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

****

Via Videoconference
July 13, 2023
Commencing at 1:00 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, Chair

Steve Shannon

Valerie Mudd

Eddie Reynolds (not present)

Mary Hass

Michael Barry (not present)

T.J. Litafik

P R O C E E D I N G S

CHAIR SCHUSTER: Good afternoon, all. We hope you're on the right flight. This is the Behavioral Health Technical Advisory Committee, affectionately known as the BH TAC. And I am the chair, Sheila Schuster.

And we have voting members. Val, you want to introduce yourself, please?

MS. MUDD: I'm Valerie Mudd with NAMI Lexington and Participation Station, a peer-run and peer-operated center. I represent the peer voice.

CHAIR SCHUSTER: Thank you.

And Steve?

MR. SHANNON: Steve Shannon with the KARP association of 12 mental health centers. Glad to be here.

CHAIR SCHUSTER: Great.

And T.J.?

MR. LITAFIK: Good afternoon. T.J. Litafik, NAMI Kentucky.

CHAIR SCHUSTER: Great. Thank you very much.

And, Kelli, if you might let me -- I'm

still expecting Eddie and Mary to be on so --

MS. SHEETS: Mary has joined. She's on now.

CHAIR SCHUSTER: Oh, okay.

Hi, Mary. You want to introduce yourself, please?

MS. HASS: Sure, Sheila. Long time no talk to. I'm Mary Hass.

CHAIR SCHUSTER: Right.

MS. HASS: I'm Mary Hass, Brain Injury Association, Kentucky Chapter.

CHAIR SCHUSTER: Great. Okay. So we have a quorum. Mike was not able to be with us today, and I'm still expecting Eddie Reynolds. So we'll go on and get started.

The minutes from the May 11th BH TAC meeting were distributed by email, and I would entertain a motion from one of our voting members for their approval.

MS. HASS: Mary Hass will make a motion.

CHAIR SCHUSTER: Okay.

MR. SHANNON: Steve Shannon, second.

CHAIR SCHUSTER: Great. Any

additions, corrections, omissions that you all spotted?

(No response.)

CHAIR SCHUSTER: If not, we'll call for a vote, then, of the voting members. All in favor of approving the minutes?

(Aye.)

MS. SHEETS: I just wanted to break in to make sure everybody -- all the members understand that in order to comply with open meeting laws, you have to have your cameras on when you vote.

CHAIR SCHUSTER: Okay.

MS. SHEETS: Thank you.

CHAIR SCHUSTER: Thank you very much, Kelli. So I think that was a vote in the affirmative. Any opposition or abstentions?

(No response.)

CHAIR SCHUSTER: If not, the minutes are approved.

And I meant to stop at the beginning of this meeting. Usually, Erin Bickers is our Medicaid facilitator. We're very glad to have Kelli Sheets with us. But Erin's father

passed away in the last couple of days, so let's have a moment of silence as we think about her and her family.

(Moment of silence observed.)

CHAIR SCHUSTER: Thank you very much. We will be thinking of her and her family at this sad time.

I'm not sure who is on from Medicaid. I think Ann Hollen was going to be on. We have a couple of things next on the agenda, the status of Medicaid unwinding and recertifications, other end of the federal Public Health Emergency changes including any changes on telehealth.

MS. HOLLEN: Hi, Sheila. I'm here.

CHAIR SCHUSTER: Hi, Ann.

MS. HOLLEN: I have at least a little bit of information on unwinding.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: So the -- for May, 34,124 individuals were disenrolled. June, 37,494 were disenrolled for a total of those two months of 71,618 individuals.

Now, we're still seeing a lot of discontinuances for failure to return

information. DMS and the MCOs continue to do outreach. One of the things that -- DMS is getting ready to request additional flexibilities from CMS such as waiving the medical support enforcement criteria for applicants.

And then I was told to give everybody the unwinding website, which is medicaidunwinding -- medicaidunwinding.ky.gov for more information. And as far as recertifications and the rest of that, I don't have any information on -- on that.

CHAIR SCHUSTER: Okay. Let me just emphasize for you all. When I sent this out to -- I know the Kentucky Mental Health Coalition and I know Kentucky Voices For Health has been sending this information out. We do have one-page explainers if anybody would like that, and we can follow up.

Thank you, Angela, for putting the website in the chat.

But this is really critically important, folks. There are a lot of Medicaid folks that are losing their Medicaid, some of them because they joined during the Public Health

Emergency, and they've never been through recertifications. So this is new to them.

The Cabinet, and particularly DMS, has done a great job of following up with phone calls. I think even text messages, as I understand it, Ann, have gone to folks.

MS. HOLLEN: Right.

CHAIR SCHUSTER: And so a lot of these folks that have been disenrolled, it's because they never responded. They never sent back a single piece of paper. And in many cases, they would still be eligible.

Now, my understanding is that they have 90 days from the date that they got the letter saying that they, you know, were no longer eligible, that they can send in that paperwork. And if it answers all of the questions, they're automatically reinstated and reinstated back to the date. It's retroactive; right, Ann?

MS. HOLLEN: That's correct.

CHAIR SCHUSTER: So we have really got to get on the stick here, folks. And I think, Val, I'm looking at you and other folks that work with peers, you know, to

really get this information out.

We also have the one-pagers available in Spanish because we know that there's a language barrier, in part. I think that people are just either not opening their mail or are confused when they get it and aren't sure what they're supposed to do.

MS. MUDD: I wanted to share. We've actually been pretty proactive about this, at least in -- at Participation Station. We have a connector who comes to our station once a week. And every time I see somebody nearly walking through our doors, I say: Hey, have you received anything from Medicaid? You know, we've asked every single person.

And if -- you know, if they haven't received something or they need help with it, you know, we send them to that connector once a week, you know. And so we've been really proactive about that.

But I tell you what. I was on Thrive Kentucky -- what was it? Tuesday. Yesterday? Whenever that was.

CHAIR SCHUSTER: Tuesday, yeah.

Tuesday.

MS. MUDD: And I heard about all those numbers, and I tell you what. It's super -- it's just, you know, bothering me that we have so many of those people that are, you know, not filling out their paperwork or whatever.

And I just think, you know, are they afraid of the mail that's coming in. You know, we've heard those -- that happening before, that, you know, some of our folks who have mental illness are afraid to open their mail. Is that the reason? Is it that a lot of our folks on Medicaid move around a lot, and they haven't received their mail? You know, I don't know what the problem is.

And, like I say, I've -- you know, at our place, we've been proactive. But, you know, where are all these other people? Why haven't they sent their stuff in? Why haven't they got the phone calls? Why haven't they got the emails? I just don't know what the answer is and...

CHAIR SCHUSTER: Well, I think your example, though, Val, is a great one, and

you're in a peer-run, consumer-run center. But to have a connector -- the connectors are really the glue here, folks, and they will reach out and get people reenrolled. And if they have lost their eligibility because they no longer meet the Medicaid criteria, they will go on and get them another insurance coverage through the Kynect portal. So we have lots of -- and there's lots of discounts and a lot of financial help available so -- even if people can't stay on Medicaid.

I know the MCOs are working very hard on that. I think we have a lot of provider groups in the audience here. We always do for the BH TAC.

So really think about this, folk -- folks. When people come in for their appointment, are you all asking them is their address up to date with Medicaid. What kind of letter -- because everybody should have gotten a letter -- if not one, maybe several letters from Medicaid at this point.

And sometimes people will bring in a letter with them and ask for help with it. So that might be another thing. If you have

an appointment with somebody on -- that's covered by Medicaid, to ask them to bring any correspondence that they've got from Medicaid with them so that we could get this resolved.

MS. MUDD: I mean, if their address is wrong -- like, right now, if their address is wrong, they're not getting Medicaid; right? I mean so -- right?

MS. HOLLEN: If their address is wrong, they're probably not getting their letter. I mean, or if they've moved and they didn't update their -- I mean, when someone moves, they've got to go in and update their address, or Medicaid thinks they still live at their old address.

MS. MUDD: Right. So they're not getting -- getting their benefits. So yeah, it's just puzzling to me.

CHAIR SCHUSTER: Yeah. Kelly, you had your hand up.

MS. GUNNING: Sheila, I was wondering -- and I just got off a meeting with David Riggsby and some folks from PS. Val was on her way to this meeting, so that's why I was a little late. Sorry.

But one of the things we were thinking of statewide as a solution to this -- because we saw the numbers and it was scary -- was -- you know how we do the expungement fairs and the job fairs and stuff like that? Is there any way that we could organize some kind of a connector fair where we could get connectors coming to certain places for groups of people in the regions, maybe coordinated with the CMHCs or the MCOs?

CHAIR SCHUSTER: Hmm. I think that -- I don't know. That's a good idea.

Steve, do you have any sense of what the various CMHCs have been doing?

MR. SHANNON: No, I do not. I mean, they've been telling people to check their mail. I think part of the problem is under a certain age, people never look at their mail; right? I mean, it just -- it's a different world for some demographics, so I think that's a concern.

I like the idea of connector fairs. I'm sure the CMHCs would like to participate. You know, we tell folks all the time, you know, when they come, make sure because we

have -- everyone knows this is happening. It just -- you know, how does it play out? I think it's a real challenge with -- people move around changing addresses and don't forward their mail.

So I think it's -- I like the idea of sponsoring those or maybe have one day a week -- I don't mind suggesting that -- that they have a connector show up every now and then.

MS. GUNNING: Definitely do the PS, and it really helps. But if we could get, like, Medicaid and the CMHCs and the MCOs all helping sponsor this to get the word out, you know, to let people know that these things were happening if we decide that could be a possibility, then we could all cooperate together.

Because I tell you what. The expungement fairs and stuff that we've been involved in with the mental health court locally have been hugely successful and so have the job fairs. But we've done them in collaboration and coalition with the voc rehab and, you know, the community colleges

and stuff like that.

So I don't think it's something that we could take on ourselves. But if we all work together, I think that could be a real draw because I think people just aren't getting the information. I don't think we would have these kind of staggering numbers if they knew.

CHAIR SCHUSTER: Yeah. I think that's right.

MS. GUNNING: And you're right. Kentucky Voices For Health and Thrive has done an excellent job. And maybe we can, you know, get them to help us organize this and get the word out because they do such a great job on the town hall meetings. Maybe it could even be something done in conjunction with those already existing things.

CHAIR SCHUSTER: Yeah.

MS. GUNNING: So that was --

MS. MUDD: I mean, in Lexington, you know, we're not going to have a town hall meeting until what? What is it? November, I'm thinking.

MS. GUNNING: October or November.

I can't remember but --

CHAIR SCHUSTER: Yeah. It's late in Lexington.

MS. MUDD: I think it's November. I mean, that's a long time, you know. And it's made -- I mean, the connector at PS has made a huge difference.

MS. GUNNING: Huge difference. And it is weekly. And, Steve, like you said, even if there could just be -- even if it was once a month, you know, or weekly would be great. But once or twice a month, if we could organize that. That was a -- that was kind of an idea that -- came up with as a result of our expungement fair successes.

CHAIR SCHUSTER: Yeah.

MS. GUNNING: But it took -- it took cooperation and partnership with other community agencies.

CHAIR SCHUSTER: Yeah. I've got a meeting coming up after this one with the Thrive Kentucky and KVH folks, and I'll run that by them. They have a lot of connectors in that group.

MS. GUNNING: I know.

CHAIR SCHUSTER: And the connectors are anxious to get out there and connect people. So great idea, Kelly. Thank you.

Taylor Tolle has their name -- their hand up.

MS. TOLLE: Hey, yes. I have a question for DMS. So we are, you know, having issues with the whole eligibility piece as well, mainly around incarceration suspensions and the length of time that it's taking to get those overturned once we submit the paperwork to them.

But we are getting feedback from some MCOs when we go to get the prior authorization for residential treatment that we only have 24 hours once the eligibility is backdated to get that new retro auth, and that is something new that we've never seen before. Typically, we always have 30 days from the date that the eligibility is backdated to request for that retro authorization.

So I didn't know if this was a new policy that had just rolled out and I missed it or kind of what the circumstances were

behind that.

MS. HOLLEN: Angela Sparrow, are you on here?

CHAIR SCHUSTER: I think she's on because I think she put something in the chat earlier.

MS. HOLLEN: Have you heard of any of this from any other provider?

MS. SPARROW: I haven't. Taylor, again, we can, I think, connect. There, again, is policy around the expectation that the authorizations be completed within 24 hours, and that has to -- I think, again, ties back to the -- the law around expedited and emergency prior authorization requests. But, again, I think we can -- if you can --

MS. HOLLEN: Email. I was going to say --

MS. SPARROW: Yeah. If you can email me kind of some language --

MS. TOLLE: Absolutely.

MS. SPARROW: -- regarding the retroactive, and we'll take a look at it.

MS. TOLLE: Okay. Perfect. I can do that. Thank you.

MR. SHANNON: Angela, this is Steve Shannon. I've been told at the Reentry TAC, Persons Returning to Society From Incarceration TAC, that it's two to four days when people have their Medicaid out of suspension mode upon release from the facility. Is that still the case?

MS. SPARROW: I'm sorry, Steve. Are you saying two to four days that their coverage is reinstated?

MR. SHANNON: Yes.

MS. HOLLEN: After leaving -- after being paroled or leaving --

MR. SHANNON: Yeah.

MS. HOLLEN: Yeah. I don't -- I haven't heard that, but I don't think -- is that what you're referring to, Taylor, is taking someone that's being released or just --

MS. SPARROW: But then, Taylor, are you saying once the benefits are reinstated, there is 24 hours?

MS. TOLLE: It's kind of two different issues. So for the incarceration suspensions, typically, they used to be we

would call as soon as we submitted the request, and they could get it flipped within a couple of hours or maybe the next day. But now we're seeing that it's taken over two weeks for some of these incarceration suspensions to be lifted.

And then once they are lifted, whether it was because they were incarcerated or just because we sign them up to Medicaid and it's -- you know, Medicaid is backlogged and trying to get those updated, we have gotten communication from I know WellCare specifically that said that we only had 24 hours to request for that retro from the day that the eligibility became active; where, in the past, we've had 30 days from the day that it became eligible for us to request those.

And that's always been the window that I was aware of. So I just wanted to make sure something hadn't changed.

MS. SPARROW: Okay.

(Brief audio interruption.)

MS. SPARROW: I'm not aware -- again, I don't think we're aware of any changes to the policy. But if you have, you

know, exact language, that's always more helpful for us to look at.

MR. OWEN: This is Stuart --

MS. TOLLE: Absolutely. I can email that over to you shortly.

MS. HOLLEN: Hi there, Stuart.

MR. OWEN: Sorry. This is Stuart Owen with WellCare. I'll put my email in the chat. If you could email me an example, that would be great.

And back to the community events -- and I think all the MCOs are doing this. I mean, we -- year-round, we've got community engagement teams that works with a lot of community partners. And everywhere and everywhere, they are talking about eligibility redeterminations and -- I mean, like nonstop. We're doing that heavy, big time with community -- all kinds of -- whole range of community events. I know we are, and I'm sure all the MCOs are.

CHAIR SCHUSTER: I guess the question would be, Stuart, if a CMHC or -- CMHC plus NAMI group or some form of Thrive Kentucky or KVH wanted to do one in an area,

does it make sense for them to reach out to all of the MCOs and include you all in it or invite you all to be a part of it?

MR. OWEN: Yeah. Dr. Schuster, I think that would be great.

CHAIR SCHUSTER: Okay. Because I think the more the merrier at these things. I think the more the word gets out, I think that would be the way to go.

MR. OWEN: Yeah. I completely agree. You know, just make sure that we know -- you know, get the -- that we're made aware.

CHAIR SCHUSTER: Right. Right. Because you do have lots of people in the community engagement space.

MR. OWEN: Right.

CHAIR SCHUSTER: Angela, let me ask you this since this question has come up from Taylor. If there's some resolution, even if the policy has not changed, could you send me a follow-up email on what that policy is so that I can circulate it to folks so that everybody is on the same page?

MS. HOLLEN: And just to be clear,

this is about getting their Medicaid eligibility reinstated; correct?

CHAIR SCHUSTER: Well, I think it's two parts. It's the Medicaid eligibility --

MR. SHANNON: It's that and the prior auth.

CHAIR SCHUSTER: -- and the prior auth.

MS. HOLLEN: And that they're getting a prior auth, but you're being told that you have 24 hours to get that back -- turned back on; right?

MS. TOLLE: Yes, ma'am. They're saying that they won't process the retro auth if it's outside of that 24 hours. So, typically, like I said, we have had 30 days in the past to get that retro requested for us to -- once we became notified of the eligibility. But that was just verbally communicated when we submitted one recently.

MS. PARKER: This is Angie with Medicaid -- Parker. Is this all MCOs, or is it fee for service? Or is it just one particular MCO?

MS. HOLLEN: She named one.

MR. SHANNON: She said WellCare.

MS. HOLLEN: Uh-huh. That's who she named.

MS. WESSLING: I believe one of them is WellCare.

MS. TOLLE: Yes. I'm sorry.

MS. HOLLEN: But you're -- and you're having it from multiple people, multiple MCOs?

MS. TOLLE: I believe -- and I apologize. My auth manager wasn't able to join us today. But from my understanding, it was just WellCare that's given that verbal information, so I just wanted to confirm because they are one of our biggest MCOs.

MS. HOLLEN: Okay.

MS. PARKER: Yes. Retroactive -- I believe, if it's prior auth, 24 hours makes sense. But retroactive eligibility within 24 hours? So I definitely need to look into that.

MS. SPARROW: Right. Again, I will drop in the -- you know, an email contact but a specific example or any, again, notification, it will definitely be helpful

to look at.

CHAIR SCHUSTER: Okay. Does that help, Taylor?

MS. TOLLE: Yes. That would be fine.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: And I just want to add this, Sheila, and I'm sure it's been said over and over again. But any provider at any time can email dms.issues@ky.gov.

And the behavioral health team in Medicaid, we monitor that from 8:00 to 4:30 and then we have someone that monitors it the next morning for overnight with these particular issues related to behavioral health services and treatment. So please do not hesitate to email us. As I said, we triage that email all day, five days a week.

CHAIR SCHUSTER: Yeah. That's a good reminder, Ann. I had forgotten that. We ought to make sure that people know that.

I will say, because I had added -- part of that agenda item was any changes on telehealth. And we did have a question from a BHSO who wanted to be sure that BHSOs could

still do telehealth and bill for it and that all of their staff including staff working under supervision could continue to provide telehealth services and to bill for it as they had before. And the answer to that is yes.

And I appreciate Ann and Leslie Hoffman, who couldn't be here today, to -- for clarifying that. So in case there's been any question about how telehealth is working, it's the same --

MS. HOLLEN: The same --

CHAIR SCHUSTER: -- as it has been. It's absolutely the same so --

MS. HOLLEN: The same as it was during the PHE. The only things that will change it is if something -- guidance comes down from CMS that changes how we can conduct services but -- you know, or a criteria that we utilize changes the way services are done.

CHAIR SCHUSTER: Yeah. All right. Great.

MS. PARKER: It's only about -- you can't use FaceTime, those types of -- anymore.

MS. SMITH: The platform. It has to be HIPAA compliant. It transitioned to a HIPAA-compliant platform, is the --

MS. HOLLEN: Right. Thank you, ladies.

MS. PARKER: Thank you, Pam. That was --

MS. SPARROW: And I'm going to drop in another link. Sorry. But, again, this is -- there's so much information on the unwinding website, which is great. But, again, sometimes maybe it can be hard to navigate where the information is.

So I'm going to drop in a link that does have some information. And at the bottom, it's specific to behavioral health services, Sheila. And, again, about the transition from the PHE to, again, the implementation of the telehealth regulation which, you know, incorporates the flexibilities under the Public Health.

So I'll drop that in. I just want to mention that. But you can -- everybody can take a look at that as well.

CHAIR SCHUSTER: Great. That's

very helpful. Thank you very much, Angela.

The next is more input on the targeted case management policy clarification. And is Tracie Horton from Adanta on or somebody from Adanta CMHC?

MS. SHEETS: I don't believe so.

MS. HOLLEN: Well, Dr. Schuster, you can tell them to reach out directly; okay?

CHAIR SCHUSTER: Okay. Yeah. I think that she had some follow-up conversation with Aetna, and Aetna was the one that had, you know, initially done some recoupments or some denials and went back after the fact, and we got that clarification. And I think I sent it out to everybody who's on the BH TAC and everybody who attends.

That provider letter was May 26th. We had made a recommendation actually to the MAC and, almost at the same time, you all had worked on -- and I think DMS worked on it with the folks from DBHDID as well. So if there's any further question --

But she did have a question. She was

concerned about a follow-up, I think, email or a spoken conversation with Aetna and had some questions, so I'll tell her to reach out directly, Ann. That would be great.

MS. HOLLEN: Tell her just to reach out to me directly.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: Please. Thank you.

CHAIR SCHUSTER: I will do that. Is Dr. Ali on or somebody from formulary, Medicaid formulary?

MS. SHEETS: No. I'm sorry. I don't believe so.

CHAIR SCHUSTER: Okay. I will email her separately. We've got a couple of issues. I had emailed her -- you may remember at the last BH TAC meeting, she was not on, or nobody was on from Medicaid formulary.

And we have a number of pharmacies in western Kentucky that just up and decided that they weren't going to fill prescriptions for psychostimulant medications, and it was about eight pharmacies out there.

And they had sent letters to both the

SUD treatment outfit and also just a general therapy group out there. And I was really concerned about it.

So I don't know -- she asked -- I sent her the information. She asked one follow-up question, but I had not heard from her.

The other thing, I've heard from several consumers that when Medicaid decided not to reimburse for name brands, for instance, for Effexor or Wellbutrin, that some people are not getting the desired help with the generic.

And I -- I don't remember the policy. I guess I'll have to ask her about it. If people are not doing well on the generic, is it ever possible that Medicaid will pay for the name brand? Do you know, Ann?

MS. SHEETS: Dr. Schuster, you can shoot her an email and ask her those two questions and ask her to follow up with you.

CHAIR SCHUSTER: Okay. That would be great because I've heard that. And, Val, you may have heard that from some consumers over the years, you know, when they no longer do the brand name but they insist on the

generic. And even though they're supposed to be identical formulations chemically, I think there are some times where people don't get the same therapeutic effect from the generic.

So moving right along -- and I guess this is you again, Ann. We always have a whole bunch of things on the different waivers so...

MS. HOLLEN: It's okay. Angela Sparrow is going to speak to --

CHAIR SCHUSTER: Oh, Angela is doing to do this. All right. Great.

MS. HOLLEN: Yeah. I don't know -- she -- we recently -- she has now been promoted as to a behavioral health supervisor, and she now oversees our 1115 initiatives so...

CHAIR SCHUSTER: Yeah. Okay. Good to know that. Congratulations, Angela. We look forward to working with you in that space because we seem to be having lots of questions about 1115s and 1915(i)s and things like that. So we just wanted a status update on the -- actually on both of the SMI waivers, the 1115 and the 1915(i) and --

MS. HOLLEN: Pam, did you want to speak to the (i), Pam? I didn't know if you --

MS. SMITH: I can real quick. So we are -- we are working on finalizing service -- kind of the service definitions. And about 30 days from today -- so we hope -- it probably will be the start of next week. We're going to announce the -- to give about a 30-day notice on the town halls.

So we're going to go out and present -- I think we're doing five locations spread out across -- spread out across Kentucky. We tried to get to -- to get to where we would be within a decent driving distance from everybody within the state if they wanted to come to an in-person session as well as holding two of those doing virtual at the same time that we're doing actually the live town hall.

So still within target to have -- to be out soon for public comments after those -- after those town halls. So we are moving right on track. I'm very excited with how it's starting to come together and what it's

starting to look like now. I'm really excited for people to hear about it.

CHAIR SCHUSTER: Okay. So you're looking -- Pam, let me be sure I understand this. Sometime after next week, you would be looking at sending out notices about, what did you say? Five town --

MS. SMITH: The location of the town halls.

CHAIR SCHUSTER: The locations and times? Okay.

MS. SMITH: Yeah, the locations and times for the town halls. We're finalizing right now the -- where those are going -- the venues where they're going to be. And then we will have virtual -- so we're going to have -- I think we've decided two of them that we're going to do a -- try to do a virtual option at the same time that we're doing the town hall so that we can kind of cover every option.

If someone is not able to come in person, that they'll be able to attend virtually. And then -- so after those are complete, we will be sending out the

actual -- posting the waiver for public comment soon after that.

So we're on target with our timeline, and it's really -- I'm excited for you all to see kind of how it's come together. I think it's going to be of really good benefit, I believe, to a lot of people.

CHAIR SCHUSTER: That's exciting progress. I always say Steve and I have been asking about the -- let's see. Kathy Dobbins says: Could you also send the information about the town halls -- yes -- to the BH TAC list serve? I will do that.

So, Pam, when you set those dates and times and so forth, be sure I get that, and I'll be sure to send it.

MS. SMITH: I will. I'll make sure Kelli -- yeah. I'll make a note to make sure Kelli sends that -- sends that to you so that you can give --

CHAIR SCHUSTER: Yeah. Because I have -- I have quite an extensive list now for the BH TAC. And then we'll also send it to the Mental Health Coalition, and the CMHCs, of course, will have it.

MS. SMITH: Okay.

CHAIR SCHUSTER: Any questions about the 1915(i)? That's exciting. We've been waiting for that for a long time.

(No response.)

CHAIR SCHUSTER: Is there any update on the 1115 SMI waiver? I think it went to CMS. We had the public comment, and you all sent that in. And I suspect it still is at CMS, but is there anything going on with that?

MS. SPARROW: That's correct. Again, we have not had any questions from CMS thus far. We did receive a notification of completeness for our application. That was sent to the state last month on June 13th, which means, again, the application is now in the federal comment period. And so that goes through Friday or tomorrow, July 14th.

So, again, no questions at this time from them. We'll continue to have our monthly 1115 calls with CMS. But, again, I think that they're just in the initial reviewing phase.

CHAIR SCHUSTER: Okay. And just so

people are -- may be confused. The 1115 SMI waiver has two components. One is an extension of what they call the IMD exclusion or workaround to get more days in the hospital for people, up to 30 days, I think it is, Angela. And before, there was a lower limit than that.

And then it also has a medical respite part for services after somebody is discharged from the hospital, and that can be for physical care or for behavioral health care. I mean, those are basically the two pieces of it, I think.

MS. SPARROW: That's correct, Sheila.

CHAIR SCHUSTER: Okay. Thank you.

MS. SPARROW: So that SMI waiver falls underneath the overall arching Kentucky's 1115 demonstration. So, again, last year around this time, we submitted to CMS an extension request to extend that demonstration, our overall state's authority for another five years. So our current waiver goes through September 30th of this year. So the five-year extension would start

October 1st of this year.

So, again, we've continued to communicate with them throughout this year. Right now, they, again, have no additional questions for the State. Initially, there were some questions around our request for the non-emergency medical transportation waive for methadone treatment. Again, they've kind of relayed that it's essentially in the CMS leadership's hands under review. So we are hoping, again, to have a response and direction soon, knowing that that's quickly approaching.

The State did notify CMS in the last few weeks that we are no longer -- Kentucky will no longer request the waive of non-emergency medical transportation to NTPs for methadone treatment. And that would be beginning in the -- the new extension period. So that would be effective October 1st of 2023 which means, again, those individuals that are receiving methadone treatment to NTPs could access non-emergency medical transportation for that service.

We are reaching out to DOT and our

partners and discussing next steps. And so, again, that hasn't been --

(Brief audio interruption.)

MS. SPARROW: It's not been, again, officially relayed to our providers or our beneficiaries. So that's part of the next steps, is to talk through those communications and determine that. So that will be forthcoming in the next few weeks and month or two. But, again, that would be a change under our current 1115.

CHAIR SCHUSTER: Okay. And then where are we with the SUD services to incarcerated persons?

MS. SPARROW: So I think we talked last time. Again, based on the guidance that was released in the state Medicaid director's letter that was released from CMS in April, our current pending amendment is not going to be approved as is. The State is going to need to make some changes. So we will need to amend the pending amendment and resubmit, again, something to CMS to ensure that we meet the guidance and requirements outlined in that letter.

So, again, we will be scheduling stakeholder and strategic design sessions meetings in the upcoming weeks. So, again, many folks may get some ask and will again start to discuss the changes that we will resubmit to CMS based on discussion with CMS in hopes for a more timely approval.

We, again, are considering proposing to include, you know, what is required of the State outlined in the letter and then, again, include our initial ask for the SUD services for our adult population and the required services outlined in that letter.

So, again, we would then phase in. The plan would be to phase in and add additional populations such as the juvenile population and other services, conditions, physical health, and services at a later time, phase that in over time.

CHAIR SCHUSTER: I had a question asked, Angela, and I don't remember the waiver well enough. The question was: Is there a provision in that SUD incarcerated persons waiver for identifying and treatment -- treating Hepatitis C?

MS. SPARROW: So that's not one of the required services. The required services is case management, which is substantial specific services that are outlined for case management. Again, medication is just a treatment which includes the counseling. So, again, that would have to be available for all recipients that would qualify for that service and then, again, a 30-day supply of all medications at the time that the individual is released at reentry.

And then, again, states can apply for additional services, and that's where we have to look at -- there's -- it's different and unique from other waiver opportunities where states are required to develop not only the budget neutrality factor but a reinvestment plan again, and so that's something that the State has to consider for additional services.

MS. HOLLEN: I just wanted to add to Bethany's comment.

MS. SPARROW: Oh, sorry.

MS. HOLLEN: I think we actually have a meeting set up with -- maybe you are

part of it. I know there are two individuals with the Department For Public Health to talk specifically about what your ask is.

CHAIR SCHUSTER: Yeah. She had asked to be part of this, and I've had this question from several people in DPH. So I just thought I'd ask it. And I guess if you all are going to be opening it up for more stakeholder input, I guess those questions -- since Hep C is so often correlated with SUD -- would seem to be reasonable.

I think there was also a question, and this gets in the weeds around Hep C. So I'm going to ask folks to reach out to you directly, Ann or Angela. There's some questions about Hep C and whether genome testing is required or had been required, and now it's not. But they're getting denials on Hep C treatment because the genome was not identified. Does that make any sense to you all?

MS. HOLLEN: Well, that -- you can send it to us, and we'll make sure to get it to the right group.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: Okay.

CHAIR SCHUSTER: Because this came from a DPH person as well. I'll send it, Angela, to you and Ann.

DR. THERIOT: Yeah. That doesn't sound right.

CHAIR SCHUSTER: Yeah. I think there was -- Judy Theriot is coming on to tell us --

MS. HOLLEN: Thank you, Dr. Theriot.

CHAIR SCHUSTER: Yeah.

MS. SPARROW: So we have to look at, again, what services are currently covered by DOC and, again, you know, what services DMS would request coverage for beyond that. And then that factors into the reinvestment plan that the State --

MS. HOLLEN: We can't supplant what's already being covered. So if it's covered for only a specific area, we might be able to cover it in more -- like, maybe it's only in one facility. We might be able to cover it in more, and that would be part of our reinvestment --

CHAIR SCHUSTER: Okay.

MS. HOLLEN: -- of the federal funds.

CHAIR SCHUSTER: Yeah.

MS. HOLLEN: I'm sorry, Angela. You may have been going there, and I just cut you off.

MS. SPARROW: No. That's -- again, it's really -- the reinvestment piece is certainly a new -- new requirement, a new ask under the 1115 in addition to the budget neutrality requirements. But, again, like Ann said, it's really -- the match funding that we -- the State would receive can't supplant any funds that are already -- that DOC is already receiving.

CHAIR SCHUSTER: Okay. Okay. And I see where Dr. Hodge has clarified that she will get back with you because that's who I had heard from, was Dia. And Hep C is out of my bailiwick in terms of what I know that you could put into the head of a pin. So I just want to be sure that it got out there because it made sense to me that, you know, when we're talking about the SUD population, that

we're talking also about that part of it.

Have we covered everything that was in the chat about the waivers? It's hard for me to monitor the chat while I'm following -- doing this as well. Anybody else have any other questions or comments about --

MS. SPARROW: I think Bethany -- hang on. There's a -- is the 1115 waiver also a mechanism for getting Medicaid approved for individuals with SUD who are finishing a period of incarceration?

CHAIR SCHUSTER: That's the whole purpose of it; right?

MS. SPARROW: It would be, yes. And so, again, it was very clear in the CMS guidance that states can, with approval, reimburse for the covered services that is approved under their waiver for 30 days. There is a potential to request up to 90 days of coverage. But, again, they were very firm that beyond 90 days would not be approved.

And then to go up to 90 days, really, the states have to kind of justify the coordination of services and the need. And so there's -- it really -- again, the case

management piece goes beyond, you know, our current target case management requirements and so forth so...

MR. SHANNON: Angela, just to help me understand the dates, the September -- or the October 1 1115 renewal has no impact on the SUD piece; correct? I mean, it won't be available September 1. I mean, it will be under that umbrella, but that is not going to happen October 1?

MS. SPARROW: That's --

MS. HOLLEN: Incarceration? Are you talking about an incarceration amendment?

MR. SHANNON: Yes.

MS. HOLLEN: No. We don't have approval for that amendment.

MR. SHANNON: Right. Yeah. I just wanted to make sure the 1115 --

MS. HOLLEN: It will not start 10/1, no.

MR. SHANNON: Right.

MS. SPARROW: That's correct.

MR. SHANNON: The one that was submitted, actually, you're going to amend that existing. And whenever that happens is

when it happens, but it's not imminent; right?

MS. SPARROW: Correct.

MS. HOLLEN: We're trying to -- we're trying to work on it as --

MR. SHANNON: Yeah. I understand.

MS. HOLLEN: -- fast as we can.

MR. SHANNON: Yeah. We just don't want people to think it's going to happen October 1.

MS. HOLLEN: No. It's -- so overarching 1115, five years is up September 30th. The overarching authority will -- hopefully will get approved to start 10/1. That keeps the SUD 1115 going. We still have pending the incarceration that we're changing and the pending SMI.

So is that all the ones we have under there, Angela, just so I -- that's the only way I can remember it, is you have to build a house and put the pillars underneath.

MS. SPARROW: Yes. We have our former foster care youth that is out of state, which is, again, under the overarching 1115. So there are other components. And,

again, you know, Sheila, you had mentioned -- and not to derail us too much -- the recuperative care piece, it won't technically fall under the SMI because it's more than SMI. It was just submitted at the same time. So there's -- you have these different components under the 1115.

But, again, like Ann said, that overarching authority, again, if hopefully renewed and extended, allows us to keep amending and adding and changing moving forward.

CHAIR SCHUSTER: Okay. I think we've got it.

MS. SPARROW: So there's lots of little arms kind of out of the 1115.

MS. HOLLEN: It is hard to keep track of. Trust me. And we deal with it every day.

CHAIR SCHUSTER: You all must have an interesting calendar that keeps all of this color-coded or whatever because you've got all these different pieces. But, you know, for those of us who have been wanting all of this to happen, and it feels like the

incarceration, you know, that's three years, I guess, has been kind of -- yeah.

Dr. Theriot says we need a 1115 infographic with the roof of the house and the pillars. That's about right.

MS. HOLLEN: I have a -- I drew one myself on a piece of paper for my own knowledge.

CHAIR SCHUSTER: There you go. There you go. All right. Thank you all so much. And glad to know, Angela, that we can get back to you as well on this.

So, Mary, I put your issue back on again, the update on ABI waiver access to therapy services. I don't know where we are, and I guess that's a Pam Smith question.

MS. HASS: I think that's a Pam Smith question.

MS. SMITH: So nothing has changed right now. We still do not have approval. Actually, one of the waivers, we got some -- the long-term care, we got questions back from CMS. I actually have a meeting with them on Tuesday. But we do not have approval back on the waiver, so nothing has changed as

far as therapies.

And there still will be -- even when we do receive official approval from CMS, there will be a 90-day transition period where we do training, meet with providers, answer any questions.

I looked at utilization of the therapies. We haven't seen any change as far as the number of requests and the utilization in therapies and the waivers than from what we had been -- from what we had been receiving. So it all is really kind of status quo right now with pending approvals or additional questions from CMS.

MS. HASS: I think that's -- we're just in limbo. I think, you know, the therapists who dropped off, I think it has kind of leveled out. So, you know, the ones that are doing it are just staying there, and they're just, like, waiting for the shoe to fall.

But I have not seen any -- we lost some initially so -- what I felt were some good therapists. But right now, I say, you know, Pam, your word "status quo" is probably at my

word's "limbo."

And, you know, we have a lot of -- July is always a busy month for brain injury. I don't know why it is but -- just with newly-injured people and a lot of other issues with the waiver.

And a lot of it -- since we're talking about behavioral health, we really need some type of crisis stabilization, somewhere that we can help providers when they get someone who is acting out or whatever because some of them are folks that are being discharged from the waiver.

One particular person had been in the waiver for a very long time. And all of a sudden, it's being said that his behaviors have intensified. Again, I don't know. He's been in there -- I don't think -- you know, usually, we see some mellowing when people start aging, so I don't know.

There's just a lot of issues, mostly around not having the crisis stabilization and not having a neurobehavioral unit that we can really treat people more appropriately.

CHAIR SCHUSTER: Yeah. And that's

been an ongoing, I think, request, concern from you --

MS. HASS: Since 2003.

CHAIR SCHUSTER: Wow. Okay. I was going to say about 20 years. That would be about right.

MS. HASS: Yeah. That's -- you're right on.

CHAIR SCHUSTER: So I'm concerned about people that have been on the waiver for 15, 20 years getting a letter from DMS saying you no longer qualify.

MS. HASS: Yeah. That they don't meet -- they're not meeting -- due to the intensity, they're -- they quoted one particular reg stating that they were a danger to be in the community. I can't quote exactly what it was. We're getting that and then, you know, we have other ones who are acting out and then actually hurting other people in the waiver. So there's been a lot of issues around that.

And then I have another, really, case that I've been working on, someone who's PDS'ing, or person-directed services, and

having problems up in northern Kentucky. Is NorthKey the only provider that can do support, brokerage or support -- being the support broker for someone doing PDS?

MS. SMITH: So, Mary, for SCL, which is that case, there is not -- they do the financial management, but there is not a -- it is traditional case management. It is not a support broker.

And I know that case, and I'm specifically -- have been working on it. Karen has been working on it. Staff from BHDID have been reaching out to that individual and working on it, so I don't want to talk about specific -- specific cases.

But I will say, just to address the brain injury piece, that yes, there has been a couple very almost scary situations lately where an individual -- the other individuals in the home are even afraid to be there because of the individual. So it's a -- it's a difficult situation; right?

And I don't know that we have what the right solution is right now other than we know there needs to be some modifications to

that waiver. And I think that's what we need to, you know, focus on and to really -- to think about.

But if there are specific examples, Mary, other than the two that I know about, which I believe the one is with a Caring Moore Homes. And the other one, I know in northern Kentucky. I'm aware of that one. If you want to send those to me, and I will address those.

But there are many people that have been working on that case in northern Kentucky, and I had asked for someone to reach out to --

MS. HASS: Anything you could do, anything you can do. Because in both of these instances you're talking about, we're looking at loss of caregiver, and I don't say that lightly. But in both cases that you're speaking of, it could be a lost caregiver.

But on a general thing -- and you alluded to it. We have folks who are in these residential homes who are scared of the folks and then we have the providers also, you know, not being able, I think, to serve

because they don't have a place.

A lot of times, it's just getting these people readjusted on their meds. You know, they -- you know, it could be a lot of different things. Now, I'll just use, you know, my own case with my brother. He became toxic on behavioral medication he was using. So a lot of times, it's very involved, and the fact that we don't have neurobehavioral care that can really look at these.

At one time, we had a place at Eastern State and then it didn't get properly funded. So really, you know, if you want to talk about this, this is probably -- 90 percent of the calls that I'm getting right now are around these behavioral health issues. And I'm not talking about the two that you just mentioned.

But, you know, I'm getting a lot of calls from providers and also from family members who are concerned about, you know, someone who is acting out in the home. And, like I said, a lot of times, I think it could be adjusted, then, instead of just kicking them out of the waiver and saying they can't

be served.

So anything you want to do with me to help me on that, that would be much appreciated.

MS. SMITH: If you will just, you know, call Karen or email me that information as soon as you hear from those families so that we can -- we can work with the providers and find out what is -- what is going on.

CHAIR SCHUSTER: Yeah. It is a shame that that unit that was supposed to open at Eastern State Hospital that Jimmie Lee really pushed for as a result of the input from Mary and other advocates and family members, that we really never got that neurobehavioral health facility.

MS. HASS: We actually had a whole floor, and it was -- you were right, Sheila. Jimmie Lee did this, and not just for that, but he had a very dear friend --

CHAIR SCHUSTER: Right.

MS. HASS: -- that suffered a severe brain injury on a motorcycle accident. And we had the neuropsychologist. We had all the ones in place and then, for some reason,

it came back up. I remember getting the letter saying that it was not properly funded, so it wasn't going to open.

But, honestly, that could answer a lot of the issues that we're having instead of just putting -- you know, I hear you, Pam. But we're just putting band-aids on a lot of things. This could really help in the continuum, in the service delivery, and that's what I'm looking at. I'm looking more at the true service delivery and not just putting band-aids on problems and, you know, whatever. We really do not have the full continuum of care.

I know there was talk at one time of one of the providers doing some neurobehavioral. But it's going to take a skilled person, and it takes an entity like at Eastern State where you can take them. You can strip them down of their medications. And it's very, very complex, especially if you have somebody that maybe has other underlying issues.

And I'll use my brother as a case. God love him. He's -- you know, he's not here anymore. But he was schizophrenic and then

you layer the brain injury on top of it. So what do you treat first? The schizophrenia or you do the -- I mean, or do the brain injury. So it really takes a skilled clinician and a team to really work on those kind of issues.

And that's what we have in the waiver. We have a lot of those folks who don't just come by way of the brain injury. They come by way of other things that happened before the brain injury and then you layer it on top of that and then you get some serious issues.

So I think, you know, we really need to look at the service delivery and how we're going to better serve those folks. So -- and then I'll mute myself after that.

MS. SMITH: One other thing. I just -- the one thing that I want to just add to that that I think we all can encourage individuals to do is to -- and I am not denying that there are gaps in the services and that there are things that, you know, we -- I wish we could do better or that we need, you know, the funding. And there's ways that we could change it.

But there's also ways that we could make services be more person-centered and get providers to focus on truly person-centered treatment and making sure that the individual is getting the services they need, even if they're not going to be the one providing it.

A lot of times, what we're hearing -- and this just isn't in ABI, but we'll hear from the case manager, well, the provider won't take them unless they can provide this many hours of these services, and they're going to be the only service provider. Well, that may not be what's best for that person.

So, you know, we really need to continue to focus on what's going to be -- we need to focus on what is going to serve that individual and do best for that individual.

And what does that individual want? You know, they may not want to go sit in six or eight hours of therapy a day or go to an ADT for eight hours a day, but the residential provider doesn't want them in the house.

So, I mean, there's a lot of things that -- I think it's a complex problem. It's going to take a complex solution. But I

think continuing to prompt, continuing to remind people that this is person-centered, and there should be input from the person.

Because I can tell you -- I mean, and I don't have a brain injury. If you go -- if you tell me I'm going to have to go sit in something for eight hours a day, I'm going to have behavioral problems, too, because I don't want to do that so...

MS. HASS: You're talking about my sister right now, so anyway.

MS. SMITH: I think if we all just -- and I think that's for any type of service that we provide for a Medicaid individual or any individual, for that part.

CHAIR SCHUSTER: Yeah.

MS. HASS: If you can do -- and I think you're right. That's something you've heard me advocate for years, if it's really person-centered and not so much provider-driven.

That's kind of why we're in some of these problems right now that you're dealing with, is that, you know, we have had -- you know, I'm not going to take Betty because

Betty won't go to ADT. You're exactly right, you know. You're not going to hear me say anything otherwise, you know.

If we -- and all along down -- that I want self-determination, person-centered. You know, I've been saying that for how many years, Sheila? For --

CHAIR SCHUSTER: A lot of years.

MS. HASS: Since 1991.

CHAIR SCHUSTER: Yeah.

MS. HASS: 1991. Since 1991 when I started doing this. So amen, Pam. If we could get that done, I'll echo it through the hills.

MR. SHANNON: That's a great message. I'd love to see it leak back to the funding mechanism as well, Pam, to really have a person-centered driven plan because then people can feel confidence if they can provide those services.

CHAIR SCHUSTER: Yeah. Kelly, you've had your hand up very patiently.

MS. GUNNING: I just wanted to weigh in in Mary's behalf and my behalf as well. We've been fighting this kind of

together for a long time because the system is diagnostically driven, not person-centered driven. And we get into this war of the diagnoses as we're trying to serve these individuals who have co-occurring. They have SMI, and they have TBI. And many times, our people with SMI, the SMI causes them to be in situations where they get brain injuries, you know.

So the thing is we can't continue this war of the diagnoses. We have to move the system. And, Pam and Mary, what you said is so spot on and, Steve, you as well. So I just want to say we need to get together and, you know, re-author something to present possibly to the legislature and to the entities that be about -- this is not about diagnoses because they have both.

CHAIR SCHUSTER: Yeah. And we know that there are co-occurring folks like IDD and SMI that are not -- because they don't -- they're really the square peg that doesn't fit in the round hole.

MS. GUNNING: And, also, they can be co-occurring with substance use disorders,

you know, so -- and Mary is absolutely right, you know. To put these people and say you have to go to TRP or you've got to do this or you've got to do that, forget about it. Forget about it. It's not going to happen.

CHAIR SCHUSTER: Yeah. Okay. Thank you all. Excellent discussion. And I think we're agreed that it should be a person-centered, person-driven system. Steve is right. How do we make that translate into the funding mechanism and the accountability mechanism on all parties?

MR. SHANNON: You got that right.

CHAIR SCHUSTER: That's what we have to work on.

Moving right along. I think Rosmond Dolen from KHA is on to give us an update on provider credentialing which we keep hoping is going to happen soon. Are you on, Rosmond?

MS. DOLEN: Yes. It's Rosmond. Thank you so much.

CHAIR SCHUSTER: Oh, Rosmond. I'm sorry. Yes.

MS. DOLEN: No. That's fine.

Thank you so much for having me. Again, it's Rosmond Dolen, and I am with the Kentucky Hospital Association.

For credentialing, we are still working diligently on this effort. I'm happy to report that some progress has been made to consolidate the process with the MCOs. Currently, we have WellCare, Passport Molina, and Aetna that are actively testing with us for a potential go live in August so just around the corner. So that's exciting news.

And then, of course, our goal with this program remains just to streamline the process for providers, lessen administrative burdens, and really just, you know, have one credentialing process instead of doing it multiple times over.

So we do have ongoing discussions with the other MCOs -- Humana, Anthem, and United -- about continued participation or beginning participation with the Kentucky Health Alliance. But, you know, we feel really good. You know, being in the testing phase right now, we are, you know, crossing our fingers and looking forward to a go live

in August as of right now.

CHAIR SCHUSTER: Well, that would be great. Then when we have our September BH TAC meeting, we can pop a bottle of champagne or something --

MS. DOLEN: Oh, my.

CHAIR SCHUSTER: -- and christen this.

MS. DOLEN: Well, that's -- it is our goal, so that's exactly what we're marching to, is August.

CHAIR SCHUSTER: Yeah. We'll meet the middle of September, September 14th. So maybe we'll have that good news.

Are there any questions of Rosmond?

(No response.)

CHAIR SCHUSTER: So, obviously, the providers in particular are awaiting this and will be really glad to hear that it's go live. Thank you very much.

MS. DOLEN: Sure. Thank you.

CHAIR SCHUSTER: Our next is changes in the delivery of mobile crisis services. I know Leslie is not on, and Ann had to leave.

Is there any report, any update?

MS. SPARROW: Sheila, again, it's my understanding that we're still in the request for proposal phase.

CHAIR SCHUSTER: Okay.

MS. SPARROW: And so, again, unfortunately, at this time, you know, can't speak to much other than what has been publicly posted or out there for view. So that's -- they're still in that process, working through that process, is what I've been told.

CHAIR SCHUSTER: Okay. We were hoping that maybe an award had been made, and we would be in that next phase so...

MS. SPARROW: I think they were, too, but it's in progress.

CHAIR SCHUSTER: We're hoping that, too, for sure, so maybe in September. Thank you very much, Angela.

MS. SHEETS: This is Kelli.

CHAIR SCHUSTER: Yeah.

MS. SHEETS: I just wanted to let you know that Tracie Horton is on now --

CHAIR SCHUSTER: Oh.

MS. SHEETS: -- as well as April Prather who is a member of DMS pharmacy team.

CHAIR SCHUSTER: Oh, okay. Well, let's go back. Tracie, we had you earlier on in the agenda, so I'm glad that you're on. You had some questions or concerns about the TCM policy. Do you want to share those with us, please?

MS. HORTON: Sure. I apologize. I was running late from another meeting. I just really -- as a follow-up to what we had discussed last time where we had an MCO that was pushing for a separate TCM care plan.

CHAIR SCHUSTER: Right.

MS. HORTON: And the State, you know, did provide some additional guidance on that. It, I think, came from Leslie Hoffmann on the May 26th.

CHAIR SCHUSTER: Right.

MS. HORTON: And in that additional guidance, it basically stated that all MCO behavioral health directors are in agreement that they interpret all DMS policy to reflect that a specific TCM plan of care is required. Providers may have an all-inclusive,

person-centered treatment plan, but it also must reflect specific goals and objectives related to targeted case management. It's also appropriate to have a separate, specific plan care as well.

So the Department did put out additional guidance on that. But I think, as an agency, we still have some concern about that because there was no grace period addressed with which to make any changes if we needed to.

And while, you know, our agency has an integrated care plan with tasks outlined for TCM, our concern is still that, you know, the MCOs still have the flexibility to determine that our format or our template within EHR is not specific enough or doesn't address their definition of a specific care plan.

So we have not received any additional feedback from the MCO that had initiated the audit with these specifications. So I know we had been told that they were going to go back and revisit our audit with this new guidance, and we have not had any additional communication from them at this point.

But the additional guidance helped, but

it still leaves a lot of uncertainty as to whether or not what you have in EHR system meets the specific MCO's definition of separate. And each MCO's definition can be different.

So that was -- that was our concern, is that, you know, we have -- we did receive the additional clarification, but it still left a lot of room for interpretation.

CHAIR SCHUSTER: Okay. And Leslie Hoffmann and Ann Hollen were not able to -- Ann couldn't stay on, and Leslie wasn't able to be here.

They had suggested, Tracie, that you email them directly, and we could supply their email addresses if you don't have it. I wonder if it makes sense, if the MCO in question said that they were going to get back to you after they looked at the guidance, to wait until you get some feedback from the MCO, I mean, as a next step.

MS. HORTON: I think so. And it was our understanding that, you know, that reach-out was going to occur pretty soon, that they were going to be reaching out for a

one-on-one call with us after this new guidance came out. And today -- and that was early June. And at this point, we've not heard any additional -- had any additional communication from the MCO about the issue.

CHAIR SCHUSTER: Okay. I would suggest -- and I think you had sent me an email that really, I think, very accurately describes your concerns. I would suggest you send that to Ann and Leslie and just put in there that, as of this date, you know, July 13th, you still have not heard anything back from the MCO in question and wonder if it would make sense to get that feedback and then get back with them. It does --

MS. HORTON: Okay.

CHAIR SCHUSTER: There is that openness to interpretation, and this is uncharted waters because we've never had that issue raised before now by an MCO. And the TCM and the care plans have been out there for a long time, and the reg has been in place for a long time. So I would suggest that.

I did -- I did ask, I think -- Steve, I

won't speak for you, but I don't know if you've heard that from your other CMHCs.

MR. SHANNON: We haven't heard specifically. We had some concerns, as Tracie reported. How will this be operationalized?

CHAIR SCHUSTER: Right.

MR. SHANNON: I'd like to keep it on the agenda. I think it's premature to make a recommendation to the MAC now pending additional information Adanta may receive. But, definitely, if there's not some sort of movement by September, I would like to raise it up to a recommendation to the MAC.

CHAIR SCHUSTER: Okay.

MR. SHANNON: That Medicaid clarifies this issue, and what does it really mean. And I think it's -- you know, it's always -- you know, people change. Someone else shows up at, you know, an MCO or even Medicaid a year from now and then targeted case management is no longer applicable, you know, the way the plans are written.

MS. HORTON: Right. And what I would say is, you know, we feel like that the

Department is still going to be evaluating us because we get scored on a rubric, and I'm sure all the other CMHCs do as well, that our care plans, you know, meet their definition of integrated. And, you know, we provide examples, and they review that. And I feel like that that's going to continue to occur.

But, then again, with the MCO's interpretation of separate TCM care plans, you know, we could have that, and we do have specific goals and objectives to TCM. But it still may not meet their justification of separate for their purposes.

MR. SHANNON: And, Tracie, that would be the Department of Behavioral Health; right, when you said the department?

MS. HORTON: Yes.

CHAIR SCHUSTER: Yeah. I did reach out to Kathy Adams about the Children's Alliance because that's the other large group that we hear from. And she had not heard anything, but my guess is, Tracie, that they're in the same kind of situation that you're in, where there's not been any further feedback from the MCO. So it's kind of a,

you know, waiting game.

But if you would follow up, and I can send you those email addresses with Ann and Leslie and just let them know that you haven't heard anything from --

MS. HORTON: Absolutely. I have their communication.

CHAIR SCHUSTER: Okay. I would just -- I would forward the email you sent me and just say you haven't heard anything, and you continue to be concerned about it.

MS. HORTON: Okay.

CHAIR SCHUSTER: And I think it's a good idea, Steve, that we'll keep this on the agenda as an operational item. Thank you for your input, Tracie, and for your initial bringing this forward.

MR. OWEN: Dr. Schuster?

CHAIR SCHUSTER: Yeah.

MR. OWEN: This is Stuart Owen with WellCare. And I don't have the memo in front of me, but I thought it said there does not have to be a separate plan of care, but the plan of care has to address targeted case management. I thought that's what it said.

MS. HORTON: It does.

MR. SHANNON: That's how it reads, Stuart. That's how it reads. That's how -- I had the same interpretation. It's just -- is it trust and verify, is where we're at right now, Tracie?

CHAIR SCHUSTER: Yeah. I think --

MS. HORTON: Go ahead.

CHAIR SCHUSTER: Your memory is correct, Stuart. I think the problem is that we thought the original reg was fairly clear, too. And then out of the blue comes a very different interpretation by an MCO that wanted to come back and recoup a lot of money for not having this plan. And this plan had been approved, as Tracie pointed out, by DBH, you know, who have the -- approve such plans as part of the CMHC functioning.

So that's what kind of threw things sideways, and we just are trying to, you know, make sure that everybody is on the same page here.

MR. OWEN: Okay.

CHAIR SCHUSTER: Yeah. Thank you.

MS. SPARROW: So, Tracie, may I

ask? Again, is the uncertainty -- are you saying that you're still unclear? I guess, let me backtrack. The guidance that was issued, do you feel that it's clear that there's an understanding that there should be separate goals for TCM? What's questionable is whether or not those goals be on a separate plan of care or whether or not those goals be within the overall plan of care. Is that --

MS. HORTON: Let me -- let me, I guess, give context on that. Adanta has an overall inclusive plan of care that has goals and objectives specific to TCM. There's -- you know, there's outlined, you know, what the goal is, who's responsible for it, timeline, you know, that kind of thing.

But in the audit results, we were cited and told that we were going to have, you know, a minimum 25,000-dollar payback because our all-inclusive plans of care with our specific TCM goals and objectives did not meet this particular MCO's definition of separate care plan.

So I think -- you know, I understand

what's in the guidance. But I think there's still room for interpretation from MCOs that what we have -- or the format that we have in which these things are outlined does not meet their definition or their version of separate.

MS. SPARROW: Okay.

MS. HORTON: Does that help?

MS. SPARROW: It does.

MS. HORTON: I mean, I think it's interpretation. Because we feel like that what we have meets -- you know, there are goals and objectives specific to targeted case management housed within this overall larger plan that includes med management or therapy or whatever.

There's specific TCM goals and objectives outlined in these plans, but yet the MCO still could determine that the format and how these goals and objectives and things that are lined out do not meet their version of --

CHAIR SCHUSTER: You pointed out, Tracie, that it's costly money-wise and time-wise to redo your EHR.

MS. HORTON: Yes.

CHAIR SCHUSTER: And you're reluctant to do that if it's going to be subject to interpretation that, you know, can't be pinned down. And is it really necessary? Because up to this point -- up to the point where the audit was done by that MCO and the recoupment letter came, you thought that your EHR and your integrated overall plan was meeting the requirements both of Medicaid and of DBH.

MS. HORTON: Correct. Correct. But yes, I mean, any -- any modification to a form or a template in an electronic health record, you know, requires rebuilding, rebuilding the forms, re-instancing data.

So it's not just as easy as going in and making a modification on a Word document and saying, you know, here it is. Use this template. It's a much more convoluted process.

And, again, you know, the guidance didn't reference that, you know, moving forward from, you know, July 1, this is the clarified expectation. It just said this

is -- you know, this is our interpretation.

So, you know, even if we needed to make additional changes, you know, it still left room for the MCO to come back and say, well, what you have still doesn't meet our definition, and we're going to recoup.

And the concern was that, you know, if you recoup on one specific period a year and it's a significant recoupment, then it just opens the door for further evaluation further back. And, I mean, we can't -- we can't fix a new interpretation of an old system.

CHAIR SCHUSTER: Right.

MS. HORTON: You know, we would have to have time to make changes and move forward.

CHAIR SCHUSTER: Yeah. All right. Thank you for the question, Angela. Thank you, Tracie, for your input.

MS. HORTON: Thank you.

CHAIR SCHUSTER: So we'll keep this on the agenda and move forward.

And, Kelli, you said that someone was on from Medicaid formulary? I missed the name. I'm sorry.

MS. SHEETS: Her name is April Prather.

CHAIR SCHUSTER: Oh. Okay. Great. So we were looking for an update. We -- I had sent Dr. Ali an email about, I think, seven or eight pharmacies in western Kentucky that had just up and decided not to fill prescriptions for psychostimulant medications. And I just wondered what the update -- if you had an update on that.

DR. PRATHER: Yes. We did take a look into that set of pharmacies, and they were mostly denying prescriptions from a particular provider's office. And when we contacted the pharmacies, they said that they now had the information that they needed from that provider's office to be able to continue to fill those prescriptions.

So they shouldn't be denying them any longer, and the issue should be resolved. But if you are still seeing that, definitely let us know.

CHAIR SCHUSTER: Okay. Well, I'll get back with my source there to find out. I guess I'm a little bit concerned -- a lot

concerned that if it was a matter of not getting the information that they needed from the providers, that was not what that letter said.

DR. PRATHER: Right.

CHAIR SCHUSTER: The letter was an absolute --

DR. PRATHER: So when we looked into it, they had some concerns with the types of prescriptions that were coming from the office and why they didn't have this or that. So they just chose as an entity not to accept prescriptions from that office. So it wasn't so much that the prescriptions were denying on Medicaid. They just decided that they didn't want to fill them.

So when we questioned them about that, they looked deeper and said that now they had the information that they needed and felt that the prescriptions were valid.

CHAIR SCHUSTER: Okay. I guess my point is that it seems like an intermediary or an intermediate communication could have been sent to the provider saying we see your prescriptions, and they continue to lack X,

Y, and Z. We need for you to change the way you're doing them or the way they're written or the way they're submitted or something. It seems fairly drastic to go to a "we're just not going to fill these anymore."

DR. PRATHER: Yes. And that's why we reached out to those pharmacies to see what was happening. Was there something that was prompting them to do that? And upon reaching out, they kind of dialed back on their stance, if you will, to not just fully no longer accept, just to do their due diligence if they did receive a prescription that they didn't feel was valid and taking the steps to, you know, address that prescription.

CHAIR SCHUSTER: Okay. And I will -- I will check back with my source because I have not heard from her. But I'll find out whether that -- the change is being seen --

DR. PRATHER: Absolutely. And let us know if it's not for sure.

CHAIR SCHUSTER: -- by the providers. Yes, I will, April. Thank you

very much.

Kelly, you had a question. You're muted.

MS. GUNNING: I just have a weigh-in, and that is when situations like that arise, it should not fall on the consumer, for the penalty to be paid by them not being able to get their medication. That is a glitch between the provider and DMS or whoever. That should not fall to the consumer.

And, you know, you don't know what the consequences to those individuals is going to be of not being able to get that medicine. I can tell you from personal experience the one time my son was turned away from medicine, from being able to refill his prescription one time, he never got it again in his life. He saw it as a sign from God to not take his medicine.

CHAIR SCHUSTER: Yeah.

MS. GUNNING: Please do not let these glitches between systems impact the end-lying user of the pharmacy. Please, please understand that people's lives are in

the balance.

CHAIR SCHUSTER: Yeah. I think -- I absolutely agree with you, Kelly, and I'm, I guess, disappointed that this happened to come from someone who used to work at one of those agencies and happened to see me at a Thrive Kentucky, you know, meeting and said, oh, I wonder if this is a problem. I mean, it was so roundabout that I even found out about it. And I was like, this is -- should not be happening.

So I don't know what the mechanism is. I mean, I appreciate very much, Ms. Prather, your reaching out on the part of Medicaid to the pharmacies. But I'm like, those consumers, those families, I mean, that had to be a lot of people that were supposed to get psychostimulant medications because it was eight pharmacies or so. And that's been going on for four months or so.

And I think Kelly is right. So do people just figure that that's the wrong prescription, and they're not going to take it anymore? I mean, obviously, on the psychiatric medications, it's even, you know,

potentially more deadly. But -- and it probably disrupted treatment for kids with ADHD and some other things.

So I'm not blasting Medicaid, but it seems like there's a problem in the system when the information about a problem like that takes so long to get out to people that can fix it. I guess that's the thing. So maybe a lesson learned.

And I think the BH TAC actually is -- has served a lot of -- I'm thinking probably about a lot of consumer situations that we've been able to intervene in even the kind of thing that Mary and Pam were discussing earlier. But there ought to be better ways of making sure that our Medicaid members are getting everything that they should be getting, that their providers are prescribing for them and so forth.

The other question that came up, Ms. Prather, who -- and I didn't have this on the agenda, so you may need to take this back. But I've heard recently from a couple of consumers who were taking Wellbutrin or Effexor, and those name brands are no longer

on the PDL. So they're supposed to be taking the generic. And they feel like -- and I don't know. I guess the prescribers feel like they're not getting the same therapeutic effect that the name brand was giving.

And I guess the question I have is: Is there a way around that in individual situations, particularly -- I guess it would have to come from the prescriber. But can the prescriber get approval to go back and get the name brand?

DR. PRATHER: Yes. So there is a brand medically necessary policy that they can do a PA for that says that they've tried the generic or different NDCs of the generic. So they've tried this manufacturer of generic, this manufacturer of generic. And they had some type of adverse event, or it doesn't give them the same effect. And if they submit a PA under that, they should be able to get approval for the brand name.

CHAIR SCHUSTER: Okay. I assumed that there was something. I was just not familiar with it. But the prescribers ought to know that that's -- that that's available;

right?

DR. PRATHER: They should. It's on the PA criteria document. There is a section in each, I guess -- like if you go to the behavioral health section, it'll have the details for that brand medically necessary category, like what you would need to meet that requirement on that document.

So if they were submitting their PA form or if they were talking to, say, Magellan or MedImpact and explaining that they needed the brand.

There's also a check box on the PA form itself that says brand medically necessary, yes or no. So that would lead them to those questions if they were doing it either electronically or on paper. Or if they were talking to someone mentioning that brand is medically necessary should get them to the right set of questions to answer to provide their reasons why they can't take a generic for whatever reason.

CHAIR SCHUSTER: Okay. Can someone send me that link or give me that link, so I can know where to find that or how to find

it?

DR. PRATHER: I might be able to drop it in the chat here.

CHAIR SCHUSTER: Thank you so much. That would be great.

DR. THERIOT: Dr. Schuster, I've done that with some of my patients with ADHD. And, you know, for some reason, they needed the name brand, and it was a very easy process.

CHAIR SCHUSTER: Okay. Great. Thank you so much Dr. Theriot. I appreciate that. I figured there had to be some way to do that or get -- work around it.

MS. SHEETS: I will be sending out a document with everything in the chat after the meeting so --

CHAIR SCHUSTER: Great.

MS. SHEETS: Just trying to make things easier on you guys.

CHAIR SCHUSTER: Yeah. That's great, Kelli, and then I will send that out to the -- everybody I've got on my list of people that are attending the meetings, too, which I will remind people.

If you are attending this meeting and you didn't hear from me directly with the agenda and the Zoom link, please put your email in the chat so that I can add you to my list. And then when I get the chat from Kelli, I can make sure -- I have a pretty long list at this point because we usually have, you know, 80 folks or so on these meetings.

Thank you so much, Ms. Prather -- Dr. Prather. I don't know who I'm talking to.

DR. PRATHER: It is doctor, but you're fine.

CHAIR SCHUSTER: Well, I'm sorry. I don't think we've met before, but thank you so much. I really appreciate that, and I will add you to my list of people over at the formulary. Because from time to time, we do have these questions.

You know, we always say that our folks getting the right medication at the right time is so, so critical. So we've appreciated the assistance that Dr. Ali and you all over in Medicaid formulary have given

us, so thank you. Thank you very much, Dr. Prather.

DR. PRATHER: You're very welcome.

CHAIR SCHUSTER: Our next is just that same question that we ask. Are we seeing any differences in the number of and the requirements for MCO audits? And, Steve, I guess I would ask you.

MR. SHANNON: I haven't heard anything from our members.

CHAIR SCHUSTER: Okay. And I think -- I don't think I remembered to ask Kathy Adams that, so I don't know. But we'll keep it on, and particularly since the audits are, I think, still being used so much because we don't have prior authorization in place.

MR. SHANNON: Right.

CHAIR SCHUSTER: Is Justin Dearinger on, by chance?

MR. DEARINGER: I am. Good afternoon, Ms. Schuster. How are you?

CHAIR SCHUSTER: I'm fine. How are you?

MR. DEARINGER: Wonderful. Well, I

have semi-good news. So I was able to see a -- kind of a mock demonstration of the demo for the dashboard, and it looked great. They have different layers and paper or writing that are going to continue to progress throughout the next couple of years. But the initial dashboard, I at least got to see what it looked like.

And so, again, I don't know -- I couldn't get an exact date, but I'm hoping sometime within --

CHAIR SCHUSTER: Whoops. You just went on mute, Justin.

MR. DEARINGER: Oh, I'm sorry about that. Hopefully sometime within the next couple of months, it'll be completed. It's at least to a stage where the demo is complete, and I've approved that. And so we should have that coming. There's definitely progress being made.

CHAIR SCHUSTER: Well, we love to hear that. We even would love it more if it was actually launched, so we'll --

MR. DEARINGER: I agree.

CHAIR SCHUSTER: We'll hold our

applause for that.

MR. DEARINGER: Sure. Sure. Thank you.

CHAIR SCHUSTER: Yeah. Thank you for being on, and we appreciate your bird-dogging that for us.

MR. DEARINGER: Absolutely.

CHAIR SCHUSTER: I -- the next item is the 2023 interim session. Just a reminder to everyone that there are lots of good discussions going on, and it is something that is well worth following. I will --

Steve, do you have the link to the interim calendar you could put in the chat?

MR. SHANNON: I could probably try to get it, I think. If not, I can send it to Kelli, and she can send it out.

CHAIR SCHUSTER: Yeah. It is really helpful to keep an eye on the interim. This is where the house and senate committees meet together, so if you have a health issue, you know, the health services from the house and the senate meet together. The two chairs take turns chairing the meeting and so forth.

I would also draw your attention to a

couple of task forces that have been appointed, and they have their own calendar. And I will send that out to you all because I made a list of --

One is a task force that's called school and campus security. But their goal is to look at mental health services in the schools. So those of you who are interested in child mental health or school service mental health, that's going to be the committee that's going to look at that. And their first meeting is July 18th, so next week.

We also -- thank you, Dr. Prather. There's the link for the PA -- for brand medically necessary.

There also is a task force on the Cabinet For Health and Family Services, their operations, their funding, their programs. And of course, it's broad-based. There's always somebody from the Cabinet. They've had the secretary there at the first meeting. They have -- Commissioner Lee from DMS is there or Deputy Commissioner Judy -- Veronica Judy-Cecil. Lots of information there, and I

think that one is worth monitoring as well.

The other things that I would suggest that you monitor is the budget review subcommittee on human resources. We call it the BR on the HR -- is meeting during the interim. They don't always meet during the interim, but they are meeting July 18th at 10:30. So that's next week. And their topic is the 1915C waivers. So I know that many of you are also waiver providers and may be interested in that. And we've talked a lot about the waivers, the various waivers today.

So all of those -- it's also a great time to set up meetings with legislators, your legislator, your house and senate member, because they're not as busy. And yet they're kind of thinking about things that they want to tackle going into the next session.

It's a great way -- if you can get on the agenda for one of the interim committee meetings because you get to present it to both the house and senate members of that committee at the same time. So I encourage you.

You can find all of that at www.legislature.ky.gov. And all of those special committees are listed -- well, task forces are listed under special committees. And you can get the calendar. The interim calendar is updated, I think, about every week or so but good to pay attention to that.

The next one is we got a response -- remember our recommendation made to the MAC was that they issue guidance around the TCM issue. And almost before the MAC finished meeting, they had issued that. So we did get immediate results from that.

Are there any recommended agenda items for the upcoming MAC meeting? I think, Steve, you mentioned that we might want to do one in another two months on the TCM guidance if --

MR. SHANNON: Right.

CHAIR SCHUSTER: -- we've haven't gotten some clarification. Anything else that comes to mind right off?

MR. SHANNON: I do not have any.

CHAIR SCHUSTER: Okay. Val or Mary, T.J.?

CHAIR SCHUSTER: I didn't have any either at this point.

MS. HASS: I don't have anything at this moment.

CHAIR SCHUSTER: Okay. Thank you.

MR. LITAFIK: Same.

CHAIR SCHUSTER: Yeah. T.J.?

MR. LITAFIK: Yes. No. I don't have any.

CHAIR SCHUSTER: Okay. All right. Thank you.

So we do have an update on the prior authorization guidance. It was issued on June 30th, and I will send it out to you. It requires now prior authorization for SUD residential and inpatient treatment services, and there's some detail given there.

But all other behavioral health and SUD services continue to be waived, which I think is always the word that we are looking for. There are some other things around medical services. So I will send that out to you. Are Tracie -- yeah. I'll send it out to you all. So that's the updated guidance.

We also had -- kind of under old

business, I got a nice email from Herb Ellis who's our champion along with Steve and the other -- and the MCO folks about the bypass list. And he says, "I wanted to let you know we continue to see positive results from the implemented commercial bypass process with zero issues noted since its implementation on May the 1st."

They're continuing to work with the department on cleaning up data on files across all the MCOs and want to continue to collaborate on reconciliation and other things. So we appreciate those efforts from Herb and from the other MCOs to work on that.

I did have one follow-up item, and I don't know -- I don't know, Angela or Angie, if you have an answer to this. You know, DMS made policy changes to allow for billing of extended services from January 1st until April 1st when that new code H0004 was implemented.

And the question was -- let me rephrase this. I think when they came up with a solution to the extended service code and said we could use that code, it was from

April 1st on. The question that Kathy Adams asked is: Is there any policy change to allow for billing that occurred between January 1st and April 1st?

MS. SPARROW: Hi, Sheila, this is Angela. Again, the effective date is April 1st. So, again, the -- those codes that were deleted -- the deleted prolonged codes, you know, that was effective. That went through the end of last year. So, again, we worked as quickly as possible to get the new code established. But, again, that will be the effective date moving forward, so it will not go back before that.

CHAIR SCHUSTER: Okay. So the answer to her question is -- she says, the last we heard about this -- this was just earlier this week -- was that it was being discussed or considered. So you're saying that a decision has been made that it's not going to be retroactive?

MS. SPARROW: I'll take it -- we can take it back to confirm. But as far as I know, again, it won't be backdated.

CHAIR SCHUSTER: Okay. All right.

If you might verify that, Angela, and somebody can send me an email or whatever. I can send you this little email from her if that's helpful.

MS. SPARROW: Yes. It's always -- that's always helpful, to have the exact question and language so...

CHAIR SCHUSTER: I will -- should I just send it to you or to you and Leslie and Ann or --

MS. SPARROW: If you want to "cc" all of us, include all of us, that would be great.

CHAIR SCHUSTER: All right. That's what I'll do.

MS. SPARROW: Thank you, Sheila.

CHAIR SCHUSTER: You all can respond to that. That would be good.

MS. SPARROW: Okay. Thank you.

CHAIR SCHUSTER: The other thing that is new -- and I don't know how many of you it affects. But I think it's something that we are very excited about, something that some of us have worked for a long time on, and that is folks known as community

health workers.

And this is something that Representative Moser worked on House Bill 525 in the 2022 session. And these are folks that work out in the community. They are members of the community. And they serve as connectors in some ways. They serve as sources of information to people in the community about a whole range of services. And they are now billable to Medicaid starting on July 1st.

So I will send that out to you because I think it was sent to the CMHCs and the BHSOs as well as to -- and to the CCBHCs. Hospitals use them. I think some of the MCOs actually have some community health workers as well. And, anyway, it was just good news to see that.

I don't think -- is there any other new business to be brought before the TAC?

MS. KOENIG: Sheila, this is Stephanie Koenig with UnitedHealthcare. I did put that in --

CHAIR SCHUSTER: Yes.

MS. KOENIG: There was new guidance

that was sent out earlier this week. I did just put that in the chat to Angela, and I know Ann had to drop. But we are looking for additional guidance what is to be effective September 1, just really trying to understand same-day billing services with same-day provider. So if they could provide additional guidance, that would be helpful.

MR. SHANNON: And, Stephanie, that's a CCBHC question; right?

MS. KOENIG: That's correct.

MR. SHANNON: Just to clarify. Before the demonstration, had some changes to the primary codes, primary care codes, so I think clarification would be helpful.

MS. KOENIG: Yes.

CHAIR SCHUSTER: Okay. And you put that in the chat, Stephanie?

MS. KOENIG: Yes. And I just copied the exact guidance that was sent out by DMS this week, so if they can just provide additional guidance. We're trying to identify: Is it a different facility with the same provider?

Because the State obviously identifies

provider types, and those are the two. So I'm trying to understand: Is this based on taxonomy? How are we supposed to identify --

MR. ELLIS: Hey, yeah. And this is Herb with Humana. We actually got an update today from -- I forgot the lady's name with the department who's over the CCBHC program. But yeah, she did identify that those primary care services would just fall outside of the CCBHC program starting 9/1. So CCBHC would no longer bill specific primary services starting 9/1, so it would be non-PT16.

She also said they're going to update the CCBHC document to show those codes are no longer under the CCBHC program starting 9/1.

MS. KOENIG: Thank you, Herb. Could you provide that to Greg or me? He was the one that really wanted me to bring this up on the TAC.

MR. ELLIS: Sure. Yeah.

MS. KOENIG: Thank you so much.

MR. ELLIS: In fact, if you want, I can forward it to the other MCOs, too, as part of -- you know, since I have their emails.

MS. KOENIG: That would probably be helpful. I'm sure we were all asking the same question. Thank you.

MS. MCFALL: Yeah.

MR. ELLIS: Sure.

MR. OWEN: Thank you, Herb.

MS. MCFALL: This is Paula with WellCare. Thank you.

MS. SPARROW: This is Angela at DMS. When you do that, if you don't mind to include Dana McKenna from the -- yeah, from DMS if she was the one that sent maybe -- she might have been the one that sent the original response, but if you'll just include her so she knows as well.

MR. ELLIS: Yep. I sure will. I think it was her, but yeah. Yeah, it was. It was Dana McKenna that sent that.

MS. SPARROW: Thank you.

MR. SHANNON: My understanding is those primary care codes can be billed by the CMHC provider type 30; right?

MR. ELLIS: Yes. That's correct. Primary care services would be under the CMHCs, which makes sense; right? We've

talked about this in the past; right, Steven?

So we -- you know, right now, they fall under both, and so it's kind of caused some issues. So it looks like for 9/1, those will -- some of the primary care will be carved out of the CCBHC and just default to non-CCBHC. And I'll -- again, I'll -- I'll even copy you on that, Steve, as well, so you can just see the guidance.

MR. SHANNON: Yeah. And --

CHAIR SCHUSTER: Yeah. Would you copy me as well, Herb?

MR. ELLIS: Yes, ma'am. Yeah. That's fine.

CHAIR SCHUSTER: Thank you.

MR. SHANNON: And that's really CMS guidance, as I understand it?

CHAIR SCHUSTER: Yeah. Steve, do you want to explain what the CCBHCs are? There probably are people on here that don't --

MR. SHANNON: Yeah. It's a certified community member health clinic. There's four CMHCs that are in a demonstration project along with these four

in nine other states, and it really is an expansion of services. The payment methodology is different. And the four that are -- Seven Counties, NorthKey, Pathways, and New Vista are in the demonstration. Others have grants through SAMHSA to do CCBHC work.

But this demonstration is -- can kind of convert a CMHC or a lot of its operations to a CCBHC. The payment is a prospective payment methodology. You get a daily rate. So if you see someone three times in a day, you get paid once. And there's a -- so there's that piece.

Bigger expansion. Focus on serving everybody. There's no debate. They show up; you serve them. Veterans are a priority. Crisis response is a priority. There's nine core services that a CCBHC must provide, and primary care screening is one of those. So that's why we're looking at those codes and how that plays out.

And we are actually in year two of the demonstration. That was extended during COVID. One of the COVID measures extended

the demonstration from two to six years. So there will be four more beyond this year through December 31 moving forward.

And, really, the goal is to get all the CMHCs as a CCBHC and provide those services. Four centers. They're seeing more people, providing a greater rate of services, being more responsive. So they think it's a good thing.

There's been growing pains obviously, some billing challenges. You get a wrap payment, so the MCO pays for the service. Medicaid -- right, Angela? -- makes up the difference through the wrap payment. That's kind of how FQHCs are paid.

So it's been a big initiative, a big lift by both DBH and Medicaid to get it implemented. And those four centers are moving forward, providing a lot more different services than they were previously. How was that?

CHAIR SCHUSTER: Excellent, Steve. You must have given that summary before at least once.

MR. SHANNON: At least once.

CHAIR SCHUSTER: All right. I'm going to give you all back ten minutes of your day here unless there's anything -- any other business to come before the BH TAC.

The MAC meeting is coming up on July the 27th, 10:00 to 12:30. And that link is on the DMS website, but I'll also send it out to you.

And then the next BH TAC meeting is September the 14th, again, at 1:00. And maybe -- seeing you, Kelly, maybe we'll have some unwinding connector fairs or some kind of Medicaid reenrollment fairs between now and then. I think that's a great idea.

So thank you all for some very excellent discussion and input, and I hope this has been helpful to everyone.

MR. SHANNON: Been good.

CHAIR SCHUSTER: Enjoy the rest of your afternoon.

(Meeting concluded at 2:52 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 24th day of July, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR