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

****

Via Videoconference
November 14, 2024
Commencing at 2:01 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, Chair

Steve Shannon

Valerie Mudd

Tara Hyde

Misty Agne (not present)

Mary Hass

T.J. Litafik

P R O C E E D I N G S

CHAIR SCHUSTER: All right. Well, we'll call the meeting to order. As they say on the plane, if you're heading to the BH TAC, then you're -- I mean -- yeah, the BH TAC, then you're in the right place. I forgot which meeting I was on.

Let's see. Valerie -- let's have our voting members identify themselves, please.

MS. MUDD: Yes. I'm Valerie Mudd. I'm with NAMI Lexington and Participation Station. I'm here as the consumer voice, someone living with mental illness.

CHAIR SCHUSTER: Great. Thank you.

And T.J.?

MR. LITAFIK: T.J. Litafik. I'm the strategic advisor and advocacy coordinator for NAMI Kentucky.

CHAIR SCHUSTER: Wonderful.

And Mary?

MS. HASS: Mary Hass here. I'm with the Brain Injury Association of America, Kentucky Chapter, and I'm an advocate for individuals with brain injuries.

CHAIR SCHUSTER: Great. Thank you.

And Steve?

MR. SHANNON: Steve Shannon, KARP Association for 11 of 14 mental health centers.

CHAIR SCHUSTER: All right. And I'm Sheila Schuster. I'm the Executive Director of the Kentucky Mental Health Coalition and a licensed psychologist. So --

MR. SHANNON: I think T.J. has some news to share.

CHAIR SCHUSTER: Oh, T.J. does? All right. Let's hear it.

MR. SHANNON: I believe he does.

MR. LITAFIK: Yes. Well, I guess since our last meeting, as of a couple of weeks ago or so, I was engaged to my now fiancée, Beth. So we're very excited about that.

CHAIR SCHUSTER: Well, congratulations, T.J. It's always nice --

MR. SHANNON: Congrats.

MR. LITAFIK: Thank you.

MS. HASS: Congratulations.

MS. BICKERS: Congratulations.

CHAIR SCHUSTER: -- to have some

good news, and that's a good news thing on this kind of dreary day, so wonderful.

MR. LITAFIK: I appreciate that. Thank you all.

CHAIR SCHUSTER: Yeah. So we'll look for Tara and Misty to join us hopefully.

I would like to get a motion from the voting -- one of the voting members to approve the minutes of the September 12th BH TAC meeting. They were sent out by the court reporter.

MS. HASS: Mary Hass here. I will make a motion to approve the minutes of the September 12th meeting, please.

CHAIR SCHUSTER: Thank you. And a second, please?

MR. LITAFIK: Second.

CHAIR SCHUSTER: All right. T.J. seconds. All those in -- oh, any additions, corrections, omissions? They're long and hard to read sometimes. But all those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed or abstaining?

(No response.)

CHAIR SCHUSTER: Thank you very much.

The voting members of the BH TAC have seen the meeting dates for 2025. We will stay with our second Thursday of the month except in -- no, all the way through from 2:00 to 4:00 p.m. So it's January 9th, March 13th, May 8th, July 10th, September 11th, and November 13th.

So I would entertain a motion to approve those meeting dates.

MS. MUDD: So moved. Valerie Mudd.

CHAIR SCHUSTER: Valerie.

All right. Thank you.

And a second?

MR. SHANNON: Second. Steve Shannon.

CHAIR SCHUSTER: All right. All those in favor of approving the meeting dates as sent out by Erin, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: Great. And they are approved.

And for those on the call, we'll send

those out with the follow-up information. We also -- next week, we'll approve the MAC meeting dates for 2025, and they're staying on the same schedule as well, the fourth Thursday except in November.

Is Victoria Smith on?

MS. HOFFMANN: Dr. Schuster, this is Leslie. Victoria, it's my understanding she won't be on today.

CHAIR SCHUSTER: Oh, okay.

MS. HOFFMANN: Sorry. She's under the weather.

CHAIR SCHUSTER: Oh. Well, I'm sorry. So we will wait to get some feedback from her about the discussion on Phase 1 completion and launching Phase 2 of the multistate study. We will roll that over to our January 2025 meeting.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: All right. And I may be in touch with her, Leslie, to see if there's anything that she might send us in preparation for that meeting that we might be able to circulate.

MS. HOFFMANN: Absolutely. I think

that would be fine.

CHAIR SCHUSTER: Yeah. She's been very good at working with us and sending out some material in advance because this is complicated stuff.

MS. HOFFMANN: It is.

CHAIR SCHUSTER: And we want to see where we are with the completion of Phase 1.

I have to say -- I was talking to an advocate from Ohio who sometimes joins these BH TAC meetings, and she wanted to know how we got that study done and who paid for it. And she was very impressed that it was actually DMS and the Office of Data Analytics that did it. So she's like, oh, wow. I've got to start working over here in Ohio on that so...

MS. HOFFMANN: There you go.

CHAIR SCHUSTER: Yeah. We have an issue, and I think Mandy and Bart are on to discuss approvals of residential SUD treatment services because this is an issue that they feel is interfering with people getting the treatment that they need.

So let me ask -- Mandy, I think maybe

you're going to start this off.

MS. MARLER: Yeah. I'm going to kick us off and then definitely want to welcome and encourage conversation from the clinicians and providers in the room. But from some of the providers that we work with --

CHAIR SCHUSTER: Why don't you just introduce yourself in terms of your organization so people know where you're coming from.

MS. MARLER: Yes. Apologies. I am Mandy Marler. I am vice president of government affairs with Bart Baldwin Consulting. Many of you know Bart. He and I teamed up about a year ago, so we're together now and have numerous providers in the behavioral health and mental health space --

CHAIR SCHUSTER: Okay. Great.

MS. MARLER: -- many of whom we've been hearing about -- it started really this summer. We know that, historically, we've really seen a pretty standard 28-day period approved in certain levels of residential care for substance use disorder both in 3.1

and 3.5. That alone flagged some concerns for us about if we do have sort of a de facto treatment limitation that may conflict with mental health parity laws.

But this summer, we started hearing increasingly that even getting 28 days combined across both those levels of care was becoming really difficult. And authorizations were increasingly being declined, that there were other requirements including homework and therapy sessions that hadn't been present before that were now being required for approvals.

And, again, I mean, I think we on this call know even if you are able to get 28 days approved at both levels of care, that's hardly long enough for even the brain to adjust if you're coming straight out of active addiction.

So wanted to raise that, see what others are experiencing, and see if maybe we can just open some dialogue about what we have going on and how we can better ensure that we really are seeing individualized treatment approved.

CHAIR SCHUSTER: Okay. Bart, do you have anything to add?

MS. MARLER: He might have just stepped away.

CHAIR SCHUSTER: All right. That's fine. Let me open it up and see -- I think we have -- typically, we have a number of SUD treatment providers on the call. Let me see if there are others that would like to -- Nina Eisner is the first person I see with a hand up.

MS. EISNER: Yeah. Raising my hand.

Mandy, will you clarify? I think you said, typically, 28 days combined across two levels of care. What are you talking about there?

MS. MARLER: That's just one pattern that we've heard, that there were some providers who used to be able to -- no matter what they requested, be able to get 28 days -- you know, even if they requested more, were getting 28 days for residential treatment approved in 3.1 and 3.5 levels of care. And that --

MS. EISNER: Okay.

MS. MARLER: -- summer, it had shifted to it being really difficult to being able to get 28 days combined. So maybe 21 days in one and 7 in the other, care.

MS. EISNER: Yeah. Got it. Thank you so much.

MR. SHANNON: And we're seeing the same thing, the CMHCs. I reached out -- Bart asked me to reach out. Mandy asked me to reach out. And we're -- I mean, independent of, you know, people responding individually, 21 days seems to be the magic number. You know, that's what people are thinking. And that's both the ASAM 3.5 and 3.1.

And it's not necessarily -- and, you know, it's almost a predetermined length of service. It's not individualized. It's not working off, you know, what the individual's needs may be. And it really is a significant change, which really, you know, being an old guy around, we had a similar experience in 2011 when we all started this, down this road.

So -- but this is again -- you know, the

prior auth process ends up being fewer. And then even when they call and request, the conversations aren't good around those -- you know, when there is a review process for more time for folks. It seems like not everyone understands the definitions. It's not necessarily -- you know, some folks report they don't feel like there's a sense of discussion. It's a decision that's already been made.

So there's concern out there for access to care for individuals, so we concur with what Mandy is reporting.

CHAIR SCHUSTER: I'll send you some -- all right. Anyone else that's on the call that's in the SUD space?

MR. BISHNOI: Hi, Dr. Schuster. This is Mots Bishnoi.

CHAIR SCHUSTER: Hi, Mots. How are you?

MR. BISHNOI: I'm good. We have a similar experience. Some MCOs are giving 7 days. We were informed today that one MCO is now only giving 14 days of initial approval on 3.5.

CHAIR SCHUSTER: So what's the experience -- Mots, Steve, or Mandy -- from your folks? Is it possible to push back to get -- to eke out more days, or is that just really almost an impossibility? Mandy?

MS. MARLER: I think our folks have found it pretty difficult in those cases they have returned to request additional days. Sometimes at the end of treatment, if certain factors aren't met within the window, that's their best shot. But they're seeing those pretty flatly denied at an increasing rate right now, also.

MS. KOEHL: Hi. This is Lucy with Isaiah House, and we're seeing the same pattern. And even when we're going peer-to-peer to try to get those additional days, we're just getting denied and not getting many approved.

CHAIR SCHUSTER: Okay. Thank you very much.

So are any of our MCO --

MR. CROWLEY: Yeah. Hi, Dr. Schuster.

CHAIR SCHUSTER: Hi, David. How

are you?

MR. CROWLEY: Doing well.

CHAIR SCHUSTER: David Crowley with Anthem.

MR. CROWLEY: Yes, sure. Happy to speak up a bit. If -- I would encourage anyone to exhaust their appeal opportunities and to use those processes in play.

I can tell you from Anthem Medicaid experience, we are paying the most out of 22 Medicaid markets across the nation for substance use disorder, residential treatment, and outpatient treatment. So our access and penetration at every level of care, whether it be residential, intensive outpatient, partial hospitalization, are increasing every quarter.

And there was one comment about how the treatment should be individualized. Well, 28 days for everybody is not individualized. That's not really the way we would treat things on an individual basis. So just -- just want to be cognizant of that. For everyone to get a prescribed 28 days at each level of care is -- that's not medical

necessity.

MR. SHANNON: Yeah. I don't disagree, David, but neither is 21 or 7.

MR. CROWLEY: 21 might be appropriate for some people. 35 might be appropriate for others.

MS. MARLER: That's exactly right, which is why I think we're so concerned about this pattern, that not only across patients but across providers we're seeing the same number of days approved consistently.

MR. SHANNON: Yeah. Yep.

MS. MARLER: So our question is really: How can we better understand what processes are happening during authorization to ensure that we are meeting medical necessity?

MR. PATEL: Hey, this is Chirag Patel, WellCare. You know, to your question what could you do better, like, I definitely agree with the aforementioned MCO speaker.

But I also -- when we do look at those documen- -- clinical documentation, I would love to be able to bring to you guys the clinical documentation that we see from some

of the providers. We can black it out and show it to you guys.

It is really left to be desired. They are cut and pasted. They're the same thing over and over. And we don't see any individualized clinical documentation. What we see is a lot of corporate jargon to supersede the appeals process, respectfully.

And so if we could come up with a date-agreed-upon clinical documentation entry form in which there can be dialogue instead of a flat denial, we'd be able to engage in more fruitful conversation about, what is the actual appropriate, clinically evidence-based duration of therapy.

MS. STEARMAN: Hi, yes. This is Liz Stearman from Humana. I fully endorse and support what David and Dr. Patel have both said as well.

You know, the other thing I'll just remind the group about is, you know, in the process of determining appropriateness of care, there always will be sort of that initial request that is going to be of a shorter amount of time. So whether it's 5

days, 7 days, 14 days, those initial requests are really looking at the presenting information at the point in time which the member is entering that level of care.

And, really, that date is set to give us an opportunity to see what happens after the member does that initial stabilization. What are the ongoing needs? How many more days do we need to do this at a medically necessary level? What supports are they going to need?

Versus at the very beginning, you're only going to have that admission paperwork. It may be the first time you've seen that member. We may not have the amount of information that's needed to determine is this, you know, X number of days. Will they be able to, you know, receive maximum treatment efficiency within a month?

You've got to have stage gates within that stay to be able to manage that in realtime based on the member's updated clinical information.

And I will say, at least from our metrics, we have not seen a substantive clinically -- or, you know, statistically

significant change in either the average length of stay or our denial rates. And, in fact, both are going -- the denial rates have gone down, and the average length of stay has gone up. So if we look at our data, I don't know that it would necessarily support these anecdotal reports, but I think that's a good thing to take a look at.

MR. CROWLEY: And to that point, Liz, I just pulled Anthem's denial rates, and it's less than 9 percent. I know this is -- you didn't ask for this information, Dr. Schuster, but --

CHAIR SCHUSTER: Yeah.

MR. CROWLEY: So we're looking at less than 9 percent denial rate of those services, and it's kind of being discussed as it's happening constantly.

But one thing that is a challenge for providers and for Managed Care Organizations is a 24-hour turnaround time on these requests; that whenever a request is made, we have to make a determination within that 24-hour turnaround time requirement. That also goes for concurrent reviews.

And we see it every day that there's not updated clinical information whenever it's time for us to do a concurrent review. And so, to be honest, we've given a lot of grace with providers to get us updated clinical information within 48 hours, and some even within 72 hours, to make that determination.

And that's what everybody is up against at this point, and I realize that is a challenge. But we have to have updated clinical in order to make the determination for continued stay.

MR. BURKE: Hi. This is Ken Burke with Volunteers of America. Sorry. I couldn't find the option to raise my hand.

We also provide SUD treatment here, and our experience has been similar to those of our other colleagues right here, that there -- we definitely have seen a decrease in the number of days authorized.

We certainly recognize the importance of using ASAM criteria to determine medical necessity. But, for example -- I'm not going to say a name. One MCO, the reviewer specifically told us at 21 days, they

automatically send the request to peer review. So that -- you know, that certainly is not individualized, too.

So I realize there's a little bit of back and forth in terms of, you know, what's appropriate and what's not. But we do -- and a lot of our colleagues use the ASAM criteria to justify the need for continued treatment. So we are getting more of a standardized approach from certain MCOs.

CHAIR SCHUSTER: Thank you.

MR. SHANNON: And from my perspective, what I've learned from folks, this is apparently a change that's occurred recently, you know. So what precipitated that is, I think, part of the concern raised by people I've reached out to. And I think other folks would -- you know, it's why now essentially, you know, and the magical 21 days.

MS. MARLER: And since there was some discussion of data, I wonder if it would be helpful if we could collectively discuss what the average duration of stays for approvals have been over time, maybe over the

past two years, maybe just over the past year, so we can really look at that and have that as an objective baseline to understand what may be happening here.

And then, you know, I mentioned parity here. We're just trying to understand what the medical parity would be for having such a regular length of stay for such an individualized condition state.

CHAIR SCHUSTER: Well, I certainly think that the BH TAC could request data from both providers and MCOs, and that may be a good next step in terms of bringing this back. And, obviously, we're not going to solve it today, but we wanted to get it out there for discussion.

I think we need to be clear on what the problem is because I hear -- I hear the 21 days and the 28 days being used in two different ways, I guess. One is that there has been a tradition certainly going back to the old days when I was practicing of, you know, what we used to call the 30-day cure for hospitalizations actually on the mental illness side. And magically, people got

cured at the end of 30 days because that's what the insurers paid for back in those days, and we're talking --

MS. MUDD: It used to be 7 days.

CHAIR SCHUSTER: Well, this is way back. This is pre-MCOs, pre- -- you know, so forth.

So I think Steve raises a point, too. I think if we are asking for data from both providers and MCOs, we may want to look at data from '22, '23, and then '24 if there's been some change. And, Liz, you mentioned denial rates. David, you mentioned that, so certainly denial rates.

MS. STEARMAN: Length of stay is the other -- because I think that's what is being purported here, is that there is a prescribed length of stay. You know, I'll say for any per diem services, when we talk about parity, you know, it's challenging when you look at inpatient medical.

Residential is not really necessarily equated to an inpatient stay and also -- but when we look at our residential per diem on the medical side, like LTACs, SNFs, and

things like that, there is a very similar process.

So, you know, if the parity is a concern, that may be something that has to be taken actually to the DMS level versus the MCO level. And if you're going to want to look at data, we really can't use '22 since '22 authorizations weren't put into place until --

MR. SHANNON: Right.

MS. STEARMAN: -- 7/1 of '22. And so if the concern here from our provider community is that this is as a result of prior auth and '22 needs to be taken out and then we would have to normalize for any new providers that may have joined and were not familiar with ASAM or were getting up to speed on the requirements.

So, you know, we just have to make sure that we're really looking at comparing apples to apples and so --

MARGARET: Hallelujah.

MS. STEARMAN: -- the date range would be important.

CHAIR SCHUSTER: Yes. Somebody

was --

MS. BICKERS: Sorry, Dr. Schuster. I was just going to say if you want to work on gathering all of that and you want to send it to me in writing, I can work on getting that data request either fulfilled by DMS or the MCOs, depending on what needs to be done. So if you want to submit that to me, I can get that taken care of.

CHAIR SCHUSTER: Okay. I think we're still kind of noodling about what we need to --

MR. SHANNON: Well, it looks like state fiscal year '23 and state fiscal year '24 was July 1 of '22. You would have a July 1 of '22 to June 30th of '23 time frame and then you could do July 1 of '23 to June 30th.

And you could break them into six-month periods as well. So you'd have four sets of data, July 1 of '22 to 12/31 of '22, then January 1. And I can email this to you, Sheila and Erin.

CHAIR SCHUSTER: Okay.

MR. SHANNON: And then you would

see, over a four-month period, has there actually -- you know, four times six-month period, has there been a change?

CHAIR SCHUSTER: Okay. I also would like to go back to Dr. Patel's comment about the data.

Oh, Liz has a question for you, Steve. Would that exclude the last five months, meaning the last five months of 2024, Liz? Are you --

MS. STEARMAN: Yeah. Just if I'm hearing correct, I heard that some folks were saying it was a recent change. So if we do those two fiscal years, we're actually cutting all our data off when that change may have occurred.

MR. SHANNON: Yeah. Is it a July 1 of '24 to current issue? I mean, we could sample the four months for this period. It wouldn't be the same time frame, but it would be -- you could do July 1 through October 31.

MS. MARLER: I think that would be really helpful.

MR. SHANNON: Does that make sense, Mandy?

MS. MARLER: Yeah. I think that would be helpful. I also wonder if we could sort of look at some mode data. Like, how frequently is this average occurring? How frequently is this period of stay occurring? What is the mode across these data periods for the duration of care?

MR. SHANNON: Right. Yeah. The most common length of time. Right. That's a good question, too.

CHAIR SCHUSTER: Okay. I'll pull this together, Erin, to get it to you.

I want to go back to Dr. Patel's point about the data that you get is not satisfactory, is not really telling you what the -- who the client is, what they need.

So do you give any guidance, Dr. Patel, to people when they send in those things and you look at them and say, you know, they just cut and pasted this out of some manual someplace?

MR. PATEL: Absolutely. I think the word that was used earlier is individualized, and so during the initiation phase, you know, we want to see that there

was a comprehensive, individualized assessment done to see what appropriate therapies and what the expected or suspected duration of therapy should be.

And then as you matriculate down the treatment path, there's always room for amending or editing the duration of treatment. But that's a dialogue; right? That's not a preset, conceived duration from the beginning where we come together without having, you know, had any experience with the member to say, oh, it should be 35 days, 28 days, 26 days.

You know, there is a reason why we say, hey, you're going to get 14 or 21 days. Let's work through these 14, 21 days to really tease out -- because medicine is an art; right? How many real days do we need? And we've gone away from that. Everybody just wants more days; right?

And there was a question about: How did we get here? I think that's a fascinating question, but let's not ask that rhetorically. We need to ask each other that. There are a lot of providers out in

the field who helped get us to where we are today. It's not just the MCOs. It's not just DMS policy. It's other provider behavior that has brought us to the milieu of the conversation we're having today, and so let's be eyes wide open.

MR. SHANNON: Yeah. I think that's a good point, but I also think focus on those providers, not all providers.

MR. PATEL: Well, we do focus on those providers. They -- you know, there is a saying; right? Don't let one bad apple spoil the apple cart. But sometimes one bad apple does start to soil the apple cart, if you will.

And we're trying not to do that as best we can, but, you know, we've had this discussion in the past. And I don't want to digress too much, but often our hands are tied in what levers we can pull. I don't want to, you know, rehash that.

And I think to an earlier point, our Medicaid book of business as well, highest utilization in BH across all services for our company. And we're the largest Medicaid

company in the United States.

And so, you know, what we'd like to see is, you know, what we're paying for. If we're going to pay for all these services, let's get great outcomes; right? Let's see the outcomes that providers are providing. And we've not been able to come together to have that dialogue, which is the dialogue we should have.

We want to pay for more evidence-based services. We want to see our members do better. But if you come and ask for more services, it's not, you know, superseded to the fact that we want to see good outcomes.

CHAIR SCHUSTER: Dr. Patel, you said it's the highest behavioral health spend. What is the highest behavioral health spend or --

MR. PATEL: I mean, we can -- look. Look at what we pay for. We have peer support, psycho ed. You know, we can go on and on. I don't think we need to do that because that's not the conversation at hand. But we do pay for -- like, look at the BH cost trend over the last two years in

Kentucky. We don't need to rehash that. We all know that it's exploding like wildfire. New BH providers providing quasi-clinical services are coming into the network every hour on the hour, and that's driving out good clinically sound care.

MS. MARLER: Just --

MR. OWEN: This is Stuart Owen with WellCare, and I will rehash one thing that I've said a couple of times before. DMS raised the rate for psychoeducation by 333 percent in 2022. And I know we've seen the spend increase tenfold for psychoeducation alone, which is not a -- it's a very low value.

DMS' own rate study shows the other ten states in the study don't pay for it. We're paying a huge amount of money. And, frankly, there are unscrupulous providers who are exploiting the heck out of that for money. And at that rate could -- and DMS is slightly, slightly going to reduce it, put some limits.

But, I mean, it's -- anyway, long story short. If that could be funneled to

clinical -- actual good quality care for the good providers that are, you know, really member-centric care, that's a whole -- I'm talking hundreds of millions of dollars being spent on psychoeducation alone. And it's essentially for profit for some unscrupulous providers. So, I mean, that alone, H2027 is being greatly exploited, and the adverse impact is on the good providers and the good quality services.

CHAIR SCHUSTER: Stuart, I wonder if -- I'm confused because, obviously, we've talked about this at the last meeting at great length when we talked about the audits. So we're talking about authorizations for residential SUD treatment here.

MR. OWEN: Right, right.

CHAIR SCHUSTER: So I guess I'm a little bit concerned that both you and Dr. Patel are talking about psycho ed, and the other one, I guess, is peer support services.

MR. SHANNON: Peer support.

CHAIR SCHUSTER: How does that affect -- or does it affect your

authorizations for residential treatment?

MR. OWEN: No. It does not affect that, and I didn't mean to imply that. But you were asking about, you know, specific services in general.

MR. PATEL: Yeah. I think that's a great point.

MR. OWEN: And that was my point. That was my point.

MR. PATEL: Stuart, let me answer that because I think that's a great point, and we don't want to conflict the two.

MR. OWEN: Right, right.

MR. PATEL: But in the spirit of answering the previous question: How did we get here? Well, because of where we were and what has transpired, we are now asking for an increased level of due diligence in the clinical documentation, and I don't think that's inappropriate.

We are doing what's in the best interests of the member and in the best interests of the state's dollar which we're a steward for. And so asking for clinical documentation to assert that the member is

getting their best care for the best outcome is our stance. I don't think that's inappropriate.

CHAIR SCHUSTER: So are you asking for things, Dr. Patel, that are not part of what typically is called SUD? I think we had a complaint or a comment that homework was being referenced as --

MR. PATEL: That's not us.

CHAIR SCHUSTER: Okay. Thank you. Mandy, you had your hand up. You're on mute.

MS. MARLER: Yes. Apologies. This is helpful context, and I appreciate it. I wanted to re-center us a little bit more on the conversation at the specific question we're asking now, which I agree can't be considered in isolation but really is about our -- do we have the information needed to actually propose and approve individualized medical necessity care?

And so my question is really if, on the MCO side, you're feeling like you need more information to demonstrate a comprehensive initial evaluation, are the factors that need

to be included in that clear to providers?

And I'm asking sincerely because I am not a clinician. And are those transparently discussed and noted and it's very evident what threshold providers need to be meeting with that initial submission?

MS. JONES: Hi, Mandy. This is Cat with Aetna, and I just wanted to make a comment, something that I had observed that has been a change since I've been with the company.

Historically, prior to, you know, the lifting of prior auth, I would say 99 percent of our reviews were done telephonically. So there was an opportunity to engage live with the UM reviewer at the facility, and that allowed more for those individualized conversations when we're collecting information. If we needed a clarification, if we needed this -- you know, to ask this question or to propose this, you know, to maybe, you know, steer in one direction or the other.

I'd say we're approaching -- the majority of our requests now are done by fax.

And it's very difficult to render an individualized determination based on faxed, you know, medical records or faxed information. And to David's point, we do have that short turnaround time.

So I'm thinking that that really impacted, you know, what looks like in claims data a very -- oh, well, you know, a very non-individualized stay. You know, so many days, same number of days. I think that that -- you know, the transition from doing the majority of live reviews really impacted that, you know, where we -- you know, if we get a faxed page, well, they may need --

You know, and also to lift the administrative burden off providers. Sometimes, you know, if they've been there 14 and we get a faxed request, we may, you know, give them an additional week but not really be able to individualize it, you know, specifically based on that active engagement with a UM where we can really fine-tune and get specific information.

So I hope that made sense, what I was trying to describe. Because we do get a lot

of kind of cookie-cutter fax reviews; whereas, you know, back in the day, we really did engage the majority of our reviews live, you know, in realtime on a phone request and were able to really have a clinical conversation. The BH-licensed clinicians would engage with those UM reviewers and really have a discussion.

So I think that as far as a pattern that you're -- that you might be seeing of those, it's the same amount of days over and over and over again, that could play into that and would be interested if other MCO partners might think the same thing.

MR. BALDWIN: Cat, this is Bart. Quick question to follow up on that. The -- so what is the -- what is the barrier to doing the phone live discussions like we used to?

MS. JONES: I think maybe it's -- it could be -- you know, staffing patterns at facilities likely have changed since the pandemic. You know, I know that UM staffing and utilization reviewers may have changed. I think it's -- it is sometimes easier just

to scan records in and send those in versus, you know, make time, you know, to get on the phone and have a review although, you know, historically, those reviews were not lengthy. But when you're trying to do that with six different MCO -- you know, so I think that that's a barrier that maybe didn't exist, you know, back in the day before everything that has happened.

But it's definitely -- I would definitely say 99 percent of all reviews for all levels of care were live, and providers liked being able to get realtime right then there's a decision or, you know, a notification. And you could have that back-and-forth dialogue from a clinical perspective.

And now we're seeing it very much, you know, they just fax in the chart notes and then we as an MCO have to take that and make a decision and, you know, think about, okay, I don't want to just give two days and then have them, you know, do this again. So we're going to authorize up to seven more days. So on paper, it ends up looking like a very

prescribed length of stay.

I don't know. Just some thoughts I wanted to share on that.

CHAIR SCHUSTER: Yeah. Thank you.

MR. BALDWIN: That's helpful.

CHAIR SCHUSTER: Liz?

MS. STEARMAN: Yeah. I was going to say the other concern, you know, and I've been around long enough to see before and after also, is that now that we have 24 hours based on, you know, regulation that's on the books for the Department -- under the Department of Insurance, 24 hours is the maximum turnaround time to make those decisions.

So in the olden days, we used to be -- you know, you might get a fax but then you had 48 hours, two business days, whichever it is, to really do that outreach, make contact. But this -- I mean, we've got to have -- in order to meet a 24-hour turnaround time, that documentation has to be pristine almost immediately at the point of time which that member shows up at your door for services. You've got to get it over to the MCO, and

we've got to make a decision on it immediately.

And so that's been a big part of our discussion, is, you know, what that's going to result in is some inappropriate denials at -- sometimes because you guys don't even have all the information within 24 hours, let alone having to be able to navigate schedules, coordinate peer-to-peers with MDs. You know, all of that takes some time. Unfortunately, that 24-hour turnaround time has really, really limited that as well.

The other two things I'll just mention -- since I came off mute and you recognized me. Thank you, Dr. Schuster. We have also had -- you know, we do -- almost the vast majority of our reviews are still live, so we make calls out on all of those to try and attempt to connect with someone. So we've not -- even if we get it faxed, we still do a live outreach.

But -- and folks are asking about additional guidelines. Managed care contracts require that ASAM criteria be used to make determinations related to substance

use disorder treatment. Any MCO that has additional guidelines, they have to be approved by the department and then posted and communicated. To my knowledge, it is ASAM.

And what we're looking for is that individualized care. We're looking across every single dimension of the criteria, and we're looking for accurate, not copy and pasted documentation. So those are the guidelines that we're looking for.

CHAIR SCHUSTER: Yeah. I appreciate that because Misty -- one of our voting members had asked about the documentation of the guidelines, and are providers aware of them. So you're saying it's the ASAM guidelines. And if there are any additional, they should be made known to providers because they would have been -- had to be approved by DMS. Is that right, Liz, in the contract?

MS. STEARMAN: Exactly.

CHAIR SCHUSTER: Okay. Thank you. I'm going to call on --

MR. SHANNON: Well, we understand

the ASAM criteria, Sheila. I mean, we --

CHAIR SCHUSTER: Yeah, yeah. Right.

MR. SHANNON: (Inaudible.)

CHAIR SCHUSTER: Yeah. Let me call on Taylor from Isaiah House and then we're going to wrap this up. So we've got lots of other stuff on our agenda. Taylor.

MS. TOLLE: I won't take up much of your all's time. I just wanted to bring a little bit of a different perspective from us. We have at Isaiah House, you know, been greatly impacted by the decrease in the average number of residential days with our 3.5 and 3.1 level of care. But I do just want to mention that, as Dr. Patel was speaking earlier, with most -- majority of the MCOs, we see the biggest impact from WellCare specifically.

However, the clinical leadership team from WellCare does do a great job of collaborating with us as a provider and meeting with our clinical leadership staff and allowing us the opportunity for more education from the clinicians that we meet

with when we do the live reviews. And this is a collaborative conversation that we have across the board.

We've even had some instances where one of our clinicians, when doing a peer-to-peer, didn't feel like it was a collaborative discussion. And when we reported those concerns, it was investigated, and it was very much a collaborative approach to figure out how we could best serve the members.

So even though we are seeing this impact across the board, we are seeing that the MCOs are responsive to allowing this to be a collaborative discussion and figuring out what is best for the member themselves.

CHAIR SCHUSTER: Okay. Thank you for sharing that.

Let's leave it that we will get back with you. I think there is some information that we need to request from providers. And I think, Mandy, you and Bart and others have been reaching out to providers to get some of that, and we will work with Erin to get a request out to the MCOs and DMS to see if we can look at some data over time and see what

the actual data tells us as opposed to anecdotes because we know that anecdotes are --

MR. SHANNON: Yeah.

CHAIR SCHUSTER: -- nothing but anecdotes. So thank you, Mandy and Bart, for bringing this up. And obviously -- and it's difficult to keep it separate from our last-time discussion about some bad apples. I'm going to be real honest about that because I think we all suffer with that, so thank you.

I'm going to change up on the agenda a little bit because Mary Hass needs to leave. And since we had a congratulations to T.J. on his engagement, I will tell you that Mary Hass' granddaughter is signing her letter of intent as a high school senior with a four-year scholarship to play soccer next year --

MR. SHANNON: Nice.

CHAIR SCHUSTER: -- at Southern --

MS. HASS: Thank you.

CHAIR SCHUSTER: Southern Indiana University at Evansville.

MS. HASS: University of Southern Indiana at Evansville. And so she was very fortunate to have three or four schools to choose from, but their business school was one that she liked. And so she gets to play soccer and also get the business degree that she's wanting.

So thank you for allowing me to jump up, Sheila. I really do appreciate that and appreciate the congrats.

My thing -- I've got threefold. First is the ABI waiver, therapy services. I know we're still kind of in limbo on that. I don't know any other way to put it.

But I did have a provider call me yesterday saying -- and I don't know if this is true, if she knew that I had this meeting coming up today, is that if someone is currently in the ABI waivers, that they would still be able to get their therapies the way they have been. But if it's a new person coming in to either of the waivers, they would have to go to the state plan first.

And I don't know if that's yea or nay, but there's still a lot of -- and I don't

know if it's misinformation, but there's a lot of questions exactly how the therapies are going to work. And I only know what they tell me, is they really have not heard much. So they asked me to bring up that question.

And then also --

CHAIR SCHUSTER: Hold on a second, Mary, and let's see.

MS. HASS: Sure.

CHAIR SCHUSTER: I know Leslie is on. I don't know if there's anybody that can answer that question, Leslie.

MS. HOFFMANN: Yeah. I think I can -- so I had to do a little bit of research, too. I did find an information and communication that went out a while back related to new members that have never received therapies before would need to go through state plan.

So that was sent out a while back prior to Pam Smith leaving. So that is true. Anybody that's currently receiving services, we are in a holding mode, as I've mentioned before. And I will give you plenty of time and make you aware of when those things

occur.

Remember, we are receiving ARPA funds, and we do have a requirement for what they call maintenance of effort. So it means that we have to exhaust all those funds, so we do have a little bit of time still -- when I say time, in state government, time is not time; right? But I'm just saying it's not now, and it's not today, and it's not next month. I will let you know as soon as I know more.

And we're currently, of course, in conversations with CMS. But there was communication that went out. I had Kelly Klass from the long-term care services to track that down. I thought I had a copy of it with me --

CHAIR SCHUSTER: Leslie, can you send me that?

MS. HOFFMANN: I can. I can.

CHAIR SCHUSTER: Yeah. That would be great. I'd like to share it with Mary and others because that question has come up before. Appreciate it.

MS. HASS: Okay. Thank you, Leslie.

MS. HOFFMANN: No problem.

MS. HASS: And may I proceed, then, Sheila?

CHAIR SCHUSTER: Yes. Sure thing.

MS. HASS: Okay. The other thing that I've had a personal experience with -- and I've had many calls from families -- is families not being able to access PDS services, not that they're not getting approval for them, is that there is no case management, or there's no support brokers. They have to go through the comp care.

And I had hoped that some of the ABI waiver case management companies would pick it up. They have -- they have no desire -- or at least what I'm being told, they're having no desire wanting to do that because of the fiscal management piece. So that's a barrier.

And I'll have to say I ran into that myself because my sister was discharged from the ABI waiver due to the fact that she's insulin dependent. And I really wanted to do PDS services but was not able to find anyone who would pick up the support brokerage or

the case management piece mainly due to the fiscal management.

And I know I've heard, you know, other ones talk about that PDS problem, is -- again, not that the ABI branch would not approve the services. It was just no one to pick up the support brokerage or the case -- I call it case management, the case management piece. So that's a real barrier for folks who are in either of the ABI waivers being able to do PDS services.

CHAIR SCHUSTER: Yeah. And I will say that that's outside of ABI as well. I'm hearing that from all kinds of people on HCB and so forth. So do you have any information on that, Leslie?

MS. HOFFMANN: I was just going to say I'm hearing it, too. I just wanted you to know. And we are aware that we've got -- I don't want to say bottlenecking, but we've definitely got some problems that we're working through. And we have identified it as, you know, an area that we need to work on.

If you remember, we are working with CMS

on -- we don't have an official cap yet. They still haven't given us anything official, but we have many things that we're working on related to PDS with CMS right now.

So I think end of the month, we're supposed to give some -- a little bit of additional information to CMS of what we're working on. But, again, I don't have a final cap, nothing formal. But it's outside --

MS. HASS: Oh, okay. And then --

MS. HOFFMANN: It is outside of ABI. It's others as well. I'm hearing complaints.

CHAIR SCHUSTER: Well -- and let me ask you this. Because PDS has gone over to DAIL; right?

MS. HOFFMANN: So it was in -- and I might have to call on Alisha if she's here. I think it was in the last waiver renewals; is that right, Alisha? Are you on?

MS. CLARK: The Department For Aging and Independent Living, they operate all of PDS, so -- for all the waivers.

CHAIR SCHUSTER: Okay. Well, that's what I thought.

MS. CLARK: And they -- yeah. They have been. That's nothing new.

CHAIR SCHUSTER: So I guess my question is -- it comes up, and it's come up quite a bit. Should we invite somebody from DAIL to be at our next BH TAC meeting to respond to that?

MS. HOFFMANN: Dr. Schuster, you're more than welcome to invite anybody you want to. We meet with them on a regular basis. I don't know that they'd have any more information than what we do, and they're also -- I have our sister agencies to participate on our CMS calls with us. So they're on those calls as well.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: But you're more than welcome. We work mostly with Marnie Mountjoy and Gina Oney.

CHAIR SCHUSTER: Yeah. I know Marnie's name for sure. Okay.

MS. HASS: It might be helpful, Sheila, to get Marnie because I did have a couple of conversations with her. And I really did not get much -- you know, and I

think she's wonderful. She answered my phone calls.

But I do think somewhere we've got to find out where the problem exists, you know. If folks are -- the services are available to them but the roadblock is the case management piece, we really need to see how we could put something in place to take care of that.

CHAIR SCHUSTER: Yeah. Okay. And then you had one final question, Mary, I think.

MS. HASS: Yeah. The last question that's been coming to me -- or, actually, it's a process question. And it's not limited to, but some of the providers want to provide professional -- or have licensed clinical counselors provide counseling services on site and if they could be supervised by a licensed professional counselor. Right now, it's not the case. But one of the services in ABI is OT, is occupational therapy can be provided by a COTA.

So they're kind of wanting to see -- and it's not limited just to the counseling, but

this is one thing I've heard a lot about. So I guess we just need to know: What is the process for being able to get those services added to the ABI?

CHAIR SCHUSTER: I think it's not services. I think it's the service providers. And the question, I think, was about licensed clinical counselor associates.

MS. HASS: Yes.

CHAIR SCHUSTER: And I think they are not currently either ABI approved, or they're not currently Medicaid providers. So I guess the question, Leslie, is: How do we initiate --

MS. HOFFMANN: So I'll have to look into that, Sheila.

CHAIR SCHUSTER: -- the process?

MS. HOFFMANN: Mary is right. We do have COTAs, and we have PTAs for physical therapy and SLPs, I think, for speech that work under the supervision of others. I can't remember exactly what's listed for the counseling. I've been out of that world for just a little while, but I can double-check on that and get back with you.

CHAIR SCHUSTER: Yeah. Because I think traditionally, we've had people that -- what I don't know is whether the licensed clinical counselor associates are at the master's level or not. If they are, then other, you know, psych associates and that level of social work and so forth have, I think, been approved. But if you'll get back to me about that, that would be --

MS. HOFFMANN: Let me double-check on that.

CHAIR SCHUSTER: -- helpful. Okay. Thank you.

MS. HOFFMANN: I know the requirements for ABI for years was a little bit higher than others just because of the complicated population that we were working with, but just -- yeah. Let me follow up on that one.

Erin, can you take that back for me?

MS. BICKERS: Yes, ma'am.

MS. HOFFMANN: Thank you.

CHAIR SCHUSTER: Yeah. That would be good. All right.

MR. SHANNON: Part of that is a

licensing board question, too; right, Sheila? I mean, they need some sort of clinical supervision.

CHAIR SCHUSTER: Yes. And I think the proposal was that they would be clinically supervised by their licensed person, you know, at the facility or where the services were delivered.

I think -- actually, Leslie, you raise an interesting point, and that is whether the providers listed for ABI are different than the providers listed generally for behavioral health.

MS. HOFFMANN: Yeah. It might not be now, but we used to -- our requirements were it used to be a little bit higher. And I don't want to speak to that because I've not written a regulation for them for quite a while so --

MR. SHANNON: It's almost that state plan versus waiver question again; right?

CHAIR SCHUSTER: Yes. Yeah. Could very well be.

All right. Thank you very much.

MS. HASS: Thank you, Sheila.

CHAIR SCHUSTER: Yeah. And before you go, Mary -- because I'm trying to keep my quorum. We had some recommendations that were sent to the MAC, for recommendations to be taken to the MAC. So I'm going to go out of order while we still have a voting quorum of our voting members. And these came from the Children's Alliance, and there were two recommendations.

One was that the BH TAC recommend that there be reasonable amounts of time for the provider to provide the requested information at a minimum 15 days when fewer than 10 records are being requested, 30 days to respond to more than 30, and 60 days, you know, when, again, more records are being requested.

There was also the recommendation that the BH TAC recommend that DMS develop a process that would allow a provider to verify whether the MCO's prepayment audit request had been approved by DMS. Apparently, this is taking an inordinate amount of time to determine that. And I think from a

provider's standpoint, it really makes a difference whether this is a DMS-initiated audit request or not.

So I'd like to have some discussion among the voting members of the TAC about these proposals or any others that you want to consider.

MR. SHANNON: Yeah. This is Steve Shannon. I mean, I'll kick it off. I mean, we had this fairly heated discussion last meeting. It appears to me there's some confusion around the amount of audits, the sheer numbers that are being requested. I hear that from folks, in the hundreds, close a thousand, you know, cases, reviews that are being conducted, there's no specific time frame for feedback. There's no: When is the audit process over? What is being done?

Sometimes we're told the audit, well, that's really CMS directed to DMS to the MCOs. It has to be done that way. It's not differentiated.

It just seems like -- is there a way to get maybe a recommendation, in addition to these two, is -- specific guidance from

Medicaid about the volume of audits, how many is appropriate? I mean, a sampling methodology. And if there's a problem in those, you ask for more. That's on the provider. It's just not a front-end question.

The time frame. We had a great presentation on what that time frame looks like. It's really hard, you know, at times, the volume of records being requested, to hit that.

And then feedback from the MCO itself. Because I've been told, you know, they send stuff. It's kind of -- you know, it goes and goes and goes, and there's no necessarily feedback loop to the provider that the audit process is over. I was on one call, and I was told by an MCO, well, you know, the audits are going to wrap up soon. No one knew what that was, you know, and it sounds like it was triggered by some other mechanism.

So I just think it would make more sense if we could move forward and understand, you know, one, how many are being asked. One of

the CMHCs told me they get 100 to 150 requests a day, it seems like, to them. And even -- that's an exaggeration. If it's that many a week for three, four, five, six weeks in a row, that's just a huge burden.

So what can we do moving forward that -- what's an appropriate number of audits? And those -- if they trigger more audits, okay. But what's a good number to start with? What's the time frame? You know, that was discussed. You can ask for an extension.

And then what's the feedback; right? I think it's almost like the prior auth question we had earlier. What is the feedback? What's the dialogue? What takes place afterwards? And what occurs, you know.

And it just seems like a fairly significant challenge to -- and, you know, this is the Behavioral Health TAC, so we're not worried about what physical health providers are saying. But from our perspective, it just seems to escalate. And if it is initiated by some other entity, tell us that. You know, we understand that.

But it's just -- at some point, it seems

like a huge number of audits are being conducted, and it's almost like, you know, we have audit staff. You know, this is their job, to make that, you know.

So is there a recommendation for guidance so we all understand? You know, we had that great presentation, but that doesn't seem to answer all of our questions. It's just that it just seems to go and go and go. I mean, it's the Energizer Bunny conducting an audit.

CHAIR SCHUSTER: Kathy, you've got your hand up. You're muted.

MS. ADAMS: Thanks.

CHAIR SCHUSTER: There you go.

MS. ADAMS: Thanks. I wanted to reiterate on the first request. It's specific to, you know, ensuring the managed care company provides the provider an adequate amount of time, what is reasonable. Depending on the circumstance and the nature of the request, how many records are requested, the time frame, et cetera.

And many of the behavioral health -- the Medicaid behavioral health regulations in

Chapter 15 include some language, especially the TCM regs do. And it says that -- in some of the ones they do, they say a reasonable amount of time given, the nature of the request, and the circumstances surrounding the request.

So that's kind of what we are asking for. And, again, it's in some regulations anyway. But it just seems to be -- clearly, based on the discussion we had at our last meeting, that's not happening when providers are being asked to provide over 100 records, and they have 8 days to do it.

So I just wanted to expand on that a little bit --

CHAIR SCHUSTER: Yeah. Thank you.

MS. ADAMS: -- and say that I definitely support everything that Steve has said. We would definitely support a sound, reasonable sampling methodology.

I don't know how -- the MCO that was discussed at the last meeting that had sent out so many requests all of a sudden, how they decided who they were sending those to. But there really needs to be some valid

sampling method. I don't know that 600 records are needed -- really? -- within 8 days.

So, again, what's reasonable, the time frame, a sampling method, and definitely that feedback loop.

MR. SHANNON: Yep.

CHAIR SCHUSTER: Yeah.

MS. ADAMS: Providers want to do what's right. But if they're not getting feedback on what they're doing wrong, they can't correct it.

MR. SHANNON: Amen.

CHAIR SCHUSTER: Yeah. Thank you. Nina?

MS. EISNER: Yes. Thank you. I think I go to meetings for a living, so correct me if I'm mixing my meetings up. But I thought that at the last one -- and Dr. Patel, I think you're on the phone -- we had talked about whether or not it would be possible to develop a simpler process to conduct the audit rather than sending in the whole chart, maybe the development of a form or something that would get at the

information that's being requested.

Am I remembering that conversation correctly?

CHAIR SCHUSTER: I don't think that that was our conversation, Nina.

MS. EISNER: Oh. That wasn't this meeting?

CHAIR SCHUSTER: We were more cantankerous --

MR. PATEL: No. That wasn't, but we would be open to that.

MS. EISNER: Yeah. I mean, that -- let's still put that out and ask the MCOs would that be possible. Because that could potentially -- if we could come up with a document that would meet the needs of the MCO in terms of determining, you know, meeting the medical necessity and all that but reduce --

MR. PATEL: Well --

MS. EISNER: -- the administrative burden on the provider to copy so many records. Maybe that was at the MAC, Sheila. I can't remember which meeting it was. But is that a possibility?

MR. PATEL: So yes, that is a possibility. And so here's what we would say to that. And I'll speak for myself, but I'll also speak for the other MCOs.

We would totally come together to work on that. But in return, what we would like to ask is -- that would then have to go to DMS for approval; right? And then we would like DMS to then expedite that review; right? That way, you guys are not just waiting around.

And we'd like DMS to, you know, give us transparent feedback without just saying no, we're not approving this. Because historically, we've had that happen, too; right? We've submitted things that we wanted that were clinically rooted in fact, and they were sub- -- summarily given the answer of no without us getting any feedback.

And so this is a huge lift requiring a lot of coordination, a lot of consensus building, a lot of coalition building. And so if we were to go down this route, we'd love for DMS to step forward and say they would be privy and party to this

collaboration as well.

CHAIR SCHUSTER: I am going to turn us back to our recommendations to the MAC and then we'll come back to this because we have an agenda item on audits, and I'm going to bring that back there.

Right now, we're talking about two recommendations that came from the Children's Alliance specific to setting those kind of time frames and also an easier process to find out whether audits were coming from DMS, and then I think Steve's recommendation about guidelines and rationale.

So let me ask other voting members of the BH TAC if you all have any comments that you want to make or any questions you want to raise.

(No response.)

CHAIR SCHUSTER: All right. Then can I get a motion from a voting member of the TAC that we forward all three of these recommendations to the MAC at their next meeting?

MR. SHANNON: So move. Steve Shannon.

CHAIR SCHUSTER: Thank you, Steve. And a second?

MS. HASS: Second. Mary Hass.

CHAIR SCHUSTER: All right. Thank you. Any -- any further discussion at this point?

(No response.)

CHAIR SCHUSTER: All right. Voting members of the TAC, all of those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed?

(No response.)

CHAIR SCHUSTER: And abstentions?

(No response.)

CHAIR SCHUSTER: All right. So we will send those three recommendations. And, Kathy, thanks to you and the Children's Alliance for getting that going. And, Steve, thank you for the additional recommendation.

We will -- Erin, I will get those to you. I have them kind of in writing.

MS. BICKERS: Thank you.

CHAIR SCHUSTER: And I'll also -- well, I'll send them in when I send in my

BH TAC report with the recommendations on it.

Since we're talking about this, let's now go to a follow-up on audits. And I think I'm hearing that, Nina, your idea is for providers and MCOs to come together and talk about what parts of or what summary of a patient record would fill their need and be less work for the provider. Is that basically what you're saying?

MS. EISNER: Yes. And that doesn't supersede the question about the number of audit requests.

CHAIR SCHUSTER: Right, right.

MS. EISNER: But there's certainly going to be some reasonable amount of audit requests for an MCO to verify the information that they need. But yeah, that is my question. And, again, I can't remember what meeting it was discussed at, but I thought that it had come up for discussion in the past.

CHAIR SCHUSTER: Okay. So this would be essentially a simplified summary of the relevant points from a patient's record.

MS. EISNER: Correct. And there

was -- somebody wrote in the chat about, you know, that psychotherapy notes weren't requested and so on. So really reaching a consensus and -- so that the payers and the providers could agree on the necessary elements to document the review and the audit of the chart.

CHAIR SCHUSTER: Okay. So I see this in the chat.

MR. SHANNON: By Rita Harpool.

CHAIR SCHUSTER: Yeah. WellCare/Datavant did not even want our psychotherapy notes. They want a one-page summary that answers about four questions.

So let me ask the other MCOs that are on. Have you all been part of this discussion about developing a more simplified way, so people are not copying pages and pages and pages of patient records? Any MCOs want to respond to that? Did we lose them all?

MR. PATEL: No. I'm still here. Look, I told you early --

CHAIR SCHUSTER: No. I know, Dr. Patel. We've already heard from you.

I'm trying to find out -- we had other MCOs represented. Aetna, Humana, and Anthem were on.

UNIDENTIFIED SPEAKER: Sorry. What's the specific question?

CHAIR SCHUSTER: The question is: Have you all been involved in any discussions or have you considered getting, I guess, a more simplified form with the relevant information when you do an audit as opposed to getting the entire patient record?

MS. STEARMAN: Right. So our standard request in order to evaluate the, you know, importance or the impact of that specific treatment is that we request the record for the service that is being audited, which includes the current treatment plan and the assessment and the service notes in and of itself.

Our goal is not to create new -- you know, we want to just absorb whatever the provider already has existing. By creating additional forms, you know, the thought is that that would then create additional administrative burden, something else to

document what's already documented. But we definitely would be willing to enter into any kind of collaborative discussions.

I will also say, you know, I very much encourage any of the providers that are on the line here to do outreach to me if there are concerns specific to the audits. And I think that that's really all we would have to say at this point.

There's not been a formal request to take any action or provide any additional data, and we believe that our current processes are as simplified as we can make them for the provider to have the least amount of rework.

CHAIR SCHUSTER: Yeah. I guess I have to say, Liz, that my initial thought when Nina brought this up was, well, that's one more task for the clinician. But copying of the record is done by other staff, I assume, not the clinician. So you're not taking the clinician offline, but you need the clinician to respond to whatever this simplified or summary form is.

MS. EISNER: There's another note

in the chat about maybe a checklist of standard documentation.

Yeah. I mean, I'm not all about developing another form. It just seems that there's a barrier between what the MCOs want and what the providers feel is necessary. And just bridging that gap, however that can be done, is really my point.

MR. OWEN: This is Stuart of WellCare. Yeah. I know we've mentioned this before. I know there's some hesitancy, but we do offer remote and vendors as well, like, giving remote -- they could pull -- and also to go on site and to do it. I know some are hesitant, but we've done that. We actually have a vendor that already has pre-existing agreements with providers to do that. So that is an option, you know, the remote access as well as going on site to assist.

CHAIR SCHUSTER: Yeah. Yeah. Thank you.

I've lost the person from Molina. Does that answer your question? I think you were asking about what this was about.

MR. CHAPMAN: This is Jeff from

Molina.

CHAIR SCHUSTER: Yes, Jeff.

MR. CHAPMAN: I didn't have a question, but we have a very similar response. We wouldn't request anything new or additional or changed. We would just like for the records that are already there. We have not been engaged in any specific groups to change the process.

We have worked with our kind of human integrity team and vendors to make sure that we're continually making it easier to submit everything, so there's less confusion on who to send it to and how to mark that and how to send it. But, you know, we're happy to work on that and create something, add a new process if it's needed.

CHAIR SCHUSTER: Okay. Thank you very much.

We have three recommendations that are going to go to the MAC and on up to DMS, and we should get a response from them before our January meeting. Let's hold on going down this road until we get some feedback from DMS.

MR. SHANNON: Yeah. That's a good path forward, Sheila.

CHAIR SCHUSTER: And we'll keep this -- obviously, it's going to stay on our agenda, but I do appreciate that coming up.

Leslie, a question about the waiting list numbers on the 1915.

MS. HOFFMANN: Just a second. Okay. Waiting list numbers. 2,397 for HCB; 9,172 for Michelle P; 3,512 for SCL. I think that's it. Yep. That's it.

CHAIR SCHUSTER: Okay. Do you -- because you're the one that typically now gives us those numbers. Pam used to give them to us, and I had a couple of people ask me -- I was in a meeting where I gave them the up-to-date. And I assume those are current as of what? A couple days ago or so?

MS. HOFFMANN: Yeah. So if you're going to ask me about the numbers, normally, I try to pull those every day. There are so many meetings that folks start asking if it's the same numbers from before.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: So we have partnered

with DBH to try to keep our answers the same on the days that we both have meetings. So we are utilizing a joint report today that we produced together from the last time that we ran a report. Does that make sense? It's just confusing to folks.

CHAIR SCHUSTER: Yeah. I'm sure, and I don't know that it changes all that much. So what's the date of that report that you just gave me the numbers from?

MS. HOFFMANN: I think it was on the 11th. Just a second. I wanted to say the 11th.

MS. CLARK: Leslie.

MS. HOFFMANN: Yes. Go ahead, Alisha. Am I saying the wrong day?

MS. CLARK: Go -- what did you say for SCL? What were the numbers again, just to confirm?

MS. HOFFMANN: 3,512.

MS. CLARK: And then Michelle P?

MS. HOFFMANN: 9,172.

MS. CLARK: Yeah. Those are from 11/1. We try to pull those at the beginning of the month every month to use for our TACs

and the MAC.

CHAIR SCHUSTER: Okay. Thank you.

MS. CLARK: You're welcome.

CHAIR SCHUSTER: So, Leslie, I'm going to talk to you offline, but one of the things I'm interested in is looking at how the numbers have changed over time.

MS. HOFFMANN: Yeah. We can probably do that. The numbers I sent to you the other day, Sheila, were for that right then.

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: When I sent those to you the other day, they were for right then.

CHAIR SCHUSTER: Yeah. But I'd like to go back, you know, even a couple of years and pull those numbers.

MS. HOFFMANN: Oh.

CHAIR SCHUSTER: Anyway, we don't need to do that right now but just planting that idea with you; okay?

MS. HOFFMANN: Yes. And then --

CHAIR SCHUSTER: And then the follow-up question is about the wait time between getting a waiver slot and actually

receiving the services.

MS. HOFFMANN: Let's see. Okay. And we -- if you remember, like, last -- I can't remember if it was the last meeting that we had. I had pulled --

CHAIR SCHUSTER: Yeah. You had pulled some data. Yeah.

MS. HOFFMANN: -- three years' worth. So this time -- and I did this fairly quickly. I had the staff -- I think we pulled a year's worth and maybe the last 90 days. So we did kind of two things and -- so that we could compare. And I pulled up the last report, too, just so I would have it.

So average day for HCBS is 52. Michelle P is 64, and SCL is 49. From the last year, we have -- if you want those as well.

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: 73.8 for ABI, 59.14 for HCB, 94.41 for Michelle P, and 63.8 for SCL.

I was going to look real quick. I think the numbers were a little bit better than what I gave you last time. Let's see.

Average last time for ABI -- yeah, the averages have decreased just a tad. Significantly, HCB looks quite a bit better and just a little bit in SCL, Michelle P, and ABI.

CHAIR SCHUSTER: Okay. All right. Thank you very much. I appreciate that, and I'll get with you separately.

MS. HOFFMANN: Sure. Yeah.

CHAIR SCHUSTER: I can try to do a visual where we can kind of see where those numbers are because I think that topic is going to continue to come up, obviously.

We have the Medicaid unwinding and recertifications.

MR. SHANNON: Sheila, I think you skipped Item 7.

CHAIR SCHUSTER: Oh, yes. How could I have done that? My gosh. Thank you, Steve. Wow. My favorite topic, and I'm looking right at Brenda Benson who is interested in this as well.

So what is the current status of the SMI SPA, please?

MS. HOFFMANN: Okay. And Ann

Hollen, as you know, is kind of the lead -- she doesn't work for me anymore. She works down in DBH. She's kind of the lead for the 1915(i) and then we're kind of the CMS oversight and compliance for that, and they administer it for us.

I asked her to give me an update, since she wasn't available, of what she wanted me to say. So it says: We've been actively having discussions with CMS and working with our sister agencies, DMS and DBH. We've all been working together through all the questions and comments for the application, and we're working directly with them to allow for a smooth and timely approval.

We have been working on a draft regulation and began discussions with needed changes for systems changes and creations of the 1915(i) provider type, and we are still on a target date of 7/1/2025.

So right now -- and I'm on all those CMS calls as well. We're on them together. We are still targeted for 7/1 of 2025.

CHAIR SCHUSTER: But we have not yet actually gotten formal approval from CMS;

right?

MS. HOFFMANN: No, we have not.

CHAIR SCHUSTER: And do we have any idea about when that might come?

MS. HOFFMANN: They're working with us informally, so we don't have to put it on a clock because it'll be quicker if we can continue to work with them and get that -- all the corrections that they're wanting now. Remember, this is something new.

CHAIR SCHUSTER: Right, right.

MS. HOFFMANN: So we're working through it, nothing bad. We've just got to get through all their questions.

MS. ALLEN: Leslie, this is Jodi Allen. I just wanted to let everybody know that I just actually submitted the clean draft that CMS requested just with all of the proposed changes, and so we're getting very close.

CHAIR SCHUSTER: Oh, that's great news, Jodi. Thank you.

MS. HOFFMANN: When was that, Jodi?

MS. ALLEN: I sent that about an hour ago.

MS. HOFFMANN: Oh, today? Okay.

MS. ALLEN: Yes. I sent it about an hour ago.

CHAIR SCHUSTER: Wow.

MS. ALLEN: Yeah. So, you know, everybody is working really as quickly as possible to move this forward. So I think we're getting really, really close. So that was just recently submitted, and CMS has been great about getting right back to us so...

MS. HOFFMANN: And, Dr. Schuster, Jodi is the lead on Medicaid side.

CHAIR SCHUSTER: Okay. Yeah.

MS. HOFFMANN: So we've got Ann Hollen on DBH side and Jodi Allen, Medicaid side.

CHAIR SCHUSTER: Great. Well, I'm so glad that you're on. That's really good news so lots of celebrating. I'm looking at Valerie and Brenda on my little screen here and, you know, any time we can get close.

You know, I think I told you all at one of the meetings that I got concerned because I thought that every time you went back and forth with CMS, it added days to -- you know,

started the clock again on the 90 days.

MS. HOFFMANN: Well --

CHAIR SCHUSTER: And then I'm thinking at that point, Lord, we should -- we could be halfway through 2025 so...

MS. HOFFMANN: So they suggested -- since they thought we could get the questions answered fairly soon, they just suggested that we do it informal, off the clock. So that was very nice of them to work through it because they know what our expectation is to get started. So they were really working diligently with us to make that happen.

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: So one of the other things I wanted to mention, CMS did send a letter for our 1115s and ask for another month, so they extended that till the end of December. All of our 1115s that we were waiting for approval on November the 30th, they've extended that out to the end of the year.

CHAIR SCHUSTER: Okay. I worry a little bit about any of these things that are hanging with CMS with the big change in D.C.

coming.

MS. HOFFMANN: Yes. Me, too. I'm, like, okay. December 30th is your drop dead date for us. Come on so...

CHAIR SCHUSTER: Yeah, yeah.

MS. HOFFMANN: Yeah. They did -- they've already sent the letter. And they told us on the phone call that that's what they were planning to do, and they've already sent a letter so...

CHAIR SCHUSTER: Yeah. There was -- there's a question on the chat from Rita Harpool about the criteria for the SMI SPA service, which is very complicated. I wonder, Jodi maybe or Ann or Leslie, can somebody send me your latest written thing that's easy to read, your PowerPoint maybe? I'm trying to think what we have that has --

MS. ALLEN: The PowerPoint presentation that was used for the town hall meeting is probably the best way to gather what had been approved. There, you know, are some proposed changes but, you know, they haven't been approved by CMS at this point so...

CHAIR SCHUSTER: Yeah.

MS. ALLEN: Yeah. So I could certainly drop in the chat some information that would help as far as what was originally approved, if that would help.

CHAIR SCHUSTER: Yeah. Can you send that PowerPoint to Erin or to me, Jodi?

MS. ALLEN: Sure, sure. Of course.

CHAIR SCHUSTER: Yeah. That would be great. I actually was looking for it the other day because somebody asked me that. And I'm like, I've got a million versions of this, and I'm like -- so if we all could be looking at or working off the same thing, I think that would be great.

MS. HOFFMANN: And, Dr. Schuster, I don't want to speak for DBH. So as we're working through with CMS, there will be -- there are some proposed changes, but I don't want to speak to that without them on the call. So just remember, what you're looking at might not -- it's not finalized yet; right? It's in draft.

CHAIR SCHUSTER: Right, right. But I think in terms -- generally speaking, I

think in terms of the criteria, the criteria to qualify for the services, I think, has not changed.

MS. HOFFMANN: Yeah. I don't want to speak to that.

CHAIR SCHUSTER: Yeah. Okay.

MS. MARKS: Can you hear me? This is Katie Marks.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: Yes. Hello, Commissioner, and welcome. We're glad to have you.

MS. MARKS: Thank you. I'm in commute and just about to hop out of my car. I apologize for having been so quiet but attentively listening.

What I would like to do is see if we could hear back from CMS within the next week because there are changes to the criteria. They continue to focus on SMI. I don't think there's any functional change to who's going to be eligible, but the way that we're approaching it has been asked to be changed by CMS.

And so I think if we could see a week --

let a week pass and see if we can hear back from CMS. That way, we don't send something outdated and then immediately turn around. So can we do that?

CHAIR SCHUSTER: That would be great. Yeah, absolutely.

MS. MARKS: Perfect. Okay.

CHAIR SCHUSTER: That would be wonderful. So if the PowerPoint, if that's the easiest thing to work off of, could be updated with what you hear back from CMS, that's perfect.

MS. MARKS: Great. We will do that, then. Thank you.

CHAIR SCHUSTER: Thank you so much, yeah. Yeah. I would rather send out something -- because even if you send it and say this isn't final, you know, people have it then and then they -- everybody thinks it's final, so that's perfect. Thank you so much.

MS. MARKS: Right. Thank you.

CHAIR SCHUSTER: Thank you so much. I appreciate that.

Thank you, Steve. I hated -- I would

have been so unhappy.

What about the status update on the reentry waiver?

MS. HOFFMANN: So what I do have to tell you about that -- of course, remember, it was approved July the 2nd.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: So we're not waiting for that approval. However, we have to wait on lots of things before we get a go live; right? So we did submit our implementation plan to CMS on time. I believe it was October the 31st. So that was -- that was completed -- or October the 30th. And then we will be now working on the monitoring protocol, which is due November the 29th, I believe.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: And the same thing --

MS. SPARROW: Hey, Leslie. This --

MS. HOFFMANN: Sorry. Angela, is that you?

MS. SPARROW: Yeah. Sorry. This is Angela Sparrow with Medicaid.

Just wanted to mention we do have a forum coming up in December, December 12th, so it will talk about the reentry services. It's going to cover the Reentry 1115 as well as the Consolidated Appropriations Act and the section -- mandatory section under that act.

So just -- we'll make sure that we drop the information in the chat, but I think the notice also went out to all of the TACs. So please feel free to send that out, but we'll have a public forum in the next month to really kind of be able to go through it specifically and then questions and answers.

But we'll drop the information in. It's posted on the website. And, again, feel free to please send that information on.

CHAIR SCHUSTER: Wonderful. Thank you so much, Angela.

MR. SHANNON: And, Sheila, folks can join the Reentry TAC that meets the same day as the Behavioral TAC at 9:00 a.m.

CHAIR SCHUSTER: Yes. That's right.

MR. SHANNON: And Angela gives a

great update every time that TAC meets.

CHAIR SCHUSTER: And Steve does a great job of chairing that TAC. There was a long time that there was not much to discuss so...

MR. SHANNON: That's still being debated, the status of my job.

CHAIR SCHUSTER: So that's right, same day as the BH TAC. Thank you so much.

MS. HOFFMANN: And, Dr. Schuster, you asked me a question, or maybe Commissioner Lee did the other day. Angela, correct me if I'm wrong. We've not posted the implementation plan. We're waiting to hear back from CMS.

Because, again, if they have any major changes, I don't want that -- it just causes mass confusion when people get things that aren't somewhat finalized. So they may change it, so I don't -- Angela, unless I'm wrong, it has not been posted yet but has been sent to CMS.

MS. SPARROW: That's correct. And then again, monitoring plan will go the end of this month, and we have our evaluator in

place and onboarding, so working towards that. And then again, we'll discuss in the forum a little bit more in detail about the implementation timeline. But that's looking, again, where -- our go live is targeted for October 1st of 2025 for reentry. Our CAA, those youth provisions will kick off January 1st of 2025.

CHAIR SCHUSTER: Okay. Thank you very much.

So I had put on here, just to give you all a heads-up, CMS issued its final rules a couple months ago, and they are requiring every state to have a BAC. So we have TACs and a MAC, and now we're going to have a BAC.

And the BAC is a Beneficiary Advisory Council, and I want to just ever so briefly tell you what I know about it because we'll learn more at the MAC meeting next Thursday. We meet at 9:30.

This is, again, a requirement of Medicaid and has to be in place by July 1st of 2025, which is coming up very quickly. It has to be made up of -- solely of Medicaid members, their families, and their

caregivers. And I understand that that's either paid or unpaid. So this is really the beneficiaries, not providers, not even advocates, per se, unless they're connected at the hip with a beneficiary.

There's a lot of concern from CMS -- and I've been on a couple of national calls -- about making the BAC, the council, a safe and supported environment for members to share their input. I think there's always a little bit of hesitation on the part of people and their families who receive services that if they are critical or speak out about services, that there may be some negative consequences. And I actually, you know, am not aware of that happening here in Kentucky from our local statewide DMS but, you know, obviously, it can happen.

So --

MR. SHANNON: I think the Consumer TAC would be a great source to develop this; right?

CHAIR SCHUSTER: Well, and that's interesting, Steve, because we had a forum -- Thrive Kentucky had a forum with the cabinet

ten days ago. And Commissioner Lee said she was looking at the Consumer TAC which has been very active in the last couple of years. It had been dormant for probably ten years.

It's chaired by Emily Beauregard who is the Executive Director of Kentucky Voices for Health. It has on it Arthur Campbell who -- if any of you know anything about disability advocates in Kentucky, he's probably one of the all-stars, once chained his bicycle to the front of a TARC bus that was supposed to be providing services for people with disabilities and so forth. So he's been super active. And she talked, Steve, about actually turning that TAC into the BAC.

The other interesting thing is that the membership of the MAC, the Medicaid Advisory Council, eventually will have -- 25 percent of its members must come from the BAC. And I think that doesn't go into effect for another year or two. So, you know, the BAC will get up and running.

There are states that already have -- you know, their MAC has a committee that is essentially a BAC, and they talk about the

kinds of support services that they provide to help consumers and family members get active and learn all the acronyms and kind of know what's going on and so forth. Their members may be virtual, and they have to, you know, participate as part of the MAC.

I wanted to get you all thinking about it because I think we want to make a real concerted effort. The state has not laid out the plan yet. We're going to talk here maybe more next week at the MAC meeting about how members might be recruited or what process there will be for people to apply to be a member of the BAC. But I think we want to be sure that beneficiaries with consumer health needs are well represented on that BAC.

I don't know if you all know the history of the BH TAC. But when Steve and I went to the legislature to start the BH TAC about 12 years ago, I guess now, Steve, we did it because there was no representation on the MAC of behavioral health. There was no TAC that addressed behavioral health.

And then when we started that legislation, it became a Christmas tree, as

they say, in the legislature where several other groups came forward. The Children's Health TAC, there had been no representation. There had been a representative of children on the MAC but no TAC. The Therapy TAC, which is OT, PT, and speech --

MR. SHANNON: Speech.

CHAIR SCHUSTER: -- started. And then the IDD TAC, I think, Steve?

MR. SHANNON: Maybe added to it.

CHAIR SCHUSTER: Maybe added to it. Yeah. I think so. So anyway, we don't need to take any action, but I just wanted to kind of -- if you start hearing about this. I think it's an important and actually a very positive development, that it would be formalized and have a status that would be equal to the MAC. The MAC has traditionally been very dominated by the provider groups.

So there are more -- you know, a couple more people that have been added to represent beneficiaries, but it will be -- 25 percent of it will be made up of beneficiaries or their families or caregivers. So let's keep thinking about --

MR. SHANNON: And going back to your comment about assistance, it's almost getting to a point -- you know, supportive employment, stealing from them, has the job coach. We're getting to the point that we need a council coach or a commission coach or someone who -- nonvoting, no input. But, you know, this is to help understand the process and what takes place. As they develop skills, that person fades away, much like supportive employment job coach.

CHAIR SCHUSTER: That's a great analogy, and I think -- yeah. I think that really does make sense.

I keep this on there about any ideas that people have for helping consumers and family members navigate Medicaid and also the waivers. I will say that a very important development -- it turns out that the connectors who are the people that really are -- help people sign up for Medicaid had not been formally trained about the waivers even though they were told that there were certain questions on the application that would alert you that people might need a

waiver.

So we took this to the Equity TAC and raised this question. And Priscilla Easterling, who is a connector who is a very active staff member at Kentucky Voices for Health, really spoke up. And out of that has come formalized training of the connectors about the waivers. So that's the kind of thing.

I was approached by several young mothers, or mothers of young kids who found out about waiver services when they put their kids in school and started meeting parents of other kids with disabilities and found out that there were things out there called waivers because if you're in a family that doesn't qualify for Medicaid because you earn too much, but your child would be eligible.

So those families never looked into it because they never knew that their child could be a member or could be a recipient of waiver services. So we've had kids that have gone for years without getting those services. So I just -- I keep trying to think of good ways to get that information

out there.

MR. SHANNON: And not getting on the wait list.

CHAIR SCHUSTER: Not even getting on the wait list, yeah.

MR. SHANNON: I think you skipped unwinding.

CHAIR SCHUSTER: No, I didn't. Veronica is out sick.

MR. SHANNON: Okay. Good. Good.

CHAIR SCHUSTER: So I'll ask her to send us something or a report in January.

Are you thinking I'm getting old, Steve?

MR. SHANNON: I would never say such a thing, Dr. Schuster.

MS. HOFFMANN: Dr. Schuster, this is Leslie.

CHAIR SCHUSTER: Did I tell you all that I had my 80th birthday two weeks ago?

MS. HOFFMANN: Oh, my goodness.

MR. BALDWIN: Oh. Sheila, I've got a --

CHAIR SCHUSTER: I'm sorry. Leslie, you were trying to say something.

MS. HOFFMANN: Jiordan, are you on

the call? Were you going to present something for Veronica today? They're actually -- we've got executive leadership coming back from the NAMD conference, which, you know, Lisa is the president. We're proud of her.

Jiordan, are you on the call? Did you have a presentation or anything for today for Dr. Schuster?

MS. GRIFFIN: I am. I was going to present on the unwinding renewals.

CHAIR SCHUSTER: Oh, okay. I'm sorry. I didn't mean to cut --

MS. GRIFFIN: No. It's okay.

CHAIR SCHUSTER: I didn't mean to cut you off, so great.

MS. GRIFFIN: No, no, no. I was just letting you all go through your agenda. I'm sitting here waiting my turn.

CHAIR SCHUSTER: It can take a while with us. Thank you, Jiordan.

MS. GRIFFIN: No problem.

CHAIR SCHUSTER: Do you need to share your screen?

MS. GRIFFIN: Yes. I think it

should be popping up here in just a second. Are you able to see that? It says: Medicaid Renewals Updates.

MR. SHANNON: We cannot.

CHAIR SCHUSTER: No. We can't see anything yet.

MS. GRIFFIN: Uh-oh.

CHAIR SCHUSTER: Here it comes.

MS. GRIFFIN: How about now?

MR. SHANNON: There you go.

CHAIR SCHUSTER: Yeah. There we are.

MS. GRIFFIN: All right. Let me get rid of that. Okay.

So this is our current Medicaid enrollment trends. It is trending downward obviously from our pandemic times. That was kind of an expected change after we started going through renewals again. And we did have a slight drop here around August of 2024 but then a slight uptick. And that can be probably due to our 90-day reconsideration period where people are coming back and re-establishing their eligibility with us within that 90-day reconsideration period.

So, currently, all PHE-related renewals for adults have been completed and processed. Any ongoing annual renewals for non-PHE cases resumed in April 2024. And a lot of the flexibilities that we've received during the unwinding are going to remain in place through June 2025. Certain Appendix K flexibilities were made permanent in 1915C waivers effective in May of 2024. And then we do CMS monthly and updating reports ongoing.

And so this is just a quick overview. It's a little bit of a busy screen, but it's showing each of our original CMS monthly reports from January through June. And then as we had to report the updated numbers to CMS after that 90-day reconsideration period, you can see our most recent submission was for June.

We submitted June's 90-day reconsideration period data, and it shows that we have zero pending cases, which is great, and that -- so yeah. So we were able to process one that was pending. There's not any left pending after that 90-day

reconsideration period. And we will be reporting July's 90-day update today, later today.

And this is just an overview of how many individuals we have reinstated, and this is as of November 8th. So it could be a little bit different from these numbers but not much. But -- so in August, we had 499 individuals come back into the program during that 90-day reconsideration period. In September, we had -- for the month of September, we had 420. And then for October, so far, we have 201 individuals that have come back in.

CHAIR SCHUSTER: So, Jiordan, for August, for instance, has that reinstatement period ended at this point, or is it still ongoing?

MS. GRIFFIN: For August --

CHAIR SCHUSTER: I forget how long that -- is it 90 days?

MS. GRIFFIN: It is 90 days. So, technically, I think they have until the end of November.

CHAIR SCHUSTER: Okay. Yeah.

Great. Thank you.

MS. GRIFFIN: Yeah. And then, of course, we have -- our connectors are licensed insurance agents that can assist with renewals as needed. We also have the SHIP hotline for individuals on Medicare or who are 65 or older, if they need assistance. And then we still have our Medicaid unwinding website, which is going to continue hosting all of our renewals data going forward.

And also, just as a reminder, we do still have this redetermination date in KYMMIS for our providers to see. I think during the unwinding, we were really adamant about providers helping us get the word out to members when they need to have their renewal completed. We're continuing to have that in KYMMIS. It'll stay there. It'll still be there in red just saying, hey, tell them to come in and see us.

CHAIR SCHUSTER: Yeah. Very important.

MS. GRIFFIN: And then on the PHE website, we still have flyers, information still pertaining to current renewals going on

even though they're no longer unwinding renewals. Lots of helpful information, information in different languages, information about ID proofing if someone is trying to gain website access, so they can do things through our self-service portal. All kinds of information on that unwinding website.

And then we also have our stakeholder sessions going on monthly. Those will continue post-unwinding. Pretty much any and all Medicaid-related things will be discussed in these stakeholder sessions going forward so really important to get the word out on those. They're held monthly. Most of DMS leadership are involved in some aspect.

We're -- I think after the unwinding and renewals, we're kind of dying down. We started doing division and branch spotlights just to learn more about what we do here in DMS and some of the projects we have that we're working on.

And that was it for me. Thanks.

CHAIR SCHUSTER: Okay. And let me just clarify because I think we talked to

Veronica at that last forum we had with her. The child renewals are still on hold; right? The renewals for kids?

MS. GRIFFIN: That's correct. They are still on hold. We were -- we were waiting for official word from CMS on how they want us to handle the child renewals. We're awaiting that guidance. But as of right now, they are still on hold.

CHAIR SCHUSTER: Okay. We really worked to get that information out to people because I think people worry. And the State has been great about protecting kids and not letting them fall off into no coverage.

So thank you very much, Jiordan. That's great.

MS. GRIFFIN: Absolutely. No problem. Thank you all.

CHAIR SCHUSTER: All right.

MR. BALDWIN: Dr. Schuster, I have a quick question if you've got a sec --

CHAIR SCHUSTER: Yeah.

MR. BALDWIN: -- for Jiordan for that one thing on her slides --

MS. GRIFFIN: Sure.

MR. BALDWIN: -- if I can real quick. One thing you had early on was the -- it said that the flexibilities would be extended to June 2025. Was that ones that were scheduled -- is that a change from some that were scheduled to end December 31 of '24?

MS. GRIFFIN: So all of the eligibility-related flexibilities for the unwinding were extended to June 2025. So that includes the ones that were set to end or sunset in December originally. CMS put out additional guidance extending those.

And then there are also a couple of the flexibilities that are being made permanent through new CMS final rules for streamlining Medicaid and CHIP. One of those is the requirement to apply for entitled benefits. That one is going to be a permanent change where we no longer have to ask or verify that members have applied for entitled benefits to obtain Medicaid coverage.

And the other one -- I'm blanking. It's on the tip of my tongue. But yeah, there were a couple of them that they're going to

continue allowing us to do.

MR. BALDWIN: Specifically, I was looking at the audio -- some of the stuff around audio-only therapy, audio-only services.

MS. GRIFFIN: Sorry. I'm the eligibility expert. I'm not completely sure about the specific services.

MR. BALDWIN: Not sure on the others. Okay. Gotcha.

CHAIR SCHUSTER: Who could answer that question for Bart, Jiordan? I mean, who could we ask?

MS. GRIFFIN: I'm not sure. Is Leslie still here? Do you know who would know about audiology services?

CHAIR SCHUSTER: No. It's not audiology.

MS. GRIFFIN: Probably someone in healthcare policy.

MR. BALDWIN: Well, it's not audiology. It's the audio-only --

CHAIR SCHUSTER: It's telehealth --

MS. GRIFFIN: Oh, telehealth services.

CHAIR SCHUSTER: Yeah. Is that Justin Dearinger?

MS. HOFFMANN: Jonathan, are you on?

MR. SCOTT: Yes. I can try to help.

CHAIR SCHUSTER: Oh, yes. I'm sorry. I meant Jonathan, not Justin.

MS. HOFFMANN: You're fine.

MR. SCOTT: You're good.

MS. HOFFMANN: I knew what you meant.

CHAIR SCHUSTER: Sorry. It's all those Js.

MR. BALDWIN: Yeah. Jiordan, Justin, Jonathan.

MR. SCOTT: Sorry. So what's the issue again?

MR. BALDWIN: No. That's fine. I won't take up -- I can reach out to you, Jonathan, if you can --

MR. SCOTT: Okay.

MR. BALDWIN: Because I've been in communication with Veronica some on it. But I think they were still trying to make a

final determination, so I was curious. But I'll reach out to you directly.

MR. SCOTT: All right. Good deal. There are some wrinkles to it.

CHAIR SCHUSTER: All right. Great. Thank you.

New business. And I think, Bart, that you had some new business that you wanted to bring to our attention.

MR. BALDWIN: Well, I know that you had heard from a provider around a -- as well around a change in terms of medical necessity for -- this is specifically around applied behavior analysis and to provide those services for children and adults, for that matter, that had a diagnosis beyond autism spectrum disorder.

So there was a notice that was sent out that was restricting, that only services would be approved with only that diagnosis. And that was the issue, and that has just recently gone out within the last few days.

And our concern with that is, one, it's tied to, I think, the Milliman medical necessity criteria. But my concern -- main

concern with that is that is not how our state Medicaid SPA reads or -- in terms of it's within the scope of practice for that particular clinicians, to serve folks with other diagnoses with ABA.

And I know some states restrict that in Medicaid because they use EPSDT funding. But in Kentucky, the behavior analyst is a Medicaid provider. So providing those services to individuals with other diagnosis has been taking place since Kentucky, I mean, put that in place in 2014.

And so that's been actually one of the things in Kentucky that we have been ahead of other states on in allowing -- without having the restrictions for that one diagnosis but allowing it for other folks.

So this was just a change, and I think our concern is that it overly restricts and is a violation of federal requirements. And -- but that's something that we're dealing with, and I just wanted to kind of raise that issue. Or we're working on it.

We trying to communicate with -- we've communicated with some folks at Medicaid as

well as start our initial outreach to the MCO. But I think that that's just a concern that that would be a sudden change in practice in the state that I believe is not allowable but...

CHAIR SCHUSTER: Yeah. Is -- Pam Marshall, are you on?

MS. MARSHALL: Yes, I'm on.

CHAIR SCHUSTER: Yes. You brought this to my attention and then we looped Bart in. But I think one of your questions, too, was: Can this change be made so quickly?

MS. MARSHALL: And the other concern I had -- can you all hear me okay?

CHAIR SCHUSTER: Yeah. Yes.

MS. MARSHALL: Right. It was provided to -- sent to providers. I have not seen it on the website, just sent in an email, less than 30-day notice, which really it should be at least a 60-day notice of this change. It's a change in medical policy. However, there are children being treated right now due to the long waiting list for a diagnosis that have letters of (audio glitch) who are waiting on those waiting lists for a

diagnosis.

But I think the concern is the federal push is to act now. And to get those children in earlier, it actually saves Medicaid dollars treating them as quickly as possible when you know it's -- suspect autism or a diagnosis that is going to respond quickly to ABA services. So I think -- I think we really need to look at this closely.

CHAIR SCHUSTER: Yeah. You were breaking up a little bit, but I think you and I had talked. And the issue, being a child clinician back in the day, you know, we really need to get services to kids early, early on. And there are long, long waiting lists to get a formal diagnosis of autism spectrum disorder.

And I do -- I am concerned about the way this notice was sent out, which was not really sent as a pretty significant notice, and it is a very significant change in policy, as I see it.

So I'm not sure, and I'm not sure -- Leslie, you're probably the go-to person here in terms of: Who do we need to speak to

about this?

MS. HOFFMANN: I think we need to put it together in a summary for us or maybe have another meeting, one site-off meeting regarding it, and then I'd want to pull in, like, Sherri Staley and some others for that meeting as well.

CHAIR SCHUSTER: Okay.

MS. MARSHALL: And the deadline is December 1st, that they're not going to pay claims for any ABA services that do not have an autism diagnosis on the claim.

CHAIR SCHUSTER: Yeah. So let me ask Bart and Pam to come together with a very succinct summary of this and send it to me, and let me -- and I'm happy to help facilitate a meeting with Leslie and whoever else she thinks because I do think this is a significant issue. Can you all do that as quickly as possible?

MR. BALDWIN: Absolutely. I'll get that to you, Sheila, Dr. Schuster.

MR. LYNN: Dr. Schuster?

CHAIR SCHUSTER: Yeah.

MR. LYNN: Hi. This is Dale Lynn.

I'm the chair of the Therapy TAC.

CHAIR SCHUSTER: Yes. And I also said to Pam that she should reach out to you.

MR. LYNN: Yes. And I -- she has.

CHAIR SCHUSTER: Okay. Good.

MR. LYNN: Her and I communicate regularly. I'd like to be part of that meeting with Medicaid regarding this new action that Aetna Better Health is taking, that it's completely out of line with Medicaid policy.

CHAIR SCHUSTER: Okay. Glad to include you, Dale, because there's a lot of overlap obviously here. So I'll ask for Bart and Pam to weigh in on the brief summary but enough that Medicaid knows what the issue is. And, certainly, we'll loop you in, Dale, also to the meeting.

So thank you very much to you all for bringing this up. I think we need to be really clear that -- particularly, for kids.

And, again, I mentioned earlier, you know, so often, the parents have no idea what their rights are or what's going on. And so sometimes we have to, you know, be the

advocates for the kids. So thank you very much, and we will --

MR. BALDWIN: Yeah. The only thing I would add to that as well is that there are also instances where kids are receiving -- currently receiving services who have a different diagnosis than autism spectrum disorder and are benefitting from ABA therapy in their overall treatment plan as one of the treatments they're receiving, and that would stop this. That would stop that from being able to happen.

CHAIR SCHUSTER: Yeah. And be sure to put that in your summary because that also can be extremely disruptive, particularly -- because we're talking about young kids in most cases here. So if they've been in a program of ABA and then it suddenly goes away, you're going to see some real backtracking.

Kelly Pullen has her hand up or his hand up.

MS. PULLEN: Hey, Dr. Schuster. This is Kelly Pullen from Aetna Better Health of Kentucky.

CHAIR SCHUSTER: Yes.

MS. PULLEN: And I wanted to bring up in this conversation I think it's really critical, too, for us to understand that our contract as Managed Care Organizations does require that we utilize MCG or InterQual criteria, and both of those criteria do require an ABA diagnosis for coverage -- or, I'm sorry, do require an autism spectrum disorder diagnosis for coverage of ABA.

So this is probably a larger policy question and discussion that needs to occur with the department, as we are following our contractual obligation to utilize that medical necessity criteria.

MR. BALDWIN: Yeah. I think that's -- I think that's the root of -- part of the root of the problem, Kelly. You're absolutely correct, and we're reaching out to some national groups to try to figure out how to influence the medical necessity criteria because I think that is completely unjustifiable, that it's limited to ASD.

But I realize that -- and I think you're right. It's a broader discussion with

Medicaid so that -- because, obviously, that medical necessity criteria is in conflict with current Medicaid -- Kentucky Medicaid policy. So I think we need to get a resolution for it, but I appreciate you bringing that up because it is part -- definitely a major part of the discussion.

MS. PULLEN: Yes. Thanks, Bart. And then I'll also add for any of our members that may be impacted by that, we are working really closely with the providers. All of our members in SKY do have an assigned care manager that can help coordinate care. If we need to have discussions about getting members assessed, et cetera, or other supports and services in place, our care management team will be available to do so.

MR. BALDWIN: Got it.

CHAIR SCHUSTER: All right. Thank you very much. And we will go forward and see what we can work out.

MR. BALDWIN: Thank you.

CHAIR SCHUSTER: Also under new business, a letter has gone out and notification, and you all may have seen it on

the news, that the Supreme Court in Kentucky did make a ruling finally in the Anthem case around whether they could continue to be a Medicaid provider as an MCO, and the ruling was against Medicaid.

And so DMS has sent out a letter. They sent out a letter on November 12th to all providers that as of January 1st, 2025, Anthem will no longer be a Medicaid Managed Care Organization, or MCO. Members who are with Anthem will be automatically assigned to either Humana or United effective January 1st. And those members will be notified, and they also have the opportunity to change their MCO at any time and then there's some information about covering and reimbursing for services.

So I will make sure that that -- a copy of that letter is sent in follow-up to you all, but I just wanted to make sure that you all knew that.

Any other new business to come before the body?

MR. HOOTEN: Hey, Sheila.

CHAIR SCHUSTER: Yeah.

MR. HOOTEN: This is Chris Hooten with Oliver Winston Behavioral Health. Our issues are much smaller than the things that have been discussed here. But, really, I think it would help us if we could get some contacts at Passport and WellCare to help resolve some ongoing issues that we're really struggling to get past. We're kind of a small clinic, so sometimes it's hard for us to get those contacts.

CHAIR SCHUSTER: And you need them with who, Chris? Remind me.

MR. HOOTEN: Passport and WellCare.

CHAIR SCHUSTER: Okay.

MR. OWEN: Hey, Chris. This is Stuart Owen with WellCare. I'll put my email in the chat for you.

MR. HOOTEN: Perfect. Thank you, Stuart.

CHAIR SCHUSTER: Yeah. I was going to say Stuart is our go-to person who is always on this. And Passport by Molina, we had several people on.

MS. NORRIS: This is Meredith Norris. I'll put my email in the chat, but

I'll get you wherever you need to go. I know Jeff had to drop, or he would have put his information in as well.

MR. HOOTEN: That's perfect. Thank you all so much. I really appreciate it.

CHAIR SCHUSTER: Sure thing, yeah. I'm glad you spoke up, Chris.

Very quickly under old business -- and this is an important issue. We ask about formulary issues. We are hearing increasingly about problems with our people with severe mental illness getting access to their long-acting injectable. And we're trying to sort out whether the problem is one of prior authorization from the MCOs or whether it's a pharmacy problem where they are not getting reimbursement for actually administering the LAI, or the long-acting injectable.

And as you all who are familiar with people with severe mental illness, these long-acting injectables are lifesavers literally. They take the place of daily medication, which is so hard for us to get people to continue to do. And so they can

go -- they can be effective for one month or two months. Actually, there's one being developed for six months, so for people that have trouble -- I hate the term "being compliant with" but taking their medication, getting it and taking it.

So if you hear of anything, email me, please, kyadvocacy@gmail.com. I would really like -- I'm trying to follow up both on the -- whether it's an MCO problem. If the MCOs have any information they can share, that would be helpful, too. I'd be real curious about whether -- or what the denial rate is for the LAIs.

And with that, my gosh, we're only two minutes over the time. I'm giving you lots of time this afternoon. Our next -- the MAC meeting is next Thursday -- I mentioned that -- at 9:30. And then the first BH TAC of the new year is January 9th. And remember, we're meeting now from 2:00 to 4:00 every BH TAC meeting.

So -- yes, Shannon, thanks for sharing that. The Pharmacy TAC voted to recommend Medicaid reimburse pharmacies for

administering the long-acting injectables. I think there's always been an issue about the cost of having them and keeping them there, but also -- and we would certainly support their being reimbursed for administering them. Thanks for that, Shannon.

If there's no further business, I will wish you all happy holidays because they are fast upon us. And before we -- thank you, Steve. There's my email address, kyadvocacy@gmail. But let's stay in touch, and we will follow up on the things we talked about today.

And I hope to see some of you on the MAC meeting next Thursday because you just can't get enough of this stuff; right? Thank you all very much, and the meeting is adjourned. Thank you, Erin.

MS. BICKERS: Thank you. Have a great day.

(Meeting concluded at 4:03 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 25th day of November, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR