DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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July 14, 2022
1:00 - 2:25 p.m.

Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter

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ATTENDANCE

TAC Committee Members:
Sheila Schuster, PhD, Chair
Bart Baldwin
Steve Shannon
T.J. Litafik
Eddie Reynolds
DR. SCHUSTER: Welcome to all. We will call the meeting to order. I'm Sheila Schuster, Executive Director of Kentucky Mental Health Coalition and Chair of the Behavioral Health TAC.

So if you are not here for the BH TAC, then you are in the wrong meeting, which happens these days with Zoom. But if you are in the wrong meeting and want to stay, we are happy to have you.

And I want to acknowledge our other voting members who are here, T.J. Litafik from NAMI Kentucky, Eddie Reynolds from the Brain Injury Alliance of Kentucky, and Steve Shannon from the Community Mental Health Centers, KARP. So we have a quorum and we are authorized to do business.

So let me ask the voting members for a motion to approve the minutes of our May 12th meeting that were distributed via e-mail.

MR. SHANNON: So moved, Steve Shannon.

DR. SCHUSTER: That's Steve. Do I have a second, please.
MR. REYNOLDS: I'll second.

DR. SCHUSTER: Who is that? Eddie?

MR. REYNOLDS: Yep.

DR. SCHUSTER: Okay. Great. Any additions, omissions, corrections that you all saw in the minutes? If not, I will ask for a vote to approve the minutes. All in favor signify by saying "Aye."

(Aye)

DR. SCHUSTER: And opposed?

(No response)

DR. SCHUSTER: And abstentions?

(No response)

DR. SCHUSTER: So the minutes are approved. Thank you. I have not heard of any issues with the Medicaid single formulary. But I wonder -- let me open it up for just a minute, too, because we have some providers on and so forth.

Have you heard anything from the CMHCs, Steve --

MR. SHANNON: No, I have not.

DR. SCHUSTER: -- any medication
problems?

MR. SHANNON: (Moved head from side
to side).

DR. SCHUSTER: Okay. Does anybody
have anything?

(No response)

DR. SCHUSTER: Because Dr. Ali and
her staff have been very responsive. So if
we have any issues, you know, for our folks,
it is so important that they have immediate
access to the appropriate medication at the
appropriate time, so we want to be sure that
we don't have any problems.

All right. Then we will go on to
an update on claims payments for services to
dual eligibles. And I think I saw that Lee
Guice was on. Are you on, Lee?

COMMISSIONER LEE: Yes, ma'am.
I just jumped on for a minute to see if you
needed anything. Does anybody have any more
trouble with that issue?

DR. SCHUSTER: Let me see. I got
something from, and I don't know if Kathy
Adams is on from the Children's Alliance.

MS. ADAMS: Hi, Sheila. Yes, I'm
on.

DR. SCHUSTER: Yeah. You had sent me a note that we still had a couple of MCOs that are not publishing or not using the commercial bypass code list.

MS. ADAMS: Yeah. This is Kathy with the Children's Alliance. I apologize, I've been sick with some kind of upper respiratory thing.

So we are continuing. There were two MCOs that don't have a commercial bypass list. And we had received -- our members were able to provide examples of one of the MCOs, of those two, an example where they had provided us with their process when a client has commercial insurance, how to get services paid. And they followed that process and the claim was still denied. So we followed back up. And they had received an EOB and provided the EOB. But the EOB didn't say that the service wasn't covered.

And that's been the longstanding issue, is if either you can't get an EOB from the insurance carrier because it is not part of their package of services or they will get
an EOB but it doesn't say that it's not a covered service, which is what it is required to say, according to this MCO.

And, so, there were three options allowed in the behavioral health, BHS Billing Manual, that the MCO referred to. And one of the options was providing a letter where you attest that you had contacted the commercial insurance and that they do not cover the service. And, so, they submitted that documentation and still the claim was denied. So that member has followed up with that MCO and we are waiting to hear back.

But very clearly we have got an actual example of the provider doing everything that the MCO has asked them to do to get reimbursed and they are still not able to get the claim paid. And it is for TCM case management services.

COMMISSIONER LEE: Well, you need to send that I think directly to -- that specific example, send it in an e-mail. If you can go ahead and send it this week, send it to Angie Parker so that she can assist with seeing what the issue is.
MS. PARKER: Thanks, Lee. Yes.
You can send it to me, Kathy.
MS. ADAMS: Okay. We will do so.
Thank you.
COMMISSIONER LEE: You're welcome.
DR. SCHUSTER: And remind me,
Angie, it is Angela.Parker?
MS. PARKER: Angela -- I will put
it in the chat. It is AngelaW.Parker. Kathy
should have my e-mail address, but I will put
it in there.
DR. SCHUSTER: Thank you.
MS. ADAMS: Thank you, Angie.
DR. SCHUSTER: Yeah. It seems to
me that this is a pretty clear example of the
provider literally jumping through every hoop
that the MCO is requiring and still not
getting a claim paid. So I appreciate that,
Angie.
I wonder if any of the other folks.
Steve, are you hearing -- is that your only
example at this point, Kathy?
MS. ADAMS: Yes. That's the only
one I've received. Because the majority --
what I have heard, anyway, is that providers,
if they have Well -- the particular MCO that
this example is with, that they just don't
serve those clients if they also have
commercial insurance because they can't
afford to because they can't get paid.

So in this instance, even though
the Medicaid client has commercial insurance,
they are not going to get the additional
Medicaid services, behavioral health
services, they are eligible for because the
provider won't be reimbursed.

DR. SCHUSTER: Yeah. Which is a
big problem. You know, it is the irony of
you have two insurance coverages and you have
less access to services than if you only had
one, basically. So thank you, Kathy. I
appreciate your detailing that.

Steve, do you have any from the CMA
side?

MR. SHANNON: It is the same
stories. I mean, we've -- it is almost to
the point where we focus on the Medicare,
Medicaid dual eligible. The commercial is a
challenge. You know, we're trying to process
those as we go.
But I can get examples, I'm sure.
It is just, you know, very little progress on
the claims.

DR. SCHUSTER: Okay. So I guess
the question for DMS, then, is: Is there
anything that can be done from the DMS side
to make this a priority, to make sure the
MCOs do it the right way?

Because what is happening, it
sounds like, is that our -- we have fewer
providers who are willing to deal with folks
if they have got Medicaid and a commercial
insurer.

MS. PARKER: Well, I mean -- this
is Angie Parker with Medicaid -- if it is one
particular MCO or if it is all six, obviously
there is that, you can contact myself and/or
Jeremy Armstrong-Derossitt, who is the branch
manager, for any MCO issues and we can look
into it further. Without knowing the
specific examples that you are having, is it
all of their claims or is it just one-off's,
those are types of -- that is the information
that would be helpful as well.

We know that not all MCOs have a
commercial bypass list. That is something that we do not -- do have -- have not mandated. But I do -- you know, that is something that they have been working on. We do have the Medicare bypass list, as you know.

MR. SHANNON: Right. We have monthly calls. I will add this to every call, the commercial dual eligible piece.

MS. PARKER: That would be -- yeah. I think that would be very good, Steve.

DR. SCHUSTER: Yeah. I understand from Kathy that four of the six, Angie, do have commercial bypass lists. Now, whether that is solving the problem every time, I don’t know that and I guess that is something that we need to follow-up on. But at least in terms of having a list, my understanding is that four out of the six MCOs do have a list.

MS. ADAMS: As far as I hear from my members, those bypass lists for commercial insurance for the four MCOs that have them is working nicely, it is working well, and, so, there is no issue.
It is just an issue -- while there are two MCOs that don't have the bypass list, one of the MCOs just doesn't have a large percentage of clients, Medicaid clients. So my members haven't had any examples for that MCO. It is just the other MCO that it is a continual problem.

And, like I said, it has been going on for years now. And most members just can't, just don't serve those clients anymore.

DR. SCHUSTER: Well, let's do another round of data gathering, then. And, you know, Kathy, I'm counting on you from the Children's Alliance because you have so many providers and Steve with the CMHCs and Bart as well.

MR. SHANNON: All 14 are on those calls.

DR. SCHUSTER: Okay. Great. But I do think that if there are other providers who are on the call today, and very often we have some of our BHSOs and some of our other groups, that we need to get that data from them as well if they are having a problem.
And we know that the problem is more likely to occur with kids having the Medicaid and commercial insurance. I'm sure it is not exclusively, but I think more so.

So let's put this on the agenda for September. And let's wait to make a recommendation to the MAC. But if we have not gotten anywhere between now and September, then I think we ought to kick it up to the Medicaid Commissioner and so forth.

MR. BALDWIN: Yeah, Sheila, this is Bart.

DR. SCHUSTER: Yes.

MR. BALDWIN: I haven't heard as much about, like the other folks, much about this lately. I don't know that that's an indication that it has been resolved. But I will reach out to my other groups and get some feedback.

DR. SCHUSTER: Yeah. That would be helpful. Thank you, Bart. And I encourage everyone to do it. I mean, I think that the current folks over at DMS have shown that if we can get them the data so that they know what to look at and what to follow-up on,
that they have been willing to do that. And
I understand they can't just blanket go on
anecdotes and so forth. Let's really make a
centered effort to get that data and get it
to Angie.

MR. SHANNON: I think some folks
have toxic burnout --

DR. SCHUSTER: Yeah.

MR. SHANNON: -- just kind of throw
their hands up, we will figure out what we
can do and go from there. And, you know, as
Kathy eluded to, some folks don't see
individuals who are members of that MCO.

DR. SCHUSTER: Well, you know, I
think it would be interesting and helpful,
actually, Steve and Kathy, Bart and others
who are on, if you could give us some idea
about either a number of providers or the
providers that you have in your group with
some idea about the number of cases that they
are not providing those services. Because,
basically, people are not getting the
services that they are entitled to.

MR. SHANNON: Right.

DR. SCHUSTER: Which is not a good
thing and I think not something that our Medicaid department wants to have happen. So...

We will move this up to a higher priority for our September meeting. Thank you for that, Kathy, for that detailed description and, Lee and Angie, for being available.

Lee, I think this next one is yours as well, the no show data gathering panel.

COMMISSIONER LEE: Well, yes, ma'am. But I know you have it on there for me. And it is still being used. But the largest number of reasons that folks are not showing up is unknown.

So the MCOs, I think, may have something that they can tell you about how they are going to use the data. But that is still the trend, the biggest reason is that they just don't show up; no one knows why.

DR. SCHUSTER: Is there any improvement or any increase in the number of reports to the panel, Lee? And I ask that because we made a recommendation to the MAC back in March that they make this a regular
part of their agenda and that they regularly remind providers to use the portal.

So do you have any sense of or could you report that at our September meeting about what the --

COMMISSIONER LEE: Well, I don't have any sense of that, Dr. Schuster. And, unfortunately, I could ask for someone to report it at the September meeting, but this will probably be a good minute just to let you all know that I am retiring at the end of this month.

DR. SCHUSTER: Oh.

COMMISSIONER LEE: And, so, there will be someone else, though, who can respond to that question. And I will make sure -- you know, I mean, it will be in the minutes. And, so, DMS will make sure to pass it along.

DR. SCHUSTER: All right. Well, thanks for letting us know, Lee.

COMMISSIONER LEE: Certainly.

DR. SCHUSTER: Congratulations on your retirement.

COMMISSIONER LEE: Thank you.

Thank you.
DR. SCHUSTER: You have put in many years of service in Medicaid and --

MR. SHANNON: You will be missed.

DR. SCHUSTER: -- we appreciate that. So thank you.

Yeah. And we will make a -- we will put it in the minutes that the request is that we get a report at our September meeting about what the reporting numbers look like and who they are from.

COMMISSIONER LEE: So I would suggest, Dr. Schuster, that you ask how many providers are actually reporting.

DR. SCHUSTER: Right. And you all -- do I recall that you have them broken out by the class of providers? Like the behavioral health providers are there, separate from the physical health; do I remember that?

COMMISSIONER LEE: We can collect the information by provider type. And, so, we have several behavioral health -- several different behavioral health provider types as well as several different physical health provider types. So we can break that out.
DR. SCHUSTER: All right. That would be great. So that's what I need to ask for. Thank you.

COMMISSIONER LEE: Yes, ma'am.

You're welcome.

DR. SCHUSTER: Always good to ask the question so that you can access the data that you have that can answer the question.

COMMISSIONER LEE: Absolutely.

DR. SCHUSTER: Yeah. Thank you very much. We will do that.

Provider credentialing. This is a question, again, that Kathy brought up but I think we have all been curious. So House Bill 438, not in this past session but in the session before that, I think was representative Ken Fleming's bill, which allowed the MCOs to join kind of a consortium or some kind of group credentialing alliance.

And, Angie, if you are still on, I think you were the one that reported on this maybe at the MOAC [ph] or advised another meeting that three of the six MCOs are currently participating in that alliance.

MS. PARKER: Yes, ma'am.
DR. SCHUSTER: So I guess the question is: Are the other -- do the other three -- is there a requirement that they join?

MS. DUDINSKIE: This is Jennifer with provider enrollment.

DR. SCHUSTER: Oh. Thank you.

MS. DUDINSKIE: No problem. The House Bill 438, they did actually remove the requirement for the state to have a single credentialing agency. So they are not required to join or utilize the same one. I know that there are a few that do, but they are not required.

So what I can offer is if there are providers who are having problems with credentialing, I'm going to put my e-mail address in the chat, they can reach out to me if there's specific problems. And my provider enrollment team, we can try to help and maybe work along with the MCOs to help resolve any problems that they are having.

DR. SCHUSTER: Okay. That would be great. And, Jennifer, is there this alliance or this consortium that three of them belong
to; is that accurate information?

    MS. DUDINSKIE: Angie knows more about that than I do. I think that's accurate. I am not sure which three.

    MS. PARKER: I'm pulling that information up.

    MR. OWEN: Dr. Schuster, this is Stuart Owen with WellCare.

    DR. SCHUSTER: Yeah.

    MR. OWEN: And I believe the three are WellCare, Aetna, and Molina.

    DR. SCHUSTER: Thank you, Stuart.

    MR. OWEN: Certainly.

    DR. SCHUSTER: And Jennifer has put her e-mail in.

    Jennifer, how do you pronounce your last name, please.

    MS. DUDINSKIE: It is Dudinskie (pronouncing).

    DR. SCHUSTER: Dudinskie (pronouncing). Okay. Very phonetic. Thank you. I don't think we have met before. We appreciate you being on.

    MS. DUDINSKIE: You're welcome.

    DR. SCHUSTER: Thank you, Stuart.
I guess, then, the question is: If there are three that have joined this, what are we calling this, I call it a consortium, alliance --

MR. OWEN: Alliance, alliance.

DR. SCHUSTER: Alliance, okay.

Thank you.

Does that mean that you all are all using the same criteria and if somebody applies to one of the three of you all they will be credentialled by the other two?

MR. OWEN: What we are actually doing is, the Bill created the option, we had the requirement, and so it has to be affiliated with the trade association. And, so, the Kentucky Hospital Association has partnered with Aperture, and they will perform all of the credentialing on behalf of all three of those MCOs --

DR. SCHUSTER: Okay.

MR. OWEN: -- and any other MCO that decides later to join. But as of now, it is just those three.

DR. SCHUSTER: All right. So I still -- I'm trying to look at this from a
provider standpoint. And since I am no longer a provider, I have to put myself back in that world.

So if I want to be a -- you know, say I'm new and I want to be a provider with all of the MCOs. Can I apply to this alliance and go through the credentialing and then if I'm approved, then I would be approved for all three of you all on the behavioral health side?

MR. OWEN: I'm 99 percent sure that that would be the case.

DR. SCHUSTER: Okay. So is this relatively new, I assume, Stuart?

MR. OWEN: Yes. Actually, the Bill, you know, was passed last year. And then KHA in particular has been negotiating with MCOs, began negotiating with MCOs, and I believe it actually goes live August 1. I could be wrong.

DR. SCHUSTER: Oh. All right. All right.

MR. OWEN: I know it is no later than August the 1st. I'm thinking it hasn't quite launched yet. But...
DR. SCHUSTER: Oh. That's why we are all asking these questions, right?

MR. OWEN: Yeah.

MS. PARKER: Well, Aetna and Molina currently have that agreement with KHA, KHA/Aperture. I believe it is WellCare that begins in August.

MR. OWEN: August. Thank you, Angie.

DR. SCHUSTER: Oh, okay. So the other two are currently in play?

MS. PARKER: Three. They have their own, either do it internally or another company.

DR. SCHUSTER: Yeah. I guess what I am asking is: The other two that belong to the alliance are Molina and Aetna, right?

MS. PARKER: Yeah. That's correct.

DR. SCHUSTER: They have already been operating within the alliance?

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: Okay. All right.

DR. JAMES: Sheila.

DR. SCHUSTER: Yeah.

DR. JAMES: Hi. Tom James. And
hi, Stuart. You and I used to work together.

DR. SCHUSTER: Hi, Tom.

DR. JAMES: With all of these things, what it does is help bring all of the material together to make it an easier application process. But under NCQA rules we each have to have our own credentialing, unless the alliance were to become a delegate of NCQA, which is another hassle. But at least we can reduce the amount of paperwork for people.

DR. SCHUSTER: Okay. And Tom is Medical Director with Passport by Molina, just in case people are not familiar with him.

DR. JAMES: And just about every other plan in the state at one point or another.

DR. SCHUSTER: Right. So an applicant, a provider who applies for Passport credentialing, knows that they will have the same form and the same requirements --

DR. JAMES: Right.

DR. SCHUSTER: -- for WellCare and
for Aetna, which is helpful. But they still have to apply to each of the MCOs; is that -- am I saying that right?

DR. THERIOT: Uh-huh.

DR. SCHUSTER: Okay. Boy, I can see why providers get really confused.

MS. ADAMS: This is Kathy Adams again. I had a quick question related to.

If KHA is an association and they are contracted I guess with Aperture or a particular credentialing agency that WellCare, Aetna, and Molina all belong to, what does that get a BHSO, like if that is what Sheila was going to -- had applied to be, was a BHSO, and she wanted to get credentialed by WellCare, Aetna, and Molina?

DR. SCHUSTER: Yeah. I guess I'm trying to figure out, what is the advantage to the provider. Are we easing the certification, credentialing process? Are we shortening it? Are we creating less paperwork?

DR. JAMES: Less paperwork.

DR. SCHUSTER: Less paperwork.

DR. JAMES: You don't have to fill
out the same forms every time.

MR. SHANNON: So standard forms
across the three that are participating?

MS. MCFALL: Yeah.

MR. OWEN: I was going to say,
all of the performance metrics are the same,
you know, established in law and in contracts
already.

DR. SCHUSTER: Okay. And somebody
was, yeah, wanting to chime in, please.

MS. JONES: Yes. This is Cat with
Aetna.

So the advantage is, is that if
they are already credentialed with Aperture,
then we can go ahead and load them, you know,
into our system once we have the request from
them. And, so, it is still a separate
process as far as they have to notify us,
"We would like to add this provider to this
group" or "We would like to, you know, be
credentialed."

But if they are already
credentialed through Aperture, whether they
are with WellCare or et cetera, then we can
go ahead and load them. They don't have to
re-go through that entire process, if that makes more sense.

DR. SCHUSTER: Oh, okay. That makes sense.

MR. SHANNON: So the provider needs to contact Aetna, right, Cat Jones?

MS. JONES: Yes.

MR. SHANNON: And say, "I've been credentialed through Aperture." And then you would go to Aperture and get their information?

MS. JONES: That's right. And we would see, yes, they have. And then we just can do what we need to do to get that provider loaded as an affiliate, you know, if it was an individual provider, to get them loaded and added to that contract in the system.

DR. SCHUSTER: So let me flip the question, Cat. Again, I'm new in the state, I want to start a BHSO, I want to get credentialed by anybody. And I pick Aetna first and I go to you all. Am I automatically applying through Aperture when I go to you to be credentialed?
MR. SHANNON: Yeah.

MS. JONES: They still have -- we have to still send that, say it is the initial, to Aperture. But if they have already been credentialed, they would -- Aperture would confirm that, "Hey, they are already credentialed. You don't need to go through that."

Or if it's their initial request, you know, it would be, you know, that process. But then let's say they went to WellCare. If they had already gone through the credentialing process, Aperture would confirm, yes, they are already credentialed, and then could go forward from there, adding them to other MCOs.

MR. SHANNON: Would you refer them to Aperture first for an initial credential?

DR. SCHUSTER: Yeah, that's what I am trying to figure out. Can people go to Aperture directly to be credentialed?

MS. JONES: No. They have -- my understanding is that they have to come to the M -- to us first.

MR. SHANNON: Okay.
MS. DUDINSKIE: So Aperture is just operating in the background, basically?

MS. ADAMS: And, so, the Aperture's contract is with KHA. So does the -- the members that are -- those that are members of KHA, I assume they can go directly to Aperture through KHA or they submit their paperwork to KHA? I think that's the piece that seems to be missing.

Do the behavioral health providers and SUD providers, do we need an association and a contract with Aperture so that our providers can go directly to Aperture, get credentialed, and then automatically be credentialed with WellCare, Aetna, and Molina once you request that?

MR. SHANNON: Yeah, does each association need to have this relationship?

MR. OWEN: So, I mean, I don't think you have to have a contract. The way -- you know, again, we have not launched yet with WellCare. But I think if you go to, for example, our enrollment credentialing page, the same with Aetna or Molina, it will direct you to Aperture; you know, that will be our
credentialing entity, our vendor, you know, just like we do with any other vendor. I mean, honestly, I don't think you have to have any kind of special contractual relationship with them to perform that.

MR. SHANNON: So you don't have to be a member of KHA, is what...

MR. OWEN: No.

MR. SHANNON: No, no. I mean, I think that's the question people are going to ask.

MR. OWEN: No. K -- KH -- no, no, no. Yeah, no.

MR. SHANNON: No, okay.

MR. OWEN: KHA and Aperture are performing --

MR. SHANNON: Yeah.

MR. OWEN: -- credentialing on behalf of the MCOs. But, I mean, you know, MCOs have -- we have a lot of vendors. So it is just like any other vendor relationship. You are still doing it through the MCO. It is just that we are using a vendor to do it for us.

MS. ADAMS: But you would still
have to submit the paperwork, then, three
different times to Aperture?

   DR. SCHUSTER: No, no. I don't
think so, Kathy. I think what Cat is saying
is that you start with one, so let's say you
start with Aetna, and you get credentialed
and since they are part of this alliance,
when you go to WellCare and you go to Molina,
Aperture will notify them that you have
already been credentialed.

   MS. RISNER: Hi. This is Krystal
with Aetna Better Health. Can you all hear
me?

   (Yes)

   MS. RISNER: Okay. I'm sorry.
Actually, how the process works is, if you
wanted to be a provider you are going to
submit that initial application to Aetna
Better Health, for example. We send that
over to Aperture. We get the provider
credentialed, get them loaded in our system.
If that provider chooses, hey, I want to be
in network with WellCare or Passport, you
know, whoever, then they would still take --
because those three MCOs are using the exact
same form, the form that you have already
used for Aetna you would send to WellCare.

So you are not having to re-do that
form. You are using that same form. And
then WellCare gets that, they would confirm
with Aperture, hey, this provider is
credentialied, then they could proceed with
the loading. It cuts out that credentialing
processing time and it cuts out the duplicate
paperwork.

DR. SCHUSTER: All right. That's
very helpful.

MR. BALDWIN: And it is for all
services, right? It is not just physical.
It is behavioral health services as well as
physical health, in terms of credentialing
the providers?

MS. RISNER: Yes. That is my
understanding.

MR. BALDWIN: Yeah. It is not
limited to hospitals or limited to physical
health.

MR. SHANNON: Yeah, primary care.

It is anybody. Okay.

