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

****

Via Videoconference
November 15, 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: All right. Are we at 1:00, Kelli, just about?

MS. SHEETS: We are, Dr. Schuster. We're at 1:00, and you do have a quorum. I just wanted to state that for the record. And I will turn it over to you.

CHAIR SCHUSTER: Okay. Thank you very much, and welcome to all. I'm Sheila Schuster -- excuse me -- and the chair of the Behavioral Health TAC. And as the pilot says as you're going down the runway, I hope you're all going the same direction we are.

We have a quorum. We have Steve Shannon from KARP. We have Valerie Mudd representing consumers from Participation Station and NAMI Lexington and Mary Hass from the Brain Injury Association of America. And hopefully Eddie and T.J. will be able to join us. Mike Barry was unable to join us today.

So I would entertain a motion from our voting members for the approval of the minutes of our September 14th meeting. We sent those out in advance. Do I have a motion?

MS. HASS: Mary Hass for a motion.

CHAIR SCHUSTER: Okay. And a second?

MS. MUDD: Val will second.

CHAIR SCHUSTER: Val will second. Thank you very much.

Any additions, revisions, corrections?

(No response.)

CHAIR SCHUSTER: All those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: Okay. And the minutes are approved. Thank you.

We have meeting dates kind of for the BH TAC and for the MAC. Can you share your screen, Kelli, please? Kelli is helping us out today. Erin is home sick, but we're delighted to have Kelli Sheets facilitating us today.

MS. SHEETS: Okay. There it is.

CHAIR SCHUSTER: There it is. So we're staying with a second Thursday of the month, and our problem comes up in November. I sent out an earlier version to the voting members suggesting November the 7th at our

regular time. But Kelli informs me that there is -- the Optometric TAC meets at that time on the first Thursday.

So our choices are to stay with the second Thursday, which is the 14th of November at the regular time of 1:00 to 3:00, or move a week earlier.

There's T.J. Hi, T.J.

MR. LITAFIK: Hello.

CHAIR SCHUSTER: And the only reason I had suggested moving it up a week is that the MAC meeting, which usually is on the fourth Thursday, is on the third Thursday in 2024 because of Thanksgiving being early. So it doesn't give me much time to write up our minutes and any recommendations that we have, but it's doable. And since I'm now the MAC chair, I won't penalize myself if I get them in late so...

Let me ask the voting members of the MAC if you have a preference. Would you rather stay on the 14th at our regular time, or is it all right to move to the 7th at 10:00 in the morning till noon?

MS. HASS: I vote whichever is the

best for you. If the 7th works easier for you, Sheila, then I vote for the 7th.

CHAIR SCHUSTER: Thank you, Mary. Does the 7th at an earlier time work for everybody? I want to be sure that we have a quorum. I didn't know if moving to the morning is a problem for anybody. That's the first Thursday in November.

Steve, is that a conflict for you?

MR. SHANNON: I don't know yet. It's a long way away. A lot can happen.

CHAIR SCHUSTER: I didn't know if you had any standing meetings on the first --

MR. SHANNON: No. No. Not offhand, no.

CHAIR SCHUSTER: All right. Val, how about you?

MS. MUDD: I mean, a year away, I think I can probably fit you in.

CHAIR SCHUSTER: Okay. And T.J., how about you?

MR. LITAFIK: Sure. As far as I know, that's fine.

CHAIR SCHUSTER: All right. Then we will move -- Kelli, and I'll send you a

final sheet. So it'll be November the 7th at our regular time -- no, I'm sorry. November the 7th but at that earlier time, 10:00 a.m. till noon.

MS. SHEETS: Okay. Sounds good.

CHAIR SCHUSTER: All right. The other thing that's on here is that -- are the dates of the MAC, and I had highlighted that the time of the MAC meeting may change. We're going to vote on that at our meeting coming up. Those meetings are two and a half hours.

If you've been on those meetings, we have been running late every time because we have so much to discuss, and I don't think that the TACs get enough time to really talk about what they're doing.

So the MAC is going to meet on the 30th of this month, and they will decide whether they're going to go from 9:30 to 12:30 or from 10:00 till 1:00 or, in the interest of bipartisanship, I guess, they're going to split the difference and go from 9:45 to 12:45, which nobody will remember because nobody ever meets on the 45s.

But anyway, once we have that determined on the November 30th meeting, we will let you all know. But they will meet on the fourth Thursday of the month in the morning for sure except on November 21st; okay?

Thank you, Kelli. We can go back to the agenda. When I did the agenda, I put on here the status update on the 1915(i) SMI. It's actually a SPA, a State Plan Amendment, and not a waiver. When will the town hall meetings be held? And since then, we have heard from DMS with those dates.

Is there anybody on from DMS to talk about the 1915(i) and those meeting dates?

MS. SMITH: I'm here, Dr. Schuster.

CHAIR SCHUSTER: Oh, great. Thank you. Pam Smith is the Director of Community Alternatives for DMS. Thank you, Pam.

MS. SMITH: I've got to figure out what screen I opened them on so that I can find them again.

CHAIR SCHUSTER: Okay.

MS. SMITH: Let me see. Here we go. Okay. So the town halls are going to be on -- and hold on. I can --

CHAIR SCHUSTER: Can you share your screen, Pam?

MS. SMITH: I will share this. Yeah. That's what I was -- was just looking to --

CHAIR SCHUSTER: Yeah. Because I think it's helpful and then we can send it out. Are these posted yet on the website, Pam?

MS. SMITH: I think Kelli was waiting to get the information about the -- to confirm the rescheduled northern Kentucky and the location for Louisville, but let me -- I'll check with her when we get done.

Kelli or Erin, can you let me share?

MS. SHEETS: Yeah. You should be able to now, Pam.

MS. SMITH: Oh, now I can. I can now. Thank you. Now I just -- it's finding the right screen. Okay. Here we go. Let's see. So -- all right. If I make this big, if it's going to move it. Okay. Let me just get to that screen.

So the first one is going to be in Morehead at the Rowan County Public Library

on December the 6th from 1:00 to 2:30.

And will you all confirm you're actually seeing that schedule because I --

CHAIR SCHUSTER: Yes. Yes.

MS. SMITH: Okay. And then the second one -- the second one is in Richmond at Madison County Public Library, which will be the next day. So it's going to be December 7th. Again, all the times are 1:00 to 2:30 Eastern.

Northern Kentucky, I had to tell everybody yesterday that I can't keep track of days in calendars and, accidentally, we scheduled one on Inauguration Day. So we are working to reschedule the northern Kentucky one for -- it looks like it's going to be December 11th, so the day before that. We were just confirming with St. Elizabeth to make sure that that was going to work.

Louisville, we are between two locations. The date is the 13th, so I'll find out -- when we get done with the meeting today, I'll find out for sure if that got firmed up yesterday evening or this morning. But, again, it'll be on the 13th of December.

And then the final one is going to be in Owensboro at the Daviess County Fiscal Court, so -- and it'll be on the 14th. And so I'm sorry. That one is Central Time, so it is the only one that's Central Time. The other four are Eastern.

We will be sending out virtual links as well. We were talking with our locations. We wanted to make sure where we held the virtual options, that we had strong Internet and would have kind of the best connectivity.

So I know Kelli was working on finalizing that and then we were going to send out the links to the virtual options so that the individuals could see those. And we will record -- we will record at least one of those virtual meetings so that we can post that to the website as well.

CHAIR SCHUSTER: And I think the virtual is being offered, Pam, on December the 7th and on December the 13th; is that right?

MS. SMITH: She -- I think that was where she was leaning towards. They were wanting to -- her and Will, one of our other

individuals working on this, wanted to make sure that the Internet and our technology would be the strongest there and would support it. Because we didn't want to offer the option of virtual and then get there and it not have strong enough connectivity to support it.

But that's what they were leaning for, was the 7th and the 13th. But they were going to confirm those dates when they sent out the actual links that had the -- to be able to join those.

CHAIR SCHUSTER: Okay. And I did confirm with Kelly Claes that that email address that's on there, Medicaidpubliccomment@ky.gov, is a good email address for you to ask questions but also to send in your comments.

MS. SMITH: Yes.

CHAIR SCHUSTER: And all the comments --

MS. SMITH: Absolutely.

CHAIR SCHUSTER: Yeah. All the comments will be collected on this version as well as going forward; is that right?

MS. SMITH: That is correct. Let me see if I have my -- so we will -- as we conduct these, the information sessions, and we collect those public comments, we're going to -- we will collect all of those. And then when we actually enter into the official public comment period, when we post the SPA to be reviewed, then those will be -- they'll be added together.

So, really, you know, we keep all of the comments that we get in that public comment box, and we'll add all of it together to be the actual public comment that we respond to. So not just that official or -- you know, public comment that happens when we post the waiver. We will include the comments that we get during the information sessions.

And we're working on a couple of different ways to collect the comments or questions during the information sessions. We were working to -- one is we'll kind of have the standard -- we'll have a card or something where individuals can fill out information and have their question.

But we're also working to develop an

electronic tool so that we can -- so somebody can scan, like, a QR code, and it'll take them to a tool that they can put information in and can submit a question or a comment that way as well.

CHAIR SCHUSTER: Okay. Pam, would you back up a slide where you lay out the three kind of main services that are being offered in the SPA?

MS. SMITH: The residential ones, yes.

CHAIR SCHUSTER: Yeah.

MS. SMITH: So the three residential --

CHAIR SCHUSTER: There we go. Yeah.

MS. SMITH: The three housing, yeah, services are the supervised residential care, so the 24/7 staffed care. Tenancy supports, which it offers, you know, those pre-tenancy and tenancy-sustaining supports. So, you know, identifying, helping them to obtain housing and sustain that housing by supporting them in -- you know, taking care of the obligations that you have as either,

you know, somebody renting or owning a house or whatever domicile they're living in or in-home supports.

So this is for, you know, individuals that are either living with family members, friends, or they have their own house or apartment. And it focuses on more of the assistance with their ADLs and IADLs.

CHAIR SCHUSTER: Great.

MS. SMITH: And really looking to be person-centered there.

CHAIR SCHUSTER: Yeah. And then the next slide talks about some of the other services --

MS. SMITH: Right.

CHAIR SCHUSTER: -- that you've mentioned before, the supportive education and employment.

MS. SMITH: Right.

CHAIR SCHUSTER: I think there have been some questions about respite, and that's included in that.

MS. SMITH: That is, yes. So respite is one of those -- is one of the services that is included in the SPA as well

as, to be expected, case management which, you know, really is the foundation to hold all of it together and to help coordinate and --

CHAIR SCHUSTER: Yeah, exactly.

MS. SMITH: To coordinate that.

CHAIR SCHUSTER: So this is basically the information that's going to be presented at the town hall with lots of opportunity for people to ask questions in person and on Zoom; is that right, Pam?

MS. SMITH: It will be. It'll be a combination of this and then with some of the additional information we shared in September on that town hall that talks about the tools, the criteria that'll be looked at, a little bit more of kind of that target -- the population we'll be serving.

So a little bit more of the upfront piece. You know, how did we get here? How do you get to -- kind of through the gate to get services on the waiver? And then we'll also include this, so the services that are going to be on the waiver.

CHAIR SCHUSTER: Okay. All right.

Well, this is exciting. A lot of people have been waiting a long, long time to see some of these housing services and some of these other services for our folks with SMI.

MS. SMITH: No. We are very -- we are very excited. It has been a labor of love, but it's been a lot of work by a lot of people. So we're very excited to see it as we inch closer and closer to when we'll be able to actually put the SPA out there for official public comment and submit it to CMS so...

CHAIR SCHUSTER: Yeah. Okay. Any questions from our voting members?

MR. SHANNON: I just want to say good work to you and your team, Pam.

MS. SMITH: Thank you, Steve. Thank you for your support. You and Dr. Schuster have both been vital and been -- always made yourselves available for questions and participated when we wanted to interview you, so thank you all, too.

CHAIR SCHUSTER: And we're there to keep nudging you in the direction that we think that people need to go, so we

appreciate that. Okay. That is really exciting. Thank you, Pam.

And who is on to talk about the status of the SUD services for incarcerated persons, or the Reentry TAC? It looks like Ann Hollen is getting ready --

MS. HOLLEN: That would be me today.

CHAIR SCHUSTER: I keep forgetting the name of it now, Ann. It's been changed so many times, so I --

MS. HOLLEN: Well, it is -- it is reentry.

CHAIR SCHUSTER: Reentry. Okay.

MS. HOLLEN: And so to answer the question that was on here, the -- sort of the interviews were finished and concluded in September. It is -- the application is out for public comment right now.

We do -- I think we're having some technical difficulties with our website, but we're aware of it. And we've got someone working on it. So it's posted there.

It's going -- we're having two public forums, which are virtual options. One is

the 27th of November. It'll be from 10:30 to noon Eastern Standard Time. And the other one is December 1st, and it'll be from 2:00 to 3:30 Eastern Standard Time. So those are the informational sessions about what's in the application.

CHAIR SCHUSTER: And what's the deadline for -- what's the close of the public comment period and --

MS. HOLLEN: Oh, let's see. Let me think. 12 -- I think 12/10.

MS. SHROYER: December 9th.

MS. HOLLEN: December 9th.

MS. SHROYER: Yes.

CHAIR SCHUSTER: December 9th. Okay.

MS. HOLLEN: Thank you, Kristen.

MS. SHROYER: You're welcome.

CHAIR SCHUSTER: And have you -- I can't remember seeing the -- I don't remember seeing the public forum notice. I'm sure I got it but --

MS. HOLLEN: I think the link and all of that is in the notice about it being open. All of that information is within that

notice.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: Kristen, can you confirm I'm right?

MS. SHROYER: Yes. It's all in there. So when you go, it'll give you the options to hit the different links to get to the different stuff. It's all together.

MS. HOLLEN: So it's in that posting we --

MS. SHROYER: It's in that posting, yes.

CHAIR SCHUSTER: Yeah. So the reentry public forum dates -- and those are virtual -- are November 27th from 10:30 to noon and December 1st from 2:00 to 3:30 Eastern Time.

MS. HOLLEN: And just an update on our application, 1115 for SMI. We have just sent back to CMS some initial questions that they asked.

CHAIR SCHUSTER: And that's on the 1115 side?

MS. HOLLEN: Yeah. It's on the 1115 side. Yes, ma'am.

CHAIR SCHUSTER: So explain to people that are confused about why we have two SMI --

MS. HOLLEN: This -- so this one has recuperative care in it as well as we're asking to cover mental health inpatient stays for an average length of 30 days, so it'll align with our SUD ask.

CHAIR SCHUSTER: Okay. And that's on a different time frame. That's already gone to --

MS. HOLLEN: It's gone. We are in an extension period with CMS on our 1115 overarching Team Kentucky -- the name has changed -- authority. They gave us a year, and I think that is to assist them with getting all of our applications aligned on the same time frame which makes life a little easier for the rest of -- for us and especially for reporting.

CHAIR SCHUSTER: Right. Right. Okay. Lots of balls up in the air for folks to think about so -- and some of us are also looking at the home and community-based waivers, which is for a different population,

although it includes the ABI folks that Mary is -- and Eddie Reynolds are advocating for. So we're trying to keep all those balls up in the air as well.

Does anybody have any questions? Post them in the chat, please, while we've got Ann on hold here.

So we have actually two pieces of SMI. One is the 1115, which has already had public comment and has gone to CMS, and that would allow more days in the hospital. It would get around the I -- what they call the Institute For Mental Deficiency -- Disease exclusion. It's a terrible name. I repress it all the time. And it will also have recuperative care in it.

And then the ones that we're just announcing, the town hall meetings, is for actually a State Plan Amendment, or what they call a SPA that is a 1915(i).

And, Pam, I think I'm right about this. The "I" is different than the 1915C waivers which are, like, home and community-based or Michelle P.

MS. SMITH: Right. So -- yeah. So

the "I" -- the main difference or the two main differences with the "I" as the State Plan Amendment is that the individuals do not have to yet meet institutional level of care. So they may be higher functioning, and so they would not have to meet the same level of care as someone that would be admitted to an institution.

And then the second biggest difference is, whereas, in the 1915Cs, there's a cap -- so, like, for example, Michelle P, you can serve 10,500. For a State Plan Amendment, it is available to anyone that qualifies. So it meets the qualifications throughout the state. There is not a cap or a limit on the number of individuals that can be served at any one time.

CHAIR SCHUSTER: So the piece that we need to look at very carefully is how we describe the target population.

MS. SMITH: Correct.

CHAIR SCHUSTER: Yeah. Okay. And that's how the limitation is done. So it's a very different way of thinking about these waivers for people that are straddling both

kinds of waivers like the community mental health centers do. You know, if you're in the 1915C world with people with intellectual and developmental disabilities, people that are dependent on -- I just lost the word -- oxygen. Anyway --

MR. SHANNON: Ventilator dependent.

CHAIR SCHUSTER: Ventilator. Thank you, Steve. I just lost it. Ventilator dependent or the people with acquired brain injury, the limitations are in the number of slots or placements in each one of those waivers. And in this waiver, there's not a cap on the numbers. The limitation will be on who can meet the requirements or the specifications for --

MS. SMITH: And we'll go -- and we will -- that'll be part of when we do the forums. When we hold those, those public comments, that'll be part of what we'll go over again, is that -- kind of that upfront criteria for both. It's what you do to be able to, you know, pass through -- I always say door one or gate one. So I pass through this gate and then now I look at my services

and what is -- you know, what services do I qualify for. So that'll be more -- we'll talk about the tools and the populations in the criteria.

CHAIR SCHUSTER: Okay. Great. And then the -- what we've always called the incarceration or the waiver for incarcerated persons, now called the reentry waiver, is one that we've been working on. I think Leslie Hoffmann and her team has been working on it for -- is this the fourth year probably? And it would allow Medicaid services to be offered while the person is incarcerated.

I had somebody ask me a question. Ann, are you still on? Is it both for prisons and jails?

MS. HOLLEN: So we're going to -- we're starting where they have MA -- medication-assisted treatment now. So we're going to start at -- like, phase one is going to be with the state prisons. So there's 14 facilities. And then the plan is to phase in the jails as we get availability of, you know, staffing and DOC being able to, you

know, cover the services in the jails.

And that is -- so yes, it feels like it has been -- it feels like four years that we've been working on it, but that is -- that is the reentry application, what you were just talking about.

CHAIR SCHUSTER: So it's going to start with the state prisons because they have those medication-assisted treatment --

MS. HOLLEN: Right. And they -- yes. Yes, ma'am.

CHAIR SCHUSTER: Yeah. And then you're going to work in -- and it's going to include juvenile facilities, too; right?

MS. HOLLEN: That -- yes. That is actually part of this application, too, is services for the DJJ population.

CHAIR SCHUSTER: And do they start out right away, also? Do they have those services, if the kids need MAT, for instance?

MS. HOLLEN: Uh-huh. It's the -- we're asking the same -- what we're -- I thought somebody was speaking. I'm sorry. What is allowed with adults is what is allowed with the juveniles.

CMS is going to come out with more guidance in the first of the year around the juvenile justice population so, you know, we'll see.

And Deputy Commissioner Cecil has put some information in the chat as well.

CHAIR SCHUSTER: Yes. Thank you very much, Veronica. And is it 60 days predischarge or release?

MS. HOLLEN: That's what we're asking, yes, ma'am.

CHAIR SCHUSTER: Yeah. Okay. Great. Wow. I know that we're still a long way from seeing these waivers being implemented, but it's exciting to have so much going on and moving ahead. Poor Steve has been running the Reentry TAC for what, a year and a half, Steve?

MR. SHANNON: A long time.

CHAIR SCHUSTER: Without much to talk about, but it's coming.

MR. SHANNON: It is coming.

CHAIR SCHUSTER: Yeah. And this is an important population for us to be dealing with, so thank you very much. And thank you,

Veronica, for posting some of those comments in the chat. That background is helpful.

If there are not any other questions about waivers and so forth, we had a whole bunch of questions about Medicaid rates for behavioral health services, and I don't know who's handling that. It looks like Justin is and Ann.

MS. HOLLEN: Oh, I'm going to listen and try to help if I can, but Justin is definitely, I think, around the report.

CHAIR SCHUSTER: Okay.

MR. DEARINGER: So hi. This is Justin Dearinger, and I wanted to go over -- it looks like on the agenda where you had asked about some of the processes, input from providers, what rates are being finalized, the Senate Joint Resolution 54 report, some of those things. So I was just going to touch on a few of those topics.

CHAIR SCHUSTER: Great.

MR. DEARINGER: Ann may be able to go into a little more detail about any specific codes as that fee schedule resides with her, but -- that they're looking at.

But as far as the process for rate changes and what we do on an annual basis as we come up to January 2024, we receive a list of changes and updates from Medicare. We have a -- depending on the provider and the fee schedule, it has a formula that goes in that gives a percentage of Medicare's rates to the fee schedule. And so then they're -- those fees are changed based on that. There are also codes that are added or deleted because of that.

And then throughout the year, we have -- I get somewhere -- it just varies. I haven't actually -- I think I haven't got any today. So -- but sometimes I'll get up to 20 a day of requests to add codes, change pricing, raise fees, or remove codes or adjust limitations.

Those are reviewed and researched over the course of the year. We look at other states' fees. We look at their fee schedules, see what they're being paid, other states' Medicaid programs. We look at Medicare. We look at private insurance, and we compare and contrast. And then we look at

our own budget, our own fiscal analysis to see what we can and cannot do, and then we run that, you know, up the -- up the ladder and see what we can get done.

And we try to compile all of those. Unless it's an emergency situation that we feel like is going to impact the health of Medicaid members, then we may do that, you know, at any point during the process. But those are usually kind of compiled the first of the year.

So a lot of things that we've done research on that we've been asked by providers to look into, whether they be a fee that is not adequate to provide the service, meaning it doesn't pay enough for the provider to actually do that, or whether it's a code that needs to be added or one that needs to be deleted, a lot of those will be done at the first of the year, too.

So all those things will come out for the first-of-the-year fee schedules. Right now, we don't have any fee schedules that are -- have any blanket increases or anything like that because we haven't had -- you know,

that was not in the budget to do that. We have -- finalized rates for those fee schedules are usually sent out to providers as soon as they're done around the first of the year.

As far as the input from the providers, that's done kind of throughout the year with the information that we receive from them. We receive that information from various TACs sometimes but usually from individual providers or provider groups. And once we make a decision on those, the recommendations they send us, we always respond back to them and let them know the decision that we made and why we made it.

There are several actual rate studies on different groups of provider rates. I know, for instance, one right now is therapy rates, looking at therapists versus -- the state plan therapy services versus EPSDT therapy service versus waiver therapy services. That is an in-depth study that's been going on for a few months now, and we hope to get some completion here toward the end of this year.

But anything that we do, we will -- on

that study, where it's an overall large study, we make sure that we get provider input, usually by submitting that and discussing that with the Technical Advisory Committees.

An example of that is we're currently working on -- or we just finished up a rate study for the inclusion of contact lenses. That rate study was completed, and we gave some, you know, fees and pricing on some of the different new contact lens -- versions of contact lenses that were out there. And that went to the Optometric TAC to get their comments and views before any changes were made.

So we work with various providers and TACs in getting input from them. In the same way, the therapy rate study would have the same type process, where we would send that out to the provider groups or provider representative before we made any kind of change, where it would be an overall, you know, change we were making to a large group of codes.

So that's -- I think I kind of may be

able to -- report 54, the preliminary report was completed. It was a two-part report. One of them was due earlier, and that was completed. And then the other one is, I think, coming due, and I think they're about done with that one. So that will be made public when that's complete.

And as far as the last agenda topic, it looks like the '24 behavioral health fee schedule, I think I saw there. I'm going to let Ann talk about that one because that's kind of not in my wheelhouse but...

CHAIR SCHUSTER: Yeah. Justin, let me ask you about the Senate Joint Resolution 54. At our last meeting, I think, Leslie said, oh, I need to send you all the report on Senate Joint Resolution 54 and -- yeah. Kelli just put the front page of it up.

So the date on this is July 15th, 2023. Is that the first part?

MR. DEARINGER: That is. That's the first part that was completed. One part was due July and then the other part was due --

MS. JUDY-CECIL: November 1. Hi. This is Veronica --

MR. DEARINGER: There you go.

MS. JUDY-CECIL: Yep. Veronica Judy-Cecil, Senior Deputy Commissioner for Medicaid. Just to chime in a little bit.

Yeah. So it was a two-part request. One was due July 15th, and that was on the rates, the pediatric therapy rates.

And then the second one we just released that was early November, and that had to do with a specific request about: Is there a way to use area deprivation index to develop rates? I think the request there is to maybe -- you know, how can we look at rural areas and do rates differently based on that. So the second report, we just completed it and sent out.

It's very intense so -- and probably deserves its own time slot for -- you know, if you all -- once you all review it -- maybe what I suggest is you all review it. And maybe if there are particular questions, we can come back or even do a small presentation on it at the next TAC.

CHAIR SCHUSTER: Yeah. That would be -- that would be good. I think it was Commissioner Lee that -- and maybe it was Leslie. I honestly don't remember -- that sent me this report, which is about a six or seven-page -- the one that Kelli has up.

And it talks about audiology; behavioral health; and then occupational, physical, and speech therapy. And I didn't realize that it's all for pediatrics; is that right, Veronica?

MS. JUDY-CECIL: That was the specific request from the --

CHAIR SCHUSTER: Okay.

MS. JUDY-CECIL: -- SJR 54, yep.

CHAIR SCHUSTER: Okay. So I know that we have people that do behavioral health with pediatric patients. So is that posted on the CHFS website someplace?

MS. JUDY-CECIL: So we don't normally post these.

CHAIR SCHUSTER: Okay.

MS. JUDY-CECIL: But whenever we --

CHAIR SCHUSTER: We can send it out. I mean, I can send it out --

MS. JUDY-CECIL: You can.

CHAIR SCHUSTER: -- because I've got it now. And I could ask Kelli and Erin to send it to, you know, whoever they typically --

MS. JUDY-CECIL: Absolutely. And then what we generally do for anyone that is not a MAC or TAC member, because we discussed it, we'll post it as part of the meeting documents. So following this meeting, when we post the YouTube and when we usually follow up with any presentations that are discussed within the TAC meeting --

CHAIR SCHUSTER: Oh, okay.

MS. JUDY-CECIL: -- we post these as a follow-up to the discussion that we're having today.

CHAIR SCHUSTER: All right.

MS. JUDY-CECIL: The TAC page.

CHAIR SCHUSTER: So we can go to where the YouTube is posted and then the documents that discuss the meeting would be there as well.

MS. JUDY-CECIL: Yeah. To the TAC page where we put the agenda and, usually, we

put any, you know, presentations from that.

CHAIR SCHUSTER: Okay.

MS. JUDY-CECIL: So it'll be on the TAC page.

CHAIR SCHUSTER: All right.

MS. JUDY-CECIL: Yeah.

CHAIR SCHUSTER: So let me just say to those who are on the Zoom right now, if you get emails from me about the TAC meetings, then you will get this report from me. If not, please send me an email. It's kyadvocacy@gmail.com, and I'm happy to add you to my list.

What about the most recent report that was done, the dense one, Veronica? Could somebody send that to me?

MS. JUDY-CECIL: Absolutely. And I thought that is what the commissioner sent to you, so I apologize.

CHAIR SCHUSTER: No. No. The one I got was the one that --

MS. JUDY-CECIL: For the therapy. Okay.

CHAIR SCHUSTER: For the therapies. And that's helpful because it does have

behavioral health in it.

MS. JUDY-CECIL: Yep.

CHAIR SCHUSTER: And we do have -- as an old, retired child psychologist, I'm glad to see the pediatric patients being looked at in particular.

I was curious, Veronica, because it says that they compared those rates to other states, but I didn't actually see the comparison in the report itself.

MS. JUDY-CECIL: Hmm. I'll have to look at it.

CHAIR SCHUSTER: I have to say that I glanced at it quickly, but I --

MS. JUDY-CECIL: I thought we did include some data, but it's been a minute since I've looked at it so --

CHAIR SCHUSTER: Well, and I did one of my very late at night, you know, glancing through it, so maybe you and I can look and see whether that -- because I would be really interested in that state comparison on those rates.

Okay. And then there was a question in the chat, and I didn't see it fully. I think

it was from Cat Jones.

MS. SHEETS: Yes. She says: Will the BH fee schedule continue to be updated on a 4/1 versus 1/1 update schedule?

CHAIR SCHUSTER: And you'll have to excuse me. Somebody is knocking at my door. Can somebody answer her?

MS. JUDY-CECIL: Sure. We can take that. Ann, I don't know that there -- is there an intent to move the -- there is. Okay. So --

MS. HOLLEN: That has been my ask.

MS. JUDY-CECIL: Okay. I think -- and one of the reasons for that, as you all who do work in reimbursement know, that we are always trying to play catchup when CMS makes changes to the fee schedules. We don't get a whole lot of notice to incorporate those changes into what we do.

And so I know for the behavioral health especially, CMS sent out the first changes to us and then sent out a subsequent one, which really caused us to have to really scramble to get that updated. So -- excuse me. So I think we are playing with the idea to be able

to -- instead of have to do retro, anything is just to give us time to implement those. Excuse me.

MR. SHANNON: So what would be the new time frame, just so we all understand?

MS. JUDY-CECIL: So an April 1 is what we're contemplating.

MR. SHANNON: Okay.

CHAIR SCHUSTER: Sorry about that. I've got -- somebody wants to lop off dead branches in my tree. You know how when you're working from home, various things come up.

All right. Cat, does that answer your -- are there any other questions about the fee schedule?

MS. JONES: Yes. Perfect. Thank you.

CHAIR SCHUSTER: Bart, you look like you're unmuted.

MR. BALDWIN: Yeah. So just a quick question on that. To have it at a set date of 4/1 versus having to retro would be great. You all have heard from me a lot on that, so certainly that would be nice. And

especially if you give yourself enough time that it's posted prior to 4/1, so you know -- I mean, it may not be effective 4/1 but enough time for the MCOs who follow this fee schedule -- I know they're not -- you know, they don't have to -- are not -- you know, but they do.

So that's what -- we run into some issues, too, because if it's out in advance enough, that for billing straight Medicaid, you can start doing that on 4/1 but enough time so that the MCOs can load to that so that they can start billing the correct rate on 4/1 to the MCOs as well.

So -- and I'm sure that's part of the plan, to moving it by three months, so hopefully that will help. Thank you.

MS. JUDY-CECIL: Yeah, it is. We want to give everybody plenty of notice to prepare for the change as opposed to having to notify everybody that, by the way, you know, we've just implemented something retroactively.

MR. BALDWIN: Two months ago. Right.

MS. JUDY-CECIL: So we really want to align all those effective dates both for fee-for-service and MCO to the extent possible.

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

CHAIR SCHUSTER: Yeah. Sure thing. And thank you, Veronica. That's very helpful. And the other -- only other thing I would say, I guess, back to Justin, the question about how rate studies are done and so forth.

That question really came up because I got contacted by an SUD provider about -- the rumor was going around about changes in some of the provider rates. And they asked me the question about, you know, is there any way to know that these things are being looked at before they get solidified. And I guess that's always the provider and, in some ways, the consumer question. And I don't know if there's a solid answer for that.

You know, if you all are doing a big, formal rate study where you're going to send out surveys to providers and do that kind of

thing, like I know has been done on the HCB waivers and some of those things.

But, I guess, the question is: When something kind of percolates with you all -- I remember years ago, it came up around services in the BHSOs. I guess I'm trying to figure out how we can have better communication so that providers and consumers could be in touch with you before things get decided.

MR. DEARINGER: Yeah. You know, it makes it difficult because of the volume, you know.

CHAIR SCHUSTER: Right.

MR. DEARINGER: The amount of research that we do on a daily basis, you know, the amount of requests we get daily. We have hundreds and hundreds of research projects going on right now, all different provider types.

Some of them -- most of them are wanting to add codes. A lot of them are wanting to increase rates. There are a few to remove codes and then there are some that are on, like, limitations, modifiers, those type

things. So I don't know -- you know, I think it would be very difficult to do for every little thing. You know, the most that that's going to affect is just a few codes.

So, like I said, whenever we do a big -- you know, for instance, that therapy study is one and the contact lens study, those are big studies that involve a large number of CPT codes changing, and so that is always precommunicated. We'll definitely make sure it's communicated with the TACs, and we also try to get any other, you know, large provider groups involved before that's kind of finalized and put in stone, so they at least know what's coming before it comes so...

You know, I think we're -- you know, I feel like our communication there is improving and going to do better, and you all won't have any big surprises like that. But as far as, like, changes, you know, to small codes and, you know, maybe a limitation on one CPT code or something like that, I mean, those things are going to change.

And we're always -- you know, whether --

you know, you could probably name five codes, and I can almost promise you one of the codes we're doing research on right now so...

MS. JUDY-CECIL: Yeah. I --

CHAIR SCHUSTER: Yeah. I think -- go ahead, Veronica.

MS. JUDY-CECIL: I was going to say, just to add to that, we're generally in a position where we have gone out and made kind of sweeping changes not related to Medicare, fee schedule changes. You know, because we've had providers come and ask us for that.

And so I think there's a lot of things that do kind of maybe happen at that level and not more publicly, you know, general public ways because we're working directly with the providers that are affected by the fee schedule.

Sometimes it just -- just to be very candid, it's out of our control. So, you know, we might have -- we might get a request from leadership to do something, and so we're working with them. And we're not at liberty to really be very public with the

information. And then those decisions get made very quickly.

And a lot of that is really, we hope, towards improvements. The -- I think the dental, vision, and hearing is a good example of we did not really -- even though it had been discussed at TAC meetings and in general, we didn't have a lot of time to really put that out there for public comment before we needed to implement.

So we do -- we are trying to be better about that. I think major changes to the behavioral fee schedule, the therapy -- you know, the Therapy TAC is talking about the report and, you know, overall increases in the therapy rates. Those are things that we are having those conversations with.

But ultimately, you know, these do have -- most of them have significant budget impacts, and we have to go back to leadership and have them, you know, make final decisions. So it's just not -- it doesn't really lend itself to have big public comments, you know.

So we just -- as Justin mentioned, I

think, we just really work on a kind of case-by-case basis with the provider type that's being impacted by that.

CHAIR SCHUSTER: Okay. I understand -- when Justin talked about getting, you know, on a single day 20 different requests, you know, it kind of puts it in perspective in terms of the volume.

I guess the providers would say -- you know, it's the old thing about the surgeon saying, you know, this isn't going to hurt much. And the question is -- you know, it's not your body. You know, if your ax is the one that's getting gored -- or your ox is the one getting gored, then, you know, you're going to be on it even if it's only one code that's being changed or whatever.

I think -- I guess I would just make the request that if it has anything to do with -- remotely with behavioral health, that you would use our TAC and do the same. And I'm sure you do do that with the other TACs as well, and so we appreciate that and appreciate you all being on.

So thank you very much.

MS. JUDY-CECIL: And we will definitely try to do that. I know with SUD -- because we've got -- you know, we've got a process set up with our SUD providers, that we provide them regular communications. And when we are considering changes to the fee schedule, we always do try to get feedback from the providers about how it's going to impact them.

You know, generally, if it's an increase in rates, there's no problem. But when there's a decrease in rates, that -- you know, it starts to get a little sticky.

So for SUD, there's kind of a process for that, where we've been working very closely with the providers through that process. But certainly could bring that to the Behavioral Health TAC, too, when those conversations are happening.

CHAIR SCHUSTER: Yeah. I mean, I think, obviously, we're concerned about both mental illness and substance use disorder. So if there's a way to get that process in place around the more, if you will, psychiatric or the more mental illness kinds

of -- and those providers, the BHSOs as opposed to the AODEs, I guess. You know, the CMHCs have a foot in both camps, obviously. But yeah, I would think that the behavioral -- the mental health providers would be very interested in that same kind of process.

All right. The next question was about information from DMS on plans to expand the use of behavioral health associates, the other behavioral health provider types in addition to the CMHCs. Is that you, Ann?

MS. HOLLEN: Yes, ma'am.

CHAIR SCHUSTER: Thank you.

MS. HOLLEN: So there are some -- we're working on guidance that's going to come out soon. Once we get it drafted, we send it to our leadership for approval. But I would say -- not giving out dates. I learned my lesson early from that, in this TAC actually, several, several years ago.

It'll go live, so to speak, or be available in 2024. But it is a person with a minimum of a bachelor's degree who is working towards a master's or a master's working

towards a Ph.D. And it's also a person that may be working towards a credential such as a CADC. Minimum -- as I said, a minimum, they have to have a bachelor's degree.

And then the provider type expansion is to -- it is for outpatient services only. It's for Tier 1 and Tier 2 BHSOs, behavioral health multispecialty groups; the certified community behavioral health clinics, which is a demonstration we're doing; a community mental health center; a federally qualified health care center; a rural health clinic. And then on our crisis where we've -- we're going to be adding 23-hour crisis stabilization. They can also work in that setting as well.

There will be an application process that's turned in to DMS, and we've established a specific email box for that. And Amanda Taylor, who also goes by Mandy, will be the person that will be the oversight of that.

So we do expect a big flux at the beginning, and it'll be all-hands-on-deck to get them out. I believe we said 14-day

turnaround on our end so -- and as soon as we get the approval for the policy guidance, then we will issue that and give a date of when to start doing the applications.

And I see a hand up from Stephanie.

CHAIR SCHUSTER: Stephanie, yep.

MS. KOENIG: Hi, Ann. Good afternoon to the BH TAC. Regarding the application process -- and it sounds like you're saying DMS is going to house that information. How will the MCOs be notified of the approval of the certifications? Is that a report we'll receive or --

MS. HOLLEN: Yeah. I think it'll be similar -- similar to how we notify you of the self-attestations.

MS. KOENIG: Okay.

MS. HOLLEN: That way. And then the provider would need to keep that documentation and that approval letter in that individual's file. There's a process if the person leaves -- leaves the facility and they go to a new one. There's a process -- all that is lined out in our policy.

The rate will be the bachelor-level rate

for the services, and we're going to use a modifier as well. I don't have the modifier -- I don't want to give it out -- I don't want to give out the wrong one, but there will be a modifier with this.

CHAIR SCHUSTER: Is there already a bachelor's level rate, Ann?

MS. HOLLEN: Yes. Yes, ma'am, there is. Yes.

CHAIR SCHUSTER: Oh, okay. I don't do billing, so I didn't know that.

So, Karen Garrity, let me just read your -- Karen, you want to come online?

MS. GARRITY: Yeah. Sure. I was just not sure about the -- this is not about what we're talking about but going back to what Veronica Cecil said about regular communication with SUD providers. I just wasn't sure when or how that was happening. Because we have plenty of SUD providers, and I wasn't familiar with this regular communication.

MS. JUDY-CECIL: So Ann might have to help me but -- so there's a newsletter, I know, that goes out regularly. And when

there are changes to the program, there are emails that go to the providers. We have a distribution list. Is that right, Ann?

MS. HOLLEN: And then a lot of the communication is with the self-attestation for residential. There's a lot of back and forth with that. To be honest with you, I don't think we've done a newsletter in a little bit, so I will --

MS. JUDY-CECIL: Oh. There you go.

MS. HOLLEN: I will get back on that. We'll circle back on that, but we do have a distribution list. And it does all go back to the -- you know, when we got our 1115 and the ASAM requirements that we use.

But I do want to say this. There are new criteria for ASAM, and so we'll be communicating going forward on some of that as well.

MS. GARRITY: If we wanted -- like, if I wanted to put my email on the distribution list, who would I contact?

MS. HOLLEN: You can send that to me, and I'll make sure it gets sent.

MS. GARRITY: Okay. All right.

Thank you.

MS. HOLLEN: Okay. Anyone on this TAC, by the way, if you want to be on a distribution list that we have for substance use disorder treatment, you can email me your contact and just tell me -- make sure you say to me because I will forget why I'm getting an email -- that it's for an SUD distribution. And I will get -- make sure that you get on the list.

MS. TOLLE: Can you drop your email in the chat so that we have the correct spelling?

MS. HOLLEN: Sure.

MS. TOLLE: Thank you.

CHAIR SCHUSTER: And Cat Jones has a question about the rates. Cat?

MS. JONES: Right. And I may be misthinking, but I was trying to remember. I don't remember a bachelor's level rate, for example, psychotherapy.

MS. HOLLEN: There is.

MS. JONES: Oh, there is? Okay.

MS. HOLLEN: Yeah. At least on my -- on the fee-for-service fee schedule,

there is.

MS. JONES: Right, fee-for-service. I was thinking on the BH fee -- Medicaid fee schedule, okay, there's not.

MS. HOLLEN: You mean Medicare?

MS. JONES: Medicaid. Like, for example, 90837, the licensure with -- I believe the U4 would be your associate under supervision, which would still be a master's level individual. I don't remember a bachelor's level rate, but I could be totally -- for a CADC.

MS. HOLLEN: So --

MS. JONES: CADC would be a U6.

MS. HOLLEN: -- that is a rate for someone with a bachelor's degree.

MS. JONES: Got it. So it would be CADC rates. Okay.

MS. HOLLEN: Right. Yeah.

MS. JONES: Got it. Thank you so much.

MS. HOLLEN: The column 5. Column 5 is the --

MS. JONES: Column 5.

MS. HOLLEN: Would be the

bachelor's level rates.

MS. JONES: So for services that a CADC can't provide -- and I'm not sure off the top of my head which ones that would be -- there might need to be some things changed on the fee schedule.

MS. HOLLEN: Yeah.

MS. JONES: Okay.

MS. HOLLEN: Well, it'll -- you'll -- they should be doing -- like, a CADC cannot do mental health, you know, under that credential.

MS. JONES: Right.

MS. HOLLEN: So that would be communicated and to be understood that you can't use that credential to do mental health psychotherapy. Only --

MS. JONES: Right.

MS. HOLLEN: -- substance use, yes.

CHAIR SCHUSTER: Okay. Any other questions? So I think you said, Ann, that you're going to be sending out guidance.

MS. HOLLEN: Very detailed, yes.

CHAIR SCHUSTER: Very detailed guidance about the BHAs.

MS. HOLLEN: Behavioral health associate, yes.

CHAIR SCHUSTER: Yeah. And DMS is going to be in charge of accepting the applications and --

MS. HOLLEN: Granting this.

CHAIR SCHUSTER: -- essentially granting the credentialing.

MS. HOLLEN: Yes. And I will say it will be for -- they'll get this for five years. So we had some back and forth with our sister agency, Department For Behavioral Health, Intellectual and Developmental Disabilities, about the policy. I believe it was shared out maybe to Mr. Steve Shannon possibly. I think you've eyeballed it before. It's been a while so --

MR. SHANNON: And we like the five years.

MS. HOLLEN: Yes.

MR. SHANNON: We think that was fair for folks. The initial time frame may have been three, Ann.

MS. HOLLEN: Yeah.

MR. SHANNON: And we didn't think

they could complete their master's program in three years.

MS. HOLLEN: So there's -- I mean, five years is it. That's all -- it's not -- like, you can't apply for another five. It's, like, a lifetime allowance. Okay.

CHAIR SCHUSTER: So the idea being that people are in school moving toward that degree, that we really are more comfortable with people doing these --

MS. HOLLEN: It's really our way of trying to help the work -- you know, we hear everywhere about the workforce shortage. And just recently, I heard on the news about the paramedic shortage in Kentucky.

So it's everywhere, so this was a way for Medicaid to try to assist, you know, and as you just said, get clinicians out there and trained and working.

CHAIR SCHUSTER: So I'm assuming, Ann, that the guidance that you're going to be issuing talks a lot about supervision and those requirements and who has to be the supervisor and so forth.

MS. HOLLEN: So, you know, I can

speak from my college of social work. You know, when you're in school, you have your educational piece that has supervision, but yeah, you also have -- would have to have a master's level. But for billing Medicaid, it would have to be the license enrolled as they're billing. So it's -- you will have billing supervision for us but then you have your clinical side as well. Does that make sense?

CHAIR SCHUSTER: Yeah.

MS. HOLLEN: Now Bart has got his hand up.

CHAIR SCHUSTER: Yeah. Bart?

MR. BALDWIN: Yeah. So quick question. To clarify, you said column 5. I pulled up the fee schedule, so that's where you need to look at what the fee would be for --

MS. HOLLEN: The rates, the reimbursement rates for fee-for-service.

MR. BALDWIN: The rate would be for the BHA.

MS. HOLLEN: Yes.

MR. BALDWIN: And back to that

question you were just talking about in terms of the licensing boards -- because I don't know that there exists -- it may be a billable, but I think there -- the speculation would be there would be changes in the --

MS. HOLLEN: Education -- all right. I'm sorry. Let me hush and let you finish.

MR. BALDWIN: Yeah. No. I know what you're talking about as far as education. They have to -- you know, in order to get their supervision to move towards being able to sit for licensure and those types of things as they're --

But in terms of -- would it put individuals at odds with --

MS. HOLLEN: License.

MR. BALDWIN: -- licensing boards that says you can't do this therapy without a master's or an associate? Do you see what I'm saying?

MS. HOLLEN: Yes, I do.

MR. BALDWIN: So I think there would -- there probably would need to be

changes -- I mean, those regs I don't know nearly as well as some of these. But if it's the social work board or marriage and family therapy --

MR. SHANNON: Social work board especially. BSWs prohibit it.

MS. HOLLEN: Yes. They -- yes.

MR. SHANNON: LSWs really, licensed social workers. So that would be something that those -- that cadre of folks need to really understand.

MS. HOLLEN: Right. So if they have a bachelor's, they would still need to license even -- like you just said, an LSW and working towards a master's.

MR. SHANNON: I think their board says you can't do that at the bachelor's level. It is prohibited for a bachelor's level. No? So some folks have gotten in trouble over that.

MS. HOLLEN: Yeah. How will the guidance be -- it will be in a -- we will send it out in a provider letter. The guidance will come out in the provider letter.

MR. SHANNON: And there will be a regulation, I suspect; right?

MS. HOLLEN: Which -- yes. It's -- Jonathan is probably not on here to speak to that.

MR. SHANNON: But it will go through the public comment process.

MS. HOLLEN: Yes, it will. Yes, it will.

CHAIR SCHUSTER: Okay. And, Michelle, you have your hand up.

MICHELLE: My question was regarding the licensure boards because this -- using bachelor's level folks at the -- in a clinical manner would be against many of the licensure boards. So I just wanted to see where we were in talking with them.

MS. FITZPATRICK: Ann, could I say something real quick?

MS. HOLLEN: Yeah.

MS. FITZPATRICK: So the college -- not college. But the Board of Social Work has now put out a temporary CSW, so that would be the perfect person that would apply

for a BHW -- I mean, a BHA; for instance, and then, of course, the temporary CADCs. This is a perfect example of someone that would apply for a BHA status with Medicaid.

MR. SHANNON: But does a temporary CSW already have a master's degree?

MS. FITZPATRICK: They do have a master's degree.

MR. SHANNON: Right. The BHA may not have a master's. Yeah. The CMHCs have used MHAs for a very long time, and we are really concerned about those folks with a bachelor's in social work because their board has some -- to date has said no. Maybe that will change. Maybe there's another option.

But right now -- so that's an area that we're always paying attention to, those bachelor's of social work folks. But a bachelor's in psychology, I think in sociology, human services, clearly eligible right now to be an MHA. And from our perspective, the new requirement is enrolled in the program and limited to five years.

MS. HOLLEN: I think we will -- I mean, it's not here yet; right? I think --

MR. SHANNON: Right.

MS. HOLLEN: -- what we can do on our end is we can reach out to the licensure boards and show them what we're proposing and get feedback from them.

I will say if you all have any pull with getting them to respond, that would be most helpful. Sometimes we send things out, and we don't get a response back from licensure boards. So, I mean, I think that that's the route we should probably take before we go live with this, is to send our proposal out to the licensure boards, behavioral health practitioner licensure boards, and get some feedback.

CHAIR SCHUSTER: I think that would be --

MR. BALDWIN: That's all I was raising, Ann, just to be sure --

MS. HOLLEN: No. I appreciate that. I appreciate that.

CHAIR SCHUSTER: Yeah. I really think that's the way to go because I'm not sure, for instance, that the psychology licensing board, which is called the Kentucky

Board of Examiners of Psychology, KBEP, will approve a licensed psychologist, either at the master's or the doctoral level, supervising someone to do psychotherapy who doesn't have at least a master's degree, which is the issue that I think the social work board is going to raise.

I mean, that -- you know, the master's has been the lowest level of licensure for someone to do what we have traditionally called psychotherapy. And there are lots of other things that bachelor level people can do but -- just like they would not allow a bachelor's person to do psychological testing.

Yeah. Ramona says special level RNs can't either so --

MS. JUDY-CECIL: I think there will be services that they won't be able to perform. And ultimately, we always say within the scope of your -- you know, what you're allowed to practice.

I think Ann brought up a good point about the licensing boards. We don't control them. We understood there was a need for

this. We're trying to fill that need. If -- you know, willing -- there should be groundswell from the providers, from you all, the practitioners, going to your licensing board and said this is something we need. Can we have a conversation about it?

Because, you know, we can only -- we can only do what Medicaid is able to do. And then we always say if your licensure permits you to do this, if it's within your scope.

So, you know, if -- again, we felt there was a need for this. I think we all have to work together if you really want to see this come to fruition and be what people want this to be so -- so good to note.

MS. DOBBINS: Well, I mean, I would say that many years ago, there was something called an MHA, mental health associate, and bachelor's level -- bachelor's in psychology, Sheila. I know because I was one before I got my master's. You could bill.

MR. SHANNON: Yeah. Still today at a CMHC.

MS. DOBBINS: It was a CMHC. It was when I was working at Seven Counties long

ago. Yeah. So it's been around a long, long time. I mean, it was around a long, long time ago. Put it that way.

And, I guess, has it continued, Steve, in the CMHCs, then?

MR. SHANNON: Yes.

MS. DOBBINS: Yes.

CHAIR SCHUSTER: So are they -- I guess my question is: Are they billing -- were you billing for doing psychotherapy?

MS. DOBBINS: For good or for bad, yes. But I think it -- you know, as Ramona commented in the chat, you know, I think it's a valiant effort to try to address some of the workforce issues.

MR. SHANNON: Yeah. I agree.

CHAIR SCHUSTER: I guess my question is: Are there things that a bachelor's level person who's working on their master's can do that is helpful in addressing our workforce issues but does not include what I think of as psychological evaluations or psychotherapy (inaudible) functions?

MS. DOBBINS: But they would be

under supervision, and hopefully more complex cases would not be going to those individuals. But that's another issue.

CHAIR SCHUSTER: Yeah.

MS. DOBBINS: But it is in existence at the CMHCs already.

CHAIR SCHUSTER: Oh. Michelle, you still have your hand up. Do you still have a question, or is your hand still just up?

MS. HOLLEN: She's also driving.

MICHELLE: No. Yeah. I just asked that question about licensure because what we need is therapists, and I just know the licensure boards do not want bachelor's level folks doing therapy because they're just not qualified. They just don't have the education and information at the bachelor's level to provide therapy. And so I just didn't know what they were saying about this change that we are doing.

So -- but yeah. I don't know if I can take my hand down.

CHAIR SCHUSTER: Oh, yeah. It's down now so -- yeah. I just wanted to be sure.

So, Ann, let me know when you're ready to reach out to the licensure boards because I have some working relationships with a lot of the behavioral health licensure boards.

MS. HOLLEN: I will. I may even "cc" you on the communications. How's that?

CHAIR SCHUSTER: That would be fine.

MS. HOLLEN: Thank you.

CHAIR SCHUSTER: And I do think that this came up years and years ago, back when we had two different cabinets, the Cabinet for Health Services and the Cabinet for Family Services. And I remember being in a meeting and saying, you know, you have licensure boards that are set in statute, and they really have purview over this.

And I do applaud Ann and Veronica, the desire of Medicaid to help with the workforce thing. I think we just have to be really careful about who's out there doing what.

MS. HOLLEN: Right.

CHAIR SCHUSTER: You know, we don't want people to get harmed in some way or think they're getting a service that they're

actually not getting if the person just is not ready to give that service. I guess that's where I'm coming from so...

MS. DOBBINS: I assume that a licensed professional would have to sign off on everything, I would assume.

CHAIR SCHUSTER: Yeah. And that's my question, Kathy, from the -- you know, the board perspective.

MS. DOBBINS: Yeah.

CHAIR SCHUSTER: If you're -- you know, are they going to see that as, you know, aiding and abetting the licensed practice of social work or psychology or whatever. I mean, that's where the boards are going to be coming from, and I think that's going to be the question.

So -- and we've run into this -- as Michelle knows, Kathy Adams and Steve and I go way, way back with the social work board over some of these --

MR. SHANNON: Yeah.

CHAIR SCHUSTER: -- issues for a long, long time.

MS. HOLLEN: They've come to

Medicaid in previous years about some of it as well --

CHAIR SCHUSTER: Yeah, some of these things.

MS. HOLLEN: -- when I first started in policy, behavioral health policy.

CHAIR SCHUSTER: Yeah.

MS. DOBBINS: But it's time limited; right?

MS. HOLLEN: Yes.

MS. DOBBINS: Five years.

MS. HOLLEN: Yes.

MS. DOBBINS: And assuming -- I think you were saying that they need to be working towards something more.

MS. HOLLEN: Yes. Yes, ma'am.

CHAIR SCHUSTER: Yep. All right. Well, that was a simple discussion. Thank you very much. You know, nothing is simple in behavioral health, I think.

Justin, if you're still around, my question was: Have all the providers been notified that your dashboard is up and running?

MR. DEARINGER: We've tried to talk

about it in each of the TACs and -- but as far as a formal provider letter, that provider letter was sent today to our contractor that sends -- sends out those letters.

CHAIR SCHUSTER: Okay.

MR. DEARINGER: It also went to the MCO branch today to be distributed to the MCOs, and it went to our online specialist to put on the website. So those -- I think it was about 10:00 this morning, that went out to each of those groups. So any -- you know, any day now within the next week or so, you know, providers should start getting that letter, and that will pop up on our provider letter website so...

CHAIR SCHUSTER: Great. Well, this is great timing; right?

MR. DEARINGER: Absolutely.

CHAIR SCHUSTER: Today's the day.

MR. DEARINGER: That's right.

CHAIR SCHUSTER: Hooray. Thank you. Thank you so much, Justin. You have really labored. I don't know if it's been a labor of love or frustration for you, but

we're really glad that it's at least up for the providers. Appreciate that.

Pam Smith, if you're still on, we had a question about the 1915C waiting list numbers.

MS. SMITH: I am here. Let me get my screen back up that's got that on there. So we have two waivers that currently have a wait list. So -- and these are numbers as of Monday, the 13th. So Michelle P --

CHAIR SCHUSTER: Are you sharing your screen?

MS. SMITH: No. But I can do that. Let me -- how do I do that? Oh, okay. Let's see. There we go. Okay.

CHAIR SCHUSTER: And while you're doing that, Bart says there was a regulation filed November 13th for the BHA; is that right, Bart? The behavioral health associate.

MR. BALDWIN: Yeah. Yes. I had somebody send it to me just earlier today.

MR. SHANNON: Yeah.

CHAIR SCHUSTER: Okay.

MR. SCOTT: That's right. We're in

a 75-day comment period on 907 KAR 15:005.

CHAIR SCHUSTER: 75-day? Is that what you said, Jonathan?

MR. SCOTT: There we go. Sorry. I got my mute stuck on. Yes. We'll be in a 15-day comment period the rest of this month and then it'll be two months after that.

CHAIR SCHUSTER: Oh, okay.

MR. SCOTT: It should be hitting the LRC website soon if it hasn't yet and then we've sent out our RegWatch email today.

CHAIR SCHUSTER: All right. Thank you. And thank you, Bart, for that heads-up. Sorry, Pam.

MR. BALDWIN: Yeah. I mean, it should be out there now.

MS. SMITH: Oh, no. That's fine.

MR. BALDWIN: That's how I got it, so yeah. But yeah, so comments would be due late January.

MR. SHANNON: Yep.

MR. BALDWIN: End of January.

MR. SCOTT: Or go ahead and send them, so you don't forget because we run into that sometimes, too.

CHAIR SCHUSTER: Yeah. If you give us too much time, Jonathan, we don't know what to do.

MR. BALDWIN: Jonathan, we'd rather have more as we go than all of them on the last day; right? I'm sure.

MR. SCOTT: Yes, yes.

MR. BALDWIN: Thanks.

CHAIR SCHUSTER: Okay. Pam, we're --

MS. SMITH: Okay. So for Michelle P -- so we only have two waivers right now with a wait list. Michelle P as of Monday, the 13th, it was 8,781 total on the wait list. SCL, we were at 3,356 total on the wait list. No one in the emergency category, 81 in the urgent, and 3,275 in future planning.

And, Sheila, I'll go ahead and share the extra stats that -- like I did yesterday. Because I think it's important to know because those are big numbers. But when we look at Michelle P, so 84 percent of the individuals that are on this wait list have Medicaid eligibility, which means they could

be receiving some type of services. They may be in an MCO. They may be receiving them through state plan, but they do have Medicaid eligibility to have access to services outside of the waiver.

And then also within that group, we have 25 percent that are receiving services in a different waiver. So they remain on the Michelle P wait list, but they're receiving services in one of the other waivers. And a smaller percent -- we have four that aren't receiving services yet, but they're in the process of getting there. They've had capacity assigned in a waiver, and they're just working their way through the process of getting a prior authorization for services.

For SCL, 93 percent of the individuals on the wait list have Medicaid eligibility. 65 percent are currently receiving services in one of the other waivers with another 10 percent that are in the process of completing that enrollment in a different waiver. So they are either getting their level of care done or developing that person-centered service plan to get to the point where

they'll actually be able to receive and bill for services as well.

CHAIR SCHUSTER: Okay. So those are stats that we've not had before, and I appreciate that, your ability to go back and kind of look at those individual cases. So, for instance, for Michelle P, you're saying we've got 8,800 people on the waiting list, but 84 percent of them have Medicaid. So they are getting some Medicaid services.

MS. SMITH: Uh-huh.

CHAIR SCHUSTER: And another 25 percent, so a quarter of them, are actually getting waiver services in a different waiver, a different kind of waiver.

MS. SMITH: Correct.

CHAIR SCHUSTER: So they could be in HCB or something else.

MS. SMITH: Yeah. Most of them are in HCB. We do have a few that are in SCL. It's kind of a bizarre -- there's this lore around Michelle P, that it is kind of the end-all, be-all of waivers that -- you know, I don't know what exactly caused that to happen. But we have some people that are

on -- that are actually receiving SCL services, but they do not want to give up their spot on the Michelle P wait list.

And so we don't -- you know, if they -- because usually the goal is to get -- you know, it's kind of a bridge. You get Michelle P. And then later, at a time where you're going to need residential or need more intense services, then you go to SCL. But there's just this kind of idea about what Michelle P is that caused some of those individuals to not want to give up their spot on the wait list.

You know, we verify every year. We, you know, check their demographics. We check -- you know, follow up with them. Are you still in the state? Do you want to remain on the wait list? And so unless they -- unless they ask us to take them off the wait list, then we do leave them on, on the wait list so...

CHAIR SCHUSTER: Okay. And then the 4 percent that you talked about, Pam, are in process of getting enrolled in Michelle P?

MS. SMITH: Yeah. So there are 4 percent -- so for Michelle P, there are 4

percent. In SCL, there are 10 percent. So what that means is they've been given a spot, so they've been allocated a spot in the waiver. And so they're in the process of getting their level-of-care evaluations, you know, setting up their team, getting a PA established. They just have not started receiving services yet.

CHAIR SCHUSTER: Ah. Okay. So -- and the same thing, although in SCL, it's 93 percent that have Medicaid.

MS. SMITH: That have Medicaid, uh-huh.

CHAIR SCHUSTER: And another 65 -- and I assume most of that 65 who are getting it in other waivers are on Michelle P?

MS. SMITH: Yeah. The majority of them are on Michelle P. There are a couple that are -- or a couple. I don't have the exact number. That was a bad word to use, some that are in HCB. But the bulk of them are in Michelle P.

CHAIR SCHUSTER: Okay. And then another --

MS. SMITH: We actually --

CHAIR SCHUSTER: -- 10 percent that are getting enrolled.

MS. SMITH: Right. That are getting enrolled. They've been given their slot, and so they're just in the process of getting all the way through all the steps to actually have an authorization and receive services. I don't move them up to that other category until they actually have received -- we know they're actually receiving services.

CHAIR SCHUSTER: Okay. Any questions? Mary, do you have any questions about those numbers?

MS. HASS: I have a couple of questions. Pam, I know you say what's on the wait list. What are the actual numbers for ABI waiver? Because I was given -- I don't know if there were some people in transition, but there were four people waiting for the ABI long-term care.

And then I'm working on another project right now and have been out to see some of the ABI waiver providers. And they're telling me that there's some holdup of getting people into the acute waiver.

Do you know what they're talking about, and can you give me those exact numbers on ABI, please?

MS. SMITH: I have no idea. So if you can find out, Mary, and you either have them call me or you let me know. But for ABI acute -- and this, again, is as of Monday. We had 264 that were in slots receiving services. There were 23 that were reserved.

And that's kind of like -- so the reserved is kind of like this 4 and 10 percent I quoted with Michelle P and SCL. They've been given a slot, but they haven't got all the way to the point that they're receiving services yet. And there's 96 available.

For ABI long-term care, we've got 413 that are receiving services; 15 that are in that reserve, so they're working their way to getting services; and 10 slots.

MS. HASS: Will you be kind enough to email that to me? That was a lot of numbers to try to write down all at once, if you'll send that to me. And then I can work -- like I said, I'm working on another

project right now with the ABI waiver providers. And so then, you know, that was just mentioned to me the other day that there was difficulty in getting people to the acute -- again, it was just mentioned, and so I can go back and find out more on that. I knew we had this meeting today, and I knew I was on the agenda for today.

The other question that's coming up -- and I know Sheila has therapy services on there. We're still in limbo on the therapy services, so really nothing -- no one really had anything to report on that.

The other thing they're reporting to me is on the behavior specialist, that the behavior specialist could write the plan, but they cannot be in with the development or in -- that's a bad choice of words, in with the actual implementation. So they say it creates a problem because they're getting this information from, you know, different sources when they write up the behavior plan. But until they actually put it into effect -- so they're not really able to work in with those individuals.

So that's a problem, and I know that's something, I think, Bart has addressed with you guys, also. But that's something we probably will be bringing to the legislature in the upcoming session, is they feel very strongly about not being able to actually work with that person as they implement the plan.

So anyway, that's what I have to report, and I appreciate if you can send me the numbers -- the actual numbers on the ABI. But as far as therapy, I think it's just -- you know, we're still in limbo right now.

MS. SMITH: So, Mary, I will send you that, and I will ask, too, if you send me some more details on the behavior so that I can kind of research that situation a little bit more and understand what they're -- kind of the question.

MS. HASS: I think Bart could also help you on that, also. But I don't want to speak for you, Bart. I know you're on here. But anyway, I will -- I will get the exact -- like I said, I'm surveying the ABI providers. And those were just some things, like I said,

that were brought to my attention but not to any real depth of detail for me to discuss. So anyway, I will work on it.

MR. BALDWIN: Yeah. Mary, just copy me on what you send Pam. And that way, we'll connect on that.

MS. HASS: Okay. Sounds good, Bart.

MR. BALDWIN: Thank you.

MS. HASS: That's all I have to report.

CHAIR SCHUSTER: Okay. Thank you. Thank you, Mary. Let me know for our January meeting if you want me to put the behavior specialist issue on the agenda, if that --

MS. HASS: I can say for now, I would like for that to be on there.

CHAIR SCHUSTER: Okay. All right. All right. Thank you very much, Pam.

Proposed changes in the delivery of mobile crisis services in Kentucky.

MS. JUDY-CECIL: Hey, it's Veronica.

CHAIR SCHUSTER: Hi, Veronica.

MS. JUDY-CECIL: We don't really

have a substantive update today. We are still navigating the contracting from the request for proposals that we issued for the administrative services organization. Do anticipate that to hopefully get completed in the next couple of weeks.

Then the next step will be working with the new ASO to develop an implementation plan which will absolutely include stakeholder meetings. The ASO will hold stakeholder meetings. We'll start working with providers about what the requirements will be as part of the mobile crisis initiative. So, you know, stay tuned for more information on that hopefully in the next month or so.

CHAIR SCHUSTER: Okay. So that's a delay. I think you all had hoped maybe for October?

MS. JUDY-CECIL: We had hoped, yes.

CHAIR SCHUSTER: Well, you know, hopes are always good but --

MS. JUDY-CECIL: As you can see, we have a lot going on.

CHAIR SCHUSTER: Yes. You have a few balls in the air, as they say.

MS. JUDY-CECIL: Just a bit. Just a bit.

CHAIR SCHUSTER: So -- and we'll get -- I assume when the announcement is made that the contract has been awarded, we will get more details?

MS. JUDY-CECIL: That's correct, yep.

CHAIR SCHUSTER: So that would be the next point of information.

MS. JUDY-CECIL: It will be, yes.

CHAIR SCHUSTER: Okay. All right. And do you want to take us through Medicaid unwinding and recertifications?

MS. JUDY-CECIL: Would absolutely love to do that.

CHAIR SCHUSTER: I know it's your favorite thing to talk about.

MS. JUDY-CECIL: It is. It very much is.

CHAIR SCHUSTER: You can do it in your sleep, as they say.

MS. JUDY-CECIL: I do. I do. In the interest of time, I'll try to breeze through these a little bit. But please know

that we will provide the slides, both Pam's slides and our slides, to the TAC and then they'll get posted on the TAC page as part of the supplemental to the meeting agenda. So just --

CHAIR SCHUSTER: And I will also send them out to everybody who gets my emails, so thank you for that, yes.

MS. JUDY-CECIL: Well, I appreciate you taking that action.

Want to just note a couple of key flexibilities and strategies we've recently implemented that I think is really great for Kentucky. One is that we are suspending child renewals, and what that means is that starting with October renewals, if a child was up for renewal, we are going to automatically grant that child 12 months' continuous coverage.

Just as a reminder, we did implement continuous coverage for children back in April. All states are mandated to do that starting January of 2024, but Kentucky went ahead and implemented it as part of our unwinding plan.

With continuous coverage for children, what that means is if a child is determined eligible, that child is granted 12 months' continuous coverage. And the only reasons why that child's coverage could end is if they turn 19, if they move out of state, if a guardian or a parent has requested disenrollment, like to be moved to other coverage. And, of course, if the child passes away, then coverage ends.

But what we're doing now for the unwinding is we won't have to make that determination. We can just go ahead and grant them the 12 months and then the rules apply for continuous coverage during that period of time.

We're talking about 400,000 children that we're going to be able to just go ahead and extend them for those 12 months. So the renewal is from October to April of '24, which is the end of our unwinding period. We're not allowed to do it past that time.

The other one I want to talk about is we are going to do our redistribution of December renewals. What that means is that

states have discretion about how we allocate the cases across the unwinding period. Because there is a bit of a backlog both in renewals and applications, what we would like to do is to lessen the work in December for our workforce and then reallocate those or redistribute those cases later on into the unwinding period.

You will still see some cases that will be in December because if we're able to go ahead and what's called passively renew the member -- so the member has to take no action. They don't have to provide any documentation. We're just able to go out and check the databases and verify their eligibility. We'll still continue to do that.

What we won't do is terminate somebody for ineligibility or for an active renewal if we need a request for information. We will redistribute that case to give them a new renewal date. So they won't even know that that's happened because we run that at the beginning -- we'll run that at that beginning -- well, we did run that at the

beginning of November. So they won't get any kind of notice if we're not able to passively renew them. But if we are able to, they're going to get that notice of eligibility that they've been renewed.

We also are not going to change any December renewals that align to another program. So as you all may remember, one of the efficiencies that we've done through unwinding is if somebody has a SNAP or TANF case, we've aligned the renewal date for Medicaid with those other programs so that the caseworker only has to touch the case once. Because we are renewing Medicaid based on SNAP eligibility. So this way, that case doesn't get bifurcated, so it stays together.

So you will -- you may still see terminations in December as a result of that. Because if the person is ineligible across all the programs, then they will lose eligibility for Medicaid as well.

And then we will also allow for that -- if somebody has an income that's above the Medicaid federal poverty level and makes them eligible for a Qualified Health Plan with

advanced premium tax credits so, you know, makes that premium either at no cost or low cost, we will still transfer those individuals for them to be able to access a Qualified Health Plan. So, again, December, you're going to see a very small number of cases but still some activity as a result.

And I'll show you how we're -- what the caseload is going to look like going forward in a few slides. We also -- a new flexibility we've not talked about is that we are extending all populations by one month if they've not responded to a notice. So most -- people who don't respond to a notice get what we call procedurally terminated, and we're trying to prevent those procedure terminations by giving folks additional time to get the response to the notice in.

So we've been -- for long-term care and for 1915C members, we have been, through the unwinding period, extending them up to two months. Right now, we just got authority to extend them for one more additional month, so a total of up to three months.

So what happens is if they were due for

a renewal in October and they didn't respond, we could move them to November. If they don't respond in November, we could move them to December. So we can move them up to three months if there's no response on file.

Now, the one-month extension is for all other populations to be able to do that. And, again, I think those are helpful to our population, to members going through renewal.

Talk a little bit about -- we've talked a lot about HCBS 1915 waivers today but just specifically how that's going with unwinding. As you all may know, in the HCBS world, that Appendix K is the -- has been the vehicle for the flexibilities we have for the Public Health Emergency.

And in order to continue those past November 11th, which was the deadline for those flexibilities to end, we had to implement those -- we had to incorporate those flexibilities in our six waivers. So to do that, we went out and amended those waivers, sent them out for public comment, got a lot of great public comments back.

Pam and the team have done a great job

of incorporating those, going through and, obviously, will be responding to them. But we were able to amend those waivers and get them submitted to CMS prior to November 11th, which means they can -- we can maintain those flexibilities, including the rates, through the rest of the unwinding period or until the waiver gets approved.

We asked for an April 1st, 2024, effective date. It just sort of depends on how that process goes with CMS. Because we are not the only state that had to do this. Any state that wanted to extend flexibilities had to amend their waivers to do it, so we'll see what happens with that.

But this is a list of the flexibilities that we're going to move to become permanent through the waivers. And so those of you who went and reviewed the waivers prior -- for public comment probably saw these. So, again, we'll send this out, so you all can take a look at it.

Just to quickly touch base on where we are with our renewals. So six months in, hard to believe it. November will be month

seven. And just to go through for just the previous month, October, we had 155,000 individuals that were subject to renewal. We were able to approve almost 90,000 of them, which is a tremendous number, and our termination rate is dropping. We had about 12,000. Excuse me. I've got a cold.

And then the pending bucket means that they're pending processing by our eligibility workers, and you'll see the large extended number. Again, those are because we're reflecting -- if we've moved a renewal from a previous month, that's in that bucket. Excuse me.

CHAIR SCHUSTER: Do you have a question, Bart?

MR. BALDWIN: Yeah. Real quick. Veronica, while you catch a breath there real quick, I appreciate everything that you all are doing in terms of those flexibilities on the renewals. That's really important right now, so I appreciate that.

I have a question that this kind of -- talking with a provider the other day, a light bulb kind of went off in my head of

some of what's going on. So, you know, in terms of -- so if you had somebody in -- and just making up these numbers. If you had somebody in 2020 or 2021 that got on Medicaid, they were making nine dollars an hour, you know. And now they're going up for renewal, and they may be making -- because wages have changed due to the market and due to inflation, et cetera, and they're making 12.50 an hour.

And so now they're no longer eligible for Medicaid because it's a percentage of the federal poverty level. But that 12.50 really doesn't buy them any more than the 9 dollars did because of the cost of -- because of inflation.

So has the federal poverty level that Medicaid eligibility has been tied to, has that been adjusted, or has that lagged behind -- lagged behind the basic rapid increase of the cost of living, you know, is what I'm getting at.

MS. JUDY-CECIL: Yeah. It absolutely has adjusted up. So I think at one time in 2020, it might have been 18,000

something. It went up to 19,000 and something, and now it's, like, 20,000 something. So yes, the federal poverty level has been adjusted. Is it sufficient? I can't answer that question because I don't get to make that decision but...

So the problem is that we did see -- for instance, the cost of living for Social Security was a really good cost of living, and I know people were really happy about that. But guess what it did? It put them over the Medicaid federal poverty level. And so we're, you know, grappling with that. Or, you know, we're seeing folks lose coverage now as a result of that.

So it's an excellent point. I think what's important with that, if they have exceeded the Medicaid federal poverty level, that is why it's critically important that we connect them to a Qualified Health Plan. And I'll talk a little bit about that, too, although I know we're running up on time.

But we -- our goal has been if you're no longer Medicaid eligible, let's get you covered some other way, employer, you know,

Qualified Health Plan. So we've really worked to try to message that to folks in getting them to move over to a Qualified Health Plan. And we have seen folks do that. We're monitoring it because we want to -- we want to see that. We're really pushing for that.

MR. BALDWIN: Yeah. Thank you.

MS. JUDY-CECIL: You're welcome. Reinstatements. So we are tracking if somebody is terminated because they didn't respond to a notice and they realized the next day that, oh, wait, I had a notice I had to respond to. They can still provide the information, and we'll reinstate them back 90 days to their termination date if they can do it within that 90-day period. So they don't have to ask for that. It should be automatic, but they do have to be determined eligible for that to apply.

But you can see we're tracking those as well, so we're really glad to see that. Because if we're losing them because just they didn't respond to a notice, you know, we really want them to get back in.

We've got a new demographic report out. It's on our unwinding website. We're really excited about it. It starts in September. We're working on the one from October. I should be able to release that very soon.

But, you know, it just gives us an opportunity to reflect where are we seeing, you know, trends. There's a -- in the report, it goes down to the county level, so you can see approvals and terminations at the county level. Just, again, a way for us to kind of see who is the population being impacted by our renewals.

And just overall trends. As you all can see, we've got a 60 percent overall rate. But I think the good news for approvals, 83 percent of those are through that ex parte passive renewal. The members had to do nothing. We were able to go out and check and verify all the databases, income, assets. And they didn't have to do a thing. We were just able to tell them, guess what, you've been determined eligible.

I mentioned that -- our redistribution plan. So this is an update of what those

projected cases are going to look like. As I noted, there are still cases in December, so we're going to attempt to do that passive renewal for -- for the members, or they may be tied to another program, the renewals tied to another program so -- but a very small number.

And then I think the good news is, is what we're seeing as we keep aligning cases, as we keep implementing our flexibilities, the caseloads are -- you know, are fairly manageable. I'm going to say fairly. It's still a high number. But at least, you know, we're trying to keep that manageable.

I mentioned Qualified Health Plan enrollment. So as you see Medicaid trend down in enrollment, we want to see Qualified Health Plan trend up, and that is what we're seeing. So that's good news.

And then just to note, we are in open enrollment. So we're tracking the fact that, guess what, we've got -- just since open enrollment started, we've got over 1,000 new members. And we're seeing current members renewing, so that's great, to keep them

covered.

So just a plug for open enrollment for a Qualified Health Plan. This is for a Qualified Health Plan. That's running now through January 16th. After January 16th, you can do a special enrollment if there's a qualified life event.

And for anybody who loses Medicaid, there is an unwinding special enrollment. So all you have to do is attest that you lost your Medicaid, and between now and July 31st next year, any time, you can come on. Even if you've been disenrolled now, you can still come back on for that reason.

Just a reminder to all the folks on here, providers and stakeholders and advocates and members. We have a lot of information on our website about unwinding, lots of flyers. We have a new one about reinstatement, to try to help people understand how to navigate the reinstatement process.

We're working on a new one about navigating the identity proofing that has to happen to create that Kynect account. We

have heard that that's an issue for folks, so we're creating a special flyer around that. And we'll be circulating that soon.

And then our next stakeholder meeting is tomorrow at 11:00. If you can't make it, we always record it and post it. So at your convenience, you know, if you're trying to get to sleep at night, you can go out there and look at it. It'll probably put you right to bed.

But Facebook, Twitter, and Instagram is the best way to stay on top of information around unwinding. If we find out about a scam, we'll push something out about it. So you don't have to do all three, just one, because the same information is delivered on all three programs.

So there you go.

CHAIR SCHUSTER: Great. And I think your voice almost held out --

MS. JUDY-CECIL: Thank you.

CHAIR SCHUSTER: -- so rest your voice. And we'll get those slides from you; right, Veronica?

MS. JUDY-CECIL: Yes.

CHAIR SCHUSTER: Thank you very much.

MS. JUDY-CECIL: You're welcome.

CHAIR SCHUSTER: That's excellent information.

I'm going to move through quickly. I thought we -- the next agenda item is the interim session, and I thought we would have some of the recommendations from the task forces, but we do not. So I'm going to skip over that.

I'm particularly interested in whether the school safety -- school and campus security task force, which some of us -- Steve and I and Joe Bargione, a school psychologist, testified. And we were hoping for some recommendations, but it may not be happening.

Agenda -- oh, I need new recommendations to the MAC for their November meeting. Anything from any of the voting members? Steve, you unmuted.

MR. SHANNON: Just in case there was a discussion. I don't really think so. I mean, there's a lot going on. I don't know

if there's a recommendation after everything that's taken place but --

CHAIR SCHUSTER: That was my feeling, too. We've got a lot of balls up in the air. We may need a few -- we may need to catch a few before we can figure out what a recommendation would be.

For agenda items in January besides our carryover, I've got the behavioral health specialist issue and the ABI waivers. And then we'll send out both reports of Senate Joint Resolution 54 on the rates, and we'll put that on the agenda to see if there are any questions.

And maybe Veronica or Ann or somebody could find somebody, if we formulate some questions, that might be able to answer. It depends on how technical that second report is.

I do want to get to an issue that came up that I put under new business, and that is that we're hearing that there are problems in schools billing Medicaid for mental health services to students.

MS. JUDY-CECIL: That would be news

to me. I don't know if -- anybody else on the Medicaid team has any idea that there are barriers?

CHAIR SCHUSTER: Or problems. Justin, your name came up in this discussion.

MR. DEARINGER: Did it? If it was problems, then it shouldn't have been my name. No. I'm joking.

CHAIR SCHUSTER: Well, no. I didn't mean to lay that on you but...

MR. DEARINGER: Right. No. I know that we had a few -- we've been having multiple discussions and talks with school districts on if they were having -- one of the things that we've noticed, you know, with our new child and maternal health branch is they reach out to school districts, and they run reports, and they do research on utilization of all services in school-based services. But in particular, with behavioral health services, is that there are a lot of school districts that don't utilize those, or at least they don't bill Medicaid for those.

And so we have reached out to school-based -- or to schools. We've been

meeting with school representatives and behavioral health representatives and different groups with the Department of Education trying to see why they're not billing and if there are any barriers or issues for schools to bill for mental health services to students.

And so the goal is to make sure that there are not, to make sure that we don't have any goals or barriers up, No. 1. No. 2, to increase education. So we've went on kind of a campaign to push for all school-based services and to increase education to school districts on how they can bill, what their options are, you know, all the different ways that they can utilize Medicaid services in school systems.

And so that's -- that's what I know that we're actively involved in right now. I don't -- I don't know of any particular barriers in place. We have been able to remove some prior authorizations that -- and some other administrative burdens that -- those weren't really specific to behavioral health. But we've been able to do a few

things like that for school systems and school-based services.

We've been able to open up some contracting options and some telehealth options for them also that have alleviated a lot of issues for, you know, large school districts, I know Fayette County being one.

But as far as -- you know, in particular, I know that this is a topic that we have tried to target because we've seen a lack of billing for mental health services in schools. And so maybe that's what -- what you've heard, is that we're kind of targeting some schools that are -- some school districts that aren't utilizing those and saying: Why? What can we do to help?

CHAIR SCHUSTER: Yeah. I think that's exactly it. Is Joe Bargione on?

MR. BARGIONE: Yes, ma'am. I'm on.

CHAIR SCHUSTER: Joe is my go-to school psychologist, retired, but still working. Does Justin's report match what you had been hearing, Joe?

MR. BARGIONE: Yeah. I think -- part of the issue, I think, is -- the concern

we have is with some financial resources that are available through Medicaid to go for behavioral health services for school districts, they're not. I think some of the districts -- currently, they're using some of those federal dollars, you know, from the -- they got from the pandemic to hire behavioral health specialists or practitioners. And then when those dollars go away, the question will happen is: How are schools going to be able to fund those behavioral health specialists?

Because, you know, with Senate Bill 150, the School Safety & Resiliency Act of 2019, they're trying to shoot for the goal of 250 -- a behavioral health practitioner to every 250 students. So I'm wondering: If schools are under-utilizing Medicaid as a funding stream, what is it that's keeping them from doing that?

MR. BALDWIN: Hey.

MS. JUDY-CECIL: That's what we're working on definitely, is how can we encourage them to increase -- we would love, love to cover a behavioral health

professional in every school. We'd be more than happy to do it. But the schools have to be willing to -- you know, to bill for that. And so part of our effort is to go out and make sure they understand how they can navigate that process and, you know, we'd love to see it.

MR. BARGIONE: Veronica, over the last few years, have you seen an increase in two ways, one, the number of districts billing for behavioral health service under Medicaid and also the totals? So if I'm, you know, school district X and I'm billing, say, over the last three years, am I actually billing more time over the last three years or -- you know, it's relatively consistent, or it's gone down? So the two questions -- like I said, one is: Are more districts billing for Medicaid? And then the ones who are billing, have you seen a steady incline in reimbursing them for services?

MS. JUDY-CECIL: Justin, can you --

MR. DEARINGER: Absolutely. So two different questions. I think there's been -- it's been stable as far as the amount of

individuals that are billing. So we haven't seen an incline in that when we did the study, when we initially did -- when we initially reviewed that.

But we did see that those school districts that were billing, that billing increased, had been increasing over time. And so the school districts that are billing are increasing that billing. They're increasing services. They're billing Medicaid more. They're receiving more paid claims.

But the amount of school districts that were billing was stagnant. And so that was one of the things that -- one of the reasons why we started this, you know, project and this outreach. You know, there's so many different things that, you know -- that we're working on right now individually with different school districts.

You know, some school districts have, you know, agreements in place with providers in their community, and those agreements don't really line up with the way Medicaid is billed. So we've tweaked and made changes to

policy and billing to allow that to work so that they can bill.

Other school districts are kind of too small to hire a behavioral health professional, or maybe there's not a behavioral health professional within their immediate area. But there's two or three other school districts in their adjoining counties that have the same issue, and there's a behavioral health specialist in a county adjoining them.

We get all of them together, have them talk. They go together and contract with that behavioral health specialist, and that gives them the amount of students they need plus the -- and now they all have a behavioral health specialist.

So it's very individualized. Our staff is doing a lot of work individually with individual school districts. So that's going to go up as we continue to work with school districts and continue to find these unique solutions to each of their issues, and so that's going to increase as we work with them and as education gets out.

MS. JUDY-CECIL: Yeah. I think the other thing to note with that is even if the school might not be billing it up through the school-based services, they have a contract with a behavioral health provider, like an FQHC, RHC, or a CMHC, that's delivering the services and billing Medicaid directly.

So those are the two models. You know, the school can do it and provide it. And even if they contract with somebody, they can bill it up through the school-based service. Or they have a provider in the community. They've just said we want to send our kids to you or is willing to be the school clinic and bills Medicaid directly.

And so that also is something we're really trying to do an environmental scan on, is to try to figure out -- you know, if a school is not wanting to do it through school-based but instead is utilizing a clinic that's billing Medicaid directly, how do we make sure that, you know, the services are being delivered?

MR. BARGIONE: Thank you.

CHAIR SCHUSTER: Karen, you had

your hand up.

MS. GARRITY: Yeah. Just dovetailing with what Justin and Veronica just stated, there are some school systems that don't want to become behavioral health providers. They want to focus on education and have the behavioral health experts handle that.

And I know in the life skills region, we've entered into contracts with a couple of different school systems where we've put therapists in the schools. That's their work site, and they're there. They're part of the faculty and, you know, the community there.

So there are different things happening, so just -- I think you all stated that you are aware that just because the school isn't billing school-based services, that doesn't mean it's not happening. Yeah.

MR. BALDWIN: Right.

MR. DEARINGER: Yeah. That's one of the good things about what we're doing, working with each individual district like this. Because each one of them is unique, each one of them has something that they want

to do, and each one of them has, you know, a different model that they would like to have.

And so it allows us, when we go into school districts that's not really billing at all, to say, well, you can do it this way, this way, this way, this way, or this way.

And our job as Medicaid is to make sure that we make all of that work for each individual school district and that we remove any barriers, whether they be administrative or financial, to allow them to be able to do that. And so it's been great work.

Erica Jones is our branch manager of that child and maternal health branch. She's done an amazing job, and so we are consistently seeing more school districts bill and provide services and expand services in, like you said, a variety of ways.

We've recently started to expand, you know, care in different hours in school-based settings. There's all kinds of exciting things that we're doing there but...

CHAIR SCHUSTER: Yeah. That's great to hear.

Bart, you have your hand up.

MR. BALDWIN: Yeah. Just real quick as a resource. And, Justin and Veronica, you all may know -- probably know this already. But the Kentucky School Boards Association has -- works a lot with and has a whole program for Medicaid billing for their members. And so yeah, so I was thinking about that, that that might would be a resource to -- if they could identify -- if there's barriers, they would probably be ones that might know what they are so...

But anyway, that was something I talked with them years ago, so that's probably still in place.

MS. JUDY-CECIL: Yeah. I appreciate that. We've been working both with the Kentucky Department of Education and the School Board Association because, as Justin mentioned -- so school-based services, or at least services for students regardless of the model the school wants to utilize, is going to be our focus for 2024.

We're really going to, as Justin mentioned, go out there, make sure schools know and understand what's available and how

to provide those services or provide access to those services, is probably the better way to put it. And so we've been working on a campaign around that as well that we hope to -- you'll see a lot more of this in 2024.

MR. BALDWIN: Great.

CHAIR SCHUSTER: I'm going to put a pitch in for the school nurses, Veronica and Justin, because, you know, there's a big push on to get some funding in this budget coming up to complete the coverage. 59 percent of our school districts have a full-time nurse in every building, but 41 percent don't.

And if we could get 8.8 million, which is really peanuts in terms of the money we have available to spend if they're willing to spend it, we could get the rest of those nurses in there.

And trying to get the schools to bill for those physical health services that the nurses are providing. So I hope that you are including those as well in your work with the schools.

MS. JUDY-CECIL: Yeah. Absolutely.

CHAIR SCHUSTER: Good.

Steve, do you have anything to add?

MR. SHANNON: It was said. I think -- I mean, everyone said this. The focus is our kids getting services. Does it necessarily matter who's billing it, you know, as long as -- and I think that's the real question, I think, we all need to ask. Is there sufficient capacity in schools for kids?

And if schools are doing it, what's the interface with families, you know? How do you make sure all those things happen, you know? So if families need support, they get supports. So -- and what happens in summer months?

CHAIR SCHUSTER: Yeah.

MR. SHANNON: You know, there's a lot of questions about how to make this work well for everybody.

CHAIR SCHUSTER: Yeah. I think this is an excellent topic, and I appreciate the input from Justin and Veronica and the good questions that were asked.

Anything on targeted case management policy clarification?

(No response.)

CHAIR SCHUSTER: I think that --

MS. HOLLEN: Sorry. What's the ask about the clarification?

CHAIR SCHUSTER: Well, I thought there was somebody from -- well, there was a question that came up from Tracie Horton at Adanta, and I think -- in terms of --

MS. HOLLEN: Okay. Let me follow up with Leslie. I think she was working on that.

CHAIR SCHUSTER: Okay.

MS. HOLLEN: Maybe with Tracie. Just, I mean, directly with Tracie; okay?

CHAIR SCHUSTER: Yeah. All right. Thank you.

MS. HOLLEN: You're welcome.

CHAIR SCHUSTER: Any formulary issues that anybody has?

(No response.)

CHAIR SCHUSTER: Good. Nobody has any complaints.

All right. The next MAC meeting is the week after Thanksgiving. I put 10:00 to 12:30, but it may actually -- yeah. That one

will be 10:00 to 12:30, maybe 1:00, and then we'll start the new time frame in 2024.

And our next BH TAC meeting will be January 11th. And remember that in January and March, we meet from 2:00 to 4:00 instead of 1:00 to 3:00 because, you know, all those legislators are in town doing whatever it is that they do, good, bad, or indifferent, hardly ever indifferent.

So if there are no other issues to be brought before the MAC -- I held you a little bit late -- I'd like to wish you all a very Happy Thanksgiving to you and your families, and thank you for all of this joint work to make our folks in Kentucky healthier and happier in every way. So Happy Thanksgiving to you all.

MR. MUDD: Sheila, you're saying our meeting in March is from 2:00 to 4:00 as well?

CHAIR SCHUSTER: Yes. Yeah.

All right. Thank you all very much. And thank you, Kelli, for guiding us through. Appreciate it.

MS. SHEETS: Happy to do it.

CHAIR SCHUSTER: All right. You all take care.

MS. JUDY-CECIL: Happy Thanksgiving.

CHAIR SCHUSTER: Bye-bye. Happy Thanksgiving.

(Meeting concluded at 3:05 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 30th day of November, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR