COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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November 3, 2021
1:00 P.M.
(All Participants Appear Via Zoom or Telephonically)

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APPEARANCES

Sheila Schuster
CHAIR

Eddie Reynolds
Sarah Kidder
Valerie Mudd
Steve Shannon
Diane Schirmer
Mike Barry
TAC MEMBERS PRESENT

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APPEARANCES
(Continued)

Veronica Cecil
Judy Theriot
Angie Parker
Dawna Clark
Leslie Hoffman
Jonathan Scott
Jennifer Dudinskie
MEDICAID SERVICES

Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

DR. SCHUSTER: We will call the meeting to order. We have our court reporter on as well. I'm Sheila Schuster, the Chair of the BH TAC and welcome to you all.

We have a new voting member of the TAC, Eddie Reynolds, who is on representing the Brain Injury Alliance of Kentucky and we welcome Eddie who we've known for a number of years.

And we say thank you to Gayle DiCesare who had represented the Brain Injury Alliance of Kentucky for a number of years and has retired from their Board and rotated off. So, glad to have you, Eddie.

So, for the court reporter and for people that are on, Steve, do you want to introduce yourself, please.

(INTRODUCTION OF TAC MEMBERS)

DR. SCHUSTER: So, we have all seven of our voting members. And as we go along, I'm sure we have folks from Medicaid on and hopefully DBH also and the MCOs.

If you have not gotten emails from me directly with the agenda and the Zoom link and want to get those, please put your name and your email in the Chat function so that I can get those

and add you to my email list.

For the voting members, I sent out the draft minutes from our September 1st TAC meeting. It feels like it was months and months ago instead of just two months ago. So, I would entertain a motion from a voting member, please, to adopt the minutes.

MR. SHANNON: So moved to adopt the minutes.

MS. SCHIRMER: I'll second.

DR. SCHUSTER: All right. Steve and Diane. Any additions, corrections, omissions, revisions? All right. All those in favor of approving the minutes, please signify by saying aye. And opposed and abstaining. Thank you very much.

I have down here the response from Medicaid to our recommendations to the MAC but I couldn't find that I had gotten them. Do you know, Leslie, whether they were sent, whether Medicaid sent us any replies?

MS. HOFFMANN: Sheila, it looks like the responses are due on the 8th and they actually will be going out today.

DR. SCHUSTER: Okay. All right. So, what I will do, for those of you who are new to

this, when we have recommendations that go to the MAC, we read those into the record at the MAC meeting and, then, Medicaid sends a written response.

So, our recommendations in September, number one, that prior authorizations for all behavioral health services except pharmacy continue to be suspended to the end of this fiscal year which would be June 30th, 2022. That was our first recommendation.

Our second was that Medicaid develop and submit a waiver for adults with severe mental illness and children with severe emotional disturbance focused on supported housing, supported employment and other needed services.

So, once I get the written, I will circulate those to the voting members of the TAC and also to all of you that get the information from me. So, that includes the MCOs and, then, those of you from the behavioral health community that attend the TAC meetings.

The next thing on our agenda is an update on the data request from Medicaid on targeted case management issues.

And I meant to look up, Leslie. You may remember when that meeting was that we had

where we got a first run of the data. I want to say it was in September.

MS. HOFFMANN: Yes, I believe it was the end of September.

DR. SCHUSTER: The end of September, and we had a very productive discussion with the data folks at Medicaid.

For those of you again who are new to this, this came out of really the suggestion of the Commissioner, Medicaid Commissioner, Lisa Lee, that we use Medicaid data to help inform our recommendations and decisions.

So, we have been talking for several meetings which goes over a period of several, several months about the difficulty with targeted case management and its impact on people when they didn't get that service, particularly people with severe mental illness.

So, a small workgroup led by Dr. Allen Brenzel, the Medical Director of DBH, and some other knowledgeable behavioral health folks met with the Medicaid staff and proposed some parameters, some things that we wanted to look at that included number of visits to the ER and whether they were for psychiatric or for physical health reasons, the

number of days of hospitalization and whether they were for psychiatric or physical health, getting prescriptions filled, those kinds of things that we think are going to be impacted with someone with severe mental illness in terms of whether they have targeted case management services or not.

So, we had a very good discussion with the data folks and really kind of honed in on a kind of second set of fine tuning of those questions.

And, so, they were going to go back and run another data set, and I've not heard anything from them. Leslie, do you know? Do you have any update in terms of where they might be with that?

MS. HOFFMANN: I was looking. I did reach out to Barbara. Barbara, are you on? I'm not sure if she's on or not. I did reach out to her, though, Sheila; and as soon as I find out where we are with that, I will let you know ASAP.

DR. SCHUSTER: All right. Thank you. Yes, they have certainly been great. I think they really worked hard to pull the data that we were looking at and I think we got a first kind of swipe at it but not enough yet to complete the study and,

then, come back to you all with the results.

MR. SHANNON: Sheila, it looks like that meeting was September 17th.

DR. SCHUSTER: Thank you, Steve. So, that was the meeting with the data folks and the little workgroup, the data workgroup. Okay. Thank you.

Let's move on to our perennial, it seems like perennial discussion now about dual eligibles. Is Lee Guice on? I'm assuming not.

MR. SHANNON: I don't think so, Sheila.

MS. HOFFMANN: Sheila, she's actually in another area today. I'll get this information back and get that to you, if that's okay. We had her down for Number 5 and 6.

DR. SCHUSTER: Okay. Again, for people that are new to this issue which has been going on - I think Steve and I have been talking about dual eligibles for a hundred years.

So, we think first of people that have both Medicaid and Medicare and, then, secondly another group are people that have Medicaid and a private insurance.

So, we really tried to work

through some things and Lee was helpful in terms of - and I think, Leslie, that Ann Hollen also worked on what they call the Medicare list----

MS. HOFFMANN: Yes, that's correct.

DR. SCHUSTER: ----which is the bypass list. It's a list of services that are known to not be covered by Medicare but should be covered by Medicaid.

And for those of you who are new to this, the problem is that Medicaid is the payer of last resort. So, the MCOs will say we're not going to pay this until the primary insurer, whether that's Medicare or private insurance, sends a denial. And since these services are not covered by Medicare at all, we don't get a denial.

So, I understand. I got an email from Lee that the edits in the system had gone into effect at the end of September. So, the combination of having the bypass list and not being put into the system should be expediting claims, payment for claims on dual eligibles where it's Medicaid and Medicare.

So, Steve, do you have any update on that?

MR. SHANNON: No. That's what we've been told as well. We had one deal where a call with an MCO said that the CMHC's were - there was some question about the bypass list and Type 30 which is the CMHC.

I shared the provider email address as well with Lee Guice and Leigh Ann Fitzpatrick, and Lee Guice was going to get back with me what that really meant, but I have not heard any real concerns about that and we've had calls. We've had claim payment issues throughout September and October and a couple this week, one this week.

So, I think hopefully that's the case. We're still kind of figuring out that commercial side.

MS. SCHIRMER: Sheila, this is Diane. I've probably had at least a half a dozen participants who have brain injuries who have recently converted to Medicare just because of their age or disability, and we're having difficulty with them because they've got Medicare or Medicaid and none of the providers that we work with accept Medicare.

And, so, they have been in counseling and they've been working with Applied

Behavior Analysts and none of them will continue their services because they don't want to deal with Medicare even to get the denial to get Medicaid to pay for them.

So, I think we're interested in whatever can be done in working through this because this is going to impact our clients and many others as well to continue continuity of services. Am I making sense?

DR. SCHUSTER: Yes, you are.

MR. SHANNON: Does Medicare pay for applied behavioral analysis services?

MS. SCHIRMER: No.

MR. SHANNON: This hopefully would help that.

MS. SCHIRMER: Exactly. And I've talked to several - I've talked to three different providers, none of which are willing to take it on at this point. It's just been a nightmare

DR. SCHUSTER: Who is doing the counseling, Diane, because Ph.D. level psychologists and LCSW's are covered by Medicare? Behavior therapists are not.

MS. SCHIRMER: The only counselor that we found that I could go to was

through the Jewish Community Center in Louisville. I couldn't get anybody - I went to somebody that used to work for us who works in Louisville and has a contact at Humana and we couldn't get anybody there, especially with brain injury experience.

And we went through Heartfelt Solutions and two other agencies and Applied Behavior Analysts and none of them could provide counseling to the individuals as well.

DR. SCHUSTER: So, I'm a little confused. Before the Medicare issue came up for these folks with ABI, were they seeing some counselors?

MS. SCHIRMER: Yes, they were. They were all seeing counselors through some of the agencies that I just mentioned and they've all been dropped like hot potatoes because they were switched to Medicare.

MR. SHANNON: So, they no longer have Medicaid?

MS. SCHIRMER: They have Medicaid as the secondary.

DR. SCHUSTER: It seems to me that the providers need some education because they really should not be dropping these people. I mean,

it's a matter of having somebody sit down with them and say all you have to do is file the claim.

MS. SCHIRMER: Yes, file the claim. I've talked ad nauseam - and I'm not a billing expert but I dealt with this on the acute site - to Heartfelt Solutions and two other providers to say this is really simple. It's a billing issue, you'll get paid, but nobody is willing to do this thus far.

MR. BALDWIN: Sheila, this is Bart. We have a client, ABA Advocates which is a coalition of ABA providers, and this is the first I've heard of this. So, I'll get with you, Diane, offline and we'll talk.

MS. SCHIRMER: Okay.

MR. BALDWIN: Heartfelt Solutions, that particular provider, is not a part of our group but maybe the others are, but, anyway, we'll take this to them because this is the first I've heard of the issue and see if we can do some education with the providers when this comes up.

MS. SCHIRMER; This would be great. It's a nightmare.

MR. BALDWIN: I do know that we've never in that group talked about billing

Medicare for ABA services. So, it would make sense that none of them are Medicare providers but we'll see if there's a way around that, I mean, because on this issue, this dual eligible piece, I never really thought about it in the sense that if you're not a Medicare provider, can you get the denial or do you have to become a Medicare provider in order to get the denial?

MR. SHANNON: No. You won't get a denial from Medicare for services they don't pay for regardless of who you are.

MR. BALDWIN: Right. So, they just need to bill the bypass code.

MR. SHANNON: And I don't know if those ABI codes are on the bypass list - I think Leslie Hoffmann could probably help you with that - and Sheila's question about the clinician, because if it's not a Licensed Clinical Social Worker or a Ph.D. level psychologist, they're not going to get any from Medicare either because they don't recognize licensed behavioral therapists, right, Sheila?

DR. SCHUSTER: Right.

MR. SHANNON: So, they're not going to send anything to those psychologists.

MS. SCHIRMER: Right. I know

that.

MR. SHANNON: Right. Now, are these in a waiver as well or not in a waiver that you're worried about?

MS. SCHIRMER: They're not.

MR. SHANNON: Okay. For therapy services Medicare doesn't pay for, Medicaid will pay for.

MR. BALDWIN: Right.

MS. SCHIRMER; So, if we could talk, I'd like to figure this out.

MR. BALDWIN: It's a bypass code issue.

MS. SCHIRMER: I know it is. I know it can be figured out.

MR. BALDWIN: We'll talk and we'll take that and do some education with them around that.

MS. SCHIRMER: Okay. Sorry to take up time but thank you.

DR. SCHUSTER: No. That's an important issue.

MS. SCHIRMER: It is.

DR. SCHUSTER: And we don't want people to lose their services. I could see where the

provider is saying, oh, I don't want to become a Medicare provider and they don't have to to use the bypass list. I think that's what is not getting communicated to them.

Thank you, Bart. Iv appreciate that. And if we could work on the ABA part of it and, then, let's see if we could get the same providers and the same agency to also listen to the counseling part of it.

MS. MUDD: I think the Medicare provider must be a really difficult thing or just a pain in the butt.

Literally, I had to nudge my therapist earlier this week to bill Medicare because she hadn't been billing my copays and she wound up putting in ten visits in one day. So, it must be a really big pain in the butt. It sounds like that providers just don't want to deal with it.

MS. SCHIRMER: They want nothing to do with it.

DR. SCHUSTER: so, I had a brainstorm about how to tackle the commercial insurance side. Is Kathy Adams on? Are you on, Kathy?

MS. ADAMS: Yes, ma'am, I'm on.

DR. SCHUSTER: Okay. And I was going to ask you. Now, do you have kids that have Medicaid and Medicare?

MS. ADAMS: Maybe a few but that's very rare, but, yes, six or seven.

DR. SCHUSTER: Okay. I just wondered if you had had any success with the bypass list with even those few.

MS. ADAMS: Not that I've heard back from members. I've not heard anything either way.

DR. SCHUSTER: Okay. Well, between now and our January meeting, let's do a little bit more data collection on the Medicaid/ Medicare, but here is my brainstorm about - and it's mostly kids, I think, who have Medicaid and a private insurance because when we talked to Lee Guice at our last meeting, she said there's just too many private insurers and we don't know who covers what and so forth.

I'm going to make a recommendation that we would take to the MAC that Kentucky Medicaid gather data on behavioral health services which have been denied by commercial insurance carriers over the past two years in order

to determine the top ten services which are not covered by commercial carriers and should be covered by Medicaid so that we can get a systems change to create a bypass to make those claims eligible for Medicaid reimbursement.

So, I'm going backwards. Medicaid has the data about what claims have been denied by the commercial insurers, and I think we should ask them to look at that data to come up with the list so that we could create a bypass list for those people that have Medicaid and private insurance.

MR. SHANNON: I think that's a great suggestion. I think it makes sense.

DR. SCHUSTER: At least it would be a start because, otherwise, we're doing nothing with the commercial insurance. It doesn't help any of the kids through the Children's Alliance.

MR. SHANNON: Right.

MS. ADAMS: One question I would have, Sheila - this is Kathy - is some of the MCOs do have a commercial bypass list that they use. Aetna does and I know there's one other MCO that does.

So, if Medicaid does this and they come up with the top ten, would the MCOs be

required to honor what Medicaid comes up with, because I think we just got it clarified maybe at our last meeting that if Medicaid comes up with the Kentucky Medicare bypass list, that all the MCOs need to follow that because historically they hadn't been.

So, that's a question I would have because we do have some that are fee-for-service but the majority of the clients that our members see are MCO clients.

DR. SCHUSTER: My thought was that Medicaid, then, would make that systems change so that the system would bypass and go directly to the MCO which is what I think happened on September 30th, according to Lee, on the Medicare side.

MR. SHANNON: Right.

DR. SCHUSTER: So, it's not up to the individual MCO about whether they do it or not, Kathy, is my understanding. You come up with the list of the codes. Medicaid puts those codes into their system so there's an automatic bypass for those codes so that they go directly to the MCOs for payment.

MS. ADAMS: But, see, we're not putting into the Medicaid system. We're submitting claims to the MCO. And unless the MCO has

implemented that bypass list in their system, I don't think it works.

MS. CECIL: This is Veronica Cecil, Deputy Commissioner for Medicaid. I think what we need to do is to take it back and see what was in our contract to make that mandatory.

To your point, Kathy, the fix that we've made is within our system for fee-for-service claims. It also won't reject an encounter from the MCO, but the claim that a provider may submit to the MCO probably has different bypass codes and different lists.

So, we'll take that back and see what can we do across the entire program, both fee-for-service and MCOs, to come up with a list.

And certainly it would be our recommendation and guidance that we would provide to MCOs if we do discover that there are codes that just do not make sense to push to TPL, to third-party liability. And, so, we'll continue to work through these challenges that you all are experiencing.

DR. SCHUSTER: Thank you, Veronica. Thanks for being on. My thought was to get a start on it because the question I had from Lee was kind of throwing up hands and saying there's just

too many and we can't do it, and it just seemed to me that there ought to be a way to take a first bite at the apple, if you will.

MS. CECIL: And we have discussed pulling that data to look at the top ten most denied for TPL and starting there. I think that's a great recommendation.

DR. SCHUSTER: Okay. Well, great.

MR. BALDWIN: And, Sheila, in the Chat, it said that Humana and Anthem already have a commercial bypass list apparently. So, that might be a great----

DR. SCHUSTER: Another place to start and look.

MS. ADAMS: And, Sheila, after our last meeting, we were asked to send any bypass code lists that we have from the MCOs. So, I know I shared Aetna's with Medicaid and I'm pretty sure I also shared Anthem.

MS. CECIL: Yes. And I'm certain it would probably be most effective to have a consistent list across, again, the entire program, both fee-for-service and MCO, to the extent that that's possible. And I think that's what we will

work towards because we're certainly interested in doing that.

DR. SCHUSTER: Okay.

MS. ADAMS: Thank you.

DR. SCHUSTER: All right. Great.

As long as we're talking about that, could I get a motion from a voting member of the TAC to make that recommendation?

MR. SHANNON: Steve Shannon. So moved.

MS. SCHIRMER: I'll second.

DR. SCHUSTER: Steve and Diane. Any other discussion from any of the voting members of the TAC about this recommendation? We'll put in that they were denied for third-party liability. I will amend the recommendation to put that in.

All right. All those in favor of putting forward that recommendation to the MAC, signify by saying aye. And opposed and abstained? Okay. Thank you very much.

We're still looking at the issue of EMS transportation of individuals with behavioral health issues, and I don't know whether anybody has any other examples to share. There's a

note in here about Passport and the bypass list. Thank you.

MS. BLANDFORD: Sheila, since our last meeting, I had an encounter with something that happened that could have made it a lot easier for this person to get the care that they needed because they couldn't call EMS when they are requiring to call LMPD 911 first.

This person was in obvious distress and she was obviously in psychosis and she was screaming and ranting and injuring herself and potentially others, and I had to call them several times because they had another event down the street which is understandable. If there's a shooting down the street, you're going to go there police officer-wise, but they had available ambulances.

So, they could have sent the ambulance to pick this person up instead of two hours later when she could have already completed her threats of self-harm and I had to stay there to wait until somebody got there.

They finally did get a police officer there, but by that time, it took several of us standing around trying to keep this person calm when they were on the street and it was a situation

that could have been easily remedied with an ambulance.

DR. SCHUSTER: I'm sorry. Who is speaking, please?

MS. BLANDFORD: This is Rhonda Blandford from NAMI Louisville.

DR. SCHUSTER: Okay.

MS. BLANDFORD: I was just walking in to my office and this lady was crying and laying on the sidewalk and everybody kept passing her by; and come to find out, she was in crisis.

She had been kicked off the list for her provider because she wasn't able to make it to her appointments because she was in psychosis which really sucked and that made it worse because, then, she couldn't get her medication. And when she was in crisis, everyone walking by her outside of the therapist who dropped her, and we couldn't even get an ambulance to her.

DR. SCHUSTER: So, you called 911, Rhonda?

MS. BLANDFORD: Yes, and we tried to get LMPD here that's supposed to respond and they couldn't find an available officer.

So, I called back on the third

call trying to get somebody to come and get her some help because it was escalating, and for safety reasons, I was trying to urge them to hurry up. And I said, hey, can we just skip the car and send I call it a bus - it's the squad ambulance - and they still denied that as well, even though it was urgent and I had called multiple times from the location.

MS. ROBINSON: Hi, everyone. This is Reylene with Seven Counties and Bellwood & Brooklyn.

So, this call that you're talking about is what we are aiming to respond better to with the DOVE Project that was announced a few weeks ago with the City of Louisville and we are in the process of hiring those folks.

And the idea is, is at the call level to deflect cases to a social worker or a crisis intervention person to avoid having to send the police or having to send an ambulance.

So, that program will not get off the ground until probably - I don't know - January, February. So, it's probably going to take them some time to sort of run the system, train the 911 callers, but we are hoping that the response is aimed exactly at the situation that you just

described.

DR. SCHUSTER: Thank you, Reylene. That's good to know and that kind of response would be wonderful.

I think the difficulty in getting particularly ambulance services - and I've been doing a good bit of work with the Kentucky Hospital Association on this.

We have situations where somebody comes in to a hospital that does not have a psych unit and presents and needs to get transported to a hospital with a psych unit and is in distress and they call an ambulance and, then, we've had a range of responses or non-responses like, well, we don't have to transport behavioral health or we don't have to transport those crazy people, that kind of thing, or just incredibly long waits is the other problem.

And I think Nina Eisner from The Ridge was in one of these meetings - I don't know if she is on the TAC meeting today - but talking about getting somebody transferred even from The Ridge to a different level of care and not being able to get an ambulance there as well.

I'd love for you to keep us

posted, Reylene, on when the DOVE Project actually goes into effect. At our January meeting maybe----

MS. BLANDFORD: I'm part of the project as well. In this instance, The DOVE Project may not have been able to take care of this situation because she was needing additional care as well because she was already bleeding and injured and had already hurt herself and it could have been a lot worse.

So, an ambulance was necessary, but even with injuries, they still were not sending an ambulance because it was initially a CIP call.

So, that's part of the problem is the DOVE Project will be sending out one licensed person, one unlicensed person but they won't be sending out first-aid care and all those things with a medically licensed person or an EMT or those types of things.

So, in instances where it is necessary to have an ambulance, that's what I'd like to see happen from those hospital-to-hospital transfers or in front of a Seven Counties' building which it was to a hospital.

It's one of those things that it's not just a one-time thing. A lot of people who

are in mental health crisis are already injured. So, they may need an ambulance and not just a Band-Aid or talking to. They may need actual care because they've already attempted to complete suicide and they may need that medical care and I'm not seeing the response with an ambulance each time that the CIP has been sent out.

And that's what I worry about with the DOVE Project as well and they're still in the building process, building phases and how that's going to be launched or who they're going to go out with first or if it's just going to go the way it's going to go.

But that's one of the things that I'd like to see addressed in all of Kentucky is that when it's a mental health call, you still have the medical care that's needed as well. And that's not just an ambulance situation. That's both directions.

When you have a patient in the hospital and they have a medical need versus a mental health need, one or the other is going to give instead of both being addressed at the same time. I've seen that way too many times where medically it gets left behind or mental health gets left behind

because one is more urgent than the other when they could be simultaneously taken care of because it's the whole body.

DR. SCHUSTER: I appreciate that. I will keep you all posted on further discussions with the KHA group. And, then, I think, again, this is something that we need to reach out.

Probably, Steve, this might be something we could talk about on Friday with the Commissioner as well, if it's not already on the agenda, with all the health care centers there because it's been a rural area issue for sure and it needs to get improved across the board.

There was an LRC alert kind of thing that went out about somebody that had died waiting for an ambulance, had a heart condition and there are two ambulances in that county and there aren't any other - you have to get special permission to cross the county line from another county to send an ambulance. And by the time they got there, the gentleman had passed away. So, those are the kinds of things that we're hearing as well.

MS. CECIL: Dr. Schuster, let me add to that. I think we all recognize that this is an issue that there's a lot of external impacts that

Medicaid doesn't have control over.

And, so, this is something that's going to require a cross-sector solution. So, there are conversations going on within the Cabinet, not just Medicaid but among several of the Cabinet agencies about what are some of the things that can be done to help resolve this.

And to your point, I know that this is being discussed in another TAC - the Hospital TAC - and that KHA has been very interested in helping try to get us to a solution, too.

So, we all recognize it. I think the difficulty is that there's no quick solution. There's workforce issues. I mean, there's just so many impacts to it but we're absolutely committed to trying to be a part of the solution and there definitely are conversations going on about it.

DR. SCHUSTER: Thank you for that, Veronica, because I did bring it up with the Commissioner because some of you will remember that when we were meeting during the Bevin Administration that we brought this issue up and had recommendations to the MAC that somebody have conversations with the ambulance providers.

We thought it was much more

focused on behavioral health, and since then we've learned - and there are certainly, I think, the LRC article that I was referring to talked about the ambulance companies saying they just can't get enough ambulance drivers and EMT's. It's the same kind of workforce issues.

So, I do think it's bigger than Medicaid certainly, but I put it on here because that's where it first came to our attention was in terms of coming to the TAC.

So, I appreciate that the Cabinet - and we probably need to be talking to the Transportation Cabinet and some other - right? I mean, it's really across multiple sectors. So, thank you for that.

Do we have any issues with the Medicaid single formulary? I didn't have anything in particular. I put it on there just to check in with you all to see if there was anything.

I think the latest round of changes were made. I think that deadline was at the end of September when the drugs that were on some of the MCO formularies were going to roll into the single formulary and probably not be on the PDL or Preferred Drug List and were going to require prior

authorization.

So, are you all aware of any issues about people not being able to get their medications? Has that come up at all? I'm hoping that silence means that there's not any problems. I would be very happy if that were the case.

So, I'm going to put no issues there. We'll check in again, and we appreciated Dr. Ali being very responsive when things were not going so well. So, maybe the single formulary has kind of settled into what we had hoped for when we recommended it.

Leslie, if you're still on, the status update - and I don't know that there's anything new - on the SUD waiver for incarcerated persons.

MS. HOFFMANN: Unfortunately, Sheila, they've not given me any additional information. I meet with them on a regular basis and keep it on the agenda every month.

So, I'll meet with them again at the end of this month and will, of course, bring it up again.

DR. SCHUSTER: So, hopefully, the people that needed to come on board with the

change in Administrations have come on board.

MS. HOFFMANN: Yes. I was hoping. They came on board around May and now they're trying to make policy decisions, but, again, they never say anything negative. It's just that they need to make sure that they're prepared before they roll anything out.

DR. SCHUSTER: Okay.

MS. HOFFMANN: But we're still very much in favor of it. Nothing has changed there.

DR. SCHUSTER: Well, maybe something will happen still in 2021. So, can we hope for that for sure?

All right. I had put down the General Assembly Interim Session Task Forces. The two, of course, of greatest interest to us are the HCB or the 1915(c)Waiver Task Force which is actually in its second year of meeting.

And, Steve, you presented at the last meeting of that task force. Do you have any updates from them? They're probably getting ready to make some recommendations.

MR. SHANNON: At the next meeting, there will be recommendations. The theme has really been the need for those services and many

of those residential and clinical kind of services is finding staff, adequate staff to support individuals either in a three-person home or their own home.

So, I think that's part of the recommendation. There's a group working on a proposal that will be shared. It was presented to the task force last week and it's been kind or refined since then, but it's all about making sure you have sufficient staffing.

DR. SCHUSTER: Okay. And are they asking for money?

MR. SHANNON: Yes, they are, across all six waivers, a fair amount of money so those providers can be competitive in the marketplace. Both AB waivers are captured in their funding request as well as the Model II waiver which is another kind of waiver but the HCB waiver as well and both Michelle P and SCL.

DR. SCHUSTER: Okay. Do you have a ballpark figure?

MR. SHANNON: It's not finalized and I don't think I can release it to this group until it is.

DR. SCHUSTER: Okay.

MR. SHANNON: But you can go

back and look at the website and my Powerpoints there and there's a number that I shared based on that and that was about $280 million but that was my number. So, whether that's the number or not, that's the Steve Shannon number based on getting the starting salary to $15 an hour, move the median salary to $15 from $11.24.

DR. SCHUSTER: The median salary.

MR. SHANNON: Median. Half below, half above.

DR. SCHUSTER: To $15 an hour.

MR. SHANNON: Correct.

DR. SCHUSTER: Well, why don't you tell folks what your estimate is on the SMI waiver because that's a whole lot more doable.

MR. SHANNON: The SMI waiver State General Fund - and that's total money, that two eight. The SMI waiver to roll out - and this is just Sheila and I presented this last week again, I guess - it all kind of runs together - but it's just an initial proposal for the biennium budget, fiscal year '23 to '24, which is July 1 of '22 to June 30th of '24.

The first year is planning.

Leslie Hoffmann and Deputy Commissioner Cecil have a lot of work to do to get an SMI waiver in place, but we did not anticipate any people participating in fiscal year '23; but in fiscal year '24, we just picked a number of 100 participants, people with SMI, and that process actually involved phasing people in throughout the year.

So, July of '23, which is the first month of fiscal year '24, there would be eight people enrolled, not 100 because we don't know who they are yet. We don't have the criteria. Are they ready to go? And you just add to it throughout the year. So, by the end of the year, you get to 100.

But that number for '23, State General Fund, was about $1.4 million for '24. So, that's our funding request.

I did not have a number for Cabinet staff; but in our testimony, we pointed out there would be costs associated with Cabinet staff working on the waiver. I didn't have a number but I did point out there was a number that should be included in that for planning purposes so our friend, Leslie Hoffmann, can afford to buy food and then go forward.

And, then, the next year is

more expensive because you have 100 people. I think that number I had, total cost was around I think it was 2.7 or whatever but it was higher in '25, but that's their next budget cycle; and by that point, Medicaid will know those 100 people, but adding 100 more in the next year is still about $1.4 million State General Fund.

So, our recommendation was you can have 200 people served and maintain those people, I think it was $9.2 million total in the biennium of '25-'26.

DR. SCHUSTER: That's pretty cheap compared to $280 million.

MR. SHANNON: Correct, and that's modeled off the cost of the SCL waiver that has a full 24/7 residential option as opposed to Michelle P which does not.

DR. SCHUSTER: So, if you all want to see that PowerPoint, it's on the LRC website. That's www.legislature.ky.gov and go to Committees, Special Committees and, then, click on the Medicaid - Statutory Committees - I'm sorry - Medicaid Oversight and Advisory Committee and Steve's and my PowerPoint will be there for October 23rd, I think it was.

MR. SHANNON: Yes.

DR. SCHUSTER: The last meeting and you will see that PowerPoint. Steve is always the great guy with the - I'm the kind of razzle dazzle - thank you - Sarah just put it in the Chat - and, then, Steve is the numbers' guy. So, his is kind of boring but really important.

MR. SHANNON: Right. And part of what we were asked is where do you find that money which is fine. We're looking at that.

Part of our challenge has always been as you expand the service and provide people who don't have a residential option, with a residential option, you save money in law enforcement, you save money in jails and that's not a quantifiable number that we really get to.

We've had this conversation before. Jailers say, well, you're not saving any money because I'm not closing beds. I'm not diverting staff.

But looking at the involuntary commitment to state psych hospitals, if you decrease those by fifty, that's about $500,000 of the 1.4. So, we're about a third of the way there and I still contend it's a better service.

One of the drivers is you

ensure people have access to physical health care. If you're familiar with the SCL waiver - I'm sure Leslie could give us more information, maybe Eddie on the ABI or Diane - there's robust requirements for physical health care. There's clear expectations of medication administration that people have to take.

(Inaudible) testimony back in 2018. In the SCL program, if you're an hour late, right, Leslie, with medication, that is a reportable event. That gets reported as - it's not the highest reportable event but it is a reportable event.

There's a mental health center that took two van loads of people to a Reds' game. On the way home, they had a flat tire. Everything was fine. They actually had a great experience with a couple of guys in a pickup truck who fixed the tire and had a good time interacting with folks, but they were more than an hour late for some medications for an event they couldn't control. It wasn't staff negligence but they had to report that.

Well, if you're severely mentally ill, if you're an hour late, you're a day late, a week late, a month late, no one knows until your neighbors and family members know, and other states have this.

Again, these are my talking points. So, for $10,000 spent on HCB waiver services, $13 are spent on people who have a serious mental illness, thirteen out of over ten thousand, which, if someone owed me $10,000 and paid me $9,987, I would probably take it and be happy about it.

So, it's time to do this, I think, and Leslie has heard this before, right, Leslie?

MS. HOFFMANN: I have, Steve.

MR. SHANNON: At least once.

MS. HOFFMANN: Every meeting in the last three months. No, I'm teasing, and I understand.

MR. SHANNON: That's good. That's part of my strategy. If you say it often enough, it must be a good idea.

DR. SCHUSTER: The other things that we've heard at the SMI Task Force, we had excellent testimony from Dr. Carmen Pinto from Commuicare who many of you know talking about long-acting injectables, and there is now one that is six months in duration which is phenomenal when you think about that.

Excellent testimony from Seven

Counties Services, Scott Hedges and some other folks talking about integrated care which certainly we need more of.

And it was unfortunate because there were a number of family members from way Western Kentucky, from Murray, who came all the way to Frankfort to talk about a housing program they had found down in Tennessee and really just ran out of time. So, the PowerPoint is there and so forth.

MR. SHANNON: At previous meetings, other housing advocates have testified. I think Christy Shuffett is on this call. (Inaudible) testified on their housing options. Medicaid is not in the housing game for people with certain mental illnesses.

DR. SCHUSTER: Yeah. We've heard housing and we've also heard about mental health courts. So, there's a number of things and we're looking at the November meeting as a time for recommendations.

Do you want to add anything, Leslie, on the task forces?

MS. HOFFMANN: I was just going to mention. We've spoken at several of those meetings these past couple of months, but we are

diligently working on an SMI/SED possibility.

We do have technical assistance right now through the State Health Values Initiatives' group, what we call SHVI's. We had a first initial meeting with them and we've got four more meetings. So, we're making sure that that free technical assistance is highly utilized. So, we're making sure that we're prepared between each meeting with them.

Currently, right now, I know that you all were presenting relating to 1915(c). We've been veering towards an 1115 amendment to our existing authority that we currently already have and that was based on some conversations we had with CMS.

I was trying to find my information. One of the things that I'm concerned about on the 1915(c) - and I'm not saying I'm opposed to anything either - but that is long-term type of care services for institutional level of care or nursing facility level of care and that's not exactly where we wanted to go.

I was hoping that we could look at something across Kentucky and maybe identify - I'm not sure how this is going to work - maybe levels or something like that that would assist with us

determining what level they would be in an SMI/SED waiver, but, again, that's just we're in the beginning stages.

Sheila and Steve, I do have the original draft that you all wrote a couple of years ago regarding the 1915(c)that had housing and employment in it and those are some things that are on our agenda - care coordination, housing, after-care kind of things, if they're in and out of facilities.

I've been working with the MCOs just on some other things that are going on housing-related. We've got a housing ad hoc meeting that's going on currently to discuss housing across the board, housing and homelessness and employment.

So, I've scheduled a meeting with you all, I think, on the 8th because this has been a busy couple of months and we probably just need to give you an update on where we are and what we're looking at. That way, you'll know what we're working on, but again, we're not opposed to it.

We had staff to come on board September 1st, I believe. So, I've got dedicated staff now to help work us through the long processes of waivers.

So, we've been excited about it and we're working hard on it; but, again, I think I can give you more on the 8th if that's okay.

MR. SHANNON: And our testimony and our PowerPoint referenced 1115 that's done in a couple of states - Florida and Hawaii, I think, 1915(c),other states have done it that way, and the 1915(i),twelve states have done that.

So, the number I had - and I testified on the need for an SMI waiver on the 1915(c)task force as a (inaudible) on several occasions.

So, again, I don't know that I necessarily care what the authority is but more that the services are robust and are sustainable going forward, right?

MS. HOFFMANN: Yes. Sheila, I really want to make sure that we can meet more than just a smaller population. So, that's kind of where I've been going is kind of across the broad scope of who needs the services in Kentucky rather than just one particular group.

DR. SCHUSTER: If we could do a bigger array of services at different levels, then, obviously you would be bringing more people in at

those particular levels.

MR. SHANNON: We've talked about in-home support for some people. Maybe you could get them not 24/7 but eight hours a day. I think that will help a lot of folks as well.

MS. HOFFMANN: CMS has been pretty hard on us about not paying room and board. So, we have to be creative and we've been looking at a ton of other states.

MR. SHANNON: Again, the SCL staff residence, there's (inaudible).

MS. HOFFMANN: Those levels in the 1915(c)waivers are usually based on levels of supervision and that's not exactly where we are with these folks.

So, I've been very honest with CMS that we want to be creative and figure out how to meet the needs. So, they've been very open to listening to us, too. So, that's been something that we bring up on our monthly call with them as well.

MR. SHANNON: Good.

DR. SCHUSTER: And the other thing, and we have the presentation by Tom Walton and Andrienne Bush last time the TAC met about medical respite and they were asked to testify in that same

MOAC meeting, Medicaid Oversight and Advisory Committee, and Tom did an excellent job of really honing in on kind of the bare bones.

I do think there ought to be a place in a waiver for medical respite or at some place there needs to be a place for medical respite. That's part of the revolving door. That's part of everything that's going on when people are released from the hospital with their behavioral health or physical health.

MS. HOFFMANN: We're just in the beginning stages, Dr. Schuster, looking at the medical respite, but our staff person for SMI/SED knows to take a look at some of the other states before our meeting on the 8th.

DR. SCHUSTER: Great. All right.

I didn't see on the prior authorization guidance anything since September 29th. I know that you all meet kind of each month and see if there's any changes and there were no changes in terms of the suspension of prior authorization for behavioral health services except for pharmacy.

I did have a question that came to me from Marcie Timmerman who couldn't be on today

but she said that she met up with the president of the Kentucky United Methodist Children's Home who said that they were unable to receive reimbursement for case management with 16- to 18-year-olds even though they now can receive mental health treatment as homeless youth.

So, remember the bill that we passed in this last Session that allowed homeless youth 16 to 18 to be able to sign for behavioral health services?

And, so, I was kind of curious about it. I'm not real sure who to ask the question to, Leslie. So, I guess I'll ask it to you since you're the behavioral health guru here for Medicaid, but it seems to me that case management would be part of the behavioral health services.

MR. SHANNON: In the SED. They've got to be SED.

DR. SCHUSTER: Well, that's targeted case management.

MR. SHANNON: Yeah, but that's another one.

DR. SCHUSTER: Oh, there's not? Just case management?

MR. SHANNON: No.

MS. SANBORN: Sheila, this is Michelle Sanborn. I'll follow up with Julie, but my assumption is based on working on that bill, it's probably because they still have to have parental consent because that bill was really for LCSW's, etcetera, like master's level therapy.

DR. SCHUSTER: Yeah, I think that's right. I think what she was expressing was surprise because now these kids were able to get the therapy services without parental consent but they were unable to bill for case management.

So, what was the exact language in that bill, Michelle? I thought it was a very broad mental health services or behavioral health services.

MR. SHANNON: Escorted, though, right?

DR. SCHUSTER: Well, no. These kids are on unescorted. I don't think that's the issue.

MS. ADAMS: Sheila, this is Kathy Adams. One of the issues may be the fact that the TCM regulations require them to have a face-to-face visit or some type of a contact with the parent I think once a month.

So, I'm not sure if that's what they are referring to as to why they can't bill for TCM. And if they're homeless, they can't make that contact with their parent usually. So, that might be an issue.

DR. SCHUSTER: Okay. Well, it sounds like you all know her.

MS. ADAMS: Yes.

DR. SCHUSTER: Is she a member of the Children's Alliance?

MS. ADAMS: Yes.

DR. SCHUSTER: Okay. It was Reverend Julie Love. What a neat name for somebody who works for the United Methodist Children's Home. I love that.

Anyway, that would be great, and I'll let Marcie know that you all know her and will follow up.

So, I guess one of the issues is that they have an SED diagnosis so they would be eligible for targeted case management and, then, are they being on there because of the reg that requires a parental visit?

My only thought was - and I hadn't thought about it because I didn't know those

details - I was trying to think of it as, well, surely the language of the bill was broad enough that both therapy and case management would have been included as behavioral health services. That's where I was coming from. Thank you very much for that.

We also had - Kathy, do you want to talk about the letter that you got from DMS, the provider letter about the fee schedule?

MS. ADAMS: Sure. Yes. This is Kathy Adams again with the Children's Alliance.

And we became aware of a DMS provider letter that affected numerous entities including BHSO's, behavioral health MSG's and community mental health centers, among others.

DMS was recently made aware of a change in the Kentucky-specific Medicare physician fee schedule; and as a result, several of the DMS fee schedules have been revised, including the behavioral health and SUD inpatient and outpatient fee schedule.

So, Medicaid has indicated that they are doing claim adjustments, so, those affected should see adjustments by the end of the year.

The concern that I've heard from our members is many of the MCOs tie their reimbursement to the Medicaid fee schedule. And, so,

that would mean increases or changes for them as well in their contracts with those MCOs that tie to the fee schedule.

And the concern is when the MCOs will implement the changes to the fee schedule, and our advocacy is that there be as less of an impact and any extra work on providers as possible in regards to how claim adjustments are done. We would specifically obviously be advocating that providers not have to resubmit claims so that they have to be reprocessed in that way.

DR. SCHUSTER: And are your providers being asked to resubmit claims, or this is just in the offing, so, you don't know yet?

MS. ADAMS: We don't know yet. Members haven't heard from the MCOs on how they plan to implement this for the ones that do tie the reimbursement to the fee schedules, Medicaid fee schedules.

So, we're trying to advocate proactively that the burden of reprocessing and the claim adjustments not be placed on providers.

Usually, MCOs, I think it might even be tied to the DMS contract with the MCOs, that they have to provide at least a 30-day notice to

providers when there's a change in reimbursement.

So, again, this just came out from Medicaid in early October. So, our members haven't heard from any of the MCOs yet on how they plan to implement.

DR. SCHUSTER: May I ask if any of the MCOs that are on the call want to weigh in if you have a plan that you could share with us about how you're going to deal with these changes in the fee schedule?

MR. CROWLEY: Hello, Sheila. This is David Crowley with Anthem. Kathy, we definitely take your points and your advocacy in consideration on that plan and change in fee schedule and can set up some time with Andy Fox and a few of our provider solution folks to review that game plan.

I don't know the specific details of it at this point but I do hear and empathize with you.

MS. ADAMS: Thanks, David.

DR. COOK: This is Dr. Cook for United Healthcare. We just recently received those and, so, we're reviewing that. So, at this time, we don't have any updates or communications that we'll be sending out; but once we do, we can definitely

work with our Provider Relations' team to talk to any of the providers that need that information to make sure that we're communicating.

So, at this time, we're just reviewing and it will be a to be continued what we may or may not do as far as billing requirements or anything that we're speaking to, but I don't have an answer at this moment because we're still reviewing.

DR. SCHUSTER: Okay. Thank you, Dr. Cook, but I think you're hearing from the providers what their preference would be. So, you might take that into consideration as you're reviewing.

DR. COOK: We'll definitely take it into consideration, yes. Thank you for that.

DR. SCHUSTER: Okay. Thank you.

MR. BALDWIN: Sheila, just on that same topic, I don't think Kathy covered this, but seeking clarification because the fee schedule is a 1/1/21 fee schedule and I'm trying to remember if this change - because I know when we did the annual update, it was not until March, it was updated, but it was retroactive back to 1/1.

I'm not 100% sure. I can't remember off the top of my head if this one goes back

to 1/1; but if it was, I don't think the MCOs are required. I know Medicaid fee-for-service - this is probably a Medicaid question. Medicaid fee-for-service, I believe, does go back to the retro date on these claims, but I don't think the MCOs are required to.

Even though they reference the Medicaid fee schedule in their contracts, I don't think that they have to go back to the effective date. It would be great if they would but I don't know that. I'm trying to seek clarification on that.

MS. SANBORN: If the rates changed a long time ago and, then, our Medicaid didn't put them in, why wouldn't our MCOs not have to follow these rates?

MR. BALDWIN: Well, I agree. I mean, I agree but I don't think that's a requirement. I don't know if anybody from Medicaid can confirm or not that question.

DR. SCHUSTER: So, your question, Bart, if I understand it, is are these changes retroactive to 1/1/21? Is that basically what you're asking?

MR. BALDWIN: Well, I think they are, but the question is when Medicaid updates their

fee schedule for fee-for-service, it's effective at that prior date; but when the MCOs reprocess the claims, do they have to go claims all the way back to that prior date, to 1/1, or could it be sixty days or ninety days back because the issue with this is the fee schedule was updated but it's not just from this date moving forward. It's a retroactive date on when it's effective.

DR. SCHUSTER: Okay. So, is anybody from Medicaid on that an answer that question?

MS. CECIL: Veronica. A couple of things. One is that our contract with the Managed Care Organizations specifies that they must give a 30-day notice before a change in reimbursement and that that change should be prospective.

And, then, the agreement between providers and MCOs about changes in reimbursement are driven by their contract.

So, I will tell you that it's the Department's intent and the guidance that we're providing to the MCOs is that because we've heard from so many providers around this, it seems to be the consensus that they would prefer a retroactive adjustment.

So, we certainly have indicated to the MCOs that that would be our preference but we do not have any authority to require them to go back to January 1.

I think there is a little bit of a gray area here as to how you interpret what the change in fee schedule was. Is that truly a change in reimbursement?

So, I think there's some gray area about how you would characterize what just happened with the change in the rate, but, nevertheless, those are the parameters in terms of what we require between our contract with the MCO and what the MCO may require with, you know, might have negotiated with their contract with the provider.

DR. SCHUSTER: Does that answer your question, Bart?

MR. BALDWIN: Well, yes. I mean, it's still a gray area in the sense that the fee schedule was changed retroactive to 1/1, but I guess it depends on the specifics in the contract with the providers on whether or not they have to because even though they reference it and it's officially changing retroactively, right?

So, you would assume that if

you're going to officially reference that, then, if it was changed retroactively, you would have to follow it but I don't know this. You'd have to encourage that. And I think when this has happened in the past, I think it's been a varied experience between one MCO to the other, how far back they've gone.

I was just seeking clarification - thank you, Veronica - on whether it was a requirement or not but it sounds like it is not.

MS. CECIL: I will add that whichever way the MCOs intend to implement this is that they need to be consistent.

So, if rates retroactively get reduced and they go and they try to create an overpayment and recoup based on that, that would be inappropriate.

And, so, I just want to make sure that, again, I think it's difficult because sometimes rates, when they're retroactive, may increase or decrease and it's hard to only ask for the retroactive process thing if it's an increase and not if it's a decrease.

So, that's the difficulty, I

think, but, again, I'll reiterate that the Department's position on this is that and the guidance has been because of the overwhelming amount of contact we've had on this is that we've requested that they go back and reprocess, not require providers to resubmit but to reprocess those rates, but they're sensitive to the fact of what their contract says with the provider.

MR. BALDWIN: Thank you. Thank you, Sheila.

DR. SCHUSTER: Okay. I think that helps.

MS. ADAMS: Thank you, Veronica.

DR. SCHUSTER: And also in the Chat, Passport and Humana both said that they were also reviewing and will be in touch with providers. I think our Humana rep is permanently on mute which I didn't do but apparently her Zoom is doing that to her.

Kathy, you brought also a question about the increasing number and requirements of MCO audits and we've heard this also from the comp care centers, and I don't know if it's related to the fact that there isn't prior authorization going on. And, so, we're seeing more audits from the MCOs, but

it sounds like part of the question is - and maybe I'll ask Veronica.

Is there anything in the contract about the kind of notice or the kind of volume, Veronica, that MCOs can require in these things? I mean, we're hearing stories about ten days' notice and hundreds of case files, that kind of thing.

MR. SHANNON: Hundreds.

DR. SCHUSTER: I'm sorry, Steve.

MR. SHANNON: Hundreds. Hundreds and hundreds. Four hundred for one center, four hundred.

MS. CECIL: So, first of all, I'd like to see examples of that and if that's just a record review or is that an actual overpayment.

We just recently requested a report from the MCOs to provide us both the number of record reviews and the number of audit letters they've sent out for overpayment.

So, we're going to review that because we hear it's excessive but without data, I don't know. It's anecdotal to me.

So, generally, obviously for an overpayment audit, it's thirty days to respond. Now,

I think we've been very clear about this an I'm happy to reiterate it.

Right now during the pandemic, we have instructed the MCOs to give additional time to providers when they request additional time to either provide records or even to appeal. So, we have told them to always extend without cause, without reason. If a provider asks for additional time, we've told the MCOs you should give additional time.

So, if you've not made that request, I definitely recommend you do that; but, again, we're trying to monitor it because we're hearing it bubble up with all these audits going on and we're trying to figure that out.

MS. ADAMS: And, Veronica - this is Kathy again - I have submitted examples of some audit letters that our members have received, especially the one where they're given ten days to mass produce all these records and was just advised maybe yesterday or Monday or Tuesday by Angie Parker to advise our members to request an extension if or when needed because I don't know that they felt they had that flexibility to ask. So, I'm definitely going to advise our members to ask for that

flexibility.

The other thing we've seen in addition to the ten-day is - I'm going to lose it, I'm going to forget - and, again, it's the volume. It's the short turnaround time but, then, it's a list of clients. They might be given thirty days but it's a list of sixteen clients.

DR. SCHUSTER: I think you mentioned, Kathy, they requested a year's worth of records.

MS. ADAMS: Yes. That has happened.

DR. SCHUSTER: So, they want a year's worth of records on a particular case, a particular recipient?

MS. ADAMS: Yes.

MS. CECIL: Angie had to drop off for another meeting and I will follow up with her, Kathy, on what's going on.

I think the difficulty is that these are very case-specific. The other thing that we have been very clear with the MCOs on is that you should probably have a really good reason why you're asking for those records and not just to, again, create a burden.

So, we've tried to tell them to be very judicious in what records they end up requesting unless it's a random audit.

Again, you all have to remember that CMS requires us and the federal laws require us to ensure that services are medically necessary, that they're provided in the manner in which are approved through our State Plan or our regulations.

And, so, the only way we can determine that is doing a retro audit. So, it's just a check and balance. That's a part of the program integrity of Medicaid.

But, Kathy, I'll go back and talk with Angie on the information we specifically have.

MS. ADAMS: Thanks, and we totally get the audit and the necessity of audits and that they need to occur. We totally get that. It's just that it's really bad timing in that some of them seem really excessive.

Folks are inundated already with additional clients and additional need for services due to the pandemic in the behavioral health field and they're also very short-staffed, the same issue that's hitting everyone these days, and a lot

of times they're the type that we can't close on Mondays, not when you provide crisis services. You can't close because you don't have enough workers like Wendy's can.

So, we appreciate what you have communicated to the MCOs, and I will also say that we've not seen it from all six MCOs. It's just a couple.

MR. SHANNON: Correct. It's not everybody. And send that to Angie Parker, right?

DR. SCHUSTER: Her email is angelaw.parker@ky.gov.

And, Veronica, if you might respond back to me so I could share because I know that we are getting that so often from the CMHC's.

MS. CECIL: Absolutely.

MR. SHANNON: I mean, I got a report of four hundred and they communicated with Medicaid a couple of weeks ago about that.

DR. SCHUSTER: And, then, Kathy, you brought up one other thing about the new Medicaid fee-for-service, adding a place of service, a 99 code.

MS. ADAMS: Yes. We're excited about that. The issue that I've heard from members

for well over a year, two years is that there's no place-of-service code when the service is provided in the community. And we know especially with services like comprehensive community support services where you're working with clients to learn a new skill, to teach a skill, to implement a skill, those types of services, that often that is done in the community. So, if they're learning to grocery shop, they're going to be at Walmart or Kroger.

So, Medicaid worked on it and they've issued - it's not in production yet - it should be in production soon or at least that was the last I heard last week - that they're going to implement the new place-of-service code 99 for peer support services and community support services, for those two services.

Then, the question becomes, you know, we said, so, will the MCOs be required to also implement the place-of-service code and was explained that it would be up to the MCOs.

And, so, the question then becomes, well, that would be helpful to know is whether or not the MCOs plan to implement it in a time frame, if they have one.

DR. SCHUSTER: So, your

understanding is that this is being developed and it makes sense, particularly for the kind of services that you have described that are happening in the community, but the question is are the MCOs required to use the new place-of-service 99 code; and if so, when might that happen, right?

MS. ADAMS: Yes. And if they aren't required to implement it, will they implement it anyway? It just gets really confusing obviously with six MCOs and they've all got a little different nuances. And, so, it would just be helpful to know if the MCOs plan to implement the POS 99 code for community-based settings, for peer support and community support services.

DR. SCHUSTER: Do you have an answer for that one, Veronica? I'm looking at you.

MS. CECIL: No. Obviously, we're not prepared to discuss these issues because they weren't on the agenda, but if I could request that maybe you put it on the agenda for the next meeting and that way we'll have an opportunity. And, then, also, maybe the MCOs can speak to what they plan to do.

DR. SCHUSTER: We will definitely do that. And I apologize. This was last

minute. We had a little time, so, I put it in there. We will definitely put that on.

MS. ADAMS: Thank you, Sheila. Thank you, Veronica.

DR. SCHUSTER: Thank you. So, we have a recommendation to the MAC on the dual eligibles, Medicaid and private insurance. Any other recommendations that anybody wants to make to the MAC from the voting members of the TAC? Do you have anything else that we talked about or that is a burning issue for a recommendation to the MAC?

All right. On the January agenda, we're going to follow up with Lee Guice about she was going to report back to us on the no-show data-gathering panel and how that data is being used.

Veronica, I don't know that you were on our last meeting. We had a discussion. We're just a little bit concerned about making sure that people that are having trouble keeping their appointments don't get stigmatized in some way or kind of labeled as - if they get labeled as people that need assistance, that's great, and I know that's the intent.

We just want to make absolutely sure that that's what is happening, and we're, I

guess, particularly sensitive that many of our own behavioral health folks might be more likely to miss appointments than maybe some of the other groups. So, that's all, and Lee said she would gather the data and get back to us.

We need to set our calendar. And if we're not prepared to do it today, I wondered about moving our meetings to a Thursday at the same time, a 1 to 3; or when we meet during the Session, we meet from 2 to 4.

And I had sent Sharley an email asking her if there was a conflict with other TACs but not realizing that she was not going to be available. And I don't know, Veronica, if any of the other DMS folks on had some idea about whether a Thursday is doable.

MS. CECIL: I apologize. We'll check that and get back with the TAC members.

DR. SCHUSTER: Okay. Thank you very much, Veronica.

Let me ask the TAC members if you all have any objections to moving to a Thursday, and we can check when we hear back, either the first or the second Thursday of the month which would be like January 6th or 13th, March 3rd or 10th.

MS. MUDD: The third Thursday is difficult for me. I've got a meeting nearly all day that day, on the third Thursday.

DR. SCHUSTER: I'm sorry. I meant to say first or second, Val.

MS. MUDD: That will work.

DR. SCHUSTER: Because the MAC meets on the fourth Thursday and I've got to give myself enough time to get the write-up of the meeting and so forth. So, we're looking at either the first or second Thursday.

MS. SCHIRMER: That's fine for me.

DR. SCHUSTER: Does that work for you, Diane? So, Val, that would be all right if we stay away from the third?

MR. REYNOLDS: That works for me.

DR. SCHUSTER: Eddie, that's all right? Okay. Steve, any problem with that?

MR. SHANNON: I don't think so. We'll make it work. KARP is usually the first Friday, so, maybe some back to back but that's okay.

DR. SCHUSTER: Okay.

MR. SHANNON: The second would

be better.

DR. SCHUSTER: Yeah. We might go to the second.

MS. STEPHENS: Sheila, this is Kathy. I have my calendar pulled up and I have all these TACs, but on the second Thursday, the Incarceration TAC meets from 9 to 11 but there are no TACs in the afternoon on that first Thursday. The second Thursday is pretty packed because there's Primary Care and Optometric, if that helps you at all. I thought since I had my calendar, I'd let you know.

DR. SCHUSTER: Thank you. I appreciate that.

MS. STEPHENS: It looks like Thursday afternoon, the second Thursday would be workable.

DR. SCHUSTER: Yeah, because we always meet 1 to 3 or actually we delay it a little bit when they're in Session and start at 2 so that we can go to committee meetings and so forth.

MS. CECIL: I was going to say, Dr. Schuster, if you all want to tentatively put the second Thursday, so, that's starting in January the 13th, and what was the time you were interested in?

DR. SCHUSTER: On the 13th, it would be 2 to 4.

MS. CECIL: Okay, because it's starting the Session.

DR. SCHUSTER: Yeah, and, then, March, it would be March 10th from 2 to 4. And, then, the others would be May 12th, July 14th, September 8th and November - in November, we might do the first because the MAC gets moved up by a week in November.

So, it would be the 13th of January, the 10th of March, the 12th of May, the 14th of July, the 8th of September and the 10th of November.

So, let's do this just to make it official; and if we need to change it, we can, but would a voting member of the TAC recommend that that be our meeting schedule for 2022.

MS. SCHIRMER: I will.

DR. SCHUSTER: Is that Diane?

MS. SCHIRMER: Yes, ma'am.

MS. MUDD: I'll second.

DR. SCHUSTER: And Val will second. All right. All in favor, signify by saying aye. Opposed or abstentions? All right. And, then,

we'll go from 1 to 3 in May, July, September and November. Thank you all.

The next MAC meeting is November 18th - so, it's a week earlier - 10 to 12:30, and I'll send out that Zoom but it's also on the website.

And I recommend - I mean, the TAC members don't have a role particularly - I'll be there to give a report - but you could learn a lot at those meetings because you hear what the other TACs are talking about and, then, just the general discussion items, the update from the Medicaid Commissioner and, then, the items that are carried over.

I think the November meeting is going to focus a lot on maternal and child health because that's been a topic of great interest to Commissioner Lee with some recommendations that came from the MAC and, then, they're following up. I think Dr. Theriot, the Medical Director for Medicaid, is doing a follow-up report to the MAC. So, that's one of the items that we will be looking at at the MAC meeting.

And, then, our next BH TAC meeting, then, would be January 13th from 2 to 4.

I want to thank everyone who has participated and been here, and thank you very much to Veronica and Leslie and other DMS folks for stepping in. We appreciate that.

If there is no other business, I did give you all back about twenty minutes of your day. I think I ought to get some stars for that, right?

Happy Thanksgiving to you all. I'm thankful for you all and for the dedication that you show for all of our Medicaid folks but particularly for the Medicaid folks who have these behavioral health issues.

So, I appreciate you all very much and your participation. And with that, we will adjourn the meeting and give you all back twenty minutes.

MEETING ADJOURNED