MR. BALDWIN: Like primary care,
MR. OWEN: Yes, yes.

MR. BALDWIN: Just confirming, that's all.

MR. SHANNON: Yeah. So the process is, you apply to one MCO, that information is shared with Aperture, so you don't have to submit the application to the other two that are participating?

MS. MARSTON: Yeah. Hey, Steve, it's Joanne Marston from Aetna as well.

MR. SHANNON: Yes.

MS. MARSTON: You know, we discussed, I have been involved in setting up the alliance, you know, since the beginning, we discussed trying to have one submission for all three to kind of cut down, you know, the paperwork for providers and make it a little easier.

MR. SHANNON: Right.

MS. MARSTON: And that still is in discussion. But the problem is, you have to contract with each MCO.

MR. SHANNON: Right.

MS. MARSTON: So credentialing is
part of the contracting process. So, you know, if you want to outreach to WellCare or Aetna and say, hey, I want to join your network, credentialing is part of that. So, you know, we are cutting down, to Krystal's point, we are going to cut down, you know, we are not going to take 30 to 40 days and then WellCare's going to start you over and then Molina is going to start you over.

MR. SHANNON: Right.

MS. MARSTON: So we are cutting down that. And then on the recredentialing side, you know, as we recredential providers, we are all three going to be on the same schedule. So you won't get three different pieces of paperwork from three different. So it will really -- you will see some realtime savings on the back-end for the recredentialing.

Right now we don't have a way to kind of iron out the contracting piece. Because you have to contact each MCO, negotiate a contract, and kind of start from there. So...

You know, to the point earlier,
you know, we are hoping to kickoff in August. So I think the more we get into this the more I think we can streamline and you might see some benefits. But that is kind of where we are at today.

DR. SCHUSTER: That is super helpful. I really appreciate everyone chiming in. I didn't realize it was quite this new and just being launched in some cases. So...

MS. DOBBINS: And, Sheila, can I just ask a point of clarification?

DR. SCHUSTER: Yeah. Sure.

MS. DOBBINS: So if the organization, the BHSO or the practice, whatever, is already credentialed, already has contracts, excuse me, with the MCOs but they -- you are hiring a new employee who needs to be credentialed to bill under your BHSO contract, then to -- when we go to credential that person, we could do one application and, say to Aetna, and then it would be the same for Aetna and Molina and what is the third one --

DR. SCHUSTER: WellCare.
MR. SHANNON: WellCare.

MS. DOBBINS: -- WellCare; is that right, we would notify those other two we have already applied through Aetna and they would just pull that form?

MS. MARSTON: You would still -- the way I understand it is, you are still going to have to take that form, it would be one form, but you would still have to submit it to all three MCOs. So we have an intake box for Aetna. You would submit that over to us. We would take that in. We would confirm, you know, everything is in place. We would put it on what they call a start work file. So we would send it over to Aperture to say, "Hey, we want to start credentialing these folks."

So when they get that file, if you had already, you know, been credentialed with WellCare or whatever, they will kind of align those. But you, as it stands today, you will have to take that same form and sent to all three MCOs. But it is the same form. You don't have to complete an Aetna one, a WellCare one, and then a Molina one. But you
are going to submit to three, as it stands today.

MS. DOBBINS: Okay. So you just save the form and submit it to the other two?

MS. MARSTON: Yeah. So if you have got it saved. You know, I mean, I wouldn't see any reason you couldn't put all. I mean, people do it all the time. You could put all three of them in the same e-mail; you know, if you have got like -- you know, we have an intake box, if you are sending it to, you know, a WellCare intake and then to Molina, you could put all three of them on the same e-mail with the same form and say, "Hey, I have got a new provider I want to add to -- you know, I want to add to my network."

You could always copy all of us and it is one e-mail, one form. But it is technically three notifications. We don't have anything in place yet where that you can send and then we are going to, you know, send that to everyone else. So you do have to notify all MC -- all three MCOs as it is today.

MS. DOBBINS: Right. Okay.

DEPUTY COMMISSIONER HOFFMAN: This
is Leslie. I think we need a -- maybe a quick, like, one or two-pager or an FAQ. Folks may have this down-pat or they may not, but it sounds like it is a little confusing on the call right now. So we probably need to work with -- get some information out for folks that kind of streamlines it, if that's okay.

DR. SCHUSTER: You took the words right out of my mouth, Leslie. Because --

MS. MARSTON: Yeah. I think we can take that back and kind of work together. Again, the alliance meets, so all three of us together. I'm happy to take that back and get some information.

I think, you know, at least going out of the gate it's -- you know, it was some back-end work, just trying to streamline the process and cut down some time. But, yeah, we could definitely talk about that and get some more information out that is a little more helpful.

DR. SCHUSTER: That would be great. I'm going to put it on the September TAC meeting agenda. And if we, you know, had at
least a rough draft of a one-pager or an FAQ, I think that would be great. This is exciting, that it will cut down on duplication of paperwork and cut down on time. Time I think is the big issue that I hear from providers.

    Also, if you all can coordinate the re-cert times so that they are all the same, that would be huge. And then if it's just working beautifully, maybe the other three MCOs will be so dazzled by the success that they will want to join as well. Because it would really be nice to have all six in there.

    MS. PARKER: Dr. Schuster.

    DR. SCHUSTER: Yeah.

    MS. PARKER: There is Claire Arant from KHA on the call. And she had put in the chat that, although she is not part of the credentialing aspect at KHA, that she can connect us with the appropriate KHA staff member to kind of help and facilitate like this -- what is necessary to help understand the process better.

    DR. SCHUSTER: I appreciate --
thank you. I appreciate that, Claire. And I didn't see that in the chat. That was going to be my next ask, was whether somebody from KHA might be able to come to our September meeting and be available to answer questions. And maybe, Claire, you and I can talk off-line, you know, about the timing of that and so forth.

But whoever is working on this from the KHA end, I think it is always helpful to have somebody be an active participant to answer any questions, because I'm sure they will be more questions going forward.

MS. ARANT: Yes. Thank you, Sheila. And I didn't really want to interrupt to give you guys a non-update, just that I am not a part of it, but I'm happy to connect you with those that are and clear up any questions that you have.

I already have an e-mail out to the staff member to see if we have any one-pager's on our website that I can put in the chat as a link. I don't know that we do. But if we do, I will put them in the chat before the end of the meeting today. And I
will certainly pass along your request for September.

   DR. SCHUSTER: Yeah, that would be great. Thank you so much, Claire. Appreciate it. And, Kathy, thank you for bringing this issue up. The timing was great for us to be talking about it.

   So next up is telehealth. And there are a couple of things. And I don't know, Leslie, who is prepared to talk about, there is a recent reg I think that DMS put out on telehealth.

   DEPUTY COMMISSIONER HOFFMANN:
   Jonathan Scott is on the line for you, Dr. Schuster.

   DR. SCHUSTER: Oh, wonderful. Hi, Jonathan.

   DR. SCOTT: Good afternoon, Dr. Schuster.

   DR. SCHUSTER: How are you?

   DR. SCOTT: I'm doing good. How are you?

   DR. SCHUSTER: I'm fine. The guru of all regs.

   DR. SCOTT: I hope.
DR. SCHUSTER: So give us the reg number, if you will. I meant to look it up but I forgot to.

DR. SCOTT: Sure. 907 KAR 3170.

DR. SCHUSTER: And that just went through, right?

DR. SCOTT: Yes. And it is -- the current reg is now on the LRC website, if that's where you normally go.

DR. SCHUSTER: Yeah. Okay. And can you just describe briefly what the reg does.

DR. SCOTT: Sure, sure. So this is our general telehealth reg. And, so, with this reg we made some changes, you know, just kind of to catch up to some of the stuff we have learned during the pandemic.

So the updated version of the reg, we have added a new Section 2 that creates a recipient rights clause. So a recipient has the right to receive care either in-person or via synchronous telehealth. That is at the provider's choice, if they are offered an audio only or an asynchronous telehealth visit.
So then we have a new section that kind of more clearly states just kind of the general policies, as we understand them, as it complies with House Bill 140, which passed in the 2021 session.

DR. SCHUSTER: Right.

DR. SCOTT: So that, you know, that was -- so as I'm looking at it here, you know, just we wanted to be really clear that it is scope of licensure, scope of practice, enrollment with Medicaid as a telehealth care provider; you know, if you are a licensed provider operating within your scope and of licensure and practice that we believe that telehealth is generally going to be appropriate with some restrictions; you know, the restrictions set by licensure bodies, by billing code requirements, and, you know, professional criteria standards.

As we were starting to write it, we kept coming up against maybe a couple of pieces of ASAM criteria up in the higher levels, where it really did seem like that was a direct in-person service. So that was kind of the thought we had there.
Another piece of it was, there are a lot of CPT behavioral health codes that have an audiovisual requirement in their definition. So that's why we have that billing code requirement in there or, you know, just that clarification in there.

DR. SCHUSTER: Uh-huh.

DR. SCOTT: And then what are some of our other highlights? I'm so sorry to -- I'm trying to...

MR. SHANNON: Is there a reference that an MCO can pay less for the audio?

DR. SCOTT: So that's going to be up to the MCO contracting process. That's House Bill 140. We don't have --

MR. SHANNON: Okay.

DR. SCOTT: That's outside of the scope of our regulation.

MR. SHANNON: Okay.

DR. SCHUSTER: So along those same lines, Jonathan, I had been in touch with Commissioner Lee, because I keep getting these requests for people.

MR. SHANNON: There is a lot of frustration for this Bill, misinformation I
DR. SCHUSTER: Yeah. A lot of misinformation out there about this reg and it is doing stuff that is bad and so forth.

DR. SCOTT: Yes.

DR. SCHUSTER: But one of the questions that I have had from -- and this comes up with people for whom English is a second language and you have to have interpreters and so forth.

Is there anything in that reg, and I apologize that I have not studied it, about the use of interpreters or know or whether audio only can be offered if there are, you know, significant problems with the recipient having synchronous?

DR. SCOTT: So --

(Interruption by unmuted microphone)

DR. SCHUSTER: I'm sorry.

DR. SCOTT: Sorry. I didn't hear that.

But, so, for interpreters the -- you know, that would be acceptable. But if a platform is being used that is not friendly to interpretation services, you know, that
there is another potential issue there. I would just caution about that, you know.

DR. SCHUSTER: Yeah.

DR. SCOTT: A synchronous platform that is, you know, not allowing for meaningful participation by individuals with limited English proficiency is an issue. So, you know, I would mention maybe we should migrate away from platforms that are not fully inclusive. But...

DR. SCHUSTER: Yeah. Well, I've even had some providers say that, and it may be coming from the MCOs, I don't know, that they understood that there was some change in the Medicaid regs or the Medicaid rules about telehealth, in that it had to be -- in-person had to be offered at all times before telehealth could be offered or used.

DR. SCOTT: No. I have also seen that letter. I have several pages of notes on why I don't think it is correct.

DR. SCHUSTER: Okay.

DR. SCOTT: But our reading of that, our reading of what we have put into Section 3 of that reg, is that it is an
in-person or synchronous telehealth encounter.

There has been language suggested for this specific reg in the past that would have allowed Medicaid recipients to be treated like -- by providers as kind of a second class citizen group, right, that can be put into asynchronous messaging and not accommodated or forced into audio-only encounters.

So if the recipient wants asynchronous messaging or -- you know, not "asynchronous." But asynchronous telehealth encounters or if they want audio-only encounters, there is nothing in this reg that prevents that. If they want to participate -- you know, if they want a synchronous interaction or an in-person interaction, we feel that it is important that that is guaranteed for them if they want it. It is only if they want it.

DR. SCHUSTER: Okay.

DR. SCOTT: So, you know, if the recipient approaches requesting an asynchronous or an audio-only encounter,
you know, provided that it is acceptable via
the rest of the reg and the rest of
telehealth law, as we understand it, we are
not -- this reg is not in conflict with that.

MR. SHANNON: So you offer
in-person or synchronous, right, that's okay?
Because people have the same message Sheila
has gotten, that you have to offer in-person
first. That's not how I read that.

DR. SCOTT: Yeah. That is an
incorrect reading.

DR. SCHUSTER: Okay. So the offer
is in-person or synchronous.

DR. SCOTT: Yes. And it is
provider discretion what is offered. So,
you know, the telehealth only providers are
still welcome to participate in the Medicaid
program and, you know, encouraged to
participate. Our language says in-person or
synchronous. So if a telehealth only
provider is offering only asynchronous
messaging and no synchronous elements to
their encounters and a recipient wants a
synchronous encounter, then that's what that
is focused on.
MR. SHANNON: And synchronous is realtime, more or less?

DR. SCOTT: Yeah, yeah.

MR. SHANNON: And asynchronous is not.

DR. SCOTT: Right.

MR. SHANNON: Okay.

DR. SCOTT: You know, if it is just like, you know, a recorded question and then somebody does a video or audio response and then the provider gets to it later, you know, not that there is not a place for that --

MR. SHANNON: Right. We understand.

DR. SCOTT: -- in the medical system, but we want to make sure that there is a realtime option as well for our recipients.

MR. SHANNON: Because, you know, Sheila and I have done a lot of regs over the years. And this kind of blew up at the end of the process. We had looked at it in the initial filing --

DR. SCHUSTER: Right, right.

MR. SHANNON: -- and, you know, we
like telehealth, we don't see telehealth being restricted in any way in this regulation, and then suddenly, the weekend before, Health and Welfare, Family Services go look at it, you know, everyone get up in arms. And I bet Sheila and I, both of our inboxes were full of questions.

DR. SCOTT: Yes, yes.

DR. SCHUSTER: Yeah, it really rattled everyone, you know.

DR. SCOTT: Yes.

DR. SCHUSTER: And we were like, "No, that is not what it says."

DR. SCOTT: I was also rattled by it, by that.

DR. SCHUSTER: Yeah. I'm sure.

MR. SHANNON: I got a call last week about this. I mean, it is still out there; you know, like you could no longer do telehealth. I said, "No."

DR. SCOTT: Right. That's --

DR. SCHUSTER: Right, right.

DR. SCOTT: A lot of the telehealth restrictions that we are seeing right now are -- you know, the real ones are licensure
board driven --

MR. SHANNON: Yes.

DR. SCOTT: -- or some other things like that or maybe the provider is not licensed in Kentucky or is not enrolled in Medicaid.

MR. SHANNON: Right.

DR. SCOTT: But those are the real issues that are coming up right now.

DR. SCHUSTER: Well, that leads us to House Bill 188, which essentially, for those of you who don't know this, this came from Representative DuPlessis out of E-town. And he called me about it. It came from a constituent of his. The mother called him just in a panic because her daughter, who I think was college age, had an eating disorder. And there are so few providers of eating disorder services. And, so, the youngster was on spring break someplace and had an emergency situation come up. And when she called her therapist, who is back in Kentucky, the therapist said, "I can't talk to you. I can't provide that service."

Which is really, I think, a licensure board
interpretation and not anything else.

And, so, House Bill 188 essentially forbids the licensure boards from having those rules. And I guess, and this is not obviously a -- necessarily a DMS or a reg issue, but I'm just curious about, well, you would know I guess, Jonathan, or somebody who does regs would know for the licensure boards whether they are changing any of that as a result of 188. Have you heard anything?

DR. SCOTT: I haven't heard anything. When 188 was first proposed, we did have a piece of this reg that may have possibly conflicted with it. And we actually ended up removing that via agency amendment at ours.

So we don't think we had any remaining issues with 188. But, you know, I would defer to the individual licensing boards on some of this as well. But...

DR. SCHUSTER: Yeah, I just -- I think it is something that all of us are going to have to be watchful of. Because each of those licensure boards are likely to react in very different ways. They had very
different rules to start with. Some of us now are in compacts with other states and some of these rules are kind of getting to be encased in stone. Some of you know that the professional counselors just passed their compact legislation this -- in 2022. Psychology passed it in 2021. And, so, you get into multi-state kinds of rules around this. So we are just going to have to keep an eye on this, I think, with the individual licensure boards.

But you don't see anything that's in the current reg from DMS that is going to create a problem with what 188 says at this point?

DR. SCOTT: We believe that we are in compliance with 188. And as you were speaking I remembered something else about this reg that I completely forget earlier.

We are really happy about the remote patient monitoring that we have put in as well. We put some other language in there and really worked to try to make it as broad as possible.

MR. SHANNON: I agree.
DR. SCOTT: So I know it doesn't hit behavioral health quite as much. But please let us know as it is rolling out what you think of it and how we can, you know, make it as effective as possible.

DR. SCHUSTER: Yeah. That's very helpful.

The last question I would have for you, Jonathan and Leslie, when the federal emergency period ends, and there have been -- you know, CMS has allowed much more flexibility on platforms in terms of HIPAA compliance and so forth, tell me what you think would be the impact. Use your crystal ball and tell us what the impact is going to be on telehealth in Kentucky.

DR. SCOTT: That's going to be up to the OCR, Office of Civil Rights. And I really hope that they will, you know, re-assess FaceTime and, you know, a lot of the other --

MR. SHANNON: Yeah.

DR. SCOTT: -- products like that.

DR. SCHUSTER: Yeah.

DR. SCOTT: Because of, you know,
there has been a lot of adoption by that, a lot of access to care that those platforms have enabled. So, you know, we have tried to keep a running tally of those platforms that we think will be effective at the end. But, you know, this also gets into -- not only does this get into potential licensure board issues, but it is also going to be provider and provider groups' in-house counsels deciding how far they want to go with some of these platforms as well.

So, you know, this will be really kind of a patchwork, I think, as they step down. I think it may also be a patchwork right now in some ways. But I am -- you know, that's going to be something interesting to see. I understand that they may also preliminarily extend a little bit. So they -- it may not immediately fall off a cliff with the end of the PHE.

DR. SCHUSTER: No, no. That would be --

DR. SCOTT: I think they may give it another six months or nine months or a year.
DR. SCHUSTER: Yeah, yeah.

DR. SCOTT: So I think there are going to be several things in play with the platforms. And hopefully some of these platforms have also --

MR. SHANNON: Upped their game, yeah.

DR. SCOTT: Right. You know, but, because the ball is also kind of in their court to make sure that people can encrypt and, you know, secure communications can happen. So I, you know, I certainly hope that their own infrastructure work is ongoing and people can continue to use them when it is over.

DR. SCHUSTER: Yeah.

MR. SHANNON: We expect the public health emergency to be extended through October now, correct?

DR. SCOTT: That is what I understand.

MR. SHANNON: There is no official word, though, right?

DR. SCOTT: Yeah, I just checked their website a little bit ago. This is the
time in the 90 days I start to get really worried and really twitchy, check it a couple of times a day. But I have checked it again a little bit ago. I think we will probably see something maybe end of day tomorrow on their website.

MR. SHANNON: Yeah.

DR. SCOTT: But we have not heard that it is not going to be extended. So it is possible they will put something else in play, like a 60 day extension instead of a 90 day extension or something like that. I just -- you know, I think that there's still some different strategies they may employ. But I haven't heard anything to make me think it won't be a 90 day extension.

DR. SCHUSTER: All right. Well, thank you so much, Jonathan. We really appreciate it. And I love the idea that, you know, maybe the hope that even when the emergency period ends that maybe OCR will extend or give us six months to kind of sort all of this out. Because I think you are right, I think the platforms that have been used and used effectively have really allowed
services to get out to people. And we can't just drop that, you know, without any -- and we don't have broadband --

DR. SCOTT: Exactly.

DR. SCHUSTER: -- all over Kentucky, and we are not the only state I'm sure, but we still have huge deserts where people just cannot use a more secure platform. So I'm sorry I've dominated with these questions.

Let me open it for just a minute and see if anybody else on the Zoom has any questions, since we have the brain trust here on the reg and so forth.

MR. BALDWIN: Sheila, this is Bart.

DR. SCHUSTER: Yeah.

MR. BALDWIN: I have a quick question for Jonathan on the reg, and broadband is kind of the issue.

Good to see you, Jonathan. I haven't seen you in a long time in-person.

But, you know, I have a quick question, just a clarification. And I don't have the reg in front of me, so I will paraphrase a little bit.
But there was a section specifically addressing audio only and the ability to bill a normal rate for audio only.

DR. SCOTT: Yes.

MR. BALDWIN: But it seems like there was some language in there that that was allowable if there was a breakdown in service or a breakdown in the connection.

DR. SCOTT: Yes.

MR. BALDWIN: So, and, that makes sense on one hand. My question is, is what if that's the only option? Is there is no service, there is no ability to set up a telehealth service but audio only is the only -- because, as you know, in many parts of the state, and speaking with other folks, and that's one of the things that we are grateful that that is still even allowable to be billable within the reg. Because, you know, that -- but it's been very effective for a lot of folks over the pandemic.

So can you just kind of describe. I guess my question is, is if it breaks, sure. But if it doesn't even -- if you don't even have the ability to do it in the first
place and audio is the only option, is that still billable at the normal rate?

    DR. SCOTT: Yes. If you get --
    yes. You know, I think we were looking at some scenarios when this started. So I would say, the first thing is, it is not totally clear if there is not the possibility for, you know, some kind of a documentation requirement to come into play with audio only telehealth, you know, with certifying that it was the only option or anything like that.

    And we have also seen that a lot of the telephonic codes, the nine-nine -- oh, of course I -- of course I -- but the three codes that were, as well as the G-2010 and G-2012 codes, so I guess there were five maybe that were introduced.

    But we wanted to introduce the telephonic codes as part of this reg as well. So if a phone call happens and it falls within that limited space, within those limited scenarios, that you can just use that and there's no need, there's no, you know, documentation requirement beyond what would normally be required. So that was a big
piece of it.

And then I think the technological issue, I guess it has kind of been cleared up. If it is not a possibility, you know, it is not a possibility. And House Bill 140 says audio only. So, you know, we would have to -- to my understanding, we would have to otherwise establish an audio only rate. And that's just coming from DMS. The MCOs may do that differently.

MR. BALDWIN: Right, right. Well, and from -- and my information may be old. But I remember when those G-codes and we first started getting into this, that the rate of payment on those, for one, they were really kind of designed for more of a check-in and not an actual therapy session, from what -- you know, to paraphrase from what I recall, and they were woefully lower in terms of the rate of payment.

So I am not sure how much -- you know, if you are just doing a well check or a check-in or something for five minutes, that's one thing. But if this is your scheduled 45 minute, hour, whatever session,
then you can't bill a G-code that pays
15 bucks an hour or whatever the amount is.

DR. SCOTT: Right.

MR. BALDWIN: So that's why I was
asking. Because, obviously, the access, it
is the access to services that has been a
benefit to folks, and to avoid dealing with
crises and avoid hospitalizations and those
ER visits and those types of things that have
been able to be done through the audio only
when that is the only option.

DR. SCOTT: Yeah. And as we
understand it, that telephonic discussion is
really just a very small circle of the
overall universe of audio only --

DR. SCHUSTER: Audio only, right.

DR. SCOTT: -- mental health. But,
you know, we just included that kind of
clarification. And it may end up that in
practice it is not something that ever really
comes up.

DR. SCHUSTER: There was a question
in the chat, this may be more for you,
Leslie, from Terri Wilson at Bridgehaven,
asking if someone who is working under
supervision can do telehealth and bill for it.

DEPUTY COMMISSIONER HOFFMANN:

Yeah. I'm going to check on that. I have wrote down her question and I will check.

DR. SCHUSTER: Thank you.

DEPUTY COMMISSIONER HOFFMANN:

I just wanted to make sure before I answer about it.

DR. SCHUSTER: Okay. And you can let me know, and I will just circle it to the group.

DEPUTY COMMISSIONER HOFFMANN: You sure can. I just sent an e-mail, so I am right there with you.

DR. SCHUSTER: Okay. Thank you. Appreciate it. Any other questions?

MR. OWEN: Dr. Schuster?

DR. SCHUSTER: Yeah.

MR. OWEN: Sorry. Stuart Owen with WellCare. And not regarding that reg but something related to telehealth and behavioral health.

DR. SCHUSTER: Okay.

MR. OWEN: Have you got a moment?
DR. SCHUSTER: Yeah.

MR. OWEN: There was a study published on Monday, the Journal of the American Medical Association, an eight-year study of the use of telehealth for members with severe mental illness. And, so, you know, they have paranoia schizophrenia disorder, bipolar disorder. And it looked at the impact of telehealth. And it showed -- and this was in 2,900 rural counties, an eight-year study. And it found that it increased, using telehealth, increased the percent of members getting follow-up outpatient behavioral treatment within 7 days of hospitalization by about 14 percent. And this was Medicare members. But nevertheless...

And this was -- the study was before COVID, you know, before the big widespread use of telehealth. So, anyway, I thought that was really encouraging. And obviously, you know, all of the MCOs promote telehealth, I know at WellCare we certainly do, and I know all of us, all of the MCOs, promote telehealth.
DR. SCHUSTER: Great. If you have got that link to that article or can give us a reference in the chat, Stuart, that's great.

MR. OWEN: Yes.

DR. SCHUSTER: Yeah. Thank you very much.

MR. OWEN: Will do.

DR. SCHUSTER: Jonathan, you are welcome to stay with us, but you probably have other things to do. But we are delighted to have you and your expertise. Thank you very much.

MR. SHANNON: Go check on the public health emergency.

DR. SCHUSTER: Yeah, keep letting us know about that.

MR. SHANNON: Yeah, give us a synchronous update.

DR. SCHUSTER: That's right. Leslie, our tried and true, where are we on the SUD waiver?

DEPUTY COMMISSIONER HOFFMANN: So believe it or not, we have made another step, which is awesome. We finally met with CMS
about our proposed budget neutrality. We told them what we were planning. They liked it. So we were planning on having a meeting with them last week to discuss it. But they said they wanted the budget neutrality workbook first to comb through it themselves before they meet with us. So we have got to schedule an additional meeting.

But the good news is, the new budget neutrality was sent in last week. It does look very hopeful that we might be able to make a few other changes, so excited about that. And I can share those things with you later, if that's okay.

But, yeah, on the home front that is very good that we are at least getting to that phase with CMS. So I do want to just mention, and I know I feel like a broken record sometimes and you probably have heard me speak, even lastly, on MOAC.

Our Kentucky authority, our big Kentucky 1115 authority, which is the one that allows us to have flexibility, creativity, and all of those pieces, the demonstration authority is set to expire.
September the 30th of 2023. So that means we have to have our request for an extension. So, remember, that is a demonstration. And we don’t call it a renewal. We call it an extension, if it can be any more confusing. So...

So we are doing it. We are requesting the extension. Not a lot of pieces will change in that. We have to get that submitted September the 30th of this year for the extension to go past '23. I know that's confusing.

So I've got all of these amendments and different initiatives that I am currently working on right now, right, and we have the 1115 incarceration amendment that is sitting there in cue that we are currently working on. We do mention that in our renewal, that they currently have it and that we will continue on working with that particular amendment. We have been told that no matter what is in cue, they are not going to approve anything until we get the big 1115 authority approved.

So that is kind of a little
aggravating, that the timing hit the way it did, but it is what it is. So I just wanted to let you know that, as our timing may be driven for just a little while based on what CMS does and when they do it. So that's where we are.

DR. SCHUSTER: So does that mean that even if they love your budget neutrality of the SUD, that until they have gone through your extension request, is that what you are calling it --

DEPUTY COMMISSIONER HOFFMANN: Yes.

DR. SCHUSTER: -- and approve that, that they won't come back and do a final thing on the SUD?

DEPUTY COMMISSIONER HOFFMANN: So it is our understanding on the incarceration amendment that one is different and they may go ahead and approve it during this current approval or they may wait until they get -- they have not given us a final decision yet. I'm hoping to meet with them at the end of this month again, and we do have this on the agenda. I make sure that this is on the agenda with them every month so that they
have to address something with me.

    But I just wanted to let you know that, unfortunately, it is getting tied up into Kentucky's authority.

    And I also wanted to mention, too, while I am on the call with you, is that we are also re-evaluating on the 1915(c) side the residential component. So what we might end up with is pieces from both. I want to make sure I can address all of the population, not just the particular nursing facility or institutional level of care. I want to make sure that I can address all populations in Kentucky that might need it.

    Does that make sense? So I've asked that we will get a meeting scheduled with you and Steve fairly soon to start discussing that.

    DR. SCHUSTER: Great.

    DEPUTY COMMISSIONER HOFFMANN: Yes.

    DR. SCHUSTER: Yeah, we look forward to that. Thank you.

    DEPUTY COMMISSIONER HOFFMANN:

    Thank you.

    MR. SHANNON: Thank you, Leslie.
DEPUTY COMMISSIONER HOFFMANN: Yes.

DR. SCHUSTER: Is there any updated prior authorization guidance? I don't think I have seen anything come through. The last was, I think, May 20th.

MS. PARKER: No, ma'am. It is still, as you know, July 1st the SUD services for inpatient went into effect, but there have been no further updates at this time.

DR. SCHUSTER: Okay. Great. And the interim task force on emergency medical services. So this was House Bill 777. I guess that was lucky. It was the third iteration of this bill. This was the Ken Fleming bill that we worked on, the mental health folks worked on with KHA and with the nursing home folks and with the hospice folks, about the lack of transportation from one facility to another.

And that task force has been formed. They are actually meeting at 3 o'clock today. So if you are dying to watch something after you get off this meeting and you want to keep listening to behavioral health stuff, that task force is
meeting. It is being co-chaired by Senator David Givens and Representative Ken Fleming. And the task force members on the Senate side are Senator Don Douglas, Brandon Storm, and Robin Webb, which, interestingly, are mostly rural legislators. I mean, Don Douglas has part of Fayette County and he is over there in Nicholasville. But Brandon Storm, David Givens and Robin Webb. It is not just a rural issue. I just want to point that out to you.

On the House side it is Representative Mark Hart, Michael Meredith, and Lisa Willner. So we will be in touch with them. They actually contacted me before this first meeting and said, "What were the issues?" And I said, "Behavioral health, behavioral health, behavioral health. Number one, that we had EMS and ambulance providers who came to a hospital and refused to take a person who had a mental health condition with a variety of unacceptable comments, like 'We don't have to take crazy people. You know, we are for people that have a medical problem, not a mental health problem.'"
Those kinds of things.

I also raised the issue of whether there was sufficient training for EMS and ambulance drivers around how to handle people who may be in a mental health crisis, not unlike our CIT training for law enforcement. And I actually don't know the answer to that. But I think the lack of responsiveness to the needs of folks with behavioral health issues is concerning.

And my third point, question actually, was: Are we dealing with stigma here? Because if the comments that were made are accurately reported, then I think we've got a real problem. And I suggested that we look at doing some anti-stigma training for ambulance drivers and EMS folks and so forth. I don't know whether any of that will be responded to.

The final thing that we heard is that Representative Josh Bray, who was the co-sponsor of, and I've forgotten the bill number, Steve.

MR. SHANNON: Yeah.

DR. SCHUSTER: Anyway, it was the
House Bill that looked at the 202A transportation issues. And there were several meetings of a task force. The Cabinet was involved in those, the Department for Behavioral Health, Developmental, Intellectual Disabilities were involved, law enforcement was there, many of us who are active on the BH TAC or in the mental health coalition were there. And I understand that Representative Bray is going to ask this task force to take on that issue as well. So I suspect that that's what is going to happen.

So I didn't see any other meetings of this task force listed on the interim calendar. I looked at August, September and didn't see them. So I'm guessing that they are going to talk about that today at their meeting. And, so, I will keep you posted so that you can, again, follow these meetings live or archived on either KET, probably on the Legislature's YouTube channel.

So have you heard anything else about that task force, Steve?

MR. SHANNON: No. With Representative Bray, I hope -- I mean, he
wants to be involved in some way (inaudible).
Also, I mean, if you look at the group, obviously Representative Willner understands our issues and Representative Meredith was on the Board of Life Skills for many years, so he is bringing some more information about behavioral health, and other folks may realize, and Ken Fleming understands some of these issues as well.

DR. SCHUSTER: Yes. Yeah.

MR. SHANNON: So I think it is encouraging as to the group. And Robin Webb.

DR. SCHUSTER: I was going to say, Robin Webb, Senator Webb certainly is -- knows this and very often talks about her work as an attorney when she is not being a State Senator and talking about some of the mental health issues.

So I think we have some people. Senator Givens is always approachable, I think, very thoughtful and was willing to take this on as a co-chair, which is I think positive.

I didn't have any recommendations for the MAC meeting. Do any of the voting
members of the TAC have any recommendations for the MAC meeting?

    MR. SHANNON: I do not.
    DR. SCHUSTER: Okay. Eddie or T.J.?
    MR. REYNOLDS: None here.
    MR. LITAFIK: No, I don't have anything.
    DR. SCHUSTER: All right. Are there any suggestions from people on the Zoom?

(No response)

    DR. SCHUSTER: I think we have a couple of issues that we are going to carry on for our September meeting, particularly around the single credentialing and the dual eligibilities for sure. And I think we want to keep an eye on the telehealth regs and the impact of House Bill 188.

    MR. SHANNON: I was wondering, is there a recommendation around, some kind of maybe one-pager, about the telehealth situation to help address some of the concerns?

    DR. SCHUSTER: I think -- you know,
and when you think about it, telehealth is not just behavioral health, it is physical health and probably not dentistry but certainly for the MAC.

MR. SHANNON: Right.

DR. SCHUSTER: Do you want to make that motion, Steve?

MR. SHANNON: Yeah. I would recommend that we, the BH TAC, ask that -- recommend to the MAC that Medicaid provides a one-pager on the recent telehealth regulation to be distributed to both providers and consumers.

DR. SCHUSTER: Okay. Particularly important for consumers --

MR. SHANNON: Yes.

DR. SCHUSTER: -- since there is kind of a recipient rights there I think.

MR. SHANNON: Yes. Uh-huh.

DR. SCHUSTER: Is there a second, either Eddie or T.J.?

MR. REYNOLDS: Yeah. I will second it.

DR. SCHUSTER: Thank you. Any discussion?
(No response)

MS. BICKERS: Dr. Schuster.

DR. SCHUSTER: Yes.

MS. BICKERS: If you want to do that recommendation in writing prior to the MAC meeting, I would appreciate it.

DR. SCHUSTER: Yes. Yeah, we would. We will do that, Erin. Thank you. All in favor of making that recommendation at the next MAC meeting signify by saying "Aye."

(Aye)

DR. SCHUSTER: All right. Aye. Thank you. That's a great recommendation, Steve. I appreciate that. So under old business we did get a report that the MCOs --

MR. SHANNON: You had recommendations for the September BH TAC, we have two of those, right?

DR. SCHUSTER: Yes. We have got the -- actually, we have got three. Remind me what we have.

We have the credentialing. We have the dual eligibles.
MR. SHANNON: Yes.

DR. SCHUSTER: And then those of us that have been working on the targeted case management data study are going to have an opportunity to meet with the Commissioner. And I would hope that we can make a report at the September meeting on that study. So we are going to have a very full agenda in September, but all important issues.

So under old business I think the MCO audit situation appears to have improved. That's what I am hearing from folks. And I think our discussion at previous TAC meetings have been very helpful with the MCOs.

Is there any new business? Is there anything that we should be considering that we are not considering?

(No response)

DR. SCHUSTER: Let me just go back and remind -- thank you, Leslie, for taking on that question about whether a supervisee can do telehealth. That would be important for us to disseminate as well.

DEPUTY COMMISSIONER HOFFMANN: Yes, ma'am.
DR. SCHUSTER: Yeah. Hearing no new business, nothing new under the sun as they say, hard to believe.

We will have to carry on without Lee Guice. But we wish her well.

The next MAC meeting is July 28th, 10 to 12:30. And, again, those are available via Zoom, and I will send that Zoom link out. I really think that those are helpful informations. You get quite a detailed update from Medicaid Commissioner Lee and answers to the questions that the MAC members have. So that's available for anyone who is interested.

And then our next BH TAC meeting will be September 8th at 1 o'clock.

MS. BICKERS: Dr. Schuster.

DR. SCHUSTER: Yeah.

MS. BICKERS: I hate to be a pain. But is there any way that T.J. could turn on his camera and you guys could vote on the recommendation again. His camera was not on, and I just want to make sure we are within our open records regulation.

DR. SCHUSTER: All right.
MS. BICKERS: Sorry about that, guys.

DR. SCHUSTER: That's all right. T.J., we need to see your smiling face.

MR. LITAFIK: Oh, goodness. Well, I have just been working from home today and I am not very presentable.

DR. SCHUSTER: Well, it is the requirement. I had forgotten about that. Erin, thank you for reminding me.

MS. BICKERS: I'm sorry.

DR. SCHUSTER: So we are not going to look at what you look like. But, let's see, Steve, you made the recommendation that the BH TAC -- that the MAC ask DMS to issue a one-page description of the recent telehealth reg and that it be provided to both providers and recipients --

MR. SHANNON: Right.

DR. SCHUSTER: -- Medicaid members.

MR. LITAFIK: Okay. If I need to come on camera to constitute a quorum, I would be glad to do it.

DR. SCHUSTER: All right. We will do that.
MR. LITAFIK: Okay.

DR. SCHUSTER: Eddie seconded that.

So now we are going to call for a vote. So are you on camera?

MR. LITAFIK: I can be.

DR. SCHUSTER: Okay.

MR. LITAFIK: Well..."unable to access camera." Oh. I need to change a setting I think. Hang on just a second.

DR. SCHUSTER: Sure.

MR. LITAFIK: Sorry about that.

DR. SCHUSTER: Not to put you under any pressure or anything, T.J.

MS. BICKERS: I'm sorry. I just want to make sure we are covered.

DR. SCHUSTER: Yeah.

MR. LITAFIK: Okay.

DEPUTY COMMISSIONER HOFFMANN:

Dr. Schuster, if I may, while he is working on the camera, the meeting that I set up for you to discuss the targeted case management analysis on the 29th, if you need to forward that, I think I had one e-mail I couldn't find. So...

DR. SCHUSTER: Yes. And I've send
it on, yeah.

DEPUTY COMMISSIONER HOFFMANN: I was just double-checking. I wouldn't want them not to get invited.

DR. SCHUSTER: No.

DEPUTY COMMISSIONER HOFFMANN: Thank you.

DR. SCHUSTER: Yeah, thank you. I appreciate that. And I did send it on. So everybody should be in the loop on that.

Thank you.

MS. BICKERS: Thank you.

MR. LITAFIK: Okay.

DR. SCHUSTER: Are you on now?

MR. LITAFIK: I should be.

MS. BICKERS: Yes, I see him.

MR. LITAFIK: Okay.

DR. SCHUSTER: All right. Yes.

Okay. There you are. Thank you.

So all in favor of making that recommendation to the MAC, signify by saying "Aye."

(Aye)

DR. SCHUSTER: Aye. All opposed, like sign.
DR. SCHUSTER: Motion carries. Is that what you need, Erin?

MS. BICKERS: Yes, ma'am. Thank you.

DR. SCHUSTER: All right. Sure thing.

If there is no other business to come before the TAC, I will give you all back 35 minutes. How is that for a great deal? Stay out of the heat. And thank you all. We had some excellent discussion, excellent response from DMS on a number of things, and I think we are making progress. So I appreciate you all. And thank you, Erin, for your facilitation and so forth.

So we will see you all in two months. And, again, feel free to join the MAC meeting and monitor that as well. Thank you. And have a great day.

(Proceedings concluded at 2:25 p.m.)
CERTIFICATE

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Behavioral Health 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 12th day of September, 2022.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR