CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
BEHAVIORAL HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 14th, 2025
Commencing at 2 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

TAC MEMBERS:

Dr. Sheila Schuster, Chair
Steve Shannon
TJ Litafik
Valerie Mudd
Tara Hyde
Misty Agne
Mary Hass

DR. SCHUSTER: Yeah, I gotta get caught up, so.

MS. BICKERS: Yeah, and then sometimes all the rest you got on vacation is kind of outweighed by all the chaos of returning.

DR. SCHUSTER: Yes, there is a little bit of that. At least I didn't get stuck overnight in Baltimore-Washington International, which I've done before on this trip. So that really wipes out the relaxation when you get stuck.

MS. BICKERS: Yes, that's never fun.

DR. SCHUSTER: Yeah, absolutely. So, all right. I think I'm actually even early. Who knew? I see that Steve and Valerie and I are on.

MS. BICKERS: That is who I have so far as well, but we are still clearing out the waiting room.

DR. SCHUSTER: Yeah. Okay, thank you. And we're still a minute or two ahead of our time.

MS. MUDD: Sorry. For some reason I was in the dark. I had my light on, but I

was in the dark.

DR. SCHUSTER: Well, we want to see your lovely face, Valerie. So I don't know why you were in the dark. Oh, Mary is on.

MS. HASS: Hey. I'm at the rehab center so I'm going to try to be muted most of the time, so, you know.

DR. SCHUSTER: All right. Glad you're with us, Mary.

MS. HASS: Okay.

MS. JOHNSON: Hi, Sheila, it's Ramona.

DR. SCHUSTER: Hey, Ramona. Good to hear from you.

MS. JOHNSON: Good to be here, I think.

DR. SCHUSTER: Well, it's your information font -- fount I guess.

MS. JOHNSON: Absolutely. Absolutely. I think Terry's going to be here from Bridgehaven, too. At least I hope so.

DR. SCHUSTER: Oh, okay, good. And I see that our notetaker, Tim Moore, is on. Hi, Tim.

MS. MUDD: Kelley Gaines sends her regrets. This is court day, so.

DR. SCHUSTER: Oh, that's right. I knew when we had to move the date that that was -- that's hard for her.

Mary Hass, I think I saw something where Eddie Reynolds had retired? Is that right? Do you know? Over at Brain Injury Association -- or Alliance of Kentucky.

MS. HASS: Sorry, I was on mute, Sheila. Yes, it's official, he did retire. It was about a week to ten days ago that I got the note that he retired.

DR. SCHUSTER: Okay. I have not heard from them about who they are going to appoint. So I may need you to text me or email me who I should contact over there.

MS. HASS: Okay, I'll do that.

DR. SCHUSTER: Thank you.

MS. HASS: No problem. Will you just send me a reminder? You know how my last couple weeks have been.

DR. SCHUSTER: Oh, I know.

MS. HASS: If you just send me a reminder --

DR. SCHUSTER: Yes.

MS. HASS: -- I will be happy --

DR. SCHUSTER: Yes.

MS. HASS: I'll be happy to send it to you.

DR. SCHUSTER: Yeah. I absolutely will, thank you.

MS. BICKERS: Good afternoon, everyone. This is Erin with the Department of Medicaid. It is officially 2 o'clock, the waiting room is clearing out. I currently have Dr. Schuster, Steve, TJ, Val, and Mary logged in. Did I miss any other TAC members?

(No response.)

MS. BICKERS: Dr. Schuster, you have a quorum. I will turn it over to you.

DR. SCHUSTER: Okay. Yeah, Mary, I'm losing my mind. Well, Misty is the representative for BIAK. I was going back to when Eddie was.

MS. HASS: Yeah, Angie -- after you said that, Angie's on now, so.

DR. SCHUSTER: Okay. Yeah.

MS. HASS: But Eddie is officially

retired.

DR. SCHUSTER: Okay. Thank you.

So we have a quorum of members. So we don't have -- you haven't seen Tara Hyde yet, Erin?

MS. BICKERS: No. I've not seen Tara or Misty yet.

DR. SCHUSTER: Or Misty yet, okay. All right.

Well, we will go on and call the meeting to order. As they say on the airline, if you're not on the Behavioral Health TAC plane, you're in the wrong Zoom. But we're happy to have you all to our rescheduled meeting, and we do have a quorum of voting members with Steve Shannon, Mary Hass, TJ Litafik, Valerie Mudd, and myself. So welcome to all.

And let me ask the voting members of the TAC for a motion to approve the minutes of our March 13th meeting, please.

MR. SHANNON: So moved. Steve Shannon.

DR. SCHUSTER: Okay. And a second, please.

MR. LITAFIK: Second. TJ Litafik.

DR. SCHUSTER: Great. All right. Any additions, corrections, omissions?

(No response.)

DR. SCHUSTER: All right. All those in favor of approving the minutes as distributed, signify by saying "aye."

(Aye.)

DR. SCHUSTER: All right. And opposing or recusing?

(No response.)

DR. SCHUSTER: Thank you. I'm going to skip the item on prior-auths for right now because we have lots of questions and I want to leave plenty of time for discussion. And let's go to the update on the 1915(i) SMI SPA. And I believe it's Tanya Dickinson who's going to be talking to us about that.

MS. DICKINSON: It is, and you caught me by surprise, so I had to find the video and audio buttons again --

DR. SCHUSTER: Oh, okay.

MS. DICKINSON: -- which I can never find twice in the same place.

Hello, everybody. Glad to be here

and share some updates on the 1915(i) project. It continues to proceed in development. We've announced that in a few other meetings, and I think -- I'm certain we've mentioned it here that it was approved at the end of March by CMS, so we are proceeding. And at this point, just, you know -- just a quick sentence or two about what it is. It's for adults. It's a Medicaid initiative for adults with SMI as their primary diagnosis, or a co-occur SMI with co-occurring. And we'll provide them 10 approved services ranging from housing to housing assistance to transportation to medication management, and certainly case management. Yeah, the goal of it is primarily to help folks remain and thrive in the community.

We are going live through -- starting July 1, but that'll be in phases. Currently, we're in the process of hiring staff who will be present by then to be able to start onboarding providers. And then probably the end of August, 1st of September, we'll be bringing on

participants, allowing them to apply.

We're working on the -- currently working on the training curricula for the providers, and that will be available online to them as well as the application to become a provider. There will be a new Medicaid -- dedicated Medicaid provider number for these folks. Most of -- many, I think, will already have experience providing Medicaid services. If not, the waiver services, 1915(c), Michelle P. and whatnot, but we do expect at least one totally new group who probably doesn't have a lot of Medicaid experience which will be those housing providers. So we'll be working closely with them to get them in a position to do that. We're getting ready, I would say mid next month, to start doing some dedicated outreach via webpage, emails, things like that. We have regulations to govern this initiative, and they've had their public comment, and they are proceeding through the LRC process, so hopefully they'll be ready about the same time we're ready to start up the program.

And those are the highlights, I think, unless you all have questions.

DR. SCHUSTER: Yeah. Thank you for that, Tanya. I know that the -- actually, it was approved after our March meeting --

MS. DICKINSON: Oh --

DR. SCHUSTER: -- so this is the first official --

MS. DICKINSON: -- okay.

DR. SCHUSTER: -- notification. Obviously, we sent out lots of emails with the good news, so --

MS. DICKINSON: We've been spreading the good word, so I don't always remember --

DR. SCHUSTER: Yes. Yeah.

MS. DICKINSON: -- who I've --

DR. SCHUSTER: You may have heard the fireworks going off across the state.

MS. DICKINSON: I think I heard a cheer or two. Yeah.

DR. SCHUSTER: Yeah. So we appreciate that. And I know that the comment period for the regs just closed --

MS. DICKINSON: Correct.

DR. SCHUSTER: -- I think on the

30th, so they'll go through the ARRS, the Administrative Reg Review Subcommittee. Will you all be issuing a document on, you know, responses to the comments received?

MS. DICKINSON: That actually -- the regs --

MR. SHANNON: That's been issued.

MS. DICKINSON: -- actually belong to Medicaid.

MR. SHANNON: Yeah.

MS. DICKINSON: And so, you know, they would have to speak to that specifically what they were going to do. I don't know that we -- I believe there are no changes as a result of the comments, although I gather there are some technical changes that may be made at the request of LRC staff.

MR. SCOTT: Hello, Dr. Schuster, this is Jonathan Scott with DMS.

DR. SCHUSTER: Hey, Jonathan. How are you?

MS. DICKINSON: Here's my hero.

DR. SCHUSTER: Yeah.

MR. SCOTT: We filed -- or the SOCs

for the 5 RISE initiative regs were filed on Monday of this week, on the 12th --

DR. SCHUSTER: Oh, okay.

MR. SCOTT: And I -- there was a bill that passed this last year, so if you're on my Reg Watch, I sent the SOCs out to everyone on my Reg Watch, and going forward, we're going to do that. Our Reg Watch list, yeah, I think Tanya's in the same boat as me. There's a whole lot of people on those, so usually we've just filed the -- only the regs when they get filed, we would send out on that, but right now, everything that we do that we are filing with the LRC is going to get sent out on those. So you may find that in your inbox. If not, I can send you a copy of it.

DR. SCHUSTER: Yes, I have to admit that I'm not on your RegWatch list. I probably have been over the years, Jonathan, and off and on, but if you don't mind sending that to me, I think it would be helpful because --

MR. SCOTT: Sure. Sure.

DR. SCHUSTER: -- I'll probably get

some questions on that from people --

MR. SCOTT: Sure.

DR. SCHUSTER: -- that don't typically follow the regs, so that would be helpful. I would probably do -- you know, if there's anything significant, do a little summary for that. So I would appreciate that. Thank you.

MR. SCOTT: And if you'd like, I'll add you to my RegWatch list.

DR. SCHUSTER: Yes, why don't you do that. My inbox --

MR. SCOTT: It's a whole lot of fun that we send out.

DR. SCHUSTER: Yes, it is a lot of fun, so appreciate that.

Tanya, I've gotten a number of emails from providers who have heard about this, obviously, over the last -- what's it been, three, four, or five years, that we've been working on this thing. So there are providers that are really kind of chomping at the bit. Is there any way for them to indicate to someone, I don't know who it would be, somebody at DBH I guess, their

interest so that they get included in anything that's forthcoming?

MS. DICKINSON: You know, and I didn't even prep you to set me up like that. Thank you.

DR. SCHUSTER: Oh, all right. Well, good.

MS. DICKINSON: The one other thing that I was going to add and what I was off busy doing before I could find my camera button, was getting ready to copy and paste the -- we have two email addresses. One for providers, and what we'd like them to do is just email us if they have an interest in becoming a provider or have some questions we might be able to answer. And then we'll put them on the mailing distribution list --

DR. SCHUSTER: Wonderful, okay.

MS. DICKINSON: -- for future. And if somebody has a more general question, we have just one generally for the initiative. We've also got a webpage set up but, it's -- right now all it says is "under construction," so there's not much there.

DR. SCHUSTER: Okay.

MS. DICKINSON: And I was also going to put in a link to the regs for folks.

DR. SCHUSTER: Ah, that would be very helpful. I'd appreciate that. And particularly, the email address for --

MS. DICKINSON: Yep.

DR. SCHUSTER: -- providers to indicate their interest.

MS. DICKINSON: Yep.

DR. SCHUSTER: So they -- once they do that, then they should expect that they'll be on your ongoing communications around the process.

MS. DICKINSON: Correct. We'll keep up with them. And I think they should come June to start looking for some --

DR. SCHUSTER: Okay.

MS. DICKINSON: -- dedicated information.

DR. SCHUSTER: All right.

MS. DICKINSON: Nobody's behind yet except us trying to get everything -- get all the parts in place at the same time.

DR. SCHUSTER: All right. Well, it's very exciting. Are there any other

questions from anyone, from our voting members or from anyone else who's in attendance about the SMI SPA?

(No response.)

DR. SCHUSTER: We always call it a waiver because that's how we think of it. So, okay.

MS. DICKINSON: It's so close. It's almost a waiver, but it's --

DR. SCHUSTER: Yeah.

MS. DICKINSON: -- the academics in the room and the bureaucrats need to know that there is a difference, so.

DR. SCHUSTER: Right. So thank you very much, Tanya. That's very helpful. And we'll -- and Erin will be sure that we all get the links that are in the chat.

Let me move on to the agenda item that's a follow-up on audits conducted by the MCOs. And I believe that's our friend Jennifer Dudinskie. I may have thrown her off since I'm moving on.

MS. DUDINSKIE: No, that's okay. A little bit, but I was prepared. Just took me a minute to get off mute and get my

camera on.

DR. SCHUSTER: Yes.

MS. DUDINSKIE: Good afternoon. So I know that there's been ongoing discussions about this. I wasn't exactly sure where you all had left out. I think at the last meeting, I actually had to jump off the call before you all got to this. So -- and I saw Veronica's email about covering this topic today.

So if I'm caught up to speed, my understanding is that there's been lots of conversation and correspondence back and forth with the MCOs regarding expectations on letters to providers, granting extensions, all of those sorts of things that we've been talking about for an extended period of time now here on this TAC meeting. And I believe we're at a place where everybody is on the same page. So what we are advising providers to do at this point is to continue to follow up with the MCOs. If you need extensions, request those extensions. They are aware that they should be granting extensions on audits.

And as always, you know, if there are issues that providers are experiencing, you feel like you're not getting what you need from the MCOs or the communications are not going well, then we would like for you to reach out to us so that we can assist through our complaint process.

Is that helpful?

DR. SCHUSTER: Yeah, that's --

MS. DUDINSKIE: Are there additional questions that I can answer for you, Dr. Schuster?

DR. SCHUSTER: I think that's helpful, Jennifer. What's happened is that I think the number of files being requested and the short length of time continues to be a problem.

MS. DUDINSKIE: Okay.

DR. SCHUSTER: And so it's a very, you know, back and forth and back and forth that puts an added burden on the providers, as you can imagine.

MS. DUDINSKIE: Yes. Well --

DR. SCHUSTER: So it's a little bit kind of, ah, why are we back here doing this

again?

MS. DUDINSKIE: Yeah. I will say that from a TCM standpoint, we recently just made some additional changes and reduced the numbers of records specifically for TCM audits, and we have made a couple of changes and in terms of the audits that might initiate from the department that we ask the MCOs to do. In those circumstances, we have gone through and tried to make sure that we have the same time frames on our audits, that we have reduced the number to what we feel like gives a solid sample but is not an excessive number of records for review to try to make that easier on providers. If you haven't seen that start as a change, then you should be starting to see that as a change moving forward.

DR. SCHUSTER: Okay, that's good to know. Bart, do you have a question?

MR. BALDWIN: Yes. Thanks -- thank you, Dr. Schuster. So Jennifer, could you send something that Dr. Schuster could share with us that details the process that providers need to follow to reach out to DMS

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MS. DUDINSKIE: Sure.

MR. BALDWIN: -- on that? Because you mentioned -- because everybody -- I mean, my feedback I hear from clients and workgroups is they follow that, what you're saying, and reach out to the MCOs and are not successful going through that process, and then --

MS. DUDINSKIE: Okay.

MR. BALDWIN: -- so just exactly what the process is and who we need to contact at DMS for support.

MS. DUDINSKIE: Sure.

MR. BALDWIN: Because even, frankly, when we've done that in the past, got -- not really gotten any response or assistance.

MS. DUDINSKIE: From the department?

MR. BALDWIN: Yes.

MS. DUDINSKIE: Okay. So I'm happy to do that. I will send the information out on what needs to be done to follow that process. But I will say we do need specific information again.

MR. BALDWIN: Yeah.

MS. DUDINSKIE: I've said this time and time again, and I will say that I continue to get emails that are vague in nature, and -- from providers.

MR. BALDWIN: So --

MS. DUDINSKIE: So if the information is vague, there's only so much that we can do. And sometimes I'll ask for additional information, and sometimes I'll get a response, and sometimes I don't get a response. So from your all's end, you know, the more you can encourage providers that -- to share the letters with us. You know, that's very helpful if they can share the actual letter that they've received, and they document the conversations that they're having with the MCOs, you know, who they're having those conversations with.

MR. BALDWIN: Okay.

MS. DUDINSKIE: That's really helpful to us to help us address it further.

MR. BALDWIN: Yeah. And we've done that, and I can -- number of instances where we provide all that specific detail, and what may be happening is the department

follows up with that information, but then there's no feedback back to the provider and they don't see anything changing.

MS. DUDINSKIE: Okay.

MR. BALDWIN: You know what I'm saying? So I'm not necessarily saying that the department hasn't followed up. They just haven't communicated back that they have.

MS. DUDINSKIE: I understand.

MR. BALDWIN: You know, it's what I'm saying. So it feels like -- the provider's like, we're not getting any response and our experience with the audits is not changing, so the assumption is there was no follow-up --

MR. SHANNON: Correct.

MR. BALDWIN: -- by the department, so.

MS. DUDINSKIE: Okay. We can discuss internally to try to make sure that we are doing a thorough job of following back up providers to let them know, you know --

MR. BALDWIN: Right.

MS. DUDINSKIE: -- that we've had

conversations, but -- so thank you for that feedback.

MR. BALDWIN: Yeah. And the only other -- and thank you. I appreciate your interest and support on this. The only other thing I would add is that, yes, I know when you're dealing with a specific audit or a specific issue, it's important to get the specifics. But I think in general, what we're seeing is a systemic problem because we're hearing it from so many different provider types. And so -- and that -- following up on a specific request is one thing, but that doesn't necessarily address the systemic problem we're having with across-the-board, very frequent -- and not all MCOs, but a lot of them. We hear from -- I see Steve shaking his head, and I'm sure the other folks that work with provider groups, we hear this from everybody, you know, pretty much on a -- on an ongoing basis. So I think that following up on the individual issues is good, but also, systemically, how can we rein this in, so.

MS. DUDINSKIE: And I hear you on

that, but I will also say that maybe you're hearing it and there are not providers that are coming to us and providing us with that. Because, again, we have to receive those complaints, and even if they're not extremely specific in nature, we do need to receive the, you know -- we need to see the volume. We need to see if it's one MCO versus another MCO.

MR. BALDWIN: Sure.

MS. DUDINSKIE: If it's across the board, all of that information is very helpful to us to help us address it.

MR. BALDWIN: Right.

MS. DUDINSKIE: So -- and I know many of you have referred providers to me directly, and, you know, I do appreciate that. It is very helpful to get the, you know -- have those conversations with the providers. So I would just encourage you to continue to do that and continue to encourage them to reach out to us.

I think sometimes you might have conversations and tell them to reach out to us, but maybe they're not actually doing

that in the end because, you know, maybe --

MR. BALDWIN: Yeah.

MS. DUDINSKIE: -- they think it's not going to help, but it certainly helps us, so, you know, and we want to be --

MR. BALDWIN: Yeah, and I feel certain that's the case in some instances, and so that's why I was asking initially just really clear what's the process so we can encourage folks to do it so that from the DMS perspective, you can get a sense of not only that individual problem, but where it might be systemically and which MCO or not it might be with.

MS. DUDINSKIE: Mm-hmm.

MR. BALDWIN: So that's why I want to be sure that we follow the process.

MS. DUDINSKIE: I'll make sure to get that out to you all.

MR. BALDWIN: All right, thank you. Appreciate it.

MS. DUDINSKIE: You're welcome.

DR. SCHUSTER: Yeah.

MS. BICKERS: Jennifer?

MS. DUDINSKIE: Yes.

MS. BICKERS: I have the MCO dispute forms I can share with the TAC group along with the email address they're to be submitted to so that way it will help the MCO contracting group monitor and track those.

MS. DUDINSKIE: Thank you. Any other questions for me?

DR. SCHUSTER: Yeah, any other questions for Jennifer? I guess, Jennifer, and you don't have an answer to this so it may be rhetorical, but I think we're hoping that since we're going to have to go back to prior authorizations, that we will see some impact on the number and extent of audits, quite frankly.

MS. DUDINSKIE: Yeah.

DR. SCHUSTER: Because the audits have certainly grown and grown and grown, and we've heard from the MCOs that are just doing their due diligence because we don't have prior authorizations. So under the burden of taking on prior authorizations again, you know, we really need some relief someplace, and I'm hoping that it's going to

be on the audit side.

MS. DUDINSKIE: Yeah. I know there's going to be more specific information coming out in regard to that, so more to come.

DR. SCHUSTER: Yeah. Yeah. Any other questions? There was a question in the chat about the fee schedule, but we're going to take that up under new business because I'm not sure that that's a question for you necessarily.

MS. DUDINSKIE: No.

DR. SCHUSTER: Yeah.

MS. BICKERS: Dr. Schuster?

DR. SCHUSTER: So I'll save you from that one. Yes, Erin?

MS. BICKERS: I just wanted to reflect for the record that Tara and Misty have both joined us.

DR. SCHUSTER: Oh, great. Welcome and welcome. Thank you very much. So we have a full complement of voting members. Thanks. Thanks, Erin, and thanks -- welcome to Misty and Tara.

Thank you very much, Jennifer, you're always very helpful.

MS. DUDINSKIE: You're welcome. You're welcome.

DR. SCHUSTER: We'll look for the document from you, and also the form that Erin is going to share. That's the MCO complaint form, right, Erin?

MS. BICKERS: Yes, ma'am.

DR. SCHUSTER: Okay, thank you. Great.

If Alisha Clark is on, could we have the current 1915(c) waiting list numbers and the wait time for PDS services?

MS. CLARK: Good afternoon, Dr. Schuster.

DR. SCHUSTER: Hi, Alisha.

MS. CLARK: Well, I had it right here in front of me. There we go. It moved on me. So the waitlist numbers right now, the Home and Community-Based Waiver has 4,286 people on it. Michelle P. Waiver has 9,473. And then SCL has 3,610. And then the unduplicated number because we know that we have many individuals that are on multiple waitlists.

DR. SCHUSTER: Right.

MS. CLARK: That is 15,257.

And then just as we talked about, you know, last time, or I believe Misty talked about this last time, is this PDS interest list is really -- it's only as good as what we're being told, right? And then if somebody is put on the waiting list or interest list -- it's not really a waiting list, but an interest list -- then if they then go get services, or maybe they're not interested anymore and we're not ever told about that, that's really going to, you know, affect your numbers and everything.

So I know -- I think Misty is on here and I was going to turn it over to her. I know she was looking at, you know, based on the data that we have, and was going to provide some information on that. Misty, are you here and available?

MS. WRIGHT: Hey. Can you all hear me okay?

DR. SCHUSTER: You're a little bit light. Can you turn up your volume or get a little closer to your speaker, please?

MS. WRIGHT: Speaker's right here,

but I can speak up a little bit. Is that better?

DR. SCHUSTER: That's better. Yes, thank you. Thank you very much.

MS. WRIGHT: That's not something I'm used to being asked to do. So the PDS interest report, as we discussed the last time, is an interest list. And on that list, we get all of that communication sent to us from the providers. And this has been a running list, so people do not get removed from this list once they're marked in an active status.

So the numbers that I was able to pull today from that running list is out of the 2,300 and some people that we actually have on the list since March of 2022, we have 1,207 of those individuals who have actually moved off of that list into active status. We currently show 775 that are still showing in an interest list form. I think, as I mentioned during the call the last time, a lot of these people can choose to stay on the list until somebody specific they're looking for -- maybe a member of

their people are trying to get validated to be doing their PDS services. So that's why we don't treat it like a waiting list. These people can be on there and stay on there for various reasons. So out of that 775 of those individuals that are currently on the list, 449 of them are actually receiving traditional services. So they are getting care through traditional services.

We had, of that list, 64 that we have been notified were no longer interested. And then we also have some where the waiver had closed for a wide variety of reasons that's not documented necessarily in my report, but there was 259 of those individuals -- and again, this is since March of 2022 -- 259 of those individuals whose waivers have closed.

Now, I did break it down because I think there was a comment somebody had asked at one point, we had discussed waiver specific, how many people do we have on this list?

DR. SCHUSTER: Right. Right.

MS. WRIGHT: And so I know that a

couple of our ABIs was a really big conversation, and I had asked somebody to please reach out and make that communication connection so that we can see why somebody in this call a few months back had mentioned over 300 people waiting for ABI. And based on what I have, I have four people on this list for ABIQ, and only two for ABI LTC. So I'm still waiting on that communication so that we can see where that's dropping. We need this data. If these people are interested, it shows us where the need is.

And so of the four for ABIQ, one of them is the only one still listed as interested, and they are currently getting traditional services. The other three have either acknowledged they're no longer interested to our team and been noted on the document. One of them actually is in PDS services and active because, like I said, we don't take people off the list. We just mark that they finally went active. And then the waiver closed was only on one individual. Everybody for ABI LTC, we have two people that were on this list and both

of those people are active in PDS services now.

HCB, of course, is going to be our big one. And over the last three years of this, there's been 2,213 people added to that list, and of that, we have 1,165 who are actually in active PDS services on the list. We have 731 that are showing as, you know, still showing interested, and their reasons vary, like I had mentioned before. But of those 731, 417 are currently receiving traditional services. We have 62 who have notified us that they were no longer interested. And 256, that's for the majority of the waiver closed information had come in from, 256 there.

Michelle P. had only 81 people on this list. We have 37 of those 81 currently active, 3 waiver closed, 2 said they were no longer interested, and 39 still listed out as interested with 29 of those getting traditional services.

SCL, we only have four. And that one, we have two people who are interested, and those two people are getting traditional

services, and two people who are active. So with the list we have, we are seeing that these people are getting moved to active, or they're at least getting traditional services.

So one of the questions I have, I know that we had discussed the last time that this was an interest list and not a waitlist. Can we please update the agenda to do a PDS interest list update instead of us thinking that we're looking for "waitlist numbers" since it's not treated that way?

DR. SCHUSTER: Okay.

MS. WRIGHT: I feel like it would give us better -- and I am happy to report these numbers each time we meet. And I'm still asking for you all to, please, if you're hearing these people say that they're communicating with us, these are the reports, these are the numbers, and if we have something missing, we need to know. So please get -- please, if somebody says they have 300 people waiting on ABI, send them to us so that we can figure out what's going on.

DR. SCHUSTER: So you want -- and I hear you. And I think calling it an interest list makes sense because they're in -- really in various stages of either being in a waiver or getting at least Medicaid services and so forth, so that makes sense. When you say that the waiver is closed, what does that mean, Misty?

MS. WRIGHT: So in a waiver closed status situation, that would be like when, let's just say that some reason they lost their LRC status. Some reason, maybe somebody passed away. The waiver closed on that is when our team is working this interest list and they see that they're no longer on a waiver for some reason.

DR. SCHUSTER: Oh, okay.

MS. CLARK: And they could've went to a different waiver as well. I mean, there's several different reasons.

DR. SCHUSTER: Okay. Yeah, I wasn't sure whether -- so we're saying it's closed for that individual, that number is closed. It's not a closing of the waiver.

MS. WRIGHT: For that individual

under that waiver.

DR. SCHUSTER: Yeah.

MS. WRIGHT: So if they're on Michelle P. and they go to SCL and it says "waiver closed," they're going to show up on the PDS active now under SCL and not Michelle P.

DR. SCHUSTER: Okay. All right. So let me ask Mary Hass if you have any questions, Mary, about, you know, maybe hearing from more people on -- waiting on PDS.

MS. HASS: What the --

DR. SCHUSTER: -- who are on the ABI waivers.

MS. HASS: Most of the ones that have came in -- now, I'm a little disadvantaged right now because I've not been working for the last four weeks due to my husband's illness. But when they were speaking to me -- and I'm a little confused on your numbers, the 300 number. I don't know exactly what that number is. But most of the ones that we're hearing for PDS was due to the case management issues in Louisville

--

DR. SCHUSTER: Right.

MS. HASS: -- with -- and I shouldn't say case management, but with the issues of Seven Counties being able to service them.

And, again, I'll be quite frank, right now, I'm at a little disadvantage because I've not communicated with anybody in the last four weeks. So, you know, I can just say that many of the issues that were communicated to me were due to not being able -- and, again, they could possibly have already been on another waiver or on the ABI waiver, but they wanted ABI Pacific services. So I don't know. I mean --

MS. WRIGHT: Yeah.

MS. HASS: -- I don't know exactly how to answer you.

MS. WRIGHT: Well, I can tell you that according to our PDS interest list since March of 2022, Seven Counties has only submitted the number for 45 individuals over that entire time.

MS. HASS: I'm having a hard time -- I'm having a hard time hearing you. Could

you speak up a little bit?

MS. WRIGHT: Absolutely. Is that better?

DR. SCHUSTER: Yes.

MS. WRIGHT: Okay. So --

MS. HASS: Not really.

DR. SCHUSTER: Oh, Mary says "no." Could you try again?

MS. WRIGHT: Mary, can you hear me better now?

DR. SCHUSTER: She's in a different setting so she may be having more trouble hearing you. You may have to really raise your voice.

MS. HASS: Yeah, I'm having difficulty hearing you, but --

MS. WRIGHT: So Mary, the number I have for Seven Counties in the last three years, they've only submitted 45 -- number 45 to us for people that they have on hold. Out of that 45, they have only reported 3 people directly for ABI services based on what they're giving us as that. So we have -- the whole Seven Counties, as far as them submitting these interest lists to us, we

have a whole total of 45 over the last 3 years, and only 3 for ABI services that has been given to us for our interest list.

MS. HASS: So you're saying there's only three people that have requested the PDS service from Seven Counties that are on the waiting list, or, you know -- or interest list. I agree with Sheila, maybe an interest list might be a better way to say it because I would say they may possibly be under only community based. One of them that I'm thinking about specifically right now, I think they were actually on the Home and Community-Based Waiver, and they were getting some of the things they needed. They really wanted to do the PDS under the ABI. So I don't know, maybe an interest list is a better way to explain it.

DR. SCHUSTER: Yeah.

MS. WRIGHT: I like using that because, like I said, we're not -- we're not saying that we're keeping the -- the waiting list in and of itself lives with our providers because our providers are the ones who are getting -- they're supposed to be

getting this data and then letting us know, we have these people who are interested in this and this and this back-and-forth, right? So the true waiting list portion is with the providers, and we're only as good as what they share with us.

So -- and that 300 number came from this call a while back, and that's what rang my bells. I wanted to find out why I'm only seeing 45 for like this group were talking about.

MS. HASS: And I'll be quite honest, I never remember a 300 number. I don't --

MR. SHANNON: Yeah.

MS. HASS: -- I'm not saying yes or not, I'm just saying --

MS. WRIGHT: Yeah.

MS. HASS: -- I don't remember a 300 number.

MS. WRIGHT: But regardless, it got my bells going and I started looking.

DR. SCHUSTER: Yeah. Yeah.

MS. HASS: Well, I would hope so.

DR. SCHUSTER: Yeah. And I appreciate, Mary, that with your husband's

serious medical issues that you've been out of the loop. Why don't we -- why don't we skip our July meeting and put this back on for the September meeting? We'll call it the interest list, and Mary, that may give you some time to, you know, look at your ABI folks, and let's figure out where these numbers should be coming from.

MS. HASS: Yeah. Did I hear Misty -- did I hear Misty's on the call? Misty, are you all getting anything at BIAK?

MS. AGNE: I've not been informed of anything like that, but I can reach out to better understand if they're getting requests specifically for the waiver services and who they're connecting them with. I can find out.

MS. HASS: Yeah. And the past, some of the information came from Eddie or, you know? And so I know Eddie has retired, so, you know, maybe we could have a better communication now, whoever the person is in charge working with the families at BIAK then that might be a better -- then we can have a better accuracy between the two

organizations.

MS. AGNE: Yeah, I can ask about that.

DR. SCHUSTER: Yeah, let's do some work on our end, Misty, so that we get some better information to you, and we'll hold off on the -- at least on the PDS part of the report until our September meeting, okay?

MS. WRIGHT: And I look forward to seeing these numbers match what you all expect them to see, and I hope I can give a great report coming then.

DR. SCHUSTER: Yeah. Well, thank you very much. We appreciate it.

And Alisha, let me go back to you to see if there's any update on the access to therapy services for ABI.

MS. CLARK: Well, so Dr. Schuster, just first, thank you, Misty on my team, for providing that information.

DR. SCHUSTER: Yeah. Yeah, absolutely.

MS. CLARK: Misty and Mary, or Dr. Schuster, if something comes up, don't

hesitate to reach out. I know Karen Maciag's on here, she's the branch manager. I'm sure you all have got her email information but reach out. If you all are hearing anything that we're not aware of, please, let us know so we can investigate that and to make sure that we have the most accurate information. You know, like we said earlier, it's only as good as what we receive.

DR. SCHUSTER: Yeah.

MS. CLARK: So, but -- okay, going onto the ABI --

MR. SHANNON: Sheila, I have one question real quick.

DR. SCHUSTER: Oh, yeah.

MR. SHANNON: Is there anyone on the emergency waitlist for SCL?

MS. CLARK: I do not believe so. Let me just double check my numbers here. I am not -- I do not believe there's anybody on the emergency SCL waiting list.

MR. SHANNON: And what about the urgent?

MS. CLARK: The urgent? I don't have

that right in front of me.

MR. SHANNON: Okay.

MS. CLARK: But while we're talking, I can double check or Misty can double check, and we can put that in the chat, if that's okay.

MR. SHANNON: That'd be great, thanks.

DR. SCHUSTER: Yeah, thank you. Thank you, Alisha and Misty. Yeah.

MS. CLARK: Okay, thank you. Once I get done talking, if she hasn't grabbed it yet, I'll get in there, grab that, and put that over.

So the -- oh, where's it at? The ABI waiver access to therapy services, nothing has changed at this point. And as we move toward the future, if there's any information or any changes that will be upcoming, we definitely will be giving you all ample notice, all of that. So as of right now, status quo. There, you know, is no changes, but we will give you all, you know, updated information and ample time.

DR. SCHUSTER: Okay. I think what we

reported at the last meeting from Leslie was that if people are on the waiver, they're continuing their therapy services. If they are new to the waiver, then they are using therapists who are in the state plan.

MS. CLARK: That is correct.

MS. HASS: Yeah, Sheila, you accurately stated that. I was going to interject, but that is an accurate statement.

DR. SCHUSTER: Yeah. Okay. And that has not changed, and if there is any change in that, then you all would notify us.

MS. CLARK: Yes.

DR. SCHUSTER: Yeah. Okay. And that's your understanding as well, Mary?

(No response.)

DR. SCHUSTER: Okay. Thank you, Alisha. I appreciate that.

MS. CLARK: You're welcome, Dr. Schuster.

MS. HASS: Sheila, that's a yes. I'm sorry.

DR. SCHUSTER: Yeah. Okay.

How about Medicaid unwinding and

recertifications? And I don't know if Veronica has joined us yet, but otherwise, Jiordan Griffin, please.

MS. GRIFFIN: Yes, give me just a moment to start up my video. Can you all hear me okay?

DR. SCHUSTER: You could speak up a little. I don't know if I'm getting old.

MS. GRIFFIN: Sorry. Can you all hear me?

DR. SCHUSTER: Yeah, that's a little bit better. Thank you.

MS. GRIFFIN: Okay. Erin, do you happen to have that PowerPoint? Or I can bring it up on my end, whatever.

MS. BICKERS: Which PowerPoint? My apologies.

MS. GRIFFIN: Oh, no, it's -- I got it. Am I a co-host?

DR. SCHUSTER: Can she share her screen, Erin?

MS. BICKERS: You are now, sorry.

DR. SCHUSTER: Okay.

MS. GRIFFIN: Thank you. Sorry. Okay. Give me just a moment. Okay, you all

should be seeing it here in just a second.

MS. BICKERS: We can see it.

MS. GRIFFIN: Okay. So this has other information not just about the renewals and things. Oh, I'm trying to put the nice one on the side, but, okay.

So the -- so during the PHE, we obviously had several flexibilities that we implemented with CMS permission in order to keep people enrolled and to reduce turn, especially for children. So this is just a quick glance of some of the important flexibilities that we have going on through June 30th, 2025. And so we had the continuous child coverage for 12 months for all children under age 19. We had one-month extensions to allow additional time for all non-LTC and non-waiver members to respond to their notices. Up to three months' extension for long-term care and waiver members to allow additional time to respond. And then also, to allow an authorized representative to sign an application or renewal form via the telephone without a signed designation. All of these, though,

will be ending June 30th, 2025.

So messaging to our members --

MS. ROEHRIG: Sorry --

MS. GRIFFIN: Sorry?

MS. ROEHRIG: -- just to let you know that your talking points and all of that are displayed as well. So just wanted to make sure you were aware in case that wasn't the intention.

MS. GRIFFIN: Thank you. Just a moment.

MS. ROEHRIG: Yeah, absolutely.

MS. GRIFFIN: Okay. Are we seeing the right thing now or is it still showing the other screen?

DR. SCHUSTER: We lost you. It's not up.

MS. ROEHRIG: It's not being shared anymore.

DR. SCHUSTER: It's not being shared.

MR. SCOTT: Hey, Jiordan, I can share my screen with that because then --

MS. GRIFFIN: Yeah, thank you. Yes.

MR. SCOTT: -- I think I have a piece of the presentation at some point, too.

MS. GRIFFIN: Thank you, Jonathan. I appreciate it.

MR. SCOTT: Sure, no problem. I'll give it a shot on my network here.

MS. GRIFFIN: I've got three screens up in front of me and I can't remember which ones one, two, and three sometimes, so apologies.

MR. SCOTT: Erin, could you let me share real quick? Sorry.

MS. BICKERS: And my apologies, I think I was left of the email chain with the presentation, so if somebody could also email it to me, I'd be grateful.

MS. GRIFFIN: Sure.

MS. BICKERS: Thanks.

DR. SCHUSTER: All right, there we go.

MS. GRIFFIN: Yeah, okay.

MR. SCOTT: Can everybody see it? All right.

MS. GRIFFIN: Yeah.

MR. SCOTT: And then you can just tell me to advance, Jiordan.

MS. GRIFFIN: Yeah, keep going. Go

about three slides up. There we go. Okay.

So we talked about the flexibilities that are going to be ending June 30th, 2025. This slide here is just a reminder that messaging to members is very important, the communication that we put out there. Make sure that members know that they need to update their information with us. They need to make sure that they respond to any kind of communications that requests that action be taken, and that they can get help anytime from a coverage navigator on kynect.ky.gov, or by calling 855-4kynect. Please move forward.

And this slide just shows our Medicaid enrollment trend. This was an expected decrease after the unwinding, so, you know, we're sitting right at about 1.4, 1.5 million members. And that was just an expected decrease, and now we've kind of leveled off at that number.

So Medicaid renewals, any annual renewals for cases unrelated to the public health emergency resumed in April 2024. We do have a member toolkit available online to

support members in understanding their coverage if they need help. We also have lots of communications materials, and our CMS monthly and updated reporting ongoing. All of those are still being posted on our Medicaid unwinding website.

So this is just a quick glance at our unwinding report updates. So every 90 days -- or after the 90-day reconsideration period, we're required to re-report that month's renewal status for any kind of pending cases or anything that's waiting to be processed. And so this is a quick glance from January 2024 all the way up to January of this year. So that bottom line there, we just submitted the updated report for that January 2025 reporting today, and it was after the 90-day reconsideration period. We only had one pending case, and that was processed and approved.

Renewals and reinstatements, individuals that are procedurally terminated on their renewal date, they, like I said, are given 90 days to respond during that reconsideration period. And so this is

showing that as of February, we had 1,201 individuals that were reinstated during that 90-day reconsideration period. In March, we had 766, and in April so far, we've had 183 individuals that have been redetermined eligible or reinstated during that reconsideration period.

And as always, help spread the word about renewals for children. All of the -- most of the flexibilities that CMS provided us are going to be ending at the end of June and that's quickly approaching. So we want to make sure that families know that, you know, children's renewals have restarted. That they need to make sure that they contact us if there's any kind of action needed or communications that they receive. And then here it just shows, you know, at a glance, we have some communications materials posted for help with spreading that information.

And just more communications materials. And again, the Medicaid member toolkit is available on our member website available at that link. And we will make

sure that Erin gets this PowerPoint so you all have a copy of that.

And this is our Medicaid unwinding website where we continue to post these things. We're repurposing it. It's not going to be just for unwinding. We're going to continue to post this and be transparent, have more communications materials available and things like that, specifically related to renewals and the coming out of unwinding.

And that's it for me. Anybody have questions? Sorry for the tech issues at the beginning.

DR. SCHUSTER: That's all right. Any questions for Jiordan on the unwinding? It's always good for us to have that update every two months of where we are.

(No response.)

DR. SCHUSTER: And I don't see any -- so we'll go on over to Jonathan if you have your screen up already. This is the update on regulations to establish the Beneficiary Advisory Council, or the BAC as it's being called.

MR. SCOTT: Yes.

DR. SCHUSTER: So take it away, Jonathan. Thank you.

MR. SCOTT: Certainly, and good afternoon, everyone. This is some information about our committee -- Advisory Committee framework that's getting restructured. So just as we start out a little bit, the -- we are implementing based on 42 CFR 431.12 -- sorry, that's a typo we'll have to fix. So eventually, we hope there'll be some implementing regulations here, but we have launched this plan, and we really have to comply by July 9th. That's our target date. And we hope to have meetings of the new Medicaid Advisory Committee and the new Beneficiary Advisory Council taking place at some point in the month of September. We want the new members and the newly constituted committees to select their times.

All right. So probably both of the committees are going to be of interest to this TAC, but the Beneficiary Advisory Council is going to be composed of people who have received benefits or been very

close to individuals who receive benefits. So we need to have 10 current or former Medicaid members in this Beneficiary Advisory Council, and then 5 parents, guardians, or caregivers. So we are looking for folks to apply. So there's folks, especially in this TAC -- this is one of the TACs that has a lot of participation from members and from caregivers. We would love to have you apply and to participate with us on this new advisory council going forward.

The other fun thing about the BAC is that the federal rule for 431.12 is requiring that BAC members be part of the MAC, so it's going to be 25 percent of the MAC. So there's going to be seven people that start out who are on the BAC and the MAC, so that's going to be a great way to get the experiences and the perspectives of members really to have a loud and important voice in our Medicaid Advisory Committee.

So we're going to start out with kind of a staggered process for our terms. Eventually, it will be four-year terms. The federal rule says that you cannot serve

back-to-back, so you'll be on for four years, or, you know, start out two or three, and then you can be reappointed after a four-year period. So we're going to need a lot of folks to participate, and we're going to cast a wide net, and we're going to really ask folks that are interested, current, former members, parents, guardians, caregivers, to stay connected with us so we -- because there will be a lot of spots that we'll need to have in our BAC.

All right. So here's some more information kind of about our goals going forward. There is a federal requirement for quarterly meetings. Another issue with the BAC is that they have to meet before the MAC meets. So that's going to be, you know, kind of difficult for just -- that's going to be a large time commitment, so keep that in mind. This is a QR code that will take you to information about the BAC website, and then applications are open for about another two weeks. So please, if you're interested in applying, if you have family members who are interested in applying, if

you know someone that would be interested in applying, please, please help us fill out the BAC.

All right. Now, the next Advisory Committee change is going to be the MAC. Now, for those of you that know the MAC, the Advisory Council on Medical Assistance, we have called that the MAC for many years despite the fact that the acronym does not quite match up. So going forward, we're going to change that name. It's going to be the Medicaid Advisory Committee, and we're going to take the old MAC and attach it to some of the new requirements from 431.12. So there's going to be one existing -- for example, there's going to be one existing ex officio member. We're adding four commissioner level folks from CHFS who will participate as ex officio members, and who will have a chance to circulate with all of the advocates and members and everything else who compose the MAC. There's the existing 13 folks who are appointed by nominating organizations. That's going to be on one of our next slides.

And then the Medicaid MCOs are also expected to participate per the federal rule. And the system that we have in place is going to be basically one representative from each MCO will serve for a year, so each of the MCOs will have a chance to participate over a five, six-year period.

And then we have the consumer advocates who are also part of that KRS 205.540, that's the existing Advisory Council group. And then we're going to get our seven new members from the BAC. Our beneficiary participation is really going to increase, so that's a really exciting thing. And so we have, again, that same staggered process where we want to have folks who are getting appointed eventually every year once this is going -- once this is up and running. So again, that same federal requirement, can't serve back-to-back terms.

So again, there's going to be a lot of advocacy bandwidth that's going to be needed kind of transitioning to the Medicaid Advisory Committee. So just hope that folks continue to apply and stay connected with us

so we can keep getting these spots appointed. It's just going to be a lot more folks will be participating in the MAC kind of on an ongoing basis in the future.

And my cat wants to say hello.

DR. SCHUSTER: Is your cat going to be --

MR. SCOTT: So they're not used to my work voice. They --

DR. SCHUSTER: I was just wondering if your cat was going to be on either the MAC or the BAC?

MR. SCOTT: They've probably applied knowing them. They're very active.

We do want to highlight that there's a couple of unexpired terms that are -- there are a few people serving in expired terms. If you're in an unexpired term and you're on the MAC, you're going to be automatically appointed. The issue is with folks who are in expired terms who have continued to participate in the MAC. Either their nominating organization hasn't reappointed them, or they just ended up continuing to participate. So we are doing

some fancy footwork with that, and we may need some help. It's going to be on one of the next pages here.

Wanted to pause for a second and let everybody look at this QR code here. If that's helpful to you, our applications, again, are going to be open for about the next two weeks, and we really, you know, going forward, there's going to be some major changes to the MAC. There's just going to be a lot of different people needed to serve in those positions since we're looking at, you know, kind of a hard stop to folks' participation. You know, they're going to have to be on for four, off for four, on for four, off for four. So we're going to need to cast a wide net and really help people get connected and stay connected with our advisory committees going forward. So hope that everyone will consider sending in a nomination or sending in an application and help us keep these committees staffed.

Here are the groups that are accepting applications. So these are groups that we need to have nominate. So if you

are a -- if you're associated with any of these groups, you do have to contact them, and then the organization will send in the application. So if you're interested in getting connected to the MAC, if you want them to consider you in future years, these are groups that are going to have to start having multiple folks on their roster who will be able to serve.

Then some consumer advocacy groups. If you're associated with the Reentering Society TAC, if that's an interest of yours, we would really, really appreciate it if you'd apply. Same thing for a consumer advocacy group. Again, this is the first time I'm seeing this slide, so I'm not entirely sure what the women parentheses means, but --

MS. BICKERS: Jonathan?

MR. SCOTT: Yes.

MS. BICKERS: That's for an advocacy group that would represent women.

MR. SCOTT: There we go. I probably should've put that together, but --

DR. SCHUSTER: Yeah, they have

them -- some of us are appointed to the MAC, Jonathan, to represent, for instance, people with disabilities, or minorities, or older Kentuckians. So they have those, I think there's five consumer advocacy groups, and some of us are on the MAC representing those groups and our terms are not expiring, so we're going to be reappointed.

MR. SCOTT: Okay, so you all will be auto reappoint, and --

DR. SCHUSTER: Yeah.

MR. SCOTT: -- we don't have an auto reappoint for the consumer groups.

DR. SCHUSTER: Yeah, the consumer advocacy group for Reentering Society is coming out of the Reentry TAC that Steve Shannon chairs, and they're looking for a consumer basically who was in that position. And then I think any advocacy group that represents, you know, primarily women who receive Medicaid services, could nominate the consumer advocacy group there.

MR. SHANNON: Yeah. A member of the Reentry TAC has applied to be on the MAC.

DR. SCHUSTER: Yes, you have a

consumer -- excuse me. You have a consumer member, Steve --

MR. SHANNON: Right.

DR. SCHUSTER: -- who has applied, yeah.

MR. SHANNON: Mm-hmm.

MR. SCOTT: Consumers, take note.

And our next step is the Medicaid Managed-Care survey, but if you all would like to stop and ask any questions, have any further discussion about this while we're here and talking about the MAC and the BAC.

DR. SCHUSTER: So basically, we need to be really sure that we have reached out to our consumer groups, our family groups, to get people to be nominated or self-nominate for the BAC.

Rita asked the question, "No mental health related organizations are required to nominate?" You know, behavioral health has not been an active part of the MAC forever, Rita, and actually, there was no Behavioral Health TAC until Steve and I took matters into our own hands and worked with Representative Jimmie Lee on legislation

about 12 years ago to establish the BH TAC. So we had recommended, and I think if the legislation House Bill 789 had been passed, there were a lot of changes in these nominating organizations, and one of them would've represented behavioral health. So there still is an opportunity, I think, to go back and make some changes. This was under a time crunch, and they could only do in regulation what was required by CMS to change the current MAC statute.

So -- and there are no changes to the TACs. That was something that was discussed, you know, at the MAC meeting at one point, and there was a lot of concern expressed from the TAC members because they were going to put the same limitation on term limits for the TACs that they have now for the MAC and that was a problem. So there are no changes to the TACs and their structure or term limits or the number of TACs or whatever.

MR. SHANNON: Yeah. And Jonathan, another change, isn't it, that the commissioner now appoints these, not the

governor?

MR. SCOTT: Yes. Yes. The MAC and the BAC will both be appointed by the commissioner.

DR. SCHUSTER: Yeah, that's a big change. So you want to go on? Are there any other questions? I'm sorry, I should have --

(No response.)

DR. SCHUSTER: Okay. You want to go on and talk about the survey, Jonathan?

MR. SCOTT: I think somebody might be on here to talk about this.

DR. SCHUSTER: I don't know that we had -- I didn't have it on the agenda, so I'm not sure what the Managed Care Survey is.

MR. SCOTT: Well --

MS. BICKERS: I think, Jonathan, we wanted to put a plug in for the survey that we put out --

DR. SCHUSTER: Oh, okay.

MS. BICKERS: -- and we wanted to share the information.

MR. SCOTT: In that case, we have a

Managed Care and SKY Program Stakeholder Survey. Please take note of this QR code, if that's easier for you, or this link here, and I think we will probably share that information with you as well, Dr. Schuster.

DR. SCHUSTER: Yeah, that would be great. And is that open? Who's supposed to be replying to the survey? What does stakeholder mean? Does that mean providers, and recipients, and advocates, and everybody --

MR. SCOTT: I think all of the above.

DR. SCHUSTER: All of the above.

MR. SCOTT: If you're an interested party in this --

DR. SCHUSTER: Anybody that's interested. Okay.

MR. SCOTT: -- we would love to hear from you on this circuit.

DR. SCHUSTER: Okay.

MR. SCOTT: Our next page, any questions or comments. I think we've hit some of those, but we can always continue.

DR. SCHUSTER: Yeah, that's very helpful. Thank you, Jonathan.

MR. SCOTT: Thank you.

DR. SCHUSTER: I'm going to go back. There's a lot of interest in the issue of prior-auths being restarted on Medicaid behavioral health services. And I guess, Angie, that's you.

MS. PARKER: That's what I understand. What can I do to help and answer any questions that I may or may not be able to? And if I cannot, I will get the answers to you.

DR. SCHUSTER: Well, Steve, you want to ask some questions?

MR. SHANNON: Yeah. We have calls with four of the five MCOs, CMHCs too, each month. And we keep asking prior authorization questions. What does it look like? What's going to happen? And one answer we get is the MCOs are waiting on guidance, or they've submitted something to Medicaid and they're waiting on feedback. I mean, it's just, you know, I can't -- it's six weeks from today is the effective date. And we're just getting concerned, one, folks are going to lose access to services if we

don't have the prior-auths in place effective June 26th. So I think we're all waiting on some sort of guidance. I mean, the bill is whatever was effective 1/1/2020.

MS. PARKER: Mm-hmm.

MR. SHANNON: I mean, I think that's whenever it was, right? Well, you know, so I think -- but it seems like some MCOs, and I don't want to speak for them, are submitting information or will be to Medicaid for approval before they go forward and issue -- I mean, we have concerns about staffing, you know, who will do the utilization management, prior authorization process. What does that look like, what services have to be included, what don't have to be -- you know, what services may not be included? And it's just -- I keep hearing the clock tick behind me, you know, and it's like --

MS. PARKER: I understand.

MR. SHANNON: So --

MS. PARKER: So to answer some of your concerns or questions, MCOs, by contract, are to submit any documents or

policies to DMS for review and approval before they can utilize them or send them to the providers. I can tell you that I have personally seen in the past few days documents from MCOs that they have requested an expedited review. So we are -- we have just recently been -- "we" being DMS -- started to receive these notices from the MCOs, and expedited means within five business days. Typically, we give -- I mean, they ask for -- I mean, we usually review in 30 days. So we are, on the DMS side, as soon as we get them, if they're expedited, we are trying to ensure that we are reviewing because we understand the time frames for the providers as well and the challenges that you all are having to get these things in place.

A lot of these are, as you said, you know, what they did in January of 2020. There could be some additional services that they could PA that would -- that do and will require our approval. But you -- or when I say "you," the behavioral health provider, should be getting notices of this

information no later than the end of next week, I would think, if we are doing our job getting these expedited reviews back to the MCOs. I know I personally approved one of United's about three hours ago.

MR. SHANNON: Okay.

MS. PARKER: Now, if there are any issues with what they're sending us, it may take a little longer, but I'm not expecting that to happen. We are doing a review and comparison of each of the MCOs as far as time and numbers of units for specific services to see if, you know, there's a lot of differences in those. So we want to -- because we know one of the issues earlier on that the providers were concerned with, this MCO does this, but this MCO does that, and how to make it more consistent. We are not currently dictating that, but we are looking at each MCO and what they are requesting to see if there's any outliers for that.

DR. SCHUSTER: But are you asking, Angela -- are you looking, Angie, for consistency with what they were doing back in 2020, or are you looking at consistency

across MCOs? Because our question --

MS. PARKER: Across MCOs. Across MCOs.

DR. SCHUSTER: Okay. Because our question was can we make this as consistent or uniform across MCOs as possible.

MR. SHANNON: Yeah.

DR. SCHUSTER: And you're looking for consistency across MCOs.

MS. PARKER: That's correct.

DR. SCHUSTER: Okay.

MS. PARKER: Now, will they all be consistent as of June 25th? I can't guarantee that. There may be some, you know, conversations because of this bill that came into effect the end of March, and the notification that, you know, it took us about a week to come up with what -- how we were going to process this, and the notification dated April 8th that was sent out electronically -- of course, snail mail took a little bit longer to get that out to everyone, but we are -- like I said, we are getting some requests from the MCOs now to be expedited for review.

DR. SCHUSTER: Okay. Let me -- Nina, you have your hand up. You have a question.

MS. EISNER: Thank you. Angela, one of the concerns that we're starting to see and have been for a few months is that some of the MCOs are trying to implement prior-auth in advance of the June 25th deadline. For example, Passport has started requiring prior-auth for IOP sessions that exceed 16. And we determined in the past and through many conversations with DMS and others, that until the MCOs have a way of actually tracking the utilization of IOP sessions across providers, because providers aren't going to be able to do that, we can't necessarily implement a prior-auth requirement. Well, they're saying that they put it into effect 1/1/25 and that they notified providers through their -- you know, through their email system. And so that's an example.

WellCare, as I'm sure you know, is another example. They had put out that they were implementing certain authorization requirements as of May 1. And then, you

know, DMS came out and said, "No, it's going to be 6/25," but some of those requirements are going forward.

So I guess one of my concerns, Angela, is that DMS take a position with the MCOs that until such time as prior-auth is officially enforced, which is June 25th --

MS. PARKER: Mm-hmm.

MS. EISNER: -- that these other, you know, sporadic requirements for authorizations should be ceased.

MS. PARKER: That has been our stance. So I had not heard about the Passport IOP across providers effective 1/1/25. So if you want to send me what the specifics are regarding that. They should not be doing any -- and I see Nicole's going off mute --

MS. BASHAM: Yep.

MS. PARKER: -- from Passport.

MS. EISNER: I appreciate that.

MS. PARKER: So it may be something I don't know.

MS. BASHAM: Yeah, Angie, if -- Nina, if you could send that, I know you're going

to send it to Angie and send it to myself, then I am happy to run that down. We aren't implementing any of the new -- what was just released based on the legislation. We aren't -- that's not going to go in effect for us until 7/1. So if you will send that over, I'll run that down.

MS. EISNER: I will. And Nicole, who do you represent?

MS. BASHAM: Passport. I'm the COO for Passport.

MS. EISNER: Oh, okay. Okay, yeah, it's happening at a couple of our hospitals. So I don't know if it's happening --

MS. BASHAM: Okay.

MS. EISNER: -- with other providers. And it is also on the log for this Friday's meeting with Passport and also with DMS.

MS. BASHAM: Okay.

MS. EISNER: So I'll forward that on.

And then the WellCare issue is another matter. And so again, you know, I just want --

MS. PARKER: The WellCare matter should have been resolved, and if it hasn't,

let me know.

MR. OWEN: Yeah, let me just -- sorry, Stuart Owen with WellCare.

MS. EISNER: Yes.

MR. OWEN: We did not go forward with PA on 5/1. So if you're seeing examples, I'll put my email in the chat, but we did not go forward with that. We had a notice earlier in the year prior to House Bill 695 --

MS. EISNER: Right.

MR. OWEN: -- but we did not go forward with implementing PA on 5/1. So if you ever have that --

MS. EISNER: Okay, yeah.

MR. OWEN: Yeah. I'll put my --

MS. EISNER: I will. Thank you.

MR. OWEN: We did not. Yeah.

MS. EISNER: Yeah, I get communication from a variety of UHS Hospitals since I represent all of them, so I'll make sure that they're sending that information forward. That had been my understanding from our previous conversations, Stuart, so thank you for

that. And Angela, also, I'll have that information on IOP sent to you. And again, I raise it here because I don't know if any other providers are having a problem.

And while I have the floor, just one other question. We had communicated through the MAC, I think it was the last meeting, and maybe the BH TAC, that what we were hoping for was some consistency in authorization processes by MCOs. Some have live review. Two of them that I know of only have authorization review via fax on weekends, which puts those organizations at a disadvantage in terms of being able to respond timely if there is a peer to peer or something else required. So is the cabinet going to move to requesting the MCOs all have the same kind of staffing patterns and processes for authorization of care?

MS. PARKER: I wasn't aware that there were difference in staffing patterns as far as what you're talking about as far as prior authorizations. If I understand your question, you say two have live reviews. Are talking about just for

weekends?

MS. EISNER: No. Two only have fax review for continuing care authorization and notifications on the weekends. Everything else is live. So I'm happy to send to you which two MCOs I'm talking about.

MS. PARKER: Sure, please.

MS. EISNER: Because again, we just -- what we're looking for is some consistency so that when our, you know, UR reps in hospitals have a specific concern know what they're supposed to do across the MCO variety of plans. So thank you.

MS. PARKER: Mm-hmm.

DR. SCHUSTER: Stephanie Koenig from UHC has a question.

MS. KOENIG: Actually, I think I didn't lower my hand, Dr. Schuster. I just, when I heard Steve's comments, I raised my hand. It sounds as though Angie has addressed them.

DR. SCHUSTER: Okay.

MS. KOENIG: Just to kind of speak on behalf of UHC, provider notification will go out the door on Wednesday, May 21st via

email and fax blast. On May 29th, we will have reoccurring open office hours and Q&A sessions that will be included in the communication to our provider community to join and talk through and ask questions on our prior authorization process.

DR. SCHUSTER: Wonderful. Thank you very much. Shannon Stiglitz.

(No response.)

DR. SCHUSTER: Are you there?

MS. STIGLITZ: Yes, I'm sorry. It just takes me a minute to always find the mute button when someone calls on me.

DR. SCHUSTER: No problem.

MS. STIGLITZ: So my question is a follow-up to Dr. Schuster's question. So 695 states that the prior authorizations for behavioral health that were in place prior to the PHE are what can be put back in place. So my question is, is as the MCOs are sending in these expedited reviews, is that the bottom line, like you can't add any new prior authorizations that didn't exist prior to 2020? Or are they opening up the -- do any prior authorizations, even

those that didn't exist prior to 2020? How are you managing sort of what is the floor for prior authorizations based on the statutory language?

MS. PARKER: As of 1/1 of '20, we had four of the five MCOs that were contracted with DMS at that time. United was not. So we are reviewing what their prior authorization list is. It's new, so they don't have those in place, so that's -- we have to look at those. As far as what the other MCOs, if they have something that's additional than what was in 1/1/20, they are highlighting those.

MS. STIGLITZ: So they could put additional prior authorizations in place even those that were not in existence prior to 1/2020?

MS. PARKER: That is correct.

MS. STIGLITZ: Okay. That answers my question. Thank you, bye.

MS. PARKER: Mm-hmm.

MS. RITTENHOUSE: Sheila, if I could ask a question?

DR. SCHUSTER: Yeah.

MS. RITTENHOUSE: This is Susan Rittenhouse with Seven Counties. One of the -- Steve mentioned the MCO calls with the CMHCs. One of those calls this morning the MCO indicated that they plan to implement their prior-auths on June 25th. And therefore, if a claim came out for the month of June for targeted case management and assertive community treatment, which are rollup monthly billings, in the month of June that an auth must be in place. We're concerned about that because obviously clients will have received services throughout the month of June, and we won't know if that auth will have been approved or not since we can't even submit that until at least midway through the month of June. We don't even know what the process is at this point.

MS. PARKER: Mm-hmm.

MS. RITTENHOUSE: So is that something that Medicaid is allowing that just because the claim comes out during that month for that rollup service, that an auth must be in place?

MS. PARKER: Was this from a particular MCO, this issue, or is it across the MCOs?

MS. RITTENHOUSE: So far, it's only come from one.

MR. SHANNON: Yeah, Humana.

MS. RITTENHOUSE: Yep.

MS. STEARMAN: Hey. Hi, it's Liz Stearman, our Behavioral Health director for Humana. Sorry, I'm trying to come on camera since I'm in a chat so I can look at you guys.

Yes, what we said was if the date of service that is on the claim occurs -- if that date of service for any claim for a service that requires prior-auth is post 6/25 when prior authorizations are required, then an authorization would be required. It has to do with the date of service on the claim.

MS. PARKER: So if the -- just so I can help understand, so if they came in -- if the service was 6/24, they don't have to send you a claim, but if it's 6/25, they have to send a claim.

MS. STEARMAN: Well, they have to send a claim if they want to get paid, but if --

MS. PARKER: Right. That's what I mean, but if they didn't -- if the service is on 6/24, they would have to send a claim, but they don't have to get prior-auth if it's 6/24.

MS. RITTENHOUSE: Right, but for active --

MS. PARKER: That's the more accurate --

MS. RITTENHOUSE: For active targeted case management, there's multiple services throughout the month --

MS. PARKER: Mm-hmm.

MS. RITTENHOUSE: -- that rollup into one monthly billing.

MS. PARKER: Right.

DR. SCHUSTER: So how does that work? I think that's the question. So --

MR. SHANNON: Yeah, procedurally what happens?

DR. SCHUSTER: So let's say three-fourths of the services did not

require a PA.

MS. PARKER: Mm-hmm.

DR. SCHUSTER: But because it's a monthly billing and occurs after June 25th, Humana is saying, "Oh, no, it all had to be PA'd."

MS. PARKER: Well, they wouldn't be able to go back to June 24th to see -- for the PA. They can't deny it for that reason. Now, they could potentially deny it if the date of service of 6/25 was not prior authorized. I understand the TCM is a monthly claim --

MR. SHANNON: Right.

MS. PARKER: -- or request.

MS. RITTENHOUSE: But it seems that's a disadvantage to the client to not -- that they're receiving services throughout the month and not even know if it's been approved yet or not. Typically, it's a prior authorization. In this case, we're not able to get a prior authorization.

MS. PARKER: Right.

MS. RITTENHOUSE: We're already providing those services for the month.

MR. SHANNON: Yeah.

MS. PARKER: I would say work with the MCO on that.

MS. STEARMAN: Yeah.

MS. PARKER: The June 25th date was not set by DMS, but I would suggest that Humana work with any provider and -- with those types of issues when those -- in this particular case.

MR. SHANNON: The reason we're asking is --

MS. STEARMAN: Yeah. So we're going to be handling -- so we would be handling that exactly like any other retro eligibility. Those requests would meet for retro because the service has already started. The requirement wasn't there when the service started, the requirement is there now. So that falls within our retroactive authorization process.

So our notice from the department I believe came through this morning, is being approved right after we met with everyone. Somebody said we didn't have our material, so those should actually be coming out

today. They -- like I said, we will be opening up the opportunity to request authorization prior to 6/25. So while it's not going to be 6/1 necessarily, feel free to send any of those in a week early or even prior to that, and state that, you know, you guys intend to bill past 6/25, and we can review those per our retro policy, which would be what would cover that.

MS. WOOTON: So just so that I'm understanding correctly because I do billing and clinical supervision with targeted case management. Their contacts is within the month, and we run billing from the first of the month to the 30th of the month --

MR. SHANNON: Doesn't matter.

MS. WOOTON: -- but to actually bill to be paid is not sent until the 30th. So what I'm hearing you say is that's going to be okay for the month of June because it would be services that was provided before the pre-authorization was required?

MS. STEARMAN: In order to pay any claim with the date of service post 6/25, an authorization will need to be on file.

Correct.

MS. WOOTON: So should we go ahead and submit a pre-authorization for the whole month of June? I'm sorry, I'm just not understanding just because our billing doesn't run for -- I mean, the work is done all month beginning at the first of the month. So they may have 3 contacts before the 25th, and then they'll get that last contact in, and then we send the bill out on the 30th of the month because case management has that whole month to do their service, which is packaged into one billing at the end.

MS. STEARMAN: Correct. If you are trying to submit a claim for services that occurred even partially prior to 6/25, but the date of service on the claim will be 6/25, I would recommend following our retro authorization process to be able to apply that.

MR. SHANNON: This is a six-day window. That's the problem. That's my frustration. It's six days. And it's a monthly service. And we're going to have to

go back and request something that we can hopefully get guidance what that looks like, but it's six days. Is there not a better solution? I mean, I'm going to tell people don't provide services after the 24th. Get your 4 contacts in by the 24th and bill. That's the easiest answer. So it's dated the 24th, and we'll see what happens on the 25th to the 30th. That's not consumer-focused services. That is business model focused services. We want to do consumer-focused services, and this six-day period seems to be a barrier that so far, Humana can't say, "Eh, let's figure out a better way to do this."

I don't get it. It seems like one, it's 90 days to make this effective, 90 days. And now, six weeks out we're getting this information now. Six days.

MS. WOOTON: Right. And here's another issue that I was thinking, because I was also thinking, "Hey, we'll just get all of our work done before the 25th and send that in." But I may be wrong on this, but I think there's some kind of stipulation in

regs that says we can only send out those case management bills every 28 days?

MR. SHANNON: Yeah.

MS. RITTENHOUSE: Correct.

MS. WOOTON: So that wouldn't put -- that wouldn't push us out the 28th eight days if we sent them in on the 24th. I just -- I'm not complaining about the PAs. I'm just worried about services that some of my youth are going to miss out on potentially.

MS. PARKER: I'll take this issue back.

MS. BICKERS: Dr. Schuster, we have some hands raised. We had Bart, and then Dr. Hannah.

DR. SCHUSTER: Yeah, I'm going to call on David Hanna first because this is -- he wants to speak to the Passport issue that came up.

DR. HANNA: Thank you, Dr. Schuster. I want to say, first of all, I think all of us on the call from Passport were shocked to discover that somebody is requiring IOP prior authorization for Passport. And I think I figured out where the problem is,

and so let me just say we are going to start PAs on July 1st. We're not going to begin in June; we're going to start on July 1st. And in the e-news that we sent out describing all of the things that would require PA, we said that prior authorization required after 16 visits per member per calendar year beginning 1/1/25. That refers to the count of 16 sessions. It does not refer to when PA starts. So PA begins on July 1st. That's in our overall statement, but the 16 sessions starts on our count of that as it does, you know, just looking at all services on 1/1/25. So if somebody has had 16 sessions, then they need a PA right from the beginning. If they're new to services, they don't need that PA until they've gotten those 16 sessions. If there's a problem with that, and I heard what Ms. Eisner said and she's messaged me that their one organization has had a problem. If there's a problem, we will fix that. But we're not requiring PA until July 1st, and the count -- that only refers to the count.

MS. EISNER: I think -- yeah, David, and I -- hi, it's Nina. I think you just identified what the problem is then. Someone misinterpreted that communication about 1/1/25. So thank you very much for addressing that. I appreciate it.

DR. SCHUSTER: All right. Thank you. And let's go to Bart.

MR. BALDWIN: Thank you. I just have a request from the MCOs or for Medicaid. When the notices go out, because I assume that we'll get something similar to what Passport sent out from all the other MCOs, that those updates could be shared with those of us that represent memberships or clients in this space to be sure it's getting to the right person. Because I know it's a challenge to be sure the right email goes to the right person at the right provider with turnover and those types of things. It's just -- it's nice because sometimes it goes to an old inbox that somebody's is not even there anymore, those types of things. Maybe they can share it with you, Dr. Schuster, and you can get it

out to this full group.

DR. SCHUSTER: Yeah.

MR. BALDWIN: I mean, it's public information you want to get disseminated, but just whenever it goes out to -- it's live and for, you know, public distribution that it could go to us, and then we can send it out in addition, too, just to be sure everybody has it. I think that would help a lot to get that information out on a consistent basis.

DR. SCHUSTER: That would be fine if that's workable. And David Hanna, there was a question from someone at VOA about the 16 IOP sessions you may be able to respond to. Thank you.

DR. HANNA: So it is definitely a problem for all services when people are having services across various providers, how many services people have had. If you have any doubt, request the PA. But -- and, you know, that's not only true of IOP, it's true of anything for which there is auth free services. And so you can always request a PA if there's any doubt about

that.

The challenge, we've had people -- if you call us, we will tell you what we know. But the problem is if you call us on Thursday morning and we say, "No, this person hasn't had any services," we may get a claim on Thursday afternoon, and then the information we gave you will be wrong. It's really better to assess with the client or to get the PA.

DR. SCHUSTER: Okay. The other question I would have, Angie, we sent -- the BH TAC sent a whole list of things that we had discussed in our March meeting about PAs, time frames, and some other things, but one of the things was the need for training of providers by the MCOs. And I wonder if you're aware, are they reporting to you whether they're doing any training? I know that the United person said they were having a session of Q&A and so forth, which at least gets to some of the questions that people have, but are you aware of anyone scheduling --

MS. PARKER: I am aware.

DR. SCHUSTER: -- any training?

MS. PARKER: I am aware that there is some training being developed, and again, going through the DMS process, and I believe I saw Chelsea Agee earlier on here. And the Health Plan Oversight Division and the Contract Compliance Branch is collecting all of that training information that each MCO is doing, so I do know that that is a part of this whole process as well.

MS. BASHAM: Angie, it's Nicole from Passport. We have a schedule we can share. We've had one session already. We certainly can share the rest to get it distributed to the TAC.

DR. SCHUSTER: All right. Do I understand from what you're saying, Angie, that if they're having training, it needs to be approved by somebody at DMS?

MS. PARKER: Well, I mean, what they are telling the providers, what they're -- like, if they're doing a PowerPoint, we have to review it, yes, and see what they're actually --

DR. SCHUSTER: Oh, okay.

MS. PARKER: Yeah, that's one of those document requirements that goes to providers that we have to review.

MR. BALDWIN: Yeah, I would chime in on that, Angela, to be sure that they feel like they can answer questions. My feedback on that first training was they read the PowerPoint and weren't able to answer any other questions, so it wasn't really helpful. I wasn't on it, but that's what I heard from providers. So I just want to be -- I mean, I understand the need for the information that goes out --

MS. PARKER: Mm-hmm.

MR. BALDWIN: -- from the MCOs to be reviewed by DMS. I think that makes a lot of sense, but I also don't want that to stifle their ability to just answer questions on a Q&A like we do -- we have already on this issue on this call, so.

MS. PARKER: Well, I don't know why they wouldn't have allowed Q&A because it's part of training.

MR. BALDWIN: Well, I don't think they had the answers to the questions.

MS. PARKER: Oh, okay.

MR. BALDWIN: Like, I think they allowed it, they just --

MS. PARKER: So you need people in those trainings who can answer their questions.

MR. BALDWIN: Yeah.

MS. NORRIS: This is Meredith from Passport. We did, on our first training, have a lot of questions to take back. And so what we're doing is creating FAQs from those questions because, as you can imagine that we can't be prepared for every single question that someone's going to ask. So we are taking that feedback from that first training that we took because it is a learning opportunity and creating FAQs from those questions, and we'll be posting those as well. I did post our training sessions in the chat, so that there's a link on our website to when those training sessions are and how to sign up and join those as well.

MR. BALDWIN: Great, thank you. I didn't mean that for that to come across as harsh as it sounded. I just think people

didn't --

MS. NORRIS: No.

MR. BALDWIN: -- they're just trying to get --

MS. NORRIS: Nope, I totally understand, but --

MR. BALDWIN: Yeah --

MS. PARKER: Well, I mean, a lot of this for the MCOs is new, too, because they haven't done behavioral health PA in five years.

MS. EISNER: Right.

MS. PARKER: So they may not have that had the staff either, so they're having the staff up as well just like you all are -- providers are probably having to staff up in certain areas, too, with this PA process.

MR. SHANNON: We are.

DR. SCHUSTER: Yeah.

MR. SHANNON: From behavioral auth services to utilization management in a tight labor force.

DR. SCHUSTER: All right. Are there any other questions for Angie or about PA? Obviously, this will be an ongoing item here

at the BH TAC, but good questions and good discussions.

MS. PARKER: And feel free to reach out directly to me as well. I mean, I know that, Steve, you sent an email to Senior Deputy Commissioner this morning, and we're gathering some information from that, too, so --

DR. SCHUSTER: Yeah.

MS. PARKER: -- based on your questions that you brought up earlier.

MR. SHANNON: Thanks.

DR. SCHUSTER: All right. Very helpful. Let me -- I realize that I missed the status update on the Reentry Waiver. I don't know if Angela Sparrow is still on.

MS. SPARROW: Good afternoon. Yes, I'm still here.

DR. SCHUSTER: Hi, Angela. I'm sorry, I didn't mean to miss you there.

MS. SPARROW: It's okay. It's okay.

So, yes, just to provide some updates on the status of the reentry, we are continuing forward towards implementation this fall. So lots of work occurring.

Again, a lot of focus in this past quarter has been on system requirements. So changes that are going to be needed to support implementation. There again, it's going to touch lots of systems across Medicaid as well as our justice partners.

A lot of discussion around our eligibility systems and how we're going to be able to identify the population pre-release and who's eligible for the subset of services, the targeted set of services. We're, with the overlap, again, with the CAA authority that took effect January 1st, again, we've talked about we've got some gaps there between our reentry population and our CAA population. So we're going to have some individuals that are eligible for the Reentry 1115 services. We are going to have some individuals that are eligible for just CAA services. And then we're going to have some individuals that are eligible for both. So we really have to be able to identify, you know, appropriately who's eligible for those services and be able to track and monitor that. So again,

there will be some significant system changes there on the eligibility side, but we also have to be able to communicate that back to our justice partners, DOC and DJJ, as well as our MCOs, right? So working through those system changes, those requirements, again, so that we can move forward with deploying those.

With that being said, you know, there are MMIS changes, so our billing system changes as well. So we're developing those, and again, those requirements to support allowing those services to be billed in that pre-release period by the appropriate providers. DOC and DJJ in return are making some changes to their systems. They're going to have to capture some additional information to identify individuals to be able to track services that they'll be billing for. So they have system changes as well. We will have some changes to our Med Impact, so our pharmacy system around, again, those 30-day supply of medications that will be provided at the time of release. So again, we need to be able to do

that accordingly.

And also, again, continuing to have some discussions with KHIE, the Kentucky Health Information Exchange, and how KHIE can be utilized to support, again, that handoff between our justice partners and our MCOs and our community providers. So we do have DJJ, I believe, is already a participant of KHIE, and so again, looking at what changes may need to be made, again, to make more integrated with an interface with KHIE and be able to support that data exchange. So lots of systems.

We, with that being said, continue to deploy workgroups. So ongoing workgroups with our justice partners, again, pharmacy around pharmacy benefits, that 30-day supply of medication, finance, so again, you know, developing that prerelease package. The rate setting for those services, and again, with our MCOs around the case management policy, both pre and post release, providing those services. We will start to kick off the MAT workgroup, so the Medication-Assisted Treatment workgroup when

we, again, kind of wrap up some of these others, if you will.

So again, lots of discussions. We'll have some of the monitoring workgroups kicking off as well around how we are going to track and monitor services, our progress, etc. We do continue to have discussion with DOC and DJJ about enrolling, so that actual provider enrollment process. So that provider type has been configured, and again, in the process of assisting them and getting them on board with Medicaid. And then next, again, follow up from there will be the contracting with our MCOs for those prerelease services, so that's to come.

We also, again, as we look towards summer Q3, we will then start with readiness assessments. And so again, that will be assessing each individual facility that would be participating, ensuring that we can support the Medicaid eligibility, identification, providing services, all the things, again. That's one of those requirements under the 1115. So each facility will have to go under that

readiness assessment, and again, of course, systems testing once we deploy these system changes. So systems internally with Medicaid, with our justice partners, and with our MCOs to make sure that we can communicate information accurately.

So a lot of work occurring. A lot of work to still occur, but we do feel like we are making progress and moving forward. So excited about that.

DR. SCHUSTER: Great. Thank you very much. Any questions?

(No response.)

DR. SCHUSTER: And just a reminder that Steve Shannon chairs the Reentry TAC, and it meets on the second Thursday of every other month starting in January. It's the same months as the MAC meetings and our TAC, and they meet at 9 o'clock. So -- and Angela, I think, is always there to provide updates, so you must be talking about this stuff in your sleep, Angela. A lot going on.

MS. SPARROW: That's right.

DR. SCHUSTER: Yeah.

MS. STIGLITZ: Just on the pharmacy changes, will those be communicated directly to pharmacists who are credentialed with Medicaid? I mean, Med Impact is usually pretty good about making sure those things occur, but I just wanted to make sure, especially since one of the issues we have is with some of the behavioral health treatments in pharmacy and pharmacies actually being able to get those dispensed effectively.

MS. SPARROW: So the intent --

MS. STIGLITZ: Or will you present to the P TAC or something so that those things can be communicated to pharmacists?

MS. SPARROW: The intent is that the individuals have the medications at the time that they're released, or again, before they're released. So those medications are ordered before that, prior to that. DOC and DJJ utilize the same pharmacy, so that pharmacy will actually be enrolling as a provider in Medicaid. And they will, again, continue that process that they are already -- that's already in place with DOC

and DJJ to dispense those medications, those release medications. And so again, they will actually just bill Medicaid for those instead of DOC or DJJ. So it will go through their contracted pharmacy that they utilize.

MS. STIGLITZ: So even once -- so even after the reentry point, they'll stay with the pharmacy that is contracted with DOC and DJJ.

MS. SPARROW: Once they're released and in the community, their full Medicaid benefits will be reinstated. So they will have access again. Nothing will change there with their pharmacy benefits, or again, their access to their medications.

MS. STIGLITZ: Okay, thank you.

MS. SPARROW: Does that make sense? Yeah.

MS. STIGLITZ: Yes, it does. Thank you very much.

MS. SPARROW: You're welcome.

DR. SCHUSTER: Okay, good question. Thank you very much, Angela. It's always exciting to think that we're actually --

MR. SHANNON: Good.

DR. SCHUSTER: -- going to start this, right, Steve?

MR. SHANNON: It'll be nice to have something concrete, right, Angela?

MS. SPARROW: That's right. We are getting there. We're paving the way.

MR. SHANNON: Yeah.

DR. SCHUSTER: Yeah, all right. We got a couple of things because we have a couple things under new business. We have a recommended agenda item for our July meeting, and that's -- we had the CCBHC, Behavioral Health Needs Survey presented, and there were a ton of questions. And the Myers and Stauffer staff and DMS met with some of us to try to answer those questions and revise their PowerPoint. And they are going to be ready to present kind of a new look at that data at our July meeting. So we will move that up there.

Also under old business, we had the multistate rate study Phase 1 wrap-up. And I understand that Victoria Smith has been in touch with Erin and says that she will be

ready to present that probably at the July meeting also. So we will add that to the July meeting.

I think there were some questions under new business that Bart or Mandy wanted to bring up.

MR. BALDWIN: Yeah. Thank you, Dr. Schuster. And I know this is a question from the Children's Alliance folks as well. But the -- and I think you answered the first question as far as the multistate rate study. I think there's been -- to finish that up, and I think there's been discussion that the Phase 2 is not going to happen.

DR. SCHUSTER: That's my understanding. Yeah, is that Phase 2 is not going to happen --

MR. BALDWIN: Right.

DR. SCHUSTER: -- at least anytime soon.

MR. BALDWIN: And I think we're still waiting on the LRC study --

DR. SCHUSTER: Right.

MR. BALDWIN: -- that was similar but broader in scope I think in terms of that

look at reimbursement rates and the plan for the future. So that's one thing.

The other question was the behavioral health fee schedule, the Medicaid behavioral health fee schedule that is traditionally, historically was updated on January 1, but a couple years ago moved it to April 1, which was great because it was effective April 1, but was never actually published until after that date. So last year, for sure, and maybe the last couple of years, that's been an April 1 update to that fee schedule. And so the question just is, is that where -- what's the status of it, I guess? Is that going to happen because I know it's tied to the changes in the Medicare fee schedule, which is some of the delay past 1/1, but I know that's been updated to the best of my knowledge. And so just the question is, is that going to happen, or are we going to -- or when, I guess? And hopefully it will be with a prospective effective date so we don't have to go back and rebill.

DR. SCHUSTER: And I don't know if anyone --

MS. BICKERS: Justin, are you on?

DR. SCHUSTER: He was.

MR. DEARINGER: Oh, hello, I am. I don't know if somebody from behavioral health wants to -- we don't typically do the behavioral health fee schedule, but I know that they are working on it. We have several fee schedules that are in the process of being updated currently.

MR. BALDWIN: Okay.

MR. DEARINGER: I'm not sure if the behavioral health fee schedule is one that's been approved or not. Right now, we just got the physicians fee schedule, the medical supplies, equipment, and accessories fee schedule. Those two are the latest ones that have been approved. I think laboratories was just approved. So I'm not sure where the behavioral health fee schedule is in the process. I'd have to ask the behavioral health folks where that's at.

But as far as the start date, all of those are -- providers don't have to go back and rebill. Those are automatically processed in the system, and usually

automatically paid, so I would hope that you wouldn't have to rebill anything, even if they did retro back to April 1st, but I'll take that back to the behavioral health folks and we can get you an update on where they are with that behavioral health fee schedule.

MR. BALDWIN: I appreciate that, Justin. And just so you know, I think that that's not folks experience. What you just described, it was automatically rebilled, I think we hear that, but that's not usually -- I mean, it probably works that way, providers can correct me on this, if you're just -- for what was billed to straight Medicaid.

MR. SHANNON: Right.

MR. BALDWIN: But as you know, MCOs -- yeah, that automatic thing is probably just the fee for service straight Medicaid, so that -- but because so many of the MCOs tie their rates to that fee schedule, then it's a lot more of changes in rebilling in -- with the MCOs. So if we could just -- if we could have the update prior to the

effective date, then we could avoid all that.

MR. SHANNON: Yeah.

MS. PARKER: Hi, it's Angie with Medicaid. As far as the behavioral health fee schedule, I do know that it is in process. It is a little bit delayed, but I do believe -- I don't want to give you a specific date because I will be wrong. But I do know that it is very close to being posted.

MR. BALDWIN: Okay, great. Thank you.

MS. PARKER: Apologize for the delay.

DR. SCHUSTER: Yeah, Angie, can you or somebody let Erin or me know just so we can tell people that it is posted, please?

MS. PARKER: It is -- it's not posted yet, but I know we're very close to that. But, yes, ma'am, I will --

DR. SCHUSTER: Okay, all right.

MS. PARKER: -- get to see if I can get the potential date that that will happen.

DR. SCHUSTER: That would be

wonderful. Thank you.

MS. PARKER: Mm-hmm.

DR. SCHUSTER: And Bart, I think there was a question about the Medicaid commercial bypass codes.

MR. BALDWIN: Oh, yeah. Is there -- because I know that's an issue that this group has worked on in the past with the Medicare and then the commercial bypass codes, but we had a question for a current version of that. I think all that we have been able to find is something that's from 2020, 2021. So if there are updated bypass code lists that are more current than that, that would be great just to share that can get out to the providers, so they know that.

MR. SHANNON: Yeah. And Bart, that's one of the questions I asked this morning as well.

MR. BALDWIN: Okay. Okay, gotcha. Thanks, Steve.

DR. SCHUSTER: Okay, so that's on there.

MR. BALDWIN: So if we could just get those current versions and get that

disseminated, that would be helpful.

DR. SCHUSTER: Yeah, that would be helpful.

Erin, would you share your screen and post that abbreviated public notice document that I sent you, please? So if you looked at what happened with House Bill 695, initially, it had some, you know, kind of permissive language around the community engagement, which is the work requirement. And then as it went through the process and it got over to the Senate in the dead of night, specific language was inserted into House Bill 695 requiring DMS, Kentucky DMS, to submit a section 1115 demonstration on community engagement. In other words, to do a waiver that would put the work requirement into effect.

I'm sorry, Erin, that's the wrong document.

MS. BICKERS: I just realized I had the wrong document. I'm sorry.

DR. SCHUSTER: All right. So a document was released by DMS a couple of days ago, and I just wanted to be sure -- I

think Erin got it out to the MAC and the TACs, but it has to do with their -- the community engagement.

There it is, yeah. So it goes through the purposes and what they're looking for, and it has the link to the document itself. And as you all know, this is something that a lot of us were extremely concerned about in the Bevin administration because we know what happens is that we have a lot of people that are working multiple jobs and so forth. It's the reporting requirements that trip people up, and if they are frequent and somewhat onerous, it's just really hard for our people on Medicaid to keep up with them. And if they have seasonal jobs, it's particularly difficult, and so it just is very difficult, so we've been very concerned.

And you may also remember in the Bevin administration, they tried to do an exemption for people that they considered to be medically frail, which was a term that we all objected to, but they used it anyway. And we were not sure where behavioral health

fell into that, both substance use and mental illness, and it just was a big mess.

So because of 695, DMS is going to have to submit this waiver. They have to have two public forums, and so they have requested that the first public forum, which is the in-person one -- or on Zoom rather, not in person -- be held during the MAC meeting. The MAC meeting is the fourth Thursday of the month from 9:30 to 12:30. So if you see down there, it lists that and it gives you the link to it. So we will be slightly revising the order of things on the agenda for the MAC meeting to allow for this one-hour public forum, which is really a Q&A opportunity, where DMS officials will be going through and describing what they are going to submit, and you have an opportunity. This is not a comment period. This is an information sharing opportunity, so I really wanted to get this out to you all and will also send it out via email to those of you who are on my list. So that at the MAC meeting that's coming up on May 22nd, that time frame from 10 to 11, is

going to be open for anyone who wants to get more information about this work requirement because it's so critically important, and I think it's particularly important for those of us who deal with Kentuckians with significant addictive disorders or severe mental illness, and we want to be sure that if there is an exemption process, that it is one that our folks can access and carry out.

So I just wanted to put that up there to draw that to your attention. And we will send that document out to you following this.

The comment period is open. Actually, it's a very short comment period so it's only open through June 12th, close of business on June 12th. So May 22nd is an opportunity to ask some questions and get more information. And then about two weeks after that, maybe two and a half weeks after that, is the end of the comment period. And again, I think for those of us in behavioral health, this is really an important thing for us to be paying attention to. So any questions on that? I don't know how much I

can add, but that's what I know. Just wanted to draw it to your attention.

(No response.)

DR. SCHUSTER: Thank you, Erin. If not, we'll go on to old business. Are there any formulary issues? Any concerns that people are having about behavioral health formulary or access to medications at appropriate times?

(No response.)

DR. SCHUSTER: Hearing none, and I've already said that the multistate rate study Phase 1 wrap-up will be at our July meeting if Victoria's ready to present then.

Do we have any recommendations for the MAC coming up May 22nd?

(No response.)

DR. SCHUSTER: All right. No recommendations.

The next MAC meeting --

MR. SHANNON: Sheila?

DR. SCHUSTER: Yeah.

MR. SHANNON: Should we make one about prior-auth, or have we kind of laid that out?

DR. SCHUSTER: Well, I actually wondered about that, Steve. I was trying to think what would be a good recommendation. What are you thinking?

MR. SHANNON: I don't know. I mean, the process is going to go to the MAC and then it goes to Medicaid, and by the time we get a response, it'll be after June 25th, right?

DR. SCHUSTER: Yes, it will, but I wonder if we want to be -- make clear our request for some clear guidance from DMS on -- I don't know what. I mean, the things that we raised in the data that we sent them was really about consistency across MCOs, which they are saying that they're doing. But I wonder if it's consistency both in services being prior-auth'd, but also the process.

MR. SHANNON: Yeah. I think that's -- I think that would help a lot of people.

DR. SCHUSTER: So it would be consistency across the MCOs on the PA process?

MR. SHANNON: Yes. I like process

and forms.

DR. SCHUSTER: Oh, and forms, very good. All right, you want to put that in the form of a motion?

MR. SHANNON: Yeah. I move that we make recommendation to the MAC that there -- that DMS establishes guidance -- or I don't know if that's the right word, Sheila -- on the prior authorization process and forms utilized by the MCOs.

DR. SCHUSTER: To assure consistency, how about?

MR. SHANNON: Yeah.

MS. MUDD: I'll second that, absolutely.

DR. SCHUSTER: Val, thank you very much. Any discussion among the voting members of the TAC?

(No response.)

DR. SCHUSTER: All right. All those voting members in favor of that recommendation at the next MAC meeting, signify by saying "aye."

(Aye.)

DR. SCHUSTER: And opposed?

(No response.)

DR. SCHUSTER: And abstentions?

(No response.)

DR. SCHUSTER: All right. We will send that up. I will write that up, Erin, for you.

MS. BICKERS: Thank you.

DR. SCHUSTER: Very good. Yeah.

And our next BH TAC meeting is July 10th, our regular second Thursday of the month from 2 to 4. And I appreciate your flexibility in making this change in the May meeting date.

And I think I'm -- we're ending only a minute or two late. Not too bad. So we'll adjourn by acclamation if that's all right with everybody. I assume that there will not be any nay votes on that. All right. Thank you all, and have a good day --

MR. SHANNON: Thank you, Sheila. Yeah.

DR. SCHUSTER: -- and June. And we'll see you in July. Thanks very much.

MS. HYDE: Thank you.

MS. BICKERS: Have a great day.

MS. MUDD: Bye.

DR. SCHUSTER: Bye-bye.

(Meeting adjourned at 4:06 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 23rd day of May, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR