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

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Via Videoconference
July 11, 2024
Commencing at 1:02 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, Chair

Steve Shannon

Valerie Mudd

Tara Hyde

Eddie Reynolds

Mary Hass (not present)

T.J. Litafik

P R O C E E D I N G S

CHAIR SCHUSTER: So welcome. As they say on the plane when you're on the tarmac, if you're on the flight for the BH TAC, you're on the right plane. So glad to have you.

And let's see. Let's have our voting members introduce themselves. Valerie, I see you first here.

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

CHAIR SCHUSTER: Great. Thank you.

And, T.J.?

MR. LITAFIK: Hello. T.J. Litafik representing NAMI Kentucky. I hope everybody is enjoying their summer.

CHAIR SCHUSTER: If we could stay away from the tornados, the storms, and the heat, I think we're in good shape. Thank you.

And, Tara?

MS. HYDE: Hi, everyone. Tara Hyde with People Advocating Recovery.

CHAIR SCHUSTER: Great. Great to have you.

And, Eddie?

MR. REYNOLDS: Right. Eddie Reynolds with the Brain Injury Alliance of Kentucky.

CHAIR SCHUSTER: Great. Thank you so much. And I'm Sheila Schuster, the representative from Kentucky Mental Health Coalition and your chairperson.

So the minutes of our May 1st meeting were distributed in advance, and I would entertain a motion from one of our voting members to approve those.

MS. HYDE: Motion.

CHAIR SCHUSTER: Who was that? Tara?

MS. HYDE: Yes.

CHAIR SCHUSTER: Yeah. Thank you.

And a second?

MS. BICKERS: Can you be on camera while voting, Tara, please? Thank you.

MS. MUDD: I'll second. This is Val.

MS. HYDE: Sure.

CHAIR SCHUSTER: Okay. Any additions, corrections, omissions in the minutes that need to be corrected?

(No response.)

CHAIR SCHUSTER: If not, we'll ask for a final vote of approval. All those in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed, like sign?

(No response.)

CHAIR SCHUSTER: All right. Thank you very much.

Erin, I don't believe that we got a response to our recommendation from the Department for Medicaid Services.

MS. BICKERS: It is under final review, and as soon as I get that approval from upper management, I'll have it out for you guys.

CHAIR SCHUSTER: Okay. Thank you. You all --

MS. BICKERS: It should be anytime now.

CHAIR SCHUSTER: Yeah. You all

may --

MS. EISNER: Sheila.

CHAIR SCHUSTER: Yes.

MS. EISNER: Can you review what that recommendation was, please?

CHAIR SCHUSTER: Yeah. The recommendation was that Kentucky Medicaid provide written guidance to providers about the pre- and post-payment audit procedures being conducted by the MCOs. And that was as a result of the excellent presentation that we had on the audits and then a lot of discussion that followed that.

So we're anxious to get that response from DMS. And as Erin noted, once we get that, we will send it out to the voting members and to all of you who are on my notification list.

So my email is kyadvocacy@gmail.com. So if you didn't get an email from me directly about this meeting, send me an email and request that you be -- thank you, Marcie. Marcie has got it in the chat for me. Appreciate that.

And is Victoria Smith on? I can't see

who all is here.

MS. SMITH: I am on, Dr. Schuster.

CHAIR SCHUSTER: Wonderful.

MS. SMITH: I have a presentation for you today.

CHAIR SCHUSTER: Yes. And we've been waiting that with bated breath, as they say. And I want to thank Victoria because she was kind enough to send that information out in advance. And I circulated it to both the voting members and to all who are on my email list, and we got a number of questions that we sent back to her.

And I think, Victoria, that you're going to try to incorporate in your presentation the responses to some of those questions; right?

MS. SMITH: I am, Dr. Schuster. Can you see my screen?

CHAIR SCHUSTER: Yes.

MS. SMITH: For some reason, when I started sharing, then I can't see my screen that I'm sharing.

CHAIR SCHUSTER: Yes, we can. Thank you.

MS. SMITH: I hope I'm sharing the right one. Okay.

Yes. What I did is I went ahead and I took all your questions, and I incorporated them into the presentation that I'll go through today. And I added some slides at the end for next steps and discussion in regards to some of the areas we might want to dive into a little bit deeper.

So I'm just going to go ahead and jump in. And at the end, we'll have plenty of time for questions and clarifications. And I'm not going to go through this entire presentation because you all got it ahead of time, but what I wanted to do is just answer your questions as we went through this today so...

CHAIR SCHUSTER: Wonderful. Thank you so much.

MS. SMITH: This will -- there we go. As you know, what was included in the presentation was just comparison tables. We identified services for further study and then we also let you know which services we couldn't match. We also provided individual

state tables as an addendum.

One of the questions that came up was -- we had some questions about this slide here, the behavioral health needs of Kentucky. What we were trying to do with this slide is just kind of point out the difficulties when looking at a Medicaid program from one state to the next.

You know, Medicaid has this lovely flexibility where each state can really design a program to meet the beneficiaries of that particular state. And so that's all we were trying to do here, is kind of keep in mind, you know, as we go -- as we go shopping and look at our comparison list, keep these things in mind.

This was not included in the study as far as whether it plays a role in determining what types of services. It was just -- it was just a thought that, you know, when Kentucky Medicaid looks at what behavioral health services to provide, they keep in mind the needs of their consumers, or their beneficiaries.

The cost of living was something that we

were trying to look at, and Dustin Wallen did some work in that area for us. And it really was negligible. We could not find a correlation to any great degree between the cost of living in the state and then whether or not the state would have had the higher or lower rates. And so that should have been eliminated, so I apologize for the confusion on the cost-of-living statement.

I wanted to back up. You know, originally, we prepared this presentation to be presented and then for you to mull it over afterwards. And we sent it out ahead of time to give you a chance to kind of really dig into it.

So I wanted to start with just letting you know the way we did this study. When I got involved with it, ODA had been working on it for a while. And they were actually looking at fee schedules across over 30 different states that they were trying to compile. They did so much work compiling and getting ready to do this huge comparison.

And then I came along and said, well, you know what? We can't really just look at

fee schedules because we have to look at the way the services are designed and defined within each state, units and all those kinds of things.

And so the way I approached this study was much like I would approach a comparison shopping study kind of thing. So if you think about we're going to compare prices for bread, milk, and eggs, and we're going to go to four different grocery stores to do that. We have to know the quantity, the size. We have to know the ingredient in what we're comparing so that we really can -- to decide whether Kroger or Aldi pays -- or costs less or costs more.

So that's what we tried to do with this study, is we really tried to compare the apple to the apple as much as possible. And, again, it's difficult state to state because of this great flexibility that states have in designing their program.

But that was our approach. Let's find the services where we can really look at the same provider level, the same unit size, the same definition, the same -- even, you know,

we found some services that we discarded from the study because they were only provided in the home. And, of course, we don't have a service that's only provided in the home. You know, so we -- again, just really trying to match them.

We started with our CMS region and then we were trying to add all the states that touch us. Now, I will just say I'm a newbie to Kentucky, and I should have looked at a map. So I was trying to think off the top of my head, and I missed Illinois and Missouri, which we are very happy to add in to any further study we do. So I do apologize about that. I'm sure it caused a little bit of confusion.

The most relevant fee schedule was used in each state. That's -- that we could find, and we dug. We spent a lot of time digging around. So if it says 2022 in, let's just say, Alabama for a behavioral health fee schedule, that was the most recent fee schedule we could find in that state.

So I know there was a couple questions from people. Why did you use this one? Why

didn't you use that one? At the time of this study, the absolute most recent fee schedule that we could find was used in the study. And that's why I listed on the individual state tables the exact title of the fee schedule so that you could go to that state's Medicaid page, and you could find that fee schedule so that you could see exactly what I was using.

So that clears up a few of those questions. We did have a question about the practitioner or the provider level, and we were advised by the behavioral health initiatives team to focus on the licensed level provider. And wherever we could find a licensed level provider comparison rate, that's what we used.

If we couldn't find that, we -- the fallback was the M.D. level. And then, of course, if the service only had one provider level, for example, peer support services -- you know, that's a non-bachelor, high school graduate with certification level. So if that was the only provider level, then that's what was compared. But -- so if license

level couldn't be found, we automatically defaulted to that M.D. level, just for some consistency.

And only one rate per service was compared in each state so that we weren't looking across all our practitioner levels. Not every state defines that the same way that we do, you know, all those different columns on our fee schedule. So we had to land somewhere.

Now, the big, overarching statement here is we may not have done that correctly. Like, it may not have been the best way to do it, but that's the way we did it. And so we are open to some suggestions, as maybe some different ways -- when we go to a deeper dive on some of these services, we are very open to any suggestions as far as a better way to look at that. But that was our rationale at this point.

Rates. We had a question about this statement here. Rates were increased from 2023 to 2024 on 20 of the 30 services.

We are trying to get together the ten-year comparison that was requested. That

is going to take me a little bit longer than the time I had to prepare the responses for this meeting. But I am looking at that as a follow-up item, and it will take me a little bit longer to kind of collect ten years' worth of fee schedules and then get a graph for y'all to see because I thought that was an interesting ask. And we're very willing to follow up on that. It's just going to take me a little bit.

CHAIR SCHUSTER: Let me just interrupt for just a second --

MS. SMITH: Sure.

CHAIR SCHUSTER: -- to let people know that we submitted additional questions to the study people from the BH TAC and then the Children's Alliance and the ABA Advocates also submitted some.

But one of the questions that we did submit was to ask whether we could get kind of a chart looking back over the last ten years at what the rates in Kentucky have looked like. And that's what -- that's what Victoria is talking about right there.

I just wanted to let people know that

that was a specific question from the BH TAC. And I'm delighted that you're going to be able to pull that information for us, Victoria. I think that'll be very helpful.

MS. SMITH: No problem. And thank you for clarifying that, Dr. Schuster. I forget that probably not everybody saw all those questions that were sent to us. And, again, we'll get that out to you.

This statement here was -- we had a question about this statement about flexibility in regard to some of our per diem services. And these services are listed. I believe all three of these are listed on our -- on our deeper dive suggestion.

Because we did find in other states where -- and I'll use IOP as an example, where IOP had to be provided in a very specific way, X number of units of psychotherapy, X number of units of peer support, X number of units of group therapy. They define distinctly within IOP what all the sub-services should be and what each unit count should be on all of those.

So in Kentucky, as you know, we say all

these things need to happen inside of IOP, but we don't tell you that it has to be, you know, two units of peer support and one unit of group therapy. We allow the providers a little bit more flexibility in that. So that was the only thing I was trying to point out there.

We felt it very difficult to compare that service as defined in Kentucky to those states who clearly define some of those distinct requirements within the service. And then there were also, in those states, quality control measures attached to that.

So that's why those -- because of the flexibility that we allow in those services, that's why you'll see in many of the states that we could not match it. We felt like we couldn't match it across the state.

I'm not going to go over this. This is just where we kind of laid out whether the state in our comparison was an expansion state or not. The percent -- I found this a very interesting statistic, the population-to-enrollee ratio, so the percent of our population that is enrolled in

Medicaid. And we did that across all the states. And it's a very interesting look. So we just added that for some background information.

This -- I'm not going to go through all of these tables, but I did want to point out this top row. And I'm sure many people may not have camped out there for a minute. But this just really shows the difficulty we had in trying to compare only 30 services state to state and really try to find that apples-to-apples comparison.

You'll see in some states, we could only find 13 that we could clearly define as being the same as Kentucky. So this just kind of reiterates the difficulty in trying to compare that, you know, shopping list from one state to another state in a real -- you know, in a clear way.

CHAIR SCHUSTER: And, Victoria, can you go back to that for a second? Is that out of the 30 that you were comparing or the 303?

MS. SMITH: This is out of the 30. So for each state, out of 30 services --

because we took the top 30 services in Kentucky, the top utilized services in Kentucky. We took the -- out of those 30 for each state.

So in Florida, out of those 30 services, we could only find 18 matches that matched it well enough for us to say apple to apple. And then you'll find the information on the ones we couldn't match on those tables, the reason we couldn't match them.

CHAIR SCHUSTER: Okay. The reason I ask is because right above that, it says 303 total services were compared across --

MS. SMITH: Across ten states, across all ten states. So we had 303 because in Alabama, we actually looked at a couple of different ones on peer support, and that skewed -- that skewed the number. If we would have --

CHAIR SCHUSTER: Oh, okay.

MS. SMITH: If Alabama hadn't messed us up, Dr. Schuster, it would have been 300 across all 10 states, because we did 30 in each state, is what we were trying to show there.

CHAIR SCHUSTER: Right. Okay.

MS. SMITH: So even cumulative, we could only match 182 of the 300 services for our comparison services.

CHAIR SCHUSTER: Okay. But on this table, the numerator is out of 30. In Alabama, it's 20 out of 30. In Florida, it's 18 out of 30, so forth.

MS. SMITH: Yeah.

CHAIR SCHUSTER: Okay. Thank you.

MS. SMITH: The X on the tables that we're going to get to simply means that an alternate provider was used, or that particular provider was not included in the study. And, again, it's because we looked for one provider for each service.

And I can give you an example of that as we go over here. So as an example, for this comprehensive community support services, because we felt our focus was on licensed level, that's where we focused. If we couldn't find it on licensed or the M.D. level, we put that we couldn't find it only in the licensed area. Because, again, we were looking at one provider type per

service.

And so you'll see that in psychotherapy, this one was comparable. This one didn't even come into play. We did not even look at the M.D. level because we focused on the license level.

So this one, you know, this one in Georgia for psychotherapy -- or I'm sorry. In Florida for psychotherapy, we could not find it at the licensed level, and so the comparison was done on the M.D. level. But, again, only one level of provider was used for each service comparison. We didn't compare across the entire fee schedule.

CHAIR SCHUSTER: And we have -- there were a number of questions, Victoria, about what some of those categories really meant.

MS. SMITH: And we're getting to that, too.

CHAIR SCHUSTER: Okay. Great. Thank you.

MS. SMITH: I have a whole slide for you on that, Dr. Schuster.

CHAIR SCHUSTER: Okay. All right.

Wonderful.

MS. SMITH: Our recommendations, basically, it was the -- they had the largest number of higher rates in other states. And so what that means is for this -- you know, for each one, they had -- out of the ten states, they had -- six or more of the states were ranked higher than Kentucky.

So we -- we grabbed those and threw them on here for further study. And they need a deeper dive, you know, to really say: Why are they higher? You know, now it's time to, like, really drill down and find out if our apples to apples mattered.

I'm not going to go through all of these, but there are a couple of them that I'll point out. We found that some services may have been discontinued. We did find that psychoeducation was not a separately reimbursed service in any of our ten comparison states.

Psychoeducation was expected to be involved in psychotherapy, group therapy, IOP, partial hospitalization, and some of the others. Alabama was the only state we could

find it separately listed and then the use of that was extremely restrictive. So we felt like we couldn't compare even what we found on an Alabama fee schedule to what's happening or the way we allow it to be used in Kentucky.

And we did find pretty consistently across all states that it's expected to be part of another service. A couple of the states even called out that they had to keep track of it for quality purposes, but they couldn't bill separately for it. So that was an interesting thing.

If the service was discontinued in the state, we listed that. These were some of your package services in Georgia where they specifically said, you know, in partial hospitalization, we expect to see this many units of this and this many units of that. And so we felt like that we just couldn't compare that to Kentucky.

MR. OWEN: Victoria and Dr. Schuster, pardon me for butting in, but I would like to point something out about psycho ed if you allow me to, if that's okay,

Dr. Schuster.

MS. SMITH: Sure.

MR. OWEN: Okay. So this is really --

CHAIR SCHUSTER: I'm sorry. Who is speaking?

MR. OWEN: This is Stuart Owen with WellCare. I'm sorry.

CHAIR SCHUSTER: Okay.

MR. OWEN: So this is a really critical point. Not only does Kentucky Medicaid pay for psychoeducation separately, it raised the rate in late -- it used to be $14 for 15-minute units. Then it raised it to $46 in late 2022 and then posted in 2023 that -- there was a noninstitutional and an institutional. Then they posted just the high institutional rate in 2023.

We directly saw providers shifting from other services, clinical service to psychoeducation in high volume, very high volume. And we've even seen providers who were doing residential, like a high volume of residential, much higher than psychoeducation, and completely flip-flopped.

And it has become basically a huge moneymaker.

MS. SMITH: Stuart, I'm sorry to interrupt, but I just wanted to point out there is, like, a separate whole study on that issue.

MR. OWEN: Okay. All right.

MS. SMITH: So if we could maybe table that discussion.

MR. OWEN: Sure. Yeah, yeah.

MS. SMITH: Because we are really doing a deep dive into psychoeducation separately. So if you don't mind, I --

MR. OWEN: Yeah, yeah, yeah. That's good. That's good. Yeah.

MS. SMITH: If that's okay, we'll table that one.

MR. OWEN: Yes.

CHAIR SCHUSTER: All right. Thank you.

MS. SMITH: So just continuing on with some of these -- another interesting thing that we found was either it wasn't -- in West Virginia, we found this really interesting thing where they're starting to

provide some of their behavioral health services either directly through the MCO period -- so we couldn't find fee-for-service rates for them, is all that means.

But they also have this group of services that they're now providing through an ASO, which was an interesting model. So that also was a reason that we couldn't do this apples-to-apples comparison.

And, again, after -- after the presentation, I'll send out this new PowerPoint to you through Erin. And if there's additional follow-up questions after that, Dr. Schuster, we can do that as well.

As far as provider level questions that you had, this chart here is an actual copy -- I copied it and pasted it right from the behavioral health fee-for-service fee schedule. And so what I did was I highlighted, and I answered your questions.

So we had a question about: Is psych APRN the same, or what level is that? Where do I find that? So the psych APRN is the same as APRN but with a psychiatric speciality. So it would be this provider

type 78.

So I threw all of these questions over to the behavioral health team, and they helped me out with this. The clinical --

CHAIR SCHUSTER: But I don't think -- I don't think you had any APRNs listed in any of your tables. I guess that was my other question, Victoria.

MS. SMITH: Yeah. Because we concentrated on this level right here.

CHAIR SCHUSTER: Okay.

MS. SMITH: Yeah. So when we met with the behavioral health team to find out -- you know, we have this continuum of rates across all of our provider levels. And we were talking about, you know, do we average them? You know, do we look at one over the other?

And it was recommended that we stick with this Column 3, this licensed level provider, wherever we could. When we couldn't find it, we would default to this M.D. level.

I do know that there are a couple of services on the tables that are at this APRN

or licensed clinical psychologist -- this SA or AH modifier level because we couldn't find the licensed or the M.D. So I do know there's a couple of services on there, Dr. Schuster, that we did look at Column 2 level provider instead of the Column 3.

But Column 3 is really where we focused on. If we couldn't find it at Column 3, we defaulted it to the M.D. level. If we couldn't find it at the M.D. level, I did go looking for another level. And that's why you'll see a couple of them with that Level 2 provider.

The Level 3 provider, we had a question about: What does it mean with supervisor? These folks can provide clinical supervisions based on the individual board policies and regulations. So what -- all that means is they can supervise others. This Column 4 level --

CHAIR SCHUSTER: So those are what we -- yeah. That's what we consider our autonomously functioning people, and I see those now in terms of LCSWs and LPCCs and LMFTs.

MS. SMITH: Yeah.

CHAIR SCHUSTER: I think it was the "with supervisor" that threw people.

MS. SMITH: Yeah. And that's why I used --

CHAIR SCHUSTER: It wasn't clear whether --

MS. SMITH: I should have made a note. Yeah. I apologize. I should have made a note that that was directly off the fee schedule so that you could have referred to the fee schedule.

CHAIR SCHUSTER: Okay. Thank you.

MS. SMITH: I tried to use the exact language from the fee schedule. And because we looked at this whole host, we didn't want it to get confusing if we were looking at, you know, an LCSW versus an LPCC because we pay that at the same rate. So that's why we used the licensed master's --

CHAIR SCHUSTER: Yeah. So it's basically with supervisory capacity or --

MS. SMITH: Yes.

CHAIR SCHUSTER: -- ability for that category. Okay. Thank you.

MS. SMITH: And then Category No. 4, these guys are the ones that need supervision.

CHAIR SCHUSTER: Yeah. The associate level.

MS. SMITH: Yeah. The non-bachelor's was less than a bachelor's degree, so that was the question we had. What does it mean, non-bachelor's?

CHAIR SCHUSTER: Right.

MS. SMITH: And it's less than a bachelor's degree, less education than a bachelor's degree.

CHAIR SCHUSTER: Okay.

MS. SMITH: And, again, you know, we focused on this Level 3 provider type so that we could try to do as closely as possible apples to apples. If we couldn't find it, we would default to the M.D. If I couldn't find that, I'd find something else. But then I clearly delineated which provider level that we -- that we compared.

And you'll see that -- if I could quickly switch gears really quick. You'll see that for each state, you'll see exactly

what we compared it to and exactly what fee schedule we got the comparison from. So if you go to the addendum document, you'll see some of that. And then you'll also see where some states, you know, had an increase because of this House Bill -- North Carolina House Bill 259 did a whole array of services where they increased behavioral health services. So that was also noted, and we were able to capture that right away. That came out while we were still working on it.

CHAIR SCHUSTER: Great. That's very helpful.

MS. SMITH: Sorry. Let me see if I can get back to where I was. There we go. So the Children Alliance and the ABA -- I'm sorry. I messed up this slide, so I apologize. Children's Alliance or ABA questions is what that should say.

Basically, rates specific to children's or diagnosis specific services were not included in the comparison. We, again, took the rate off of the Kentucky fee schedule. So the only time you would see a service looking at a specific population is if it had

that specific population on our fee schedule.

For example, you'll see that targeted case management actually looked at SUD, SMI, SED. So it was separated because it was separated on our fee schedule. But if it wasn't separated out on the fee schedule, if we didn't have a service that was specific to SMI, then we did not look at any fee schedules in comparative states that were specific to that diagnosis.

And so -- or children's. We didn't differentiate between children's. I did do a data pull quickly and look at the top 30 for children because the first data pull we did to get our top 30 in this analysis were for everybody, 0 to, you know, 100. And it is interesting because the services do rate a little bit differently.

So that is something to keep in mind going forward as we deep dive or as we take, like, this next step. We're not opposed to trying to look at something like that. You know, what are other states doing for kids that maybe Kentucky has an opportunity to do?

But we did not look at anything like the

EPSDT fee schedules or anything like that because, again, we focused on the Kentucky fee-for-service fee schedule. So we looked for the services that would most closely compare to that.

And then any states that paid an additional amount for children's or a specific population's services due to legislation or any other focus reasons, those were not compared to Kentucky, again, because it wouldn't have been an apples-to-apples comparison.

As far as the Children's Alliance goes, I was having difficulty -- I love the spreadsheet you sent me. That was really helpful. But I was having difficulty with the links that you sent me, finding some of those rates.

So if you could, as a follow-up, send me the specific fee schedules you were referencing in that spreadsheet. And if you might be able to just highlight the rate you want me to focus on. I feel like I'm missing something, and I want to make sure I see everything you want me to see.

So if you don't mind doing that as a follow-up, I would really appreciate that, if someone from Children's Alliance would not mind re-sending those fee schedules to me just with a highlight on the ones you want me to take a look at. Because I -- again, I feel like I'm missing something, and I don't want to miss anything. I want to make sure I get it all.

CHAIR SCHUSTER: Thank you. I'm sure that they will reach out to you and do that, Michelle Sanborn or Kathy Adams.

MS. SMITH: Yep.

CHAIR SCHUSTER: Thank you.

MS. SMITH: The next step discussion. I promise you I wish I had these four -- and I'm sure ODA does, too -- these four questions before we began this discussion or began this study. Because, again, we -- or I approached the study as I had a shopping list of services, and I needed to take my shopping list and go to all these different states and find out what they paid for that, for the things on my shopping list.

Understanding, you know, are rates a

barrier to service? That's a different kind of study than just finding out if somebody pays -- you know, we pay $10, and they pay $11. You know, what needs to happen to the Kentucky rates so that Medicaid beneficiaries in need of behavioral health services receive quality, timely, appropriate care? That is an additional study that really is kind of outside the "who pays how much" study. And I think it's an important work.

You know, do the rates -- do the rates hinder service in rural areas versus urban areas? That was something that we wanted to look at, and we just kind of ran out of time. You know, what's happening in urban areas versus rural areas, and can rates address that? Are there barriers that rates can address?

Those are definitely great questions, and I think my recommendation would be: As we go into this next -- kind of focused next steps, let's take those questions with us. And let's expand this study to kind of look at things a little bit differently versus simply: Does somebody pay more than we do or

pay less than we do?

You know, what's happening in their program that's reducing barriers, increasing quality, all of that, and what role does the rate play so that we can look at it really comprehensively? So I appreciate those questions. And, again, I think those questions need to be taken to the next step.

I would like to have a little bit of discussion -- we had six proposed services. I know -- oops. I know Children's Alliance had some children-specific services. Do we want to add Missouri and Illinois to the next step? Do we want to look at diagnosis or age population specifically on a couple of these services?

And I -- I don't think we're going to get the answers to that today, but I think those are the things we need to understand as we go to this next step, is: What do you all want us to look at?

And then my proposal would be that we would design that next step study and get it to you all for approval at the next TAC so that when we start this next step with these

six services, or eight or ten or whatever you want to add to it, we're giving you the information that you want to have and that you need to have to do your work.

So I'll open the floor to any questions or comments, any suggestions for next steps or, Dr. Schuster, your thoughts on, you know, us kind of designing that next step and then getting -- you know, sending it to you so that you can make sure what we're planning on looking at is what you want us to look at. But I'll throw it back to you, Dr. Schuster.

CHAIR SCHUSTER: Thank you, Victoria, so much. I'm trying to remember. Were there some specific questions from the ABA folks, and do you feel like you included those?

MS. SMITH: There were specific questions. They were population-specific questions.

CHAIR SCHUSTER: Okay.

MS. SMITH: And so the only answer I have is that we did not look at population specific. It's not to say we can't in the next phase.

CHAIR SCHUSTER: Yeah.

MS. SMITH: It's just to say that we did not -- we didn't look at those specific things in this phase. We looked at just, you know, total population. Unless the Kentucky fee schedule called out a rate differential for a specific modifier or population, we did not look at those specific rate differentials for certain populations in other states.

CHAIR SCHUSTER: Yeah. I think, you know, in light of the fact that the general assembly put money into the second year of the budget to continue the planning for a children's waiver, and autism is one of the named disorders in that which, of course, is where ABA is used so much. Also, the, you know, severely emotionally disturbed and then those kids who have both emotional and physical issues going on.

So I think having some child-specific issues, at least from my standpoint, would be very helpful, knowing that we're going to get into hopefully the development of a really good waiver, which means that more providers

are going to be needed. And, certainly, the Children's Alliance is a major provider in that area. The ABA folks, I think, would be very helpful to have that as -- as a population.

I think the other one that, of course, this BH TAC has been really concentrating on are the people with severe mental illness. You know, we have a waiver that's pending on that -- or, actually, a State Plan Amendment. So some of those population specific, I think, would be very, very helpful.

MS. SMITH: Dr. Schuster, are you thinking just -- do you want to give us a list of specific services you'd like us to look at? Or are you talking about, as we go into these six proposed services to include, separate them out and try to look at different children-specific and SMI-specific populations?

CHAIR SCHUSTER: I'm not sure, and I think I'm going to turn to my voting members of the TAC and other people that regularly attend. As you can see from the number of people on this meeting, which is --

I think we're up to 120 at this point. The behavioral health community here in Kentucky is very engaged, Victoria, and so I want to hear from people about what direction we want to go.

I love the idea that you all are open to further study, and I -- you know, I guess I feel good that we asked some impact questions that, I think, are difficult to assess probably, but I think we ought to keep in the back of our mind.

Because it's not just about rates. You know, it's about the quality and timely and appropriate care that people need and get. And, you know, what role do rates play in that and then how do we get the workforce to make sure that that's available across 120 counties?

And I do think that -- and I hear it all the time from psychologists and other mental health licensed professionals that they are not Medicaid providers because of the rates. I mean, I think it's a real problem, so I think we really need to keep that in mind.

I think if we were able to raise rates,

at least in some of the more needed areas, we may be able to get more licensed professionals to be willing to be providers for our Medicaid beneficiaries.

So I guess what I would suggest -- and I'm certainly game to hear from other people in the meeting and those who submitted questions. But I'd like to kind of take this back internally and see what's the best, you know, kind of guidance we could give you and then have a kind of back and forth with you, if you're all right with that, Victoria, where we give you what we think is good guidance and then you ask all the questions that you need to design a study.

And we've done this before. We did it around the targeted case management where we worked with the data people and with the UK people, and the back and forth was just so incredibly helpful in honing what we were looking for and putting it into things that you all could pull the data on. You know, there's no point in our continuing to ask pie-in-the-sky questions that we just simply don't have the data yet.

MS. SMITH: And I appreciate that, Dr. Schuster. The back and forth helps us give you the information that you need in a comprehensive way versus us trying to -- or thinking we know what you want. So absolutely. If you want to discuss this internally and then send kind of some parameters you'd like us to -- or some things and then the ODA team and I will get together and kind of develop a study design or a project outline for you guys to make sure we're on the right track, or we've interpreted your questions correctly.

CHAIR SCHUSTER: Yeah. I think including the other two contiguous states, just in the --

MR. BALDWIN: For sure.

CHAIR SCHUSTER: -- purpose of completeness, would make a lot of sense, if we can add Missouri and Illinois --

MS. SMITH: Yep.

CHAIR SCHUSTER: -- at least to the next phase. I'm from Missouri so -- and we're a show-me state, you know, so we want to be included. And, certainly --

MS. SMITH: Now I really feel bad, since you're from Missouri, and I missed it. Next time, I'm looking at a map. I promise you that.

CHAIR SCHUSTER: Yeah. Ask the people in Paducah. They're pretty aware of Missouri. And, certainly, Illinois brings a whole different kind of, you know, government approach and so forth.

So let me open it up to our voting members of the TAC and see if any of you all have any specific questions and then we'll open up to anybody else.

And you're going to send us this PowerPoint; right, Victoria?

MS. SMITH: Yes. I will make a few notes that I've made from some of your comments so far on this page.

CHAIR SCHUSTER: Okay.

MS. SMITH: Just -- you know, I'll change this from a question mark to yes. You know, I'll just make a few notes on some of the discussion.

CHAIR SCHUSTER: Okay.

MS. SMITH: I'll try to capture it

a little bit here today and then I'll send that out to Erin so that she can get that out to the TAC.

CHAIR SCHUSTER: That's great.

Any -- any questions from other members of the TAC?

(No response.)

CHAIR SCHUSTER: And what about -- anyone else want to weigh in?

MR. BALDWIN: Dr. Schuster, this is Bart Baldwin. I'd like to --

CHAIR SCHUSTER: Yeah. Hi, Bart.

MR. BALDWIN: Hi. Thank you.

Thank you, Victoria, for putting this together and for your work on this. ABA Advocates is a group that I work with, and so those discussions and questions came from us. And we have lots of other behavioral health providers as clients as well, so this is -- spend a lot of time in this realm, and so this is a really important study for us.

And I just wanted to re-enforce a couple of things. One is the lens that these questions look through is really what the issue is all about. It's not the rates for

comparison of who's higher or lower just for the sake of who's higher or lower. But it really -- what it impacts here.

And I think that's why the Missouri and Illinois is so important to add in because it really is a matter on the ground of when you're competing for -- when providers are competing for staff, to recruit and retain staff in order to deliver the services.

You know, we have seven border states, so that has a real impact when people can, you know, go across the river or across the state line, and the rates are significantly different. So it's all about these four questions ultimately and how the rates impact that. So I appreciate that. I just wanted to point that out.

The other thing is -- and I guess we'll talk to Dr. Schuster about the -- the services for a further study. I think we would have some, probably more so, that would need further study.

But the other thing is, I think, the look at -- for some of those codes, the licensed individual is not really the primary

provider of that service. I think it makes sense in a general statement that that's the one to compare.

But there's a few of them, you know, like the -- you know, the community support associate where it's mostly, you know, a bachelor's or a non-bachelor's level that is what that's designed to be, that it would make more sense to compare there. So just a couple of those things.

But I appreciate your work, and I appreciate the willingness to make some modifications and take a deeper dive. I think that's really important.

MS. SMITH: Thank you. And when you talk about services, one thing that would help us is if you list a service, if you could also list the primary provider level that provides that service in your eyes. That would help us because --

MR. BALDWIN: Okay.

MS. SMITH: -- if we have that information, we certainly will go look for that information. But without that information, like I said, we defaulted on the

license level. So that would be wonderful.

If you want us to -- you know, if you tell us to go look at a certain code and then also if you could tell us what the service is, you know, here in Kentucky, and we can get that off the fee schedule.

But if you have in mind something other than that licensed provider, which is the primary provider that actually is in the field providing that service, certainly that -- we're very open to looking at that.

And I do want to take the opportunity that ODA -- Jenna Burkin (phonetic) and her team from ODA, there were five or six individuals that really worked months and months and months on this before I even jumped in the middle of it.

So I want to applaud them and make sure they get all the credit they're due because they -- they really worked long and hard on this project to make sure we could get all this sent up to you, so I want to give them some kudos.

CHAIR SCHUSTER: And we're very happy to reach out to thank them as well.

Any other questions or input at this point?

(No response.)

CHAIR SCHUSTER: All right. Well, Victoria, kudos to you and your approach to this. We just are so appreciative, and we will -- and it was so helpful to have it in advance and to have us, you know, have lots of eyeballs on it to ask the kinds of questions that we asked. And I'm glad the questions were helpful to you as well.

MS. SMITH: Very helpful.

CHAIR SCHUSTER: I think it will lead us in some directions going forward, but it's so exciting to, you know, be looking at some future studies and getting closer to those impact questions, you know, to whatever degree we can. So just so appreciative to you and to the ODA folks as well. And we will be in touch, as they say.

MS. SMITH: Thank you, Dr. Schuster.

CHAIR SCHUSTER: Thank you very much.

I'd like to pause for a minute and

welcome -- we have a new voting member of the TAC, and that's Misty Agne. I'm not sure I'm saying your last name correctly, Misty, A-g-n-e. And she will be the new voting member from the Brain Injury Alliance of Kentucky. We thank Eddie Reynolds for his years of service, but we welcome Misty who is the manager of rehab services at the Center for Advanced Neuro Services at Frazier Rehab Institute here in Louisville.

So, Misty, if you would like to say hello and anything else that would be helpful for us to know about you.

MS. AGNE: Yeah. Hi. Good afternoon. Dr. Schuster, you did pronounce my last name correctly. It is Agne so --

CHAIR SCHUSTER: Okay. Great.

MS. AGNE: -- no worries there. I just want to say thank you for the warm welcome, and I look forward to learning more about what this group does and how they serve the brain injury community. So thank you.

CHAIR SCHUSTER: Well, we're glad to have you, and we're sorry that Mary Hass had a medical condition come up that she had

to address. But I think you know Mary.

MS. AGNE: Uh-huh.

CHAIR SCHUSTER: And so we'll have two expert folks, as we have, talking about the brain injury population. And there's so much overlap, as we all know, with people that have a primary diagnosis of an acquired brain injury with so many of the mental health and substance use issues as well. So we welcome you. Thank you.

MS. AGNE: Thank you.

CHAIR SCHUSTER: And is Erica Jones on?

MS. JONES: Good afternoon. I'm here.

CHAIR SCHUSTER: Hi, Erica. Welcome. This is a much-looked-forward-to report as well on the Medicaid reimbursed mental health services to students. So if --

MS. JONES: Yeah. So -- I'm sorry.

CHAIR SCHUSTER: I was going to say: Do you want to share your screen? Do you have a --

MS. JONES: I don't have a presentation, but I would like to start with

some exciting news. And I also see that Deputy Commissioner Hoffmann is on, so she may want to interject some as well.

But Kentucky was awarded a 2.5-million-dollar grant from CMS to enhance our school-based services, and we are going to have a focus on increasing behavioral health services through our expanded access program. Expanded access are the services for Medicaid-enrolled children who do not have an Individualized Education Plan.

CHAIR SCHUSTER: Great. Yeah.

MS. JONES: And, Deputy Commissioner, did you have anything you wanted to say?

MS. HOFFMANN: No. I would love to take the credit, but Erica has been all over this. I'm so proud of her and her team, and Myers & Stauffer has been assisting with this as well. So they've been spot on. Just appreciate everybody that's been working on this.

CHAIR SCHUSTER: Okay. And let me ask you, Erica. Because I thought that we were going to have actually a report of some

of that data. Are you in a position where you can do that in September?

MS. JONES: I can, but I can give you the data that we have for fiscal year '23.

CHAIR SCHUSTER: Oh, okay.

MS. JONES: That started our complete year.

CHAIR SCHUSTER: Okay. Great.

MS. JONES: It's not the best news. I will start with the Individualized Education Plan students. So these are the ones that would have the services listed in their IEP. For behavioral health services, we had reimbursement of $95,983. That's out of over eight million dollars that was spent for IEP services. So it's really just a -- it's not much of anything. It's a drop in the bucket for our IEP services that did reach 1,136 children.

And then for our expanded access -- so these are going to be for any child that has Medicaid, these services should be available to them. We had -- the reimbursement for the entire year was $80,788, and that -- of the

expanded access reimbursements, that's only 27 percent of all of the reimbursement. So about a quarter of the services for expanded access have been behavioral health.

And then of that amount, that 80,788, 44 percent of that was for one CPT code. And that is 90832, psychotherapy services rendered for 30 minutes. So that was the predominant CPT code used. We did have a handful of the psychoeducation, but it isn't an issue in the school-based services.

Let's see. So the number of behavioral health services provided for the last full year, that fiscal year 2023, is 8,235 services reaching 1,346 students.

CHAIR SCHUSTER: And that's in the expanded access; is that right?

MS. JONES: Yes. That's for expanded access, so that means the child does not have to have an IEP. As long as they have Medicaid, then they can bill for those covered services.

CHAIR SCHUSTER: So that seems so incredibly low to me. I'm trying to wrap my head around this.

MS. JONES: I agree. It is exceptionally low.

CHAIR SCHUSTER: What do you attribute that to, Erica? I know you all have been working with KDE.

And there's a question: Are these for behavioral health only or for all school-based services? And these are behavioral health only, I think you said.

MS. JONES: Yes. So that $80,000, that was just for behavioral health services. That was the reimbursement.

What I would contribute it to, we have done some surveys. We are -- and, actually, part of the grant -- the first few months of the grant is to kind of shore up all of the different surveys that have gone out regarding school-based services to find out what are the needs. What is actually the reason why school districts aren't participating the way we would hope that they would?

I think a lot of it is just not being familiar with expanded access, not being aware of all of the services that it does

cover. And so we are working on that. We have some -- a training plan that we hope to implement around September to enroll school districts in expanded access.

Even if they're not planning to bill for the school year, we want them to enroll. And then we would have an intensive, like, curriculum training for them to know the foundation of it, get them comfortable with the idea of using expanded access so that they can start billing.

CHAIR SCHUSTER: So in the Bevin administration, CMS granted the -- I guess it's called the reversal of the free care rule, which essentially said you can provide services to Medicaid-eligible kids who do not have an IEP; right? So this is the expanded access.

MS. JONES: Yes.

CHAIR SCHUSTER: And so I guess it's very discouraging because I think that was 2018. So we're a good five years -- seven years past that, and we're still not having many schools that are taking advantage of it. Am I reading that correctly?

MS. JONES: You -- you are correct. So we do have -- there's usually around 50 school districts or so out of 171 that enroll in expanded access, but those that actively bill in expanded access are even fewer, you know, maybe 40 something. You know, around 40 maybe actually bill. And then some of those are only billing for one or two services and, you know, just for maybe -- maybe the reimbursement is $5 or less for that service. So they're not utilizing it the way that they should.

Now, they are -- school districts are losing their -- I forget the -- what the grant was, but they're losing some of their funding for some of their providers. So there would be a need for funding, so we're hoping that that need can be filled by using expanded access.

So this summer, early of the next school year, we are going to be very diligent in making sure that information on expanded access gets out. There is a lot of information already on KDE's website. There's some on DMS' website about expanded

access.

But it's -- it can be intimidating, and so we're wanting that information to go out to school districts that we're not wanting you to be expert medical billers. We're going to facilitate getting you the resources that you need so that you can make sure that these services are available to children.

And I want to also add that these are just the behavioral health services that have been billed by school districts.

CHAIR SCHUSTER: I was going to ask you that next because a lot of them contract with CMHCs or with outside providers.

MS. JONES: Yes. And so we have some of that information when we were applying for the grants, so we pulled some of that information. There are some areas where contracted providers may be billing a place of service as school. Sometimes they're billing place of service as clinic.

So we want to make sure that we get that straightened out. We want to encourage providers that do contract with the school district to use the school place of service

so that we're able to distinguish what services are being provided in that school setting.

CHAIR SCHUSTER: Right. Right. Yeah. Because it's my impression that a number of the CMHCs are providing in-school services that are certainly behavioral health services.

MS. JONES: Yes.

CHAIR SCHUSTER: What you're saying is that they may be billing those from the CMHC and not from the school.

MS. JONES: They are billing as the CMHC. And then, also, some of those are billing as the clinic as the place of service, so we're not able to pull out those particular services that were just for students in the school setting.

CHAIR SCHUSTER: Ah. Okay. And is there a way to get around that or through that or over that?

MS. JONES: The only thing that I'm aware is just to educate providers to use that place of service, 03, the school setting. And we will be doing that. We will

be encouraging our school districts as well, when they do those contracts, to ask those providers to use that 03 place of service.

CHAIR SCHUSTER: Okay. Because I think that one of the things that may help is Senate Bill 2 that Dr. Bargione and I worked on -- I think Joe is probably on this -- in this meeting -- with Senator Wise and, earlier, with Representative Willner. And that's the continuation of the School Safety and Resiliency Act.

And as you probably know, Erica, a lot more of this data is going to be made public, and KDE is going to be given much more responsibility for tracking behavioral health professionals in the schools and services. So, hopefully, that will also help schools get the message that they really need to be complying with this as best as they are able.

And I think Misty just asked a question in the chat: Is the billing platform for schools online or a manual process?

MS. JONES: Most --

CHAIR SCHUSTER: How much of an administrative burden it is for the schools.

MS. JONES: Right. The school districts contract with billing agents, so there are three different billing agents that are operating in Kentucky. And so the school districts contract with them.

CHAIR SCHUSTER: And one of those used to be the school board association; right?

MS. JONES: It was. They no longer do that.

CHAIR SCHUSTER: Oh, they no longer do that. Okay.

MS. GUNNING: Sheila, it's Kelly. I'm sorry. I thought you were finished. I have my hand up.

CHAIR SCHUSTER: Yeah. I'm sorry. I can't see hands.

So there are three separate billing agencies that the schools can choose from. Is that what you're saying, Erica?

MS. JONES: Yes.

CHAIR SCHUSTER: Okay. All right. Yeah, Kelly.

MS. GUNNING: I have attended some school board, site-based council meetings

with our council member Denise Gray in Fayette County. And what we mainly hear is that it's cost prohibitive and administratively burdensome. There's just not the funding for a lot of it. And that's what we hear repeatedly.

And I know that Counsel Member Gray is really working hard on trying to find out why more kids aren't getting the mental health help they need. And it's specific -- we just talk about SMI and serious emotional disturbance and those kinds of things.

But I just wanted to offer that feedback from Fayette County, is that -- the administrative burden and the cost is prohibitive. That's all I've heard locally.

MS. JONES: I will say it -- it can benefit the school districts greatly because they can also pull down the administrative funding. So we have our health services that they're reimbursed for, but they can also claim administrative claims. And that's for their outreach for, you know, helping to get children enrolled in Medicaid and other things like that.

MS. GUNNING: So that leads me to believe it may be something they just don't have enough knowledge about.

MS. JONES: Probably so. That's what I would suspect.

CHAIR SCHUSTER: Yeah. I'm glad that question came up, Kelly, because I was going to ask about it. I thought there was an administrative payment of some kind that went to the schools to help with some of that administrative cost.

Because one of the questions that's come up is that the public schools have access to that. With "school choice" coming up on the November ballot, it's not clear that private schools would have access to that administrative cost. I won't go down that road right now but...

MS. GUNNING: In hearing from them, Sheila, I think they've got this fence, whether it's based in fact or not, or just based on other entities' involvement with Medicaid and those kinds of things. But their sense just is it's more of a problem that they just can't adequately address with

the staffing and the funding that they have.

CHAIR SCHUSTER: Uh-huh.

MS. GUNNING: And I just don't think they know enough about it.

CHAIR SCHUSTER: Yeah. And I see that my friend Shannon Stiglitz is saying, yeah. KSBA used to provide that. But apparently, they don't anymore. That's what I was remembering, too, Shannon. The school board association used to provide that service.

What -- I'm delighted that we're getting this funding, Erica, and I certainly -- you know, obviously, we all want more services to kids in schools. And if they, you know, can be paid for my Medicaid, hurray.

Is there anything that we can do as the Behavioral Health TAC to be of assistance to you, to Deputy Commissioner Hoffmann, and so forth as you move forward with this grant? You know, we're great at asking questions. We can certainly help, you know, spread the word, but is there anything that we can do to be helpful?

MS. JONES: Right offhand, I would

say part of -- one of the deliverables in the grant is to develop a provider recruitment strategy, and so I can see the TAC being very helpful with us developing that.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: Erica, you might have already mentioned this, that I think, in the first quarter, there's a needs assessment that we're going to work on, too. So that's another area, Dr. Schuster, you could assist with.

CHAIR SCHUSTER: Yeah. I think that we -- and maybe as a precursor to applying for the grant, you all did a needs assessment; right? Leslie, do I remember that, around schools --

MS. HOFFMANN: Did we do a --

CHAIR SCHUSTER: Around school services?

MS. HOFFMANN: I'm sorry. Did we do a baseline before -- for the grant? I can't remember.

MS. JONES: We did, and that we sent to the principals, superintendents, and school Medicaid administrators.

CHAIR SCHUSTER: Okay. But not to outside groups? I get a lot of these things, and I can't remember what all I've filled out. So I may be mixing it up with something else. I thought there was something that went out to the kinds of folks that would be interested, some of the agencies, some of the provider groups.

MS. JONES: So DMS' did not go to anyone outside of that specific group. But there have been several different surveys that have gone out related to school-based services, so we're just trying to find the different entities that have done that and asking them to share their data as well.

CHAIR SCHUSTER: Okay. And I see that Kathy Adams from Children's Alliance is noting that -- that some of your members, Kathy, indicate they provide services in the schools and bill Medicaid. So that would be captured, I guess. That's the same question, I think, that we have about the CMHCs because there certainly are other agencies like some of the Children's Alliance members.

And the numbers that you reported,

Erica, would not necessarily capture those; right?

MS. JONES: It wouldn't be those that have been contracted out where that contracted provider is doing their own billing.

CHAIR SCHUSTER: Okay.

MR. BALDWIN: Yeah. Dr. Schuster, this is Bart. There is significant more provision of services in schools going on by providers, either CMHCs, BHSOs, multispecialty groups, et cetera, ABA --

CHAIR SCHUSTER: Right.

MR. BALDWIN: -- that bill Medicaid and bill the MCOs directly that I don't think was captured in those numbers at all.

CHAIR SCHUSTER: Yeah. It can't possibly be captured in those numbers, so we've got to figure out --

MR. BALDWIN: Yeah. And that's a big issue with the access-to-services question we talked about earlier and waiting lists and that type of thing of kids in schools that need it. But you just need the providers and the -- you know, it's the whole

thing, the rates, et cetera, to be able to have the clinical staff to meet the need.

CHAIR SCHUSTER: Right. Right.

MS. HOFFMANN: Dr. Schuster --

MR. BALDWIN: I think this is -- yeah.

MS. HOFFMANN: Sorry. Dr. Schuster and Bart, I think, you know, Erica is at the beginning stages of her grant, and those -- we've got a well-lined-out plan about how to address those things going forward. So we started with what we have and what we have access to.

So we know that there are some gaps there. I just wanted to say that. You all know that we can start addressing that through all the projects that we'll have going on within this grant.

CHAIR SCHUSTER: Yeah. And I just want to say, again, that, you know, the Behavioral Health TAC is here to be as helpful as we can possibly be to make sure that the data is more accurately -- is gathered in a way that reflects what's really going on in the schools and that we can

pinpoint, then, where the gaps are and so forth. But anything that we can do to be helpful, we're here.

MS. HOFFMANN: Absolutely. Thank you.

MS. JONES: Thank you.

CHAIR SCHUSTER: All right. Thank you very much. Appreciate that, Erica.

Next up, we had an excellent discussion in May about the audits, and we submitted a follow-up --

MS. BICKERS: Dr. Schuster?

CHAIR SCHUSTER: Yeah.

MS. BICKERS: This is Erin. I apologize. There are a couple of questions in the chat I just noticed. Valerie had one, and I believe it's -- they're for Erica. It says: I assume that this doesn't include LBGTQ mental health services?

And then Julie had a question. It says: How do we ensure that schools billing Medicaid doesn't conflict with or undermine the work agencies are doing in billing Medicaid for within schools?

CHAIR SCHUSTER: Okay. I'm

guessing, Erica, on the LGBTQ question, that you wouldn't know if it's being billed as a psychotherapy service.

MS. JONES: Yeah. I wouldn't know.

MS. HOFFMANN: Dr. Schuster, this is Leslie. I would also say that we would, by no means, mean to exclude that group. So we can take that question back. But yeah, we would try to meet all health -- social and equity-related issues, but I don't think that she would have that information.

CHAIR SCHUSTER: Yeah. I think the question is because of Senate Bill 150 and some of the changes that were required in the schools about even talking about gender identity or gender dysphoria being banned and so forth. It's probably more difficult for LGBT kids to feel comfortable asking for services. I mean, I'm sure that Medicaid is not discriminating.

MS. HOFFMANN: Absolutely not. And let's -- Erica, let's take that one back and see if we can -- that's going to come up again probably, so let's go ahead and try to address that as soon as we can, Erica.

MS. JONES: Okay. And we have -- we have encouraged schools to start using the Z codes to capture some information, so that may be a way to do that as well.

CHAIR SCHUSTER: Okay. And then the other question, Erin, was?

MS. BICKERS: Oh, sorry. It says: How do we ensure that schools billing Medicaid doesn't conflict with or undermine the work agencies are doing in billing Medicaid for within schools?

CHAIR SCHUSTER: I'm not sure that there's a necessary conflict. Well, I guess the question -- that's an interesting question, though, Erica. Who actually was delivering those services that were billed by the schools? Do you know? In other words, were they employees of the school district?

MS. JONES: They would have been either employees of the school district, or the school district may have contracted with the provider. But the school will do the billing.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: Dr. Schuster, I

think she had a mixture of, like, they may be located at the school, or they may not be located at the school. And they could be located at somebody that the school is contracting for. Does that make sense?

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: Or the school could have employed those folks themselves.

CHAIR SCHUSTER: Yeah. Because the other question -- and part of that is -- let me think about this for a minute. If a school makes a referral of a student to an outside provider and that student is seen by that outside provider, probably billed by that outside provider, you know, as an office visit or a clinic visit or a CMHC visit or a BHSO visit, should that actually count as a school-based mental -- behavioral health service?

MS. GUNNING: Sheila, I want to echo --

MS. JONES: Do you mean outside of the school setting? I'm sorry.

MS. GUNNING: Oh, sorry. I wanted to echo what Bart was saying. Many of the

schools that we work -- or we're familiar with, they do work with outside agencies. And I think the billing is done by the outside agency because, the reason they tell us, is it's too expensive to hire in-house school personnel and to deal with the administration. That's the feedback we have gotten, you know, as recently as late this year.

And on the LGBTQ question, the school is nervous. They don't know what to do. They're afraid of repercussions and things like that. I think that's another reason why they're more comfortable in outsourcing these things.

So if anybody else knows differently -- Kathy, I -- Kathy Adams, I see you shaking your head in agreement. Bart, I don't know if this is what you're hearing as well. But just boots on the ground, that's what we were trying to figure out, is, you know, why aren't more schools, you know, dealing with this issue as a school? And those are the kind of responses that we've had.

CHAIR SCHUSTER: Uh-huh.

MS. ADAMS: Could I say something, Sheila? Just interject.

CHAIR SCHUSTER: Yeah.

MS. ADAMS: This is Kathy Adams with the Children's Alliance, and we do have a lot of our members that provide services in schools and then just bill Medicaid directly. They're already a Medicaid provider. And, again, what we hear is -- from the schools is it's just easier.

And that allows that Medicaid provider to see the child in the school and outside of the school, especially if they're also doing family therapy with the family. So -- and the pushback we hear from schools is it's just too complicated.

And one question I would ask, Erica, is: If the school contracts with individuals to provide the in-school therapy, does that individual have to be a Medicaid provider, then? I mean, if they're using school employees to do it, for instance, or contract with individuals to do it, does that person have to be a Medicaid provider?

MS. JONES: Yes.

MS. ADAMS: Because that adds another level of administrative burden and complication. It just -- it's so much easier if the outside entity that's the Medicaid provider comes in. And, again, that's what we hear from our members.

MS. GUNNING: And that's what we're told as well.

MS. CECIL: Hi. This is Veronica Cecil with Medicaid. Just, I think, maybe to put a fine point on just a couple of things.

There are -- as Erica has noted and I know most of you understand, there are various models to how a school may access services for their students. If they're billing -- if the school is billing for the service, whether it's through an employee or through a contracted provider and they bill it, it's a Medicaid school-based service. If an outside entity is providing the services, even if it's delivered in the school, that entity can bill separately. So -- but no -- obviously, you can't double bill.

But understand that each school -- we've seen schools that it works great in -- you

know, in hiring employees and schools it works great in just contracting it out and letting the provider bill. So, you know, what we are -- the approach we are trying to take is make sure schools understand what the options are and support them in whatever option they choose.

And to your point, Kathy, I think, is to make it as easy as possible on the school to be able to comply with requirements that we have to meet for federal reasons and, you know -- and just make it accessible to the extent possible.

So something we're just -- we're really working hard on this. Erica is, you know, leading a really great effort to try to get more services to students, and that's really the goal here. Regardless of which -- you know, one size doesn't fit all. What works best for each school is what we want to support.

MS. GUNNING: Well, I think the low numbers on payout as far as 95,000 -- let's say, you know, $100,000 out of eight million would speak to the fact that there's some

glitch. There's some issue with, you know, what we're doing.

And thank you guys so much for being open to look at this and to try to figure out some solutions with the schools because I know for us locally, this comes up a lot.

CHAIR SCHUSTER: Yeah. I think it -- I think, you know, bottom line, we want kids to get services that need services from a qualified provider and that the provider gets paid. And whether it's done -- you know, the advantage -- and I used to do some of this work. You know, the advantage of seeing a kid in school is that the parents don't have to fool with transportation and that kind of thing. And if there's a reasonable way to have a child, you know, excused from the class for a 30-minute session and so forth. It's also easier to deal with crises as they arrive -- arise in the school setting.

The family part of it, as Kathy pointed out, is something that doesn't happen in the school setting. And we know with kids, that that's a crucial part, whether it's their

biological family or their -- you know, whoever has custody of them at the time or has the major influence and so forth. And that needs to happen outside. So you're probably getting some bifurcated -- you know, you may get some billing for kids with that in-school part and then some outside.

I think Julie Herrmann raised the question of whether there was either duplication or competition. And I don't know, Julie, quite how to answer that. I would love to think that we have so many providers that there really would be competition, and I don't think that that's -- in the behavioral health world, that that's very often the situation.

MS. CECIL: Well, and we have -- we do have safeguards in place to prevent duplication. You know, we do regular auditing, we look at, to ensure that there's not a duplication going on.

Obviously, I think the goal here is efficient use of the funds that are available, especially for the schools. And so being able to leverage Medicaid to help

cover their costs makes sense.

CHAIR SCHUSTER: Right.

MS. CECIL: And, you know, again, we've opened up, I think, the dialogue, which is critically important to making sure that the different stakeholders, Department of Education, the schools, and Medicaid are, you know, aligned and working together. And that's what we're doing, I think, kind of more so than ever to move forward with: How do we better serve the students?

CHAIR SCHUSTER: Right. So I think, Erica, you know, let's keep the dialogue open between the BH TAC and you and Leslie and the people working on the grant. And, certainly, we want to give assistance in any way that we can, and we probably will, you know, ask for a report from you periodically just, you know, so we could add this kind of dialogue because I do think that the discussion is helpful and important.

MS. EISNER: Sheila, this is Nina. Before we leave this topic, another provider group that's in the schools, for example, is The Ridge, has been providing PHP and IOP in

Fayette and Franklin County schools for many years. And those services are obviously intensive, at least four days a -- or five days a week, four hours a day, and are billed by the hospital, not under any other grant.

CHAIR SCHUSTER: Good point. I knew that you were doing that. I didn't realize it was Franklin and Fayette, Nina, so I appreciate that.

MS. EISNER: Yes.

CHAIR SCHUSTER: And, again, those are incredibly important services to offer, so we'll have to get back to including that as well. Thank you for sharing that.

In the interest of time, I'm going to move on to the audit question. We had a great presentation by Jennifer Dudinskie. And is this the data that we requested, Jennifer?

MS. DUDINSKIE: Yes, Dr. Schuster. Good afternoon.

CHAIR SCHUSTER: Good afternoon.

MS. DUDINSKIE: I wanted to present you all with this information. You'll get a copy of this as well. I'm sorry I didn't get

to send it to you in advance. We've had a lot of illness going through my area that handles this, and so we've been a little bit delayed in trying to get it completed.

So what your request was was actually for the data from 2019 forward on the TCM audits. We were not able to go back to 2019 because that was prior to us starting a new process. A lot of this I went over in my presentation with you all, how we changed the way that we were doing audits and really kind of vamped things up in 2021. So the data is from 2021 forward, but it's consistent with how we've done things from that point forward.

Additionally, you had just asked for the total numbers. I went ahead and broke these down by the MCOs, and the fee-for-service numbers are also contained in that top table.

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

MS. DUDINSKIE: You're welcome. I mean, it's pretty consistent from year to year. We've done about the same number, really close to the same number each year.

It's pretty even between all of the MCOs as well.

I also had staff go and look at -- because we had talked about duplication and providers getting multiple requests. So I wanted to see: Of the providers that have been audited, how many of those had received requests from one MCO up to six? So that's what the bottom table is.

And so as you can see, actually, the number of requests that are, you know, three -- or four and above reduces greatly. So, you know, while there are some providers who are getting requests from multiple MCOs, that's not -- those numbers aren't as large as, I think, what maybe everybody thought they might be.

So -- but we've taken this information, and we are paying close attention to the providers that get pulled, how many times they're getting pulled, if it appears that they're going to get requested from multiple MCOs. And we're taking that in consideration before we proceed or before we provide instructions to the MCOs on the audits.

But there are the numbers for you. And, again, you'll get a copy of these, but I'm happy to try to answer any questions if you have them.

CHAIR SCHUSTER: Yeah. That is very helpful, Jennifer. And, really, the numbers are very consistent. Obviously, 2024 is just part of the year.

MS. DUDINSKIE: Correct.

CHAIR SCHUSTER: Right?

MS. DUDINSKIE: That's right.

CHAIR SCHUSTER: So is this a calendar year count, I assume?

MS. DUDINSKIE: That's correct.

CHAIR SCHUSTER: Okay. Thank you. Okay. Yeah. That's very helpful.

Questions from anyone?

MR. BALDWIN: Yeah. Dr. Schuster, this is Bart. Jennifer, I appreciate you providing this info. This is, you know, something we deal -- we helped to bring this issue forward. It is encouraging to see how those numbers drop off significantly to multiple MCOs.

But what we also hear is multiple audits

from the same MCO as -- because it's still an additional audit. You know, it's the same -- you know, so as far as timeline and capacity to provide the information.

So -- and I don't know if there's a way for you to capture that because that's not captured here. It's the same MCO, but they've got three audits from three different divisions in the same MCO going on at the same time. So that's probably what I hear more of than multiple MCOs at the same time, if that makes sense.

MS. DUDINSKIE: It does, but I'm providing you with what I have available to me.

MR. BALDWIN: Right, right.

MS. DUDINSKIE: We're not going to be able to provide what you're asking for because some of that is going to be dependent on whatever the MCO is doing that does not necessarily involve my team or DMS, like, and our directives to them to conduct something. So, you know, they have to do their own auditing. Some of that might be generated by data that they're running and that they're

seeing.

Now, we can certainly make requests to get information from the MCOs on how many audits they have, you know, with providers and that sort of thing, but that would take some time and some work to do that.

But this -- as far as this goes, this is the TCM data. This is what we kind of have a little bit tighter control on because we are telling them what to audit. I just wanted to make sure that you all had that because I know TCM is -- you know, there's been a lot of issues surrounding the TCM audits.

So I did want to take a look at that myself and see that we weren't -- the numbers weren't higher than what they are, and I'm pleased that they're not.

But yes, I do hear those complaints as well. Not easy to get to that data.

MR. BALDWIN: Yeah.

CHAIR SCHUSTER: Okay. Any other questions?

MR. BALDWIN: I think Kathy has got her hand up.

MS. ADAMS: Yeah. This --

CHAIR SCHUSTER: Yeah. I was going to say, Kathy, I think there was something that you had run by me, and now I can't remember it. So why don't you bring it up.

MS. ADAMS: Yeah. One of the questions that we had come up, and I couldn't answer it, was: So what triggered -- what were the problems that CMS identified with the State of Kentucky that has required us to be under a corrective action plan or under continuous monitoring? I know that that has since passed, but we're continuing to do -- to pull these cases. So what were the problems identified by CMS that caused Kentucky to come under the corrective action plan?

MS. DUDINSKIE: I don't know that I can answer that right now. Veronica may remember that. That was prior to me coming on board. I can't remember if I had anything included in my initial presentation about what those -- what they were. I remember, you know, just what the CAP entailed, and the CAP requires us to do the process that we're doing now.

As to the specifics on it, I can't remember that off the top of my head. I would have to go back and take a look at that to answer it.

MS. CECIL: Yeah. The same, Kathy. I don't know if I feel comfortable trying to remember specifically. But I do know that it was a direct result of them pulling those cases and auditing them specifically for not meeting requirements. But we can -- we can try to, you know, see if we can find what some of the specifics of that were. I just don't have it off the top of my head.

MS. ADAMS: It's just a good point that it would be helpful, you know, if one of our members asked us. Like, if there's something we're not doing, tell us what it is we're not doing, so we make sure that we comply going forward. And, of course, they're required to meet all the requirements. But, again, it just makes a good benchmark to know what the concerns were to make sure that we dot our Is and cross our Ts.

MS. DUDINSKIE: Well, I mean --

MS. CECIL: I think --

MS. DUDINSKIE: -- that's what we're doing now; right? That's what we're doing. So the things that we are noticing, that's what we are reporting out. So we are letting providers know if they're not doing something. So I don't know how helpful that information may -- you know, may or may not be.

But, you know, from this point forward, we -- you know, these audits -- we're doing very detailed audits. And, you know, we are letting the providers know what the problems are and what to do to correct the problems.

MS. ADAMS: But there wasn't, like -- Veronica is going to look to see what things CMS had problems with, I guess. Is --

MS. DUDINSKIE: We will do that.

MS. ADAMS: Yeah. Okay. Whether it's signatures or start and stop times, whatever it was. Thank you.

CHAIR SCHUSTER: All right. And, again, Jennifer, thank you for your excellent presentation --

MS. DUDINSKIE: You're welcome.

CHAIR SCHUSTER: -- at our last meeting and for this follow-up.

Any other questions while we're on audits?

(No response.)

CHAIR SCHUSTER: Oh, I know, Kathy, because I put on there. There was something about the provider time to respond, that maybe --

MS. ADAMS: Yes. That was another issue.

CHAIR SCHUSTER: Yeah.

MS. ADAMS: We had spent several Behavioral Health TAC meetings in the past because of the short turnaround for the record request. And, you know, I guess I was under the assumption that we had all -- the MCOs had all done a gentleman's agreement to allow 30 days and that if that didn't happen, that we were to reach out to the person on the audit request.

And we're seeing more and more -- and I actually had language from one -- of a subcontractor from one of the MCOs, that they gave the provider eight days to respond and

basically said, you know, we gave you extra days during the pandemic, but that's over. So we are no longer giving any extensions.

MS. DUDINSKIE: Okay.

MS. ADAMS: And so that's an ongoing concern of our members, is, the -- again, it's changing with some of the MCOs, and they're going back to eight days, fourteen days, much shorter time frames, and then not -- they might be willing to give a couple of days more but not up to 30 days for some of them.

MS. DUDINSKIE: So we have clarified this with the MCOs multiple times. So what I need for you to do in those cases is I need those specific examples, and that way, I can go directly to the source. But I do need specific examples in order to address that with them.

MS. ADAMS: Thank you, Jennifer. We will do that.

CHAIR SCHUSTER: So you need the date, time, the MCO involved, and probably a copy of the reply and so forth.

MS. DUDINSKIE: Ideally, the

provider should contact us directly, and I believe that's the instruction that we've provided.

CHAIR SCHUSTER: Yeah. Okay.

MS. DUDINSKIE: So, ideally, the provider needs to be reaching out to us and providing us with that specific example and then we can intervene and try to assist.

CHAIR SCHUSTER: Okay. Thank you.

MS. DUDINSKIE: Sure.

CHAIR SCHUSTER: And do you mind putting your email address in the chat again, Jennifer? You've been very kind to do that in the past. We do appreciate it.

Leslie, I guess I'll call on you for a status update on the 1915(i) SMI SPA and waiver.

MS. HOFFMANN: Yes, ma'am. So for the 1915(i) SMI State Plan Amendment, we received an informal RAI, so it's a request for additional information, from CMS on June the 15th. We had our language drafted, our questions back -- answers back to them drafted and sent back on June the 28th. And so currently, right now, we're awaiting for

them to answer our responses back.

One of the things that I've mentioned earlier was that we want to -- I would prefer to keep it on the informal clock, if at all possible. Don't know where we're going to go with that.

Once we get on the clock, then it is a longer period of turnaround. So we want to keep it moving; right? And we can stay on an informal back and forth with CMS until September the 3rd. So we're hoping to have all things lined out with them before September the 3rd.

Also, I wanted to let you know that we were asked by the HCBS ADvancing States -- we were asked to participate in their conference this year. And we are having three presentations completed, one of which, very proud to say, Kentucky, with our innovations on this 1915(i), have been asked to present with Texas and Wyoming. And all three of these states are in different phases. So it's -- I think that was a good combination.

So we will be presenting with them on a panel simultaneously, like, together in one

presentation. So that's exciting. And I will be going in August to do that presentation.

And we have two other presentations, one on disaster recovery. And there's another one that April Lowery from Long-Term Services and Supports area will be coming to present as well. So happy that we're getting noticed for innovation.

And, Sheila, you know that we've been waiting for 25 years for something like this to come about, so we're very excited.

Our 1115 that is a companion to this one, we're hoping that it will be approved around September the 30th.

CHAIR SCHUSTER: Great. So let me ask you about the 1915(i).

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: So you're trying to keep it on the back and forth, which makes sense, and that would end on September the 3rd. So what's your best guesstimate at that point about timing on approval or not approval or next steps?

MS. HOFFMANN: So we're currently

right now working with DBH as well and thinking about how we want this to flow with -- knowing that our partner 1115, our companion, will actually probably be approved even later than this one will be. We're thinking this one will be approved probably sometime in September. We had an estimated rollout date of January of 2025, and we are thinking about pushing that out.

And I've mentioned this on the Consumer Right committee meeting the other day. I want to make sure that members understand what's available, that we have their buy-in and trust. I think there's going to have to be a lot of communication to understand what this program is about and that we have to have time to build provider capacity.

So I don't want it to just be piecemealed. I want it to be as whole as we can get it and asking -- I think we're going to ask CMS, you know, what would be a good rollout plan. Since this one doesn't have an implementation time period like the 1115 would, would they listen to a rollout kind of process?

So, again, I'm just in the beginning phases of that. We plan to meet with CMS along with our sister agency at DBH in making a determination of how that rollout might look. Again, I'm thinking about that needs -- that needs to be what happens for the member because there's going to have to be trust. This is a brand-new program, and it's complex to understand. So I think we're going to have to build some trust in the community.

And, Dr. Schuster, we can do that with you as well. There will be lots of communication and partnerships along the way, and we can use this Behavioral Health TAC to drive that agenda as well.

CHAIR SCHUSTER: Well, and there's going to have to be some evaluation of people.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: And that's going to take some --

MS. HOFFMANN: I'm still thinking -- yes, and trust. Like, I really feel like the community is going to have

to -- and that's why I was thinking we could use the Behavioral Health TAC as maybe the sounding point to get those initiatives, communication in this arena, if that makes sense, to push that forward.

CHAIR SCHUSTER: Yeah. Absolutely.

MS. HOFFMANN: Yeah.

CHAIR SCHUSTER: You know, most of us involved with the TAC have worked on this and hoped for it for a long time.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: So yes, by all means.

And now good, good, great news on the re-entry waiver, which has been approved.

MS. HOFFMANN: So I think the governor may be making an announcement. We haven't made it really public, but folks already know because CMS sent the email out --

CHAIR SCHUSTER: Right.

MS. HOFFMANN: -- as well as I think there's some -- I heard that there's a newspaper article out there that I'm going to have to go track down.

So yes, it was approved on 7/2. This is one that will require an implementation plan. Like I was talking about we needed in the (i), it will require an implementation plan, and that one is due on 10/30 of 2024.

Just as a reminder, this is not for state plan services prerelease. We're going to be embedding certain services within DOC and DJJ and then that will follow the person out in the community. So I know when lots of folks are hearing about this, there's some confusion going on, and we will be addressing that in the near future as well.

We have additional stakeholder engagement that's being -- in the process of being scheduled now. We are utilizing that government -- the government structure ACRES, which a lot of the folks maybe on here are on. And that is our Kentucky Advisory and Community Collaboration for Re-Entry Services.

We are also -- just today held a core team meeting which is DMS, DBH, DOC, Department of Correction, Department of Juvenile Justice, and working on that core

team as well as Office of Drug Control Policy. So I did want to mention that DMS is also dedicated in assisting DJJ and DOC in some project management, change management kind of activities so that we can all have a Team Kentucky implementation all together. So more to come on that.

I did want to let you know -- I've mentioned it in another meeting. Kentucky was selected to participate at a national level with six other states. I believe 18 requested to be in this learning collaborative. So, you know, I'm always giving credit to all of our folks that we're integrating with.

I was very proud to walk into Washington with our Team Kentucky that consisted of Commissioner Crews from the Department of Correction, Commissioner White from Department of Juvenile Justice, Commissioner Marks from the Department of Behavioral Health. Angela Sparrow and I were representing the Department for Medicaid's Commissioner's Office and Van Ingram's office for Drug Control Policy.

We were one of the only states that walked in with a collaboration like that. It was a -- I'm very proud of everybody. I said we should have all stood together and, like, connected hands and held our hands high because there were other states that don't even talk to their partners like DOC and DJJ in other states.

So we were so proud to be able to do that, and we will continue on that collaboration. There are, like I said, six other states with us. And we're supposed to support each other in this cohort. We're all in different phases of our implementations as well as to develop some best practices and lessons learned for future states that plan to be coming on as well with the same types of initiatives. So that was very exciting and very proud for Team Kentucky.

CHAIR SCHUSTER: Yeah. I think there was a question in the chat about whether any of those meetings -- they said the Team Kentucky meetings, whether those were open meetings, Leslie.

MS. HOFFMANN: So those were

actually held in Washington D.C. for -- for the collaborative. NASHP and HARP are the sponsors of that. And then we've got core meetings going on right now. They're just to the smaller core team which is DBH, DMS, Department of Corrections, Department of Justice, and Office of Drug Control Policy. Our core team is kind of that -- it ended up being almost the same as our learning collaborative core.

But, again, there's lots more to come, and we are going to start working on the implementation plan. Again, Dr. Schuster, we will use the Behavioral Health TAC kind of as the funneling mechanism to keep you apprised of what's going on and then the Re-entry TAC as well.

CHAIR SCHUSTER: I was going to say, you know, Steve Shannon --

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: -- chairs the Re-entry TAC, and they meet at 9:00 on the same Thursday that the BH TAC meets at 1:00.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: That Zoom is

available on the website, or you could get it from me. So anybody that wants to be a part of hearing those updates because I know there's great discussion going on after many months of meeting when there was nothing to discuss except waiting. You know, that's going to be a core group as well.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: And people can follow developments through that as well.

MR. SHANNON: We had a great meeting this morning, Sheila.

CHAIR SCHUSTER: Oh, there you are, Steve. Welcome.

MR. SHANNON: I'm back.

CHAIR SCHUSTER: Yes. I'm sure you did. These are exciting times.

MR. SHANNON: Yep.

CHAIR SCHUSTER: So, you know, if people want to join the Re-entry TAC and get the -- be a part of the discussion and get the latest and greatest news, that's great.

And, Leslie, who's going to do the 1915C waiting list numbers for us?

MS. HOFFMANN: I believe that'll be

me, too, Dr. Schuster.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: So as you're aware, the numbers are fluid. I just did a presentation a day or two ago, and I'm already updating the numbers again. But I wanted to give you the most accurate that I could.

The waiting list numbers as of -- let me see. This was as of today. HCB was 1,824. Michelle P waiver is 9,214. And the SCL is 3,553 of which 146 are in urgent status. And the rest of those are in future planning.

And just a reminder. I try to always encourage people to, like, think about a couple of important things. Usually, the averages run -- about 40 percent of the waiting list are on other waivers and trying to move around, so they are receiving services. And even a higher number of that, folks are eligible to receive state plan services at any point.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: Yeah. So I just wanted to mention that. Most folks are not

just sitting on this waiting list. They're receiving services in a waiver that maybe they want to move to another waiver and/or have options through the State Plan Amendment currently.

CHAIR SCHUSTER: Right. And as most of you know, 1,925 new placements were funded by the general assembly, and there's a report due October 1st on how that transition is going to be made; right?

MS. HOFFMANN: Yes. And I have the numbers here. I believe it's 25 for ABI long-term care, 250 for HCB. Michelle P is 250. SCL is 250.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: And we have to -- in all honesty, Dr. Schuster, we've been through some high numbers like this before. We will have to try to develop a plan. We're not going to bottleneck and end up with folks not getting assessed for the programs; right?

So we're going to -- we'll probably roll those out in a way that -- we're working with our sister agencies, Department of Aging and Independent Living and Department of

Behavioral Health to figure out a plan that would best ensure that we cannot overrun the provider capacity right off the bat, if that makes sense, to reduce that risk.

CHAIR SCHUSTER: Yeah. Yeah, it does. You can't plunk 250 people out there --

MS. HOFFMANN: If you do that, it actually -- you're actually in a worse situation if we do.

CHAIR SCHUSTER: Right. Yeah. So the assessment and the strategic placement is very important. Thank you.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: What about an update on the ABI waiver, access to therapy services?

MS. HOFFMANN: I don't have an update on that today other than what, I think, Victoria spoke about a little bit earlier. I can follow up on that one.

Erin, if you'll take that for a take-back for me.

MS. BICKERS: Yes, ma'am.

CHAIR SCHUSTER: Yeah. I think

that's been an issue that Mary Hass has brought up, and Misty, I think, will be interested. And that's the shifting of the therapy services.

MS. HOFFMANN: Yeah. As far as -- and I just wanted to say that, about the shifting of the services. We will make sure that everybody has knowledge of and a plan about any therapy services transitioning.

We are also working with Justin Dearinger's group to develop training and an FAQ related to how that would look. And we know that there is a strong need for communication for everybody to understand that. And I -- I've been through some of this before, so I know how important it is for that communication to be out there.

CHAIR SCHUSTER: Right. Right. And I think that Mary had been in touch with Pam Smith about -- and I think the issue -- and, Bart, you may be helpful here -- was that the ABI -- ABA person who developed the plan was -- could not be the person that was implementing it. Does that sound familiar?

MR. BALDWIN: Yeah. It was -- from

what I recall, it was the licensed behavioral analyst does the assessment and then sets the treatment plan. But for some reason, then there was a prohibition for that particular provider to interact with the patient any further, which didn't make any sense.

So I think that was -- from what I can -- I haven't -- you know, I just heard Mary talking about it in past meetings. That's what I understood was the issue. And I don't really -- never did really understand what the reasoning behind it was. But I think that's the issue.

CHAIR SCHUSTER: All right. And when --

MR. BALDWIN: Which doesn't -- you know, it's the -- it doesn't make a lot of sense.

CHAIR SCHUSTER: Yeah. When Mary gets back from her medical issue, Leslie, I'll have her reach out to you to clarify that.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: Okay. Thank you very much.

And the status of the mobile crisis services is?

MS. HOFFMANN: So I'll just give you a little bit of an update. You're aware that the general assembly did not fund the mobile crisis program. We are looking at a couple of other options, but nothing is in stone. It's only research. I just wanted to let you know that. But since the funding is not there, we will not move forward with the continuum that we had expected.

The seven municipality co-response grants that we have, those are out and flourishing. And we have been approved to continue to support them. I don't know if any of you all saw the recent newscast for Boyle County, was very proud of them and their efforts that they are working on.

But there's seven municipalities that have those grants. They are in their implementation phase, and those grants will run for about three years. So we have been allowed to utilize the support for those municipality grants as a pilot project to measure for future evaluation and possible

expansion in the community. So just wanted to let you know that.

CHAIR SCHUSTER: Okay. But the contract with the ASO has been cancelled; right?

MS. HOFFMANN: That is correct. And you should have received a provider letter that went out --

CHAIR SCHUSTER: Yeah. I think we got a provider letter.

MS. HOFFMANN: -- maybe a week or so ago. Yeah.

CHAIR SCHUSTER: Yeah. All right. Thank you very much.

MS. HOFFMANN: Yes, ma'am.

CHAIR SCHUSTER: Medicaid unwinding and recertifications. Your favorite topic, Veronica Judy-Cecil.

MS. CECIL: Yes, it is. Thank you. And in the interest of time, I wanted to check to see -- always, I have my presentation. I can just go over the numbers. I wanted to --

CHAIR SCHUSTER: Oh, let's see your presentation briefly since you've got it.

MS. CECIL: Okay. Sure.

CHAIR SCHUSTER: And you haven't gotten to do it before, and so it's always good to actually see it. Thank you.

MS. CECIL: Absolutely. Absolutely. And I'll do my best to -- sorry. I'm looking for my start slideshow.

Okay. All right. So I am going to just touch on the fact that, as most folks know, we've been allowed to continue our flexibilities through June of 2025, which is amazing. The only caveat with that is the children automatic extensions, CMS is -- has asked Kentucky for further justification to continue those. So we're working with CMS on that right now. We hope to get approval to continue those as we move on into the -- what we call now the second round of unwinding.

So I will say that we have May and just a handful -- like about eight individual renewals in June, is the end of the first round of renewals following the end of the Public Health Emergency. So we call those our first renewal post-PHE, post-Public Health Emergency. And now we're coming into

the second round, or people's second renewal following that.

But I always want to remind folks that we had new people come on during this past year, so those folks are going through a first renewal. So if they were new to Medicaid, if they enrolled in May or June of last year, then they -- they've been going through their first renewal.

So we felt like all the effort that we have put into helping and supporting folks going through a renewal will continue for even those folks that it's new to them as they join Medicaid for the first time and want to keep those efforts going as we move forward.

Just also a reminder that those flexibilities we put in place for the home and community based service waivers, the 1915C waivers we did through Appendix K. That was the vehicle in which we implemented those flexibilities. Those ended and then became permanent within the six different waivers.

Not all of them were extended

permanently, but -- and incorporated. But the majority of them were, and we believe the ones that we feel like were probably the most effective and we knew that was really what our members and our families and our providers really kind of wanted to see.

There are separate meetings going on for that transition, and we are transitioning still even though that just happened on May 1st. If members, though, or families or providers have questions, we ask them -- case-specific questions, we ask them to reach out. That top -- email address and phone number in the top right there is a way to get in contact if you have a specific question of a situation that there was a flexibility, and you're wondering how is that being handled now. So lots of communication on our unwinding website as well as the Division of Long-Term Services and Supports and the waiver pages, web pages about that.

We have seen, not unexpectedly, that our enrollment continues to decline as people kind of rolled off of that first renewal and they have exhausted some of those

flexibilities including the extension for -- we were allowing a one-month extension if somebody didn't respond to their renewal and up to three months for a long-term care 1915C waiver member.

If they didn't respond to the notice, we were allowed to grant them that extra month of eligibility, and we tried to do additional outreach to them. So, you know, those are starting to end for those folks, and so, you know, we're seeing kind of that natural decline.

This busy -- just a reminder. This busy page is -- on the left-hand are our original CMS monthly report, the report that we had to file with the Centers For Medicare and Medicaid Services following each month of renewal to report how many individuals went through renewal, how many were approved, how many were terminated, and then kind of what subcategories those were in.

So as you can see, that's on the left. In the middle there, it says 90-day processing. CMS came to the states and said, oh, we want to find out what happened with

the cases that you processed 90 days following a renewal. So we had to file these updated reports, and that's what you're seeing on the right-hand side, is the updated report for each month.

These are all on our website. If you really want to go out and dig into them, you're welcome to do that.

But as you can see, as an example for February, we only had one pending case at the time. And by pending, I mean it was the renewal, termination -- renewal end date. So on February 28th, 29th -- I can't remember if it was our leap year -- the renewal was due, and the member actually responded, but the State hadn't processed it yet. So they cross over that renewal date, and we have to keep them eligible while that case is pending.

So we had one left over in February, and we actually processed that. And on the right-hand side, we would put them in the approval or the termination bucket. So that's what you're seeing there with all the -- kind of that busyness of those numbers.

And then I don't have June numbers up here, but I can report them to you. But just this slide is showing you the more current renewal months and the 90-day reinstatement period that we're following for those months.

So, for example, in May, we had -- at our last meeting, I didn't have May numbers. But -- so in May, we had 94,705 individuals who went through renewal. 51,534 of those were approved. 37,461 of those were terminated, and the majority of those were for lack of response, unfortunately. And then at the time, for May, we had 816 pending when we crossed over that May 31st date.

The last -- on the far right reinstatement column is, again, we follow them for 90 days. If they come back in after they're terminated and provide us what we need and we can determine them eligible, we'll reinstate them automatically with no gap in coverage back to their termination date. So we track those to try to keep up with seeing if people are coming back in, kind of that churn that you hear a lot about that we're tracking.

The numbers for June -- and our June report is up on our website if you want more detailed information. But we had 58,959 individuals that went through renewal in June. Of those, 41,336 were approved. And the majority of those were through that passive renewal where we were able to go out and verify the trusted data sources and determine them eligible.

And then we terminated 13,187 individuals. Over 11,000 of those that lost eligibility were due to that reinstatement that we did for the -- for the folks that we cascaded down to a Qualified Health Plan Advanced Premium Tax Credit eligibility.

If you recall, we did something special for them. If we cascaded them down to that and sent them a notice that their Medicaid was terminating because the trusted data source came back and told us that they were no longer eligible, their income was no longer eligible, we sent them a notice and told them: We're going to terminate your Medicaid, but you're eligible for a Qualified Health Plan and premium tax credits. We went

back and reinstated those folks and gave them a second attempt at a renewal, and the people just still didn't respond.

So the large number of our June terminations are for that reason. We reinstated them and gave them another option -- another opportunity to complete a renewal, and they didn't. So that's why there's that number.

And the good news is, as we see our Medicaid enrollment go down, our Qualified Health Plan enrollment is going up. Because as people roll off Medicaid due to no longer being eligible, they could go out and choose a Qualified Health Plan on Kynect, the state-based marketplace, and receive those tax credits.

There's other cost sharing financial support through the -- through the exchange, through Kynect. And so it can really make, you know, a plan and a premium affordable. Some people have no premium as a result of that. So, you know, we've been doing a lot of effort in trying to connect people to a Qualified Health Plan and enrollment into --

into the exchange.

Keep in mind, too, though, that there is no -- I mean, there's kind of a continuous open enrollment for anybody who loses Medicaid. So folks need to understand that. If it's a couple of months since they were terminated Medicaid and they decide, oh, I want to go get that Qualified Health Plan, they can enroll and just check the box for a special enrollment period.

That's still going on right now, and so a member doesn't have to wait for an open enrollment period to do that. So we're encouraging folks. But we have -- we've actually reached about 82,000, which is really great for Kentucky.

Just a reminder. All of our information is out there on our website, and all those monthly reports are discussed. And we have stakeholder monthly meetings. Those are recorded and posted as well as the PowerPoint presentation that we give. And that's -- we really get into the numbers that I reported today.

Starting this month -- so the next one

is on July 18th. Wanted to let folks know that as -- now that we're coming out of that initial first unwinding, we're going to use those stakeholder meetings to start talking about other Medicaid updates.

So there's a lot going on in Medicaid, and we want to keep folks updated about the things that are happening. And so we still encourage you to attend those meetings or check it out later once we record it and post it. For example, on the 18th, we'll be talking about the new final rules that make a lot of changes to Medicaid and how they're going to impact our members and providers. We're going to talk about our Managed Care Organization value-based quality program.

We're going to talk about the department's strategic planning. So we have been working on some strategic planning, and we're going to be doing some things going -- with stakeholders in the future. And we want to include them. And then we're going to talk about school-based services and just a couple of other things.

So just know that we'll continue

reporting on renewals. We're kind of switching it from an unwinding -- just unwinding to just reporting on renewals in general. And then we're going to be including some other really great information to keep folks updated.

So happy to take some questions.

CHAIR SCHUSTER: Thank you very much, Veronica. I was really excited to hear that you're kind of expanding the agenda for the stakeholder meetings. Can you put in the chat how people would register for those if they want to join?

MS. CECIL: Absolutely. Be happy to do that.

CHAIR SCHUSTER: Yeah. That would be great.

Any questions for Veronica who is a walking encyclopedia of all things unwinding and recertifications, among other things?

(No response.)

CHAIR SCHUSTER: All right. And you'll share your PowerPoint with us, please?

MS. CECIL: Absolutely. Thank you all.

CHAIR SCHUSTER: Thank you very much.

New recommendations to the MAC for their next meeting, and that meeting is July 25th. And they meet from 9:30 in the morning to 12:30, although we finished early last time. I don't know if we'll finish early again but...

From the voting members, any new recommendations for the MAC?

(No response.)

CHAIR SCHUSTER: We have not heard back, Steve, from our last recommendation, but we should get that soon. So it may be that there's some follow-up to that, but we won't know that until after we see how they replied.

And recommended agenda items for our September 12th -- thank you, Veronica, for the link. Are there any agenda items that we typically have not covered that are of interest to anybody who regularly attends these BH TAC meetings?

You know, I try to put things on the agenda and then to keep them on to kind of

follow up on them. So we obviously have lots of, you know, status reports on some things.

But is there something that we need to be discussing that we have not had maybe on an agenda for a while? If there is, I'm open certainly to that, and my email, again, is in the chat. It's kyadvocacy@gmail.com.

We talked a little bit about helping consumers and family members better navigate getting into Medicaid and the waivers. And I think I distributed some of the things that are already on the DMS website, but I'm certainly open to hearing from you all, particularly those of you -- the NAMI groups, the PAR group people that are kind of out in the community and don't really know what Medicaid is all about or what the waivers -- particularly with new waivers coming on.

And we're finding that people just don't know how to approach the whole thing and where to get information. And some of the connectors, who are very often the people that get Kentuckians hooked up with Medicaid, are not that familiar with the waivers. So we're looking at that. But if anybody has

any thoughts about how to get information out in a more easily digested way, we certainly are open to that.

Are there any formulary issues that anybody has?

(No response.)

CHAIR SCHUSTER: Good news if there aren't any. We're always worried that people are not getting the medications that they need when they need them.

In that case, I'll just remind you about the next MAC meeting on July 25th and then our next BH TAC meeting will be September 12th, the second Thursday of the month, from 1:00 to 3:00.

And if there is not any other business to bring before the body, we will just adjourn. Anybody? Last chance?

(No response.)

CHAIR SCHUSTER: All right. Well, thanks to all of our presenters, and thanks to you all for your good questions and discussion. But I will get back with you. I mean, one of the things we'll talk about next time is next steps on the rate study, and

I'll be reaching out to you for our input on that.

And I thank those who submitted questions, and I really appreciate Veronica -- or Victoria, rather, Smith's approach to that in a very collaborative way.

So thank you all and keep cool this summer, and we'll see you in September. Thanks.

MR. BALDWIN: Thank y'all. Have a great afternoon.

CHAIR SCHUSTER: Bye-bye. Thank you, Erin.

MS. BICKERS: You're welcome. Everybody, have a good afternoon.

CHAIR SCHUSTER: All right. Thank you.

(Meeting concluded at 3:11 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 22nd day of July, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR