regulations, gathered a tremendous amount of information to suggest items that were in line with what other states are doing. Language that mirrors what other states are doing, and so these suggestions very much mirror what's happening elsewhere in the country.

Expedited -- we suggest that expedited termination of a service shall occur only if approved, you know, by DDID, meaning that a provider can't just stand up and say, "This is an emergent -- this is an emergency situation," you know, "they have

to be out tomorrow." There needs to be a process by which DDID is approving -- reviewing and approving this to make sure, you know, everybody's on the same page and this truly rises to the level of emergent and critical. We suggested that the expedited and involuntary termination period -- and again, based off what is the norm and what is happening in other states -- should be implemented based upon the severity of the situation, but shall not last longer than 14 days.

And so then we kind of talked about when the expedited involuntary termination, again, within that 60-day period, quicker than that 60 days, to be used in very limited circumstances would be approved -- again, approved by DDID, not just Joe Schmoe, not just me or someone else. So again, borrowing language from other states, looking at what other states do, expedited involuntary termination would be approved by DDID. We suggest that they would approve it when the provider provides evidence that continuing the service to the participant

would: A, jeopardize the safety of the provider, an employee of the provider, or an individual receiving services from the provider in that setting; or endanger the health, safety, and welfare of the participant -- again, this is very much in line with the survey results we found -- and, so both one and two must be in place, the provider documents measures that it took to address the behavior that resulted in the request for immediate termination.

So then we looked at, again, what other states do for this process, and we created these suggestions that to request expedited involuntary termination, the provider should submit evidence to DDID, the case manager, the guardian, you know, others involved that: One, recent injuries have occurred to the participant, other individuals supported by the provider in that setting, or staff; or the participant has exhibited sustained aggressive and/or threatening behavior, including but not limited to, physical violence, sexual assault, significant property destruction or

threatening behaviors to self or others; or a licensed -- a report from a licensed medical or mental health professional indicating that the participant is at imminent risk for self-harm or those present in his or her current environment are at risk of harm from the participant. So this is a -- this is a weird thing you do when you write regulations, but this is an or, or, or situation, meaning that one of these three things -- the provider would need to submit evidence of one of these three things with the request for involuntary termination.

So this is more of kind of we went a little above and beyond here, but this is more about the process of requesting the involuntary -- the expedited involuntary termination. So within one business day of receiving the request -- this is, again, in line with what other states are doing -- the request for the expedited involuntary termination, we would suggest that the case manager convene a meeting to talk about that request, and that meeting should include the

individual; importantly, a designated DDID staff member so that they can be apprised of what's happening as they will be the one that we suggest who approves such request; the provider, obviously, who is requesting this expedited process; the guardian; and then, you know, other members of the team -- other relevant members of the team. Within one business day following that team meeting, a DDID person, designated staff person, shall approve or deny the provider's request for immediate involuntary termination, and again, we're talking about -- this process moves quickly because we're talking about a process that should be used in very extreme, very limited situations. This should not be utilized often. Again, we're talking about extreme and limited situations, and given the severity under which providers should be, you know, utilizing this based upon what happens in other states, it would definitely require a quick turnaround in response time because again, it would be a truly dangerous situation. And then if denied, a provider

may resubmit additional information for consideration, you know, at a later date if another situation arises or comes up. And if denied, then the typical involuntary termination process of 60 days would just continue and move forward just like normal.

If a request for involuntary termination is approved, based upon what other states do and the information we gather, we suggest that then the case manager would convene another team meeting so everybody can get on the same page and discuss, you know, next steps, and that that meeting should include all the traditional people, including -- but also importantly including a DDID staff person, and again, that's based upon the fact that providers have reported that they overwhelmingly would like to see more involvement from agency officials.

And so that's kind of the survey results. And Wayne, if it's okay, this kind of parlays into the conversation of creating a general policy addressing those other items, so would you like me to go into that,

the larger policy addressing the other items that would include this, or would you like to pause for questions?

MR. HARVEY: I absolutely -- I'd like you to parlay. The other thing I'd like to do before you parlay into that, Amy, is that there are some questions popping up in the chat room --

MS. STAED: Oh, I'm sorry, I can't see.

MR. HARVEY: -- and -- well, they're not questions for you really. I think they're questions that have been debated and talked about over the last several years, and what I'm going to say is what we're focusing on as a committee is what DMS asked us to assist them with. And we're not going to get sidetracked in today's meeting and go down all these other roads because we're not asked to address some of the different things that are popping up in the chat room.

So, you know, they're legitimate questions, I agree with that. I advise you to send those particular questions to the help desk and have the Cabinet answer you

directly, because ultimately, yeah, I'm just another provider. I can't speak on behalf of the Cabinet. I can't give you an official answer in regards to the different things that the state will or will not hold you accountable for. So with that, let's go ahead and proceed, Amy.

MS. STAED: Yeah, and I just, again, to add to what Wayne said, the letter from DMS to the TAC charging the TAC to develop very specific items, and one of those items was not figure out the solution to the problem we all know exists, which is there is not a level of -- a service, excuse me, between a staffed residence or a family home provider and an ICF that exists. That is a little bit, you know, higher level of needs support for someone who needs that. That doesn't exist in Kentucky, and that's not the problem that we've been asked to give feedback on by Medicaid from this letter. And so I think to just move the conversation forward, we are responding developed responses specifically to the items that Medicaid asked us to respond to in the

letter, and that's all we can do is respond to the questions that we have been asked to move the -- to continue making progress and moving the conversation forward.

Hey, let me switch my share screen. Hold on just a second.

MS. WASH: Amy, this is Barbara from DMS.

MS. STAED: Yeah.

MS. WASH: Could you please email that slideshow to me, please --

MS. STAED: Yes, absolutely.

MS. WASH: -- and I can send that out to the TAC committee.

MS. STAED: Yes, I will do that.

MS. WASH: Thank you.

MS. STAED: Let me find my -- sorry. Okay. Okay, can everyone see that?

MS. WASH: Yes.

MS. BICKERS: Hey, Wayne, this is Erin with the Department of Medicaid. Is this the regulation information that you had sent out earlier? Because our regulation person is not able to be with us today.

MS. STAED: Yeah.

MS. BICKERS: Also, everything you share in the public meeting, we have to post online.

MS. STAED: Yeah.

MS. BICKERS: And I'm curious about some of the confusion it may cause, so we'll just have to make sure that when this is shared, that it's noted that this is not -- this is TAC-driven, this is not something official from DMS.

MS. STAED: Sure. Yeah, and I can talk about --

MR. HARVEY: Absolutely, Erin.

MS. STAED: Yes.

MR. HARVEY: Just to address that real quick, just so everybody understands that's on this call, this is not official, this is for our discussion among committee members. When I sent this out to the other committee members yesterday, I made sure to include a little note indicating, "Please do not forward this to anyone else to cause any kind of confusion or misconception." This is not a Cabinet document or anything. This is just something that was drafted that

includes the different elements that DMS asked us to look at and assist them with. And it's for discussion purposes during today's TAC meeting.

MS. BICKERS: Thank you, Wayne. Amy, what I would recommend is have your members pull that up separately so that it's not showing during the public meeting while we go through it so we can have the discussion. You know, just trying to make sure we don't cause any kind of confusion or anything.

MS. STAED: Sure, that's fine.

MS. BICKERS: Thank you. And then we'll make sure Jonathan Scott can join us next time. I do apologize, he was unable to be here, he had a conflict.

MS. STAED: Oh, no, that's fine. Let me find my document again, though. I accidentally exited out of it so we can talk about it. Okay. That -- are we good? That's not sharing anymore, is it?

MS. WASH: No. Yes, ma'am.

MS. STAED: So --

MS. BICKERS: We just want to make sure where that fine line between what we

have to put online and versus --

MS. STAED: No --

MS. BICKERS: -- somebody that may pull it up and not be on the meeting, so thanks, Amy.

MS. STAED: No, no, no, I -- believe me, I get it. And that -- again, that was a concern of mine as we developed this, which is why kind of at the top of it I did put "for discussion purposes only, consideration development of policy changes."

But in looking at the letter from Medicaid to the IDD TAC in the development of a policy, we kind of thought the easiest way to address all of the items that it asked us to address was to simply write a hypothetical version of the reg that included the items that Medicaid asked us to address. So some of the things that we suggested Medicaid take a look at as it develops a policy related to involuntary termination, which is, one, in the letter, Medicaid did agree that they would put -- did agree that a 60-day time period -- that the involuntary termination of a service

should be implemented in an in-person centered manner, but shall not last longer than 60 calendar days, which was agreed to in that letter. We do believe that that should be in a policy or regulation moving forward. That the notice of involuntary termination, obviously, would just continue to be as it is in the current regulation, it stay the way it is because it's -- no issues with that. And then we really started to talk about the transition planning requirements that Medicaid asked for suggestions on in its letter, and we said that, obviously, a team meeting should be happening after -- to develop a transition plan after that notice of involuntary termination for a service is issued; and that we, again, based upon the survey results, believe that a designated DBHDID staff person should participate in that transition planning team meeting that should take place after the notice of involuntary termination of a service is issued. So again, to specifically address what was requested in the letter, which is transition

planning requirements, during that meeting we suggest that the team -- this is taken directly from several -- what several other states require in their regulations for transition planning of waiver services in these specific situations when an involuntary termination has been issued, they call it different things in different states, but same process. One, consider the current system of services and supports and the effectiveness of them. Two -- and again, these are things that are already happening, but it's really just getting them on paper and creating those requirements and outlining really what's already happening. Two, consider if additional services should be added to the support plan during the 60-day transition period to ensure health, safety, and welfare of the participant, other individual staff, etc. Collaborate with designated DBHDID staff to identify additional funding or resources that may be accessed during the 60-day transition period to ensure health, safety, and welfare. Four, and if complex medical conditions are

a concern, the person-centered team shall discuss and identify strategies or resources to ensure access to medical services and supports during that 60-day transition period.

We also said that because this is what Medicaid requested in its letter that the team should develop a transition plan after the notice of involuntary termination is issued, and that we suggested that that transition plan be submitted to DBHDID within 14 days after the notice of involuntary termination is received, and that kind of transition plan kind of outlines all of the discussion of the person-centered team, that transition planning discussion, and kind of what steps everyone's going to take during the 60-day period.

So the members of the team shall work -- we think should work collaboratively to develop the transition plan, and that the transition plan should contain the following information: It should detail the supports that will be implemented during the 60-day

transition period; it should detail interim funding or resources that will be requested during the 60-day transition period; it should contain a description of how the service provider will ensure the health, safety, and welfare of the participant, other individuals, staff during the 60-day transition period; and detail the case manager's referral efforts; and include a description of coordination and collaboration between case management, the service provider, and the members of the person-centered team during that 60-day transition period. And again, all of that is really suggestions intended to address the bullet point in the DMS letter to the IDD TAC specifically requesting transition planning requirements that should be implemented during the 60-day transition period.

Then we -- again, we talked about when we kind of get into the -- that involuntary termination of a service, the emergency, the expedited involuntary termination that we just discussed, so, you

know, those requirements that we just discussed, we firmly believe in. And then -- yeah. And then the bullet point related to provider support measures, again, we believe that this has been pretty thoroughly discussed ad nauseam and would point the Cabinet for Health and Family Services to the legislative -- the Exceptional Supports Legislative Task Force, which was specifically designed to talk about that very issue, additional provider support measures. And there are findings in -- extensive findings and recommendations related to that that, you know, we believe Medicaid is in receipt of and did receive; however, happy -- I am happy to provide a copy of that if you all need it, point them there, because there are numerous solutions outlined in that document, and there we are.

So those are -- that was a lot, and those are the items and suggestions that we kind of came up with based upon feedback from the survey, etc. to address -- specifically address the items in the Medicaid response to the IDD TAC.

MS. WASH: So Amy, this is Barbara, and Ann Jeannette Pierce would like a copy, please.

MS. PIERCE: Thank you, Barbara.

MS. STAED: Which item? Sorry.

MS. WASH: I think --

MS. STAED: Of the task force finding and recommendations?

MS. WASH: I believe --

MS. STAED: The exceptional supports?

MS. PIERCE: (speaking on mute)

MS. WASH: You're muted, Ann.

MS. PIERCE: Thank you, Barbara. You were just talking about it, Amy, that one.

MS. STAED: Oh, yeah, Barbara is it -- would it be appropriate for me to send it to you to distribute to members of the TAC?

MS. WASH: You could send it to me.

MS. STAED: Yeah, okay, I will. And it's -- you can find it on the LRC website, but that's kind of difficult to navigate.

MS. WASH: Yes.

MS. STAED: So I'll just send it.

MS. WASH: Send it to me and I will

forward it to the committee.

MS. STAED: Okay.

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

MR. HARVEY: Sure, go ahead.

MS. TYNER-WILSON: Okay. Thanks for that information, Amy. One thing that I am so excited about is that the last bullet point, conduct stakeholder engagement and survey and get feedback, because I think that is -- as someone that has lived a long time lived experience with someone I care very much about, that would be very, very important. I heard what you're talking about in regards to the involuntary termination, but I also think critically what's equally more so important are these caregivers, self-advocates that have lived life with these individuals. Their concerns are -- may be similar, may be different, but I'm so pleased that that was referenced in the letter from DMS.

The other thing is -- and help me to understand -- is when you talk about services, do you talk about things like

applied behavior analysis, ABA? Because --

MS. STAED: Sure.

MS. TYNER-WILSON: -- that's something that in -- historically, we had not had as robust of providers in our state. I think we have 260 currently, people that are certified ABA therapists, as well as RBTs, so hopefully, that number will continue to grow and expand and provide insight and information to provider agencies like you represent, because it's so much -- it's so important.

And the other thing I wanted to ask about is oftentimes when an individual has significant behaviors and they're nonverbal, sometimes there's medical concerns, like cavities, wisdom teeth, G.I. upset. Is there like a sequence in your all's world that you try to almost like be detectives to figure out what's going on with that individual?

MS. STAED: So let me address your first question first.

MS. TYNER-WILSON: Okay.

MS. STAED: Number one, I will say,

yes, so this -- the involuntary termination of a service process as it currently exists in regulation, which is 907 KAR 12:010, Section 5, it's there for everyone to see, applies to every service. So if a provider of any service feels like the needs of the individual far exceed what they can provide or if they're failing to meet those needs, they would issue a notice of involuntary termination in line with the current reg, referrals would be set out, etc. It applies to all services. And really that is important because, you know, just, for example, like a doctor, like a cancer doctor who says, "Your case has gotten much too complicated for me, I need to refer you to someone else who has more expertise." It's important that we allow providers to do this, too, to wave the white flag, and say, "This is above my ability," right?

And so, yes, it would apply to behavior supports is the service within the waiver that you're referencing for, you know, ABA, etc., but yes, it would apply to that behavior support services. And I do

agree, it's a great service and would love to see expansion of that service and more providers out there and more providers getting into it. I think that would be wonderful.

To your second question, talking about kind of that investigative process or the teams, obviously, I'm not going to speak on behalf of every single provider because every team operates differently, and they do that because we have the person-centered planning process, and the needs of that individual from team to team are very different, right? And the individual drives the team, and so every team operates very differently. But I will say is that number one, teams do an amazing job of exhausting all resources, and we do, thankfully, have very specialized medical options available for people with disabilities, you know, shout out Lee Specialty Clinic, they're wonderful. But additionally, I think that some of the transition planning requirements that we have suggested be put into regulation, these things are really already

happening, right? But in case they're not, like obviously, we all know of situations where a team might fail to do their job, it's certainly happened before, and I'm not going to pretend like it hasn't. And so I think that putting some of these transition planning requirements, you know, in place in regulation like we've suggested, really solidifies what everyone is supposed to be doing, and really, you know, kind of outlaws -- outlines, excuse me, the minimum, you know, of what everyone should be talking about and what things we could be thinking about.

And I also think that adding and requiring the participation from that DBHDID staff person in that team -- not all team meetings, but just the team meeting when we're talking about involuntary termination of the service, can really benefit the teams because oftentimes those Cabinet staff people may know of a resource that just became available, something brand new that the teams might even not be aware of yet or hadn't considered and be able to interject

and say, "Oh, what about this?" So that's why we really feel like that participation, when we talk about involuntary termination of a service, is so critical and important, because, you know, oftentimes people in the Cabinet can have that, you know, thing in the back of their head that they don't even realize there's necessarily there that gets triggered by that team conversation, and that's why we think that participation is so critical. Does that answer your question?

MS. TYNER-WILSON: Yes, and I think it's so incredibly important to have a continuum, I mean, because what happens, I think when you hear that language "involuntary termination," I think the angst that goes to my heart is that that's going to be something that's jumped on at the very beginning as opposed to really investigating a whole range of, you know, options and what's actually happening in the individual situation, as well as competency and training needs of staff, you know, because we're all kind of in this journey. I mean, you know, we -- I'm always attending

professional development kinds of things as a caregiver because I know there's a lot I don't know, and I need to learn more. And so -- but I think that -- I think that's -- comes up oftentimes when they see that term, even though the percentage of individuals that this is considered for is small, but it is kind of a scary situation. And it's almost like we need -- I wish we had kind of an intermediary step, you know, before we got to involuntary termination, and maybe that's what you tried to outline in your presentation that all of that be put in place.

MS. STAED: Well, and I will interject and say that, you know, anecdotally we see, and I think by the numbers of involuntary terminations that we did in that survey that are issued per year, they're so low.

MS. TYNER-WILSON: I know.

MS. STAED: Teams try everything in our power -- I mean, teams frequently, you know, if a new behavior arises, new medical need, or, you know, whatever the situation

is arises, teams frequently -- they can -- you can call a team meeting, you know, anytime, come to the table to address adding additional services and things like that. And so I think that, you know, it truly is, as it stands today, used as a last resort of "we just cannot do this anymore."

Because again, when we talk about service providers, I think sometimes people take -- happen to take a skeptical view, things like that, and that's just the nature of the world we live in. When you talk about caregivers and service providers no matter the setting, they truly -- I mean, there are some residential providers who have supported people for 25 years --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- you know, 20 years, and if it comes a day that they have to say, "We can't support this person anymore," that's not an easy choice, and I'm sure any provider on this call would be able to talk about that with more authority than I can. But, you know, you're absolutely right that no one should be doing this frequently, and

I think the numbers indicate that it's not, and especially given with the Involuntary Termination Summary Report that Elizabeth was talking about earlier, you know, providers are often -- we see them rescind that because they do finally --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- find that solution and then the team works really hard, and they do find that solution and they rescind it. And I think that's wonderful, you know? That's wonderful. So we are seeing that happen.

I just don't -- you know, without -- thankfully, we do have that Involuntary Termination Summary Report from the Cabinet now so we can actually get, you know, data about that happening because it's not something that you'd hear about frequently before then, and now we're -- you know, we're talking about it. So I think that's great shedding light that that is happening.

MS. TYNER-WILSON: My reason for commenting is not to villainize anybody.

MS. STAED: Oh, gosh, I know. I know.

MS. TYNER-WILSON: I think we need to -- we're in this together, and, you know, my life experience is unique to my life experience with my loved one. But I think that there's such wisdom, and I guess I would advocate for there to be a stakeholder engagement group, you know, that's pulled together because I think they do provide insight to the whole issue and challenges. You know, I think that I've learned everything -- I've learned so much from other caregivers that just happen to be a little further down the road, you know, with their loved one than me. And I think maybe that might be something to consider in the future, I don't know, but, you know, I wish there was a way that we could figure this out for what's best for the individual, because obviously, you want them to have a quality of life that's a positive quality of life, right?

MS. STAED: Oh, yeah.

MS. TYNER-WILSON: I mean, that would be my priority.

MS. STAED: Yes. Well, and I think

-- you know, I think that's what we've done here. I think all the suggestions that, you know, we've suggested today are specifically aimed at for protecting the individual --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- and also protecting the individuals that live with that individual, too, because, you know, no one should be subjected to --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- living with a violent roommate that attacks them. We wouldn't want that either, you know, right? But I think that we've tried to balance the interests of staff who don't want to be in dangerous situations, individuals who don't want to be in dangerous situations, etc., to create a situation that allows them to, you know, hopefully find a new provider, and is going to open up residential options who previously may have been worried to try -- worried to try or scared to try, and now they won't be scared to try.

And oftentimes -- and again, I'm speaking anecdotally. I think case managers

and other types of providers would be able to give you, like, concrete examples of this, but oftentimes, when someone's in a -- having extreme behaviors, etc., simply a change of scenery --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- is what's needed, right? And we have seen situations where someone, you know, moves to a new provider or a new area of the state, closer to their loved one, a different house, different roommates, etc., right? And it's -- everything changes, right? And sometimes it's as simple as that. Often -- sometimes it's not. Sometimes it's a UTI or a dental problem, like you said, and obviously, these, you know, different situations arise, but I think we've really tried to as Medicaid asked this TAC to do is balance the interests of everyone involved.

But I think it's important to refer back is that Medicaid does believe that a 60-day time period is reasonable, and creates for safety everyone involved, and of paramount importance is the safety of the

individual, because when an individual is having extreme behaviors and things like that or could be subjected to violence from a roommate, that's not safe and that's not ideal and no one wants that to be happening, right? Nobody -- no one wants anyone to have to live in a situation -- or in a situation where they feel unsafe.

And so I think that that's what we've tried to do here, hopefully, and that's where my heart's at, at least. I can't say for anyone else, but I would assume that that's where their heart is as well.

MS. TYNER-WILSON: Yeah. I hope that we can go -- I'm not sure what -- what is the -- as a result of having this presentation, what is KAPP's --

MS. STAED: So what we would love to see is -- again, to be clear, the IDD TAC cannot make policy --

MS. TYNER-WILSON: Right, right.

MS. STAED: -- it cannot make changes, etc., but we would love the TAC to agree to just forward this information to Medicaid -- to the MAC, and then the MAC can

forward it to Medicaid. We have to forward it to the MAC first just procedurally. So that the MAC can submit it to Medicaid so that just simply so that it can consider it, right? That's all we want is we want the information to be sent to Medicaid through the MAC so that it can consider it. And the key with doing this procedurally is that anything sent to Medicaid from the MAC, Medicaid has to issue a response to, and that's what we want, right? We want Medicaid to consider it and respond as it moves forward with developing a process and a criteria and making changes. And that's all we want. We just want Medicaid to be able to consider the information and respond, and they may respond "this is stupid," you know, they may respond that this is silly. I don't know how they're going to respond, but I think all we want is to forward the information so that Medicaid can talk about it and respond. That's what we're looking for.

MR. HARVEY: Do you have any other questions, Melanie?

MS. TYNER-WILSON: You know me too well, Wayne. I think --

MR. HARVEY: I noticed you didn't mute yourself --

MS. TYNER-WILSON: I know.

MR. HARVEY: -- so I'm thinking something else is coming.

MS. TYNER-WILSON: No, and my first response is to, you know, is to want -- I hear what you're saying, I don't want to be dismissive of that, but I also really -- I mean, I think that the timing of all of this, we probably need to have a chance to review and look through the information, and maybe bring this up in the December meeting, because I think that's -- you know, we got the information just recently. But I also just feel it's very important to make sure that we have, like, I -- like, the conduct stakeholder engagement, how do we -- how do we get feedback, you know, from individuals that are guardians, whatever you want to call them, that have loved ones that are in the residential facilities that are -- you know, have had experience with that? I --

I'd love to be able to hear insights from those folks as well.

MS. STAED: Well, I mean, this is a public meeting, and I would say that you represent a group of people -- your seat on the TAC, you represent a group of people, right? Like, everybody who is a member of the TAC is fulfilling a role, and that role is outlined in the statute, right?

MS. TYNER-WILSON: Yeah.

MS. STAED: And so, you know, you represent a group of people for whom's seat you sit in. Just like Wayne does and all the other members of the TAC, you know, but, you know, this is a public meeting, and this in and of itself is stakeholder feedback, just like, you know, Johnny -- I'm sorry, I'm just looking at who is on my screen right now --

MS. TYNER-WILSON: Yeah.

MS. STAED: -- represents a group of people, etc.

MS. WASH: Ann has raised her hand.

MR. HARVEY: Hold on is -- are you done, Melanie?

MS. WASH: You're muted.

MS. TYNER-WILSON: I'll mute myself.

MR. HARVEY: I want to make sure Melanie is done before we move on. I don't want to move on before you're done. Okay, she's done, go ahead, Ann.

MS. PIERCE: Thank you, Wayne. She might have more questions. I just wanted to address this issue, and I think just the same as there was a survey of providers and case managers, that it would be -- I agree with Melanie, it's a good idea to do a survey of stakeholders. I think that's what she's trying to say.

MS. STAED: I fully understand. I don't have the ability to survey stakeholders. That's not who I represent. I think, again, there are others on this call who fill seats that are specifically aimed at representing stakeholders, but that's -- I have no ability to do that --

MR. HARVEY: Well, and the Cabinet could have --

MS. STAED: -- in full transparency.

MR. HARVEY: -- that ability. You

know, they could do surveys and so forth.

MS. PIERCE: Yeah, we're not asking you to do that, Amy.

MS. STAED: Yeah.

MS. PIERCE: We realize that. You've done a good job surveying what you did, but yeah, I think we need to do that also. I agree with Melanie that we need time to look at this proposal before it gets forwarded. This is first I've seen it, so.

MR. HARVEY: Well, I emailed it yesterday. You should've seen it for a day, at least.

MS. PIERCE: I did not -- I must've mistakenly been left off that email. I have a -- two pages of questions about this so far, so --

MS. STAED: Well, I'm happy to answer what I can. I'm here.

MS. PIERCE: I'm going to ask one of them, but the others, I really need time to look this over, and so that family members with lived experience will have time to add to what you've written. But I do have a question that bothers me that I would like

to ask you that I think maybe you can answer as CEO of KAPP. And that is why do residential providers, and I guess case managers for that matter, not realize that their individual or participant can't be served within the trial time period?

MS. STAED: I'm not sure -- oh, you mean like when a residential provider goes on a visit?

MS. PIERCE: So there's a trial time period, isn't there?

MS. STAED: Well, not really. So --

MS. PIERCE: There's not?

MS. STAED: -- when a referral is sent out, a individual is -- when we're talking about a residential placement, when a referral is sent out, often an individual will go on an overnight visit or a 24-hour visit. That's kind of generally the extent of it. Sometimes a weekend, but generally, it's an overnight, and oftentimes, the significant behaviors will emerge six months later, a year later. They do not emerge in that day or that setting. Or a medical issue will emerge that was not known at the

time of the initial overnight visit, and, you know, that's a conversation that we can have. We can talk about trial periods, and certainly this TAC had talked about it extensively about five years ago and making changes to that, but it -- you know, I think it's impossible to anticipate a behavior or a change, and honestly, people change, people evolve. Six months into being served by someone, you know, a new situation can arise, some sort of trauma, whether that be, you know, a new situation, a behavior can emerge, a medical emergency can happen. It's impossible to predict for a provider to say in a 24-hour visit, that, "Yes, I am going to be able to serve this person forever, and nothing's ever going to change with that individual, and I'm never -- I'm always going to be able to meet their needs." I think that's just an impossible thing to ask of a provider.

MS. PIERCE: Well, I misunderstood. I've had a couple of case managers tell me that there's like a three-month trial period, so --

MS. STAED: That's not true.

MS. PIERCE: So I guess then -- oh, okay. Thank you, Amy.

MS. STAED: I'd point you to the regulation. That's not there, that's not true, that's not how it works.

MS. PIERCE: Okay, thank you, Amy.

MS. STAED: You're welcome.

MR. HARVEY: Any other questions?

MS. PIERCE: I do have just I guess a comment more than anything, but I think DMS -- or is it CMS or DMS? I get them mixed up. Which one's the state.

MR. HARVEY: DMS.

MS. PIERCE: DMS.

MR. HARVEY: Department of Medicaid Services.

MS. PIERCE: Thank you. DMS. I've got to remember that. I think when they asked for a transition plan, the word "transition" to me -- to me means from one place to another, so I think they are asking for somewhere to go. What would we recommend that to look like? And it could be several things. A temporary, maybe go

back, but stabilization and go back, or something more permanent.

MR. HARVEY: Ann, here's what I'm struggling with right now in regards to your comments and in regards to your questions: I asked all committee members to send me their feedback on the responses that we received directly from DMS. I asked for that prior to September the 15th. The only people I received feedback from were providers themselves. So, you know, I don't understand why now -- we've been discussing this for years, I mean, literally years. So I don't understand why we're saying that there's more time needed to look at things that we've been talking about for years. Not days, not weeks, not months, but years.

MS. PIERCE: Okay, so my -- actually, I think the point I was making is that the transition means go from somewhere to another, which you kind of changed the subject on me, so --

MR. HARVEY: Well, I don't understand why you didn't formulate those thoughts and put them in an email to me like I asked.

MS. PIERCE: I just heard Amy say it just now. I'm just now seeing what you've written here, so I couldn't get it in by the deadline. And as I understand --

MS. STAED: To be fair, I think what Wayne is referring to is that at the last TAC meeting we reviewed Medicaid's response in which everything I've talked about today is in direct response to the Medicaid letter and the issues they asked of the TAC. At the last TAC meeting, Wayne asked all TAC members to submit feedback based on those items that were outlined and did the DMS response, which again, we talked about at the last TAC meeting.

And I'm not Wayne, so I don't know, but I -- he says that he did receive, you know, feedback, obviously from me, but from several other providers. And I think maybe a member of the TAC, I'm not sure. I think that's what he's referring to.

MS. PIERCE: Right, and so we're still not talking about transitioning to somewhere. I --

MS. STAED: Well, because the

transition -- the transition requirements were a very specific bullet point in the DMS letter, and so that's kind of what we're talking about here. And when we're talking about the transition period, yes, it is one place to another, but until you have that second place identified, you need to create a plan to support someone while we're waiting to identify that second provider as well. I think that's a really important piece of this, but, I mean, certainly, when an individual transitions from one provider to another, there is a -- there are team meetings, there is, you know, onboarding of that new provider, there is a plan put in place to achieve that transition of moving -- in particular when we're talking about residential setting, transitioning from one residential setting to another just even from a logistical standpoint of what day are we going to do this? How are we going to get the -- you know, their personal items moved? How -- when does this person -- when does the individual want to move? Things like that.

MS. PIERCE: Okay. So I think that -- I just think that needs to be part of our response. I don't think this response is ready to go. But you all did a -- I can see you worked very hard on it.

MR. HARVEY: Okay, thank you, Ann. Johnny's had his hand up for some time. Go ahead, Johnny.

MR. CALLEBS: All right. Thank you, Wayne. Just a couple of comments: Thank you, Amy, for all of the great information from the provider survey. I think, you know, one good thing or piece of good news is that involuntary terminations are rare. I think we know that, and now -- and the data proves that, so that's a good thing. So I think probably close to 15,000 people in the two IDD waivers, Michelle P. and SCL combined, and out of those 15,000 people we're talking about just a very small number of people who get, you know, a notice of involuntary termination. And then of that number, only 10 are still looking for, you know, a solution, a place to transition to after more than a year. So, you know, I

think that's good, it is rare, and it should be rare.

And I think the transition requirements laid out are good, and the, you know, seeking more involvement from state officials is good. I think Amy pointed out, you know, oftentimes they're the first to know about new resources in our state and what may be coming online soon that may be able to benefit a person, so I think that's a good recommendation as well.

Amy, one thing you mentioned that I would like to emphasize is that we don't have that extra level of care that's needed beyond waiver, but is short of, you know, institutional care, kind of a crisis system, a crisis response that can help in some of these extreme situations. So, you know, I think we need that. We've needed it for a long time.

And then, you know, we won't solve that here and I don't expect it to be in the proposed regulation, but something to discuss with Medicaid is, you know, after 60 days or on the 60th day, you know, after

involuntary termination notice has been given, and the transition plan is worked through, if there still is no willing and available provider, you know, then what? So again, that would be rare, I think, but we do have 10 -- at least 10 people that would affect right now, 10 folks who have been over a year looking for, you know, a resolution to their support situation. So rare, but it does happen. So I think we need to, you know, figure out collectively with, you know, providers, stakeholders, advocates, family members, Medicaid, you know, what could be a solution on that 60th day if there is no, you know, available apparent, you know, new provider for this person?

So those are my comments, and anyway, a really good presentation, and I think it is -- this is a tough issue to solve. I think every state in the country struggles with it, and I know, collectively, we just want to do, you know, what's best for everyone involved, but especially the person receiving the services. So applaud

everybody for, you know, their commitment to doing that, and for all the effort everyone's putting into it, so thanks.

MS. STAED: And Johnny, just to speak directly to those comments, which I obviously very much appreciate, I will be distributing the findings from the Legislative Task Force that spent an entire interim just talking about --

MR. CALLEBS: Yeah.

MS. STAED: -- that very, very, very issue, and I think there's some really excellent solutions in there, and I think that -- I mean, this is an issue everyone -- everybody on this call was aware of. Medicaid knows it, you know, the Cabinet knows it, we all know it, and again, that's why I would love to just point back to the solutions from that interim task force where there was tremendous stakeholder feedback, parent involvement, provider involvement, I believe -- I think the DD Council participated, I can't remember, it was so many years ago. But there was so much involvement --

MR. CALLEBS: Yeah.

MS. STAED: -- from all of the parties who truly want a solution.

And again, so would really -- that -- I will email that out and make sure everybody gets a copy of -- all the TAC members get a copy of that, but for anyone interested, you can go on the LRC website and find those task force findings and recommendations. I believe they're from the interim of 2020 or 2021. It's -- I get the years blurred, so.

MR. CALLEBS: Yeah.

MS. STAED: But it's called the Exceptional Supports Waiver Service Task Force for everybody involved.

MR. HARVEY: Any other questions, John -- Johnny, you done? I didn't mean to cut you off.

MR. CALLEBS: I'm done, thank you.

MS. STAED: And again --

MR. HARVEY: Barbara --

MS. STAED: -- I just want to stress that, like, the IDD TAC does not create policy. I think all -- regardless of

whether that happens today or at some other point in the future, all the TAC is able to do is just forward information for Medicaid to consider. That's it.

MR. HARVEY: Thank you for saying that, Amy. It saves me from saying it. Any other questions regarding the information Amy presented on?

MS. WASH: So Wayne, there are comments in the comment box and some of them are -- I don't see --

MR. HARVEY: Yeah, most of them are -- as I've indicated, it's really taken us off the path of what the meeting was about today. I do want to say that Elizabeth Markle did respond and say that out of the 10 involuntary terminations over 1 year, 1 is for day training and 9 are residential for anyone not looking at that chat box.

Any other questions among committee members?

MR. HOYT: Mr. Chairman?

MR. HARVEY: Yes.

MR. HOYT: Just a comment: I, too, appreciate, Amy, all of the work that you've

done. You know, I do think that this is an ongoing issue. Most significant portion of this -- of any recommended change, as I understand what you've presented, is the amount of time during which a provider would be required to continue supporting an individual from unlimited to 60 days. Now, there's some language that talks about the immediate involuntary termination, but is that correct, Amy, that the suggested change, the primary focus is from unlimited support -- unlimited period of time of support to 60 days?

MS. STAED: Yes. And that is in line with the response that Medicaid sent to the IDD TAC. At the beginning of my presentation on the slides, I directly quoted from the letter, which said that Medicaid agrees that -- let me just pull it up so I don't paraphrase. I don't want to get in trouble for paraphrasing DMS noted that it "supported the implementation of a structured and consistent 60-day time frame for involuntary terminations." And then asked for additional information that it

should include in its policy as it works to develop and implement a structured and consistent 60-day time frame. And the things that it -- the feedback it asks for as it works to develop that 60-day time period policy was the exceptions for critical safety concerns. So that would be the expedited termination process that we discussed; the transition planning requirements that we discussed; provider support measures, which we discussed, and we feel like are outlined in the Legislature's Exceptional Supports Task Force finding and recommendations; and then stakeholder engagement, which we are currently engaging in and have done elsewhere.

MR. HOYT: Well, thank you for that confirmation, clarification perhaps. Mr. Chair, this is, in fact, an issue that we have dealt with and many providers across the state have dealt with for quite some time. I think given the fact that we are an advisory group, not a policymaking group, it is my opinion that this moves the ball forward and I certainly think that the

Cabinet and DMS will in fact take opportunities to engage in input as the process would move forward. And so that said, I do like the document that has been put forward, and I would like to make a motion that the Intellectual and Developmental Disabilities Technical Advisory Committee formally submit to the Medicaid Advisory Committee the proposed regulatory language regarding the involuntary termination of a waiver service as presented and discussed today in this IDD TAC meeting. The purpose of that motion is to request that the MAC consider this proposal for submission to the Cabinet for Health and Family Services so that the Cabinet can review, evaluate, and implement it as part of ongoing assessment of potential changes to Kentucky's process for the involuntary termination of a waiver service.

MR. HARVEY: Okay, we have a motion on the floor. Do we have a second?

MR. SCHNEIDER: I'll second.

MR. HARVEY: Okay, Doug made the

motion, Brad seconded the motion. Any discussion?

MS. PIERCE: Yes, what is it, a point of order? No, point of information. I'm not sure what to call it, but because family members have not had time to review these proposed changes as evidenced in the chat, I move to postpone on this item until our next regular meeting to allow adequate review.

MR. HARVEY: I'm going to deny that, Ann, because we've been discussing this for quite some time, and you've had the information as much as any other committee member has had. Any other discussion?

MS. PIERCE: For the record -- Barbara, for the record, please note that family representatives have not been given adequate time to review these proposed regulation changes before this vote.

MS. STAED: I just want to be clear that I did not propose a regulation change at all.

MR. HARVEY: I would add to that, Barbara -- yeah, we've not proposed any regulation change. But I would add,

Barbara, that they've had the same amount of time as everyone else has had on the committee.

MS. WASH: Okay.

MS. PIERCE: That's incorrect, Barbara. That's an incorrect statement. Well, I just -- this is the first time I've seen this document is just now, just me.

MR. HARVEY: You were on the same email chain as everyone else was, Ann.

MS. PIERCE: You know, even if I did get it yesterday, which I did not, with all due respect, that's still not enough time.

MR. HARVEY: It's showing delivered from my computer. So anything else, Ann? We need to move this motion along and see if anybody else has any other discussion on this matter.

MS. PIERCE: I just want to be sure my objection is registered.

MR. HARVEY: It's registered. Anybody else have any other things for discussion?

(no response)

MR. HARVEY: Okay, Barbara, I would

ask that you take a roll vote, please.

MS. WASH: A roll vote? Hold on just a second. So we have currently Brad Schneider. I think that's the roll of who's here today, correct, Wayne?

MR. HARVEY: Yes.

MS. WASH: Okay. We have Brad Schneider, Melanie Tyner-Wilson, Wayne Harvey, Johnny Callebs, Ann Pierce, Cheri Ellis Reeves, and Doug Hoyt.

MR. HARVEY: Can you start with Brad and just take a vote from each one of them as we go down through? It's either yes, no, or abstain, please.

MS. WASH: Okay. Brad, your vote?

MR. SCHNEIDER: Yes.

MS. WASH: Yes. Melanie?

MS. TYNER-WILSON: No, I'm needing more information.

MS. WASH: Okay. Wayne?

MR. HARVEY: Yes.

MS. WASH: Johnny?

MR. CALLEBS: I will vote yes, but I'd like to explain that -- or clarify that I think maybe part of the confusion is just

the fact that it was -- the information was presented in the form of regulations the way regulations are typically written. To my understanding, that was just a format used to respond to the Cabinet's request for information from the TAC. So I think, you know, some people, maybe it looks a little intimidating or a little more formal than it actually is. So I'm reading it as a -- you know, some -- yeah -- information in response to the Cabinet's letter. And so I'll vote yes in order to get the -- keep the dialogue and process going to help resolve this matter. I realize it's going to take a lot more input from stakeholders and providers and advocates and family members to get this resolved, but to move it forward, I will vote yes.

MS. WASH: Okay. So then, Ann?

MS. PIERCE: (speaking on mute)

MS. WASH: You're muted, Ann.

MS. PIERCE: I vote no. I need more time to think about this.

MS. WASH: Okay. Cheryl Reeves -- Ellis Reeves?

(no response)

MS. WASH: I don't know if she's muted. I don't see her on. The next one will be Doug Hoyt.

MR. HOYT: I, too, am going to vote yes with, I think as much as anything, agreement with Johnny that this initiative I don't believe is in its final form. I believe it is moving the initiative forward, and the initiative needs to move forward. It has been lingering for years, and in fact, there will be, through this process I'm confident, continued an additional conversation that takes place. So Johnny, well said, and I support that with my yes vote.

MS. WASH: Okay.

MR. HARVEY: Are --

MS. WASH: So we have -- yeah, so we have four yeses, two nos, and we are missing two: Frankie Hoffman and Cheryl Ellis Reeves.

MR. HARVEY: So the motion carries with the votes present, correct?

MS. WASH: I believe so.

MR. HARVEY: Thank you. All right any other discussion before we cover MAC meeting representation? Is Erin still on the call?

MS. BICKERS: I'm here.

MS. WASH: Yes.

MR. HARVEY: Do you want to give us a -- I know that you've been intricately involved with the development of the BAC and the MAC, and I know that they're very close because I got an email recently from Dr. Schuster in regards to the MAC starting their meetings back up very soon. So do you have any information on that for us?

MS. BICKERS: Sure, I can give you a brief update, and then also, Barbara Wash has been really super hands-on involved with that process. So to my knowledge, I believe they have set a BAC date for about mid-month this month, and they are in the process of getting the next MAC meeting --

MS. WASH: Yes.

MS. BICKERS: -- dates scheduled, and so as soon as that is out, Barbara will get that to all of the MAC members and all of

the TAC chairs. We'll get that posted on the website. I think they're still working on that final last date, you know, with all the providers and everything trying to make sure we accommodate everyone's schedule. But Barb, if -- did I leave anything out? I know you've been very hands-on on that.

MS. WASH: Yes, October 13th we have a meeting coming up, and --

MS. BICKERS: But that's not the MAC meeting, right?

MS. WASH: No, that's not the MAC meeting, it's the BAC meeting --

MS. BICKERS: Yes.

MS. WASH: -- but we will keep you posted.

MR. HARVEY: Okay, thank you. And as soon as I learn about the next MAC meeting, I do plan to attend, and we'll present the recommendation that came out of this particular meeting.

MS. BICKERS: Okay --

MR. HARVEY: Our next meeting --

MS. BICKERS: Oh, sorry, Wayne. I was just going to say, since we did have a

recommendation, if you want to go ahead and get that to Barbara in writing --

MR. HARVEY: Yes.

MS. BICKERS: -- she can go ahead and get that all prepped and everything and ready for the next MAC member. And it looks like Ann also has her hand raised.

MR. HARVEY: Oh, thank you, I didn't see her. Go ahead, Ann.

MS. PIERCE: Thank you, Barbara. Thank you, Wayne. I'd like to make a motion that we ask DMS to make a budget request for more crisis centers.

MS. WASH: I have that noted.

MS. PIERCE: Thank you.

MS. WASH: Mm-hmm.

MR. HARVEY: So you want to make a motion for more -- for them to make a budget request out of this particular committee?

MS. PIERCE: Barbara, do they need that or is that something you took care of?

MS. WASH: I think that is something I can bring back. Erin, I know that you're still on this call.

MS. BICKERS: I am, I'm here. It

looks like someone dropped in the chat --

MS. WASH: Mm-hmm.

MS. BICKERS: -- asking if we can make a budget request. That came from a --

MS. WASH: I think it was Nora.

MS. BICKERS: No, it's right above Nora. Last name Allison, for some reason I can't see the full name.

MS. WASH: Marie Allison, yeah.

MS. BICKERS: So who is not a member of the TAC, so the public can't make recommendations based off the TAC. Now, the TAC can take recommendations from the public to make recommendations, so if that's something you guys want to go ahead and recommend, if you want to discuss, but it was just dropped in the chat.

MR. HARVEY: Well, there's four minutes till noon here. Is there any way that you two ladies could just take that back as a question that was dropped in the chat and just mention it, and then maybe we could get some feedback on that during the next meeting?

MS. BICKERS: Absolutely. Barbara --

MS. STAED: Can --

MS. BICKERS: -- can you add that to the DMS take-back email, please?

MS. WASH: Yes, I am. I have it.

MS. BICKERS: Thank you.

MS. WASH: Go ahead.

MS. STAED: Can I offer feedback real quick, Wayne, on someone who works on budget requests frequently.

MR. HARVEY: Sure, go ahead. We are limited on time is all I'm saying.

MS. STAED: Yeah, just terming it as crisis centers, I think you just -- we need to be -- if we're going to make a motion eventually, at some point, maybe today, maybe not, we need to be hyper-specific about what kind of crisis services we're requesting funding for if to achieve a specific goal. That is just my general recommendation.

MR. HARVEY: Okay, thank you.

MS. BICKERS: And my assumption would be maybe the type of funding needed, as not a budget person.

MS. STAED: Yes, yes, yes, that, too.

MR. HARVEY: Thank you, ladies.

Next meeting date is December the 2nd, 2025, 10 o'clock via Zoom. Or actually, December the 2nd, 2025. Anybody got anything else before we adjourn today's meeting? I know we're right on top of the adjournment time.

(no response)

MR. HARVEY: Okay, thank you very much. We'll see you in December.

MS. WASH: Thank you, Wayne.

MS. BICKERS: Have a great day.

MS. WASH: Have a great day.

MR. HARVEY: You, too.

(Meeting adjourns at 12:00 p.m.)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, herby 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 16th day of October, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR