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

****

Via Videoconference
March 13, 2025
Commencing at 2 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, TAC Chair

Steve Shannon

TJ Litafik (Not present).

Valerie Mudd

Tara Hyde (Not present).

Misty Agne

Mary Hass

MS. BICKERS: Good afternoon. This is Erin Bickers with the Department of Medicaid. It's not quite 2 o'clock and we're still clearing out the waiting room, so we'll give it just a moment before we get started.

MS. SCHUSTER: Hello, folks.

MS. HASS: Hey, Sheila. Mary Hass here.

MS. SCHUSTER: Good. Thank you, Mary. Val is here.

MS. HASS: You're welcome.

MS. SCHUSTER: And Steve is here.

MS. BICKERS: Good morning, Dr. Schuster -- or good afternoon, Dr. Schuster.

MS. SCHUSTER: Good afternoon, Erin.

MS. BICKERS: We are still clearing out the waiting room if you'd like to give it just a moment.

MS. SCHUSTER: Sure.

MS. BICKERS: I currently have yourself, Steve, Val, and Mary. If I missed anyone, please let me know.

MS. SCHUSTER: Okay.

MS. BICKERS: Looks like Misty is currently logging in.

MS. SCHUSTER: Okay, great.

MS. BICKERS: And our waiting room is clear if you wanted to go ahead and proceed, or if you wanted to wait a moment. Your decision.

MS. SCHUSTER: Okay, thank you. I'll wait one more moment.

MS. HOWARD: Can you hear me?

MS. SCHUSTER: All right. Let's get going because we have a full agenda. Welcome to the BH TAC meeting of March 13th, 2025. I'm Sheila Schuster, the chair, and I apologize for my appearance. I went a couple rounds with the sidewalk and the sidewalk won. So I have a little bit of bruising, but fortunately, it was only that and not broken bones, so I'm grateful.

MS. HASS: I'm sorry that you didn't get a better hit on the sidewalk, and it won, but hopefully, you're okay.

MS. SCHUSTER: Yes, I landed on a knee which ended up getting bruised, but no broken bones, and no, you know -- my eye

looks bad, but I can see out of it, so --

MS. HASS: Well, we're grateful you're okay.

MS. SCHUSTER: Thank you. I'm trying to save people from having to look at this battered face, but I want to be a voting member of the BH TAC. So let's see, Mary, you want to introduce yourself, please?

MS. HASS: Okay. Mary Haas with the Brain Injury Association, Kentucky chapter.

MS. SCHUSTER: Great. And, Val?

MS. MUDD: I'm Valerie Mudd with NAMI Lexington, the National Alliance on Mental Illness and Participation Station, a peer run operated center. I'm a person living with mental illness.

MS. SCHUSTER: Great. Great to have you. And Steve is right next to you in my little box here.

MR. SHANNON: Steve Shannon with KARP, Association of Regional Programs. Glad to be here.

MS. SCHUSTER: All right. And, Misty, I think you're on?

MS. AGNE: Yes. Misty Agne, I'm with

U of L Health Frazier Rehab Association and the Brain Injury Alliance of Kentucky.

MS. SCHUSTER: Great. Thank you. And Tara was going to be on, although she couldn't -- I think she was driving. I don't know if you're on yet, Tara.

(No response).

MS. SCHUSTER: Okay. And, TJ?

MR. SHANNON: I didn't see him.

MS. BICKERS: I don't see either of them logged in yet, Dr. Schuster.

MS. SCHUSTER: Okay. So we do have a quorum to do business, and we will proceed with that. Thank you very much. So the minutes are distributed from the court reporter, and then I sent you a summary of those meeting minutes in draft form. So could I have a motion from one of the voting members to approve those minutes as distributed?

MS. HASS: I will motion that the minutes from January 9th be approved.

MS. SCHUSTER: Okay. It was actually January 22nd.

MS. HASS: Okay.

MS. SCHUSTER: Oh, I should've changed it on this. We rescheduled that meeting, so --

MS. HASS: Let me stand corrected to the 22nd.

MS. SCHUSTER: Yeah. Thank you, Mary. And a second, please?

MS. AGNE: This is Misty, I'll second.

MS. MUDD: Second.

MS. SCHUSTER: Okay. Great, thank you. And --

MS. BICKERS: Misty, you'll have to have your camera on to vote, please. Sorry.

MS. SCHUSTER: I think we had a second also from somebody else -- there's Misty, great. Okay. So all in favor of approving the minutes, and it should be the minutes of January 22nd, signify by saying aye.

(Aye).

MS. SCHUSTER: Okay. And any opposed?

(No response).

MS. SCHUSTER: And any abstentions?

(No response).

MS. SCHUSTER: All right. Erin, if you could put up the document I sent out around noon time today: The Resumption of Prior Authorizations for Behavioral Health Services. Yeah.

So we've been on kind of a windy road about resuming the behavioral health services. Back in December, mid-December, Secretary Friedlander of the Cabinet for Health and Family Services sent out a message saying that he was looking at resuming them and asking for input, and a number of groups and individuals sent in their input. He then had a meeting of the people that had submitted comments, and that was probably -- what, Steve, three weeks ago maybe? Something like that. And went through those initial recommendations that they had made, which were much more -- in some ways, much more specific than these, and took some input from everybody who was on that meeting. And then, last week he sent out this resumption of prior authorization for behavioral health

services.

And he said at that meeting that they would be resumed for all behavioral health services starting May 1st. There also is a bill in the legislature that also talks about resuming prior auth for behavioral health, so we'll see if that passes then what that would say.

But let me give you all a chance to look. We -- there was a lot of discussion in that meeting about consistency among the MCOs. I think a lot of providers have been concerned about very different interpretations of medical necessity and the information that they require to ensure that there's fidelity or adherence to the criteria. So it would be wonderful if we could get more consistency, I think, across the MCOs.

They also talk about provider notification and perhaps using the health information exchange. There was a letter on that third bullet point -- there was a letter issued by Commissioner Lee in mid or kind of late November of 2024 that looked at

H2027, which is psycho-educational services and kind of redefined those significantly. They had been done by peer supports primarily -- peer support specialists primarily. And the letter from the department indicated that they would now be done by licensed mental health professionals, which is, I think, from my perspective anyway as a licensed mental health professional, quite a change there.

There also were caps put on peer support specialists. And they're apparently going through another round of review. We've heard a lot in this BH TAC -- in these BH TAC meetings over the last year about peer support specialist services and psycho-educational services being overutilized by providers, and that being a source of great concern for the MCOs.

We're still, Erin, up on the first paragraph of this. If you can go back there under critical issues. Yeah, thank you. And then, they say that the return of a prior auth on outpatient services will be evaluated going forward, and, you know, most

of those are outpatient therapy services.

MR. SHANNON: Right.

MS. SCHUSTER: So if you could scroll down a little bit now, Erin, please. So the reintroduction of prior auth with the goal of May 1st. There's clear guidance that crisis and emergency services shall not be required, although -- and, Steve, please feel free to weigh in because you were at that meeting as well. There seem to be some questions asked about do we all agree on what a crisis service is and what an emergency service is.

MR. SHANNON: Right.

MS. SCHUSTER: And I don't know that that has been addressed.

Inpatient psychiatric hospital services for youth and adults for stays longer than three days would be PA'd. And the MCO may or may not require notification at the time of admission. There would be PAs for the PRTFs we call them, the psychiatric residential treatment facilities, both level I and level II, and also for partial hospitalization for

substance use disorder or mental health services exceeding 30 days.

They refer to the recently communicated, those would be the November of 2024 limits for psycho-ed and peer support specialist services. TRPs, the therapeutic rehab programs for mental health, would have a minimum period of authorization of three months. ABA services, which are given pretty much continuously in those cases, would have PAs for services exceeding 30 days. Targeted case management for anything exceeding three months in duration, and the -- further PAs would be for three-month minimum periods of time. IOP or intensive outpatient programs exceeding 30 days would be PA'd.

And then they refer to the gold card. If you look at House Bill 423, which is a bill that's moving in the legislature filed by Representative Moser, it outlines a gold card procedure for -- in the private market, the commercial market for providers, and basically, it sets a criteria. It's usually 90 percent. I think in this bill it's

93 percent. So if I'm a licensed behavioral health provider, and I routinely have my PAs for, let's say, outpatient psychotherapy approved more than 90 percent or more than 93 percent of the time, then for the next 12 month period, I would not have to have a PA anytime I requested outpatient psychotherapy services regardless of who the patient was. So it's a way of reinforcing providers that are doing well in terms of submitting the initial PA information and so forth. And that's permissive.

And then the last one on the last page is PA may be required for out-of-network providers as long as the MCO is in compliance with network adequacy standards. And I think we have found that there are lots of different rules for out-of-network providers and different reimbursement rates sometimes. So it will be interesting to see whether the MCOs want to use PAs with out-of-network providers.

MR. SHANNON: And, Sheila?

MS. SCHUSTER: Yeah.

MR. SHANNON: There's a question in

the chat about how will providers know the number of units for psychoeducation? I think it came from Taylor Tolle at Isaiah House. And I think that's a pretty good question because if it's an annual cap, but if a person changes providers, you know, you can provide services beyond the cap number and not get paid for them. How will that be communicated? And I don't know if we'll have an answer yet, but --

MS. SCHUSTER: Yeah, that's an excellent question. And there are lots of questions, I think, around those caps. And when we get to the discussion about bills in the legislature, Steve can fill you in on what -- what's happening with House Bill 695 in that regard. So that's a good question, Taylor. We'll run that up the flagpole back to the secretary and ask how providers will know what those numbers are.

MS. TOLLE: Sounds great. Thank you.

MS. SCHUSTER: Yeah. Steve, do you have any other comments about these that you wanted to make?

MR. SHANNON: There is some concern

that I've heard -- Bart's on the call -- about applied behavioral analysis exceeding 30 days, and that's really a long-term service. You know, is it going to be discontinued? If you don't modify the behavior in 30 days, I'm not so sure you're getting applied behavior analysis necessarily, so I think that's a concern.

One take away is prior auths are coming back. You know, I think that's pretty clear. Both the secretary and the General Assembly want to see prior auths for behavioral health return. Some of this document, you know, where it says may be or shall, I just wish there would be some guidance of which one it was because, you know, it may be a may one day and shall the next.

And, you know, it's not an annual cap on services with the exception of the psycho ed, but it's still, you know, reinstituting the process that was in place, you know, pre-COVID essentially. And one thing that people have asked me, will there be additional trainings made available for the

prior auth process because it's been five years, and some staff that were doing that may have turned over, may have left. So you may have new staff who is in the utilization management function of organizations who haven't done a lot of prior auths necessarily across all MCOs. I think that's a fair question as well.

MS. SCHUSTER: Yeah. And Misty asked the question about is the cap -- and, Misty, I guess you're talking about the cap on psycho ed or on peer support. Is it an annual cap that follows the patient versus a cap per insurance provider? Do you know the answer to that, Steve?

MR. SHANNON: It reads as an annual cap. I'm trying to see -- I had it yesterday, but it sure feels that way right now that it is an annual cap, which is the result of Taylor's question. So there was confusion about how that plays out and what does it look like.

MS. AGNE: I guess I was curious about that because, you know, I work in rehabilitation, and so we're very accustomed

to having therapy caps and limits on the amount of services we can provide. So, you know, if I had a patient who was with one MCO, it ends, and then they pick up a new MCO, essentially, their -- the number of visits that they have available to them, in essence, somewhat renews.

So it was just a curiosity along with the fact that I know that we, as providers, will call the insurance company and find out, you know, if we know that the psychoeducation has a cap, we ask exactly at the time that we request information how many units of that cap have been utilized. So I guess I was just globally curious about that as this is what our normal practice is where I work.

MS. SCHUSTER: Yeah.

MS. AGNE: And granted, that is not providing behavioral health services, but rather, general physical therapy, speech, occupational therapy.

MS. SCHUSTER: Right, right. Well, I think that's a question that we can ask. And Kathy Dobbins asks about residential

crisis units. Are they defined as part of crisis services? Would you guess, Steve? I mean, that's a good question to ask.

MR. SHANNON: It's been clearly articulated that way. But I think based on the conversation, even the MCO said the emergency crisis should require an MC -- I mean, a prior auth.

MS. SCHUSTER: Yeah. Nina, you've had your hand up --

MS. DOBBINS: But not hospitalization -- but not hospitalization, Steve? Because I think I -- didn't it say that was waived?

MR. SHANNON: They didn't specifically say that. They said emergency and crisis. They didn't specifically say CSUs.

MS. DOBBINS: But hospitals. I mean, didn't it waive the requirement for hospitals for the first three days?

MR. SHANNON: First three days, correct.

MS. SCHUSTER: Yeah, first three days.

MS. DOBBINS: I don't know why it wouldn't do the same for the crisis units.

MR. SHANNON: Right. I agree.

MS. DOBBINS: I mean --

MS. SCHUSTER: Yeah.

MS. DOBBINS: -- you know? It's a lot less expensive intervention.

MS. SCHUSTER: Yeah, we should ask.

MS. DOBBINS: And in the past, I do believe, at one time it was after three days when the pre-auths were in effect before.

MS. SCHUSTER: Yeah. That's a good point to ask, Kathy. We'll ask that.

MS. DOBBINS: Thank you.

MS. SCHUSTER: Yeah. Nina?

MR. SHANNON: Reading the letter now --

MS. EISNER: Yes, two questions. Will you comment on the last bullet that said -- that referred to the SKY kids? What does that mean? They don't have any pre-auth -- prior auth?

MR. SHANNON: If you go back up in that memo, it's --

MS. PARKER: PRTF.

MR. SHANNON: -- PRTF mentioned those. Angie's on, she can answer that.

MS. PARKER: Yeah, I'm sorry. It's for PRTF. There's a little asterisk by PRTF --

MS. EISNER: Oh, okay.

MS. PARKER: -- and the asterisk is for that.

MS. EISNER: Okay.

MS. SCHUSTER: Yes, that's right. I'm sorry. Yeah.

MS. EISNER: That's okay, thank you. And one other question: What about inpatient specialty EPSDT services? Do they require a prior auth?

MS. SCHUSTER: Inpatient specialty --

MS. EISNER: EPSDT services.

MS. SCHUSTER: -- EPSDT.

MS. EISNER: Yes.

MS. SCHUSTER: I don't see them on here, so that's a question that we also ought to ask.

MS. EISNER: Yes.

MS. SAMS: This is Ivy Sams with EPSDT. And, yes, they do require a prior

auth.

MS. EISNER: All EPSDT services? Does it say that anywhere?

MS. SAMS: Everything that's special service -- I don't know if it's on this list, but I can tell you that any special needs or special services have to be prior authorized.

MS. EISNER: Okay. It might be helpful to get it on the document just so we're all clear.

MS. SCHUSTER: Yeah.

MS. EISNER: Thank you.

MS. BICKERS: And, Dr. Schuster?

MS. SCHUSTER: Yeah?

MS. BICKERS: There's another question in the comment. It says, "How will the reintroduction PAs impact clients who are actively receiving the named services at the time of resumption?" From Mandy.

MS. SCHUSTER: My impression was that the PA would be on the services going forward from that point. Is that your understanding, Steve?

MR. SHANNON: Yes.

MS. MARLER: So the entire duration of those services for a person who began receiving them before this effective date would continue and would not require preauthorization at any point? Or would they essentially be at day 0 when resumptions happen, and then the specified amount of time in, they would need a pre-auth?

MS. SCHUSTER: Ah, I see what you're saying.

MR. SHANNON: Yeah, we have not had that level of discussion, that detail. Angie Parker, do you have any insight on that?

MS. PARKER: I was thinking about that. No, I do not. A lot of the comments that you're -- hi, it's Angie Parker, Director of Quality and Population Health with Medicaid. You all are asking very thoughtful questions and knowing that some of this that we've put out there, we did ask for -- we did -- did have some feedback from some providers last night that were also looking at -- that may have included some of

this. But if not, Erin will be -- and Dr. Schuster, I'm assuming as well, will be compiling all of these to make sure that they are addressed in some form or fashion.

MS. SCHUSTER: Yes. I will forward these to you, Angie, and to Secretary Friedlander. I know we're a day late from the deadline, but since this is really great input, I think, and an opportunity to get it from a wide range of providers, so we'll be sure that we capture all of these.

So the official date that these return we understand, Phyllis, is May 1. That's the goal. If you look at the document, it says, "goal of May 1 after appropriate notification." And remind me, Angie, is it a 30-day notification for something like this for providers?

MS. PARKER: Yes, ma'am.

MS. SCHUSTER: Okay. So May 1 is a goal date. And that may be a moving target, but I think he was pretty certain when we talked a couple of weeks ago that that's when he thought it would be. But there is a 30-day required notice if that helps.

MR. SHANNON: And --

MS. SCHUSTER: And can we be sure, Angie, that, you know, anything that's going to providers would also come to me as chair of the BH TAC?

MS. PARKER: Yeah, I mean --

MS. SCHUSTER: I'm not on the provider list.

MS. PARKER: -- because it's a behavioral health prior authorization, we'll make sure it goes to the BH TAC as well.

MS. SCHUSTER: Yeah, thank you. I'm not in your cadre of providers since I haven't clinically done anything --

MS. PARKER: It'll be going out on our website and every avenue --

MS. SCHUSTER: Yeah. You'll put it out every place there was. So Rita asked, "The letter I received said that the cap for H2027 and H0038 is per calendar year."

MR. SHANNON: Right.

MS. SCHUSTER: So that would be regardless of who the insurer is. If that person changes insurers, the cap would be --

MR. SHANNON: The cap would still be

--

MS. SCHUSTER: -- cumulative across the insurers. Right.

MR. SHANNON: Mm-hmm.

MS. SCHUSTER: Okay. Steve, your sound is very wonky. I don't know what you want to do about it, but you sound like you're talking with marbles in your mouth.

MR. SHANNON: I might be.

MS. SCHUSTER: I don't know. Can someone help me understand why we would not need to obtain a PA for SKY recipients for PRTF if we are asking parents in the community to obtain a PA? What's the rationale for that? Do you have any idea, Angie?

MS. PARKER: I don't other than the PRTF would be the -- would be asking for the prior authorization.

MS. SCHUSTER: Yeah. I think the question is -- Michelle, you want to clarify what your question is?

MS. SANBORN: Why would we not need to obtain a PA for all kids? What's the difference between the SKY kid versus a

child in the community?

MS. PARKER: It's -- the SKY are our foster children, and it's kind of sometimes more challenging to identify where they may be located. So that could be one reason, but that's certainly a question we can take back.

MS. SANBORN: So I mean, I'm assuming it's for ease of placement, but why would we not want to offer ease of placement for our families in the community so they don't have to come into care basically is what I'm asking? So -- you know, so what's kind of the nuance that I'm probably missing there?

MS. PARKER: We'll take that question back.

MS. SCHUSTER: Okay.

MS. MARLER: Sheila, could I underscore that just to say, I think if we're looking at a choice between resuming PAs and PRTFs one and two for the entire population or being able to exempt kiddos in SKY, we would view the exemption of kiddos in SKY as an improvement. But I think we have heard the cabinet a couple times even

during the legislative session note that the cabinet has the same opportunities and options and access as families who keep their kiddos in custody, and this does create that disparity.

So I think the intent is strong here, but I do think when you're talking about children who are actively in crisis, and to Michelle's point, we want to ensure that families are able to stay together as a unit and don't, in a moment of complete desperation, end up in a system because they were blocked access when they tried to navigate it independently.

MS. SCHUSTER: Okay. Good point. Susan says, "Have you discussed the need to clarify the three months for many of these services if they are consecutive or calendar, and that MCOs define months differently, 28 days, 30 days, in a calendar month which is very confusing. It should be clarified." And I don't think that we had any discussion about that, Steve.

MR. SHANNON: We have not.

MS. RITTENHOUSE: Yeah, so in the

past, and we've had this ongoing situation, and so -- feel very strongly that for any of these that have time frames, that they are very well-defined in the regulation so that the MCOs are held to the same standard. With TCM in the past, some MCOs did 28 days, some did 30 days, and some do calendar months. And when you have the month of February and the ones that are doing days versus a calendar month, we lose an entire month of revenue because they won't let us bill without a certain number of days in between.

You've also got the situation where it defines like therapeutic rehab three months. Is that three consecutive months? Or even with targeted case management, if someone's in the hospital and you don't bill for a month, would you need a prior authorization because three calendar months have passed, or three consecutive months of billing? And so I just think holding the MCOs to a same defined standard of what a month is, is very crucial for those kinds of definitions because we have found

significant loss in revenue based on MCOs designing their computer systems on how they define a month.

MS. SCHUSTER: Okay. Good points. So all of these places --

MS. TURNER: Also -- sorry.

MS. SCHUSTER: Yeah.

MS. TURNER: Also, in terms of TRP, if they approve three months, if someone's coming two days out of the week versus five days out of the week, how is that going to be defined?

And then, to the point of, I think Steve made earlier with ABA services a lot of times those TRP services are long time needed programs. And until Michelle P. waiver program begins allowing the people off the waitlist -- which there's been a small amount of that. There's been a small amount of movement, but there's, you know, still 8, 9,000 people on the waitlist. Until they -- those people can access TRP through Michelle P. waiver, then I think that it is the responsibility of the MCOs to provide those TRP programs to folks who

would otherwise qualify for them if they were approved for Michelle P. waiver. So three months of TRP needs to be really looked at and defined.

MS. SCHUSTER: Thank you, Susan. Are you suggesting that if people come to TRP two days a week, that the month should be defined differently? I'm trying to translate this into something that's very clear.

MS. TURNER: Yeah. I think I'm just asking how are they going to define it? So if they said, you know, three months, does that mean -- I can't do math, that's why I was a psychology major. But does that mean five days of services times three months? Or does -- so if that person only came two days a week for three months, does that still -- you know? Does that make sense?

MS. SCHUSTER: Yes. Yeah, I got you.

MR. SHANNON: Service or service over a three-calendar month period, right? So, I mean, I think that's the distinction, right? So you get it one day a week, it is three months of service and you get it a much

longer period of time, or you get January, February, March, no matter how often you use it.

MS. TURNER: Correct. And I will say, when we did TRP pre prior authorization, there was one MCO that we never ever had anyone approved. So how they define that, I think needs to be standardized, too.

MS. SCHUSTER: Okay. Yeah, it doesn't make sense that nobody would ever get approved for TRP by one of the MCOs.

MS. TURNER: And that was over a five- or six-year period. No one ever met criteria.

MS. RITTENHOUSE: Well, and I would advocate for any -- for all of these targeted case management TRP that calendar month is the definition.

MR. SHANNON: Yes.

MS. RITTENHOUSE: And also, consecutive is added, or three months in a calendar year because like I said, sometimes someone's in a hospital and there's not a billing for that month. And so we all have

to have the same definition of, is it three calendar months or three billed months? But the 28-day ones, you know, we lose revenue continually because of not being able to bill within certain sequences that they said their computers do.

MS. SCHUSTER: So what happens if somebody starts the service in the middle of the month? Does that count as a month?

MS. RITTENHOUSE: Well, for targeted case management, you still have to have the certain number of contacts, and it's a monthly billing. So, yes, I still think for targeted case management, a calendar month is very clear. I think for therapeutic rehab, the other Susan that commented, I really wonder if months makes sense because someone could go one time in a month or, you know, 25 days in a month, and that's a very different level of service. So I'm not sure months makes sense for TRP.

And I don't -- I didn't see mention of ACT team, Assertive Community Treatment anywhere in this. And I don't know if it's exempt, but it would have the same situation

as targeted case management because that's a monthly billing if somehow ACT does fall into this criteria somewhere, we would want those defined as calendar months as well.

MS. SCHUSTER: Were you needing to get PA'd for ACT before it was suspended, Susan?

MS. RITTENHOUSE: Yes.

MS. SCHUSTER: Okay. So it's not considered a crisis or emergency service?

MS. RITTENHOUSE: Well, it is -- in some definitions, it is listed as crisis, so that's why it's confusing. So I'm not sure where it fell in here.

MS. SCHUSTER: Yeah, I think -- I guess I think of ACT as being crisis. But that's a good question. Is it crisis?

MS. RITTENHOUSE: Yeah, crisis stabilization units were also not mentioned, and I assume they fall in that crisis. But I don't want to assume either because they did require PA prior to the pandemic.

MS. SCHUSTER: Yeah. And that was the kind of discussion, Steve, as I recall where there was confusion at that meeting --

MR. SHANNON: Yes.

MS. SCHUSTER: -- with the secretary. Because there were people saying I'm not sure we would all agree on what's an emergency service or what's a crisis service. And so --

MS. DOBBINS: Well, I will say that -- again, that for crisis -- CSU is crisis stabilization units. You did get that first three days because, you know, you can't -- if somebody is in a crisis, you bring them in and then you try to get the PA. But you only get -- we were only getting three days. Again, going back to Susan's point, this was pre-pandemic. And then you had to make your case to be able to --

MS. SCHUSTER: So you got three days, Kathy, and then you had to do the PA, right?

MS. DOBBINS: Right. I mean, you got the three days so you could bring them in the door basically.

MS. SCHUSTER: Yeah. Yeah.

MS. DOBBINS: You know, it could be a Friday afternoon when you bring it, but, yeah, you get the three days so you wouldn't

get cheated out of that. If it's a crisis, you have to respond quickly to people.

MS. SCHUSTER: Yeah.

MS. DOBBINS: But then you had to get it. You know, you had to get the PA as soon as possible, you know, within that three days to be able to continue the stabilization.

MS. SCHUSTER: Right. Right. Okay.

MS. DOBBINS: But I don't know what it is now.

MS. SCHUSTER: Yeah. Any other input? This has been really, really, really important and very helpful.

MR. SHANNON: Kelly has her hand up.

MS. SCHUSTER: I'm sorry, Steve, what?

MR. SHANNON: Kelly has her hand up.

MS. BICKERS: Kelly's hand is raised.

MS. SCHUSTER: Oh, I'm sorry. Kelly?

MS. GUNNING: I have just two questions, really, and that is I think I understood you to say that the cabinet wants to put these prior authorizations back in place.

MS. SCHUSTER: Yes.

MS. GUNNING: And secondly, there was a question up earlier that said what is the impact of this going to be on people with individuals -- people with serious mental illness and with all of these issues, with all of it. What we know is the impact is delayed treatment, not enough treatment. The outcomes aren't good, and, you know, I'm wondering why did the cabinet want to reinstate these?

MS. SCHUSTER: The secretary did not say. He essentially -- I think what's happened is that the MCOs have raised a bunch of hell about there not being PAs. And, you know, the providers have raised hell about the audits, which is the flip side of this. And we tried it to make the case, at least I did, and I think Steve did, when we submitted comments, Kelly, that there's no -- absolutely no data that says that this improves quality of care. It's all a cost-containment.

MS. GUNNING: Yes.

MS. SCHUSTER: And we tried to make

that case, you know, to raise that issue, but I did not sense in either the secretary's letter, initial request for input, or at the meeting that there was any doubt in his mind that they were going to restart PAs. And if you look at it, we'll talk about it in a minute, House Bill 695, the legislature has heard the same message.

MS. GUNNING: Yeah. I hear that. I'm just sad and shocked by it quite frankly because --

MS. SCHUSTER: Yeah.

MS. GUNNING: -- those are the people that are supposed to be working for us, and they're the stop gap between the MCOs and the consumers. And it really sickens me when you figure that, you know, nationally it takes a person with serious mental illness 11 years just to get into treatment to begin with on average. That's a national statistic by the National Alliance on Mental Illness. And then we continually throw up these barriers, and it just is so disheartening for family members like myself who actually lost children because of things

like this. There are real consequences to these decisions that are driven by money, and I think we've been seeing this across our country that it's just horrific. If they get their way by raising hell, maybe we need to raise more hell.

MR. OWEN: Dr. Schuster, may I say something? Stuart Owen from WellCare.

MS. SCHUSTER: Yes, Stuart.

MR. OWEN: Yeah, and I understand the points, but the other points, as well. We have particularly seen with addiction providers, but not always addiction providers, where there are members who get -- it's not individualized care at all. They get 20, 30 hours a week of peer support, as much psycho-ed as possible because that's where the money is. It's not tailored to the individual's needs, their actual diagnosis, their conditions.

And our own data shows because we've compared like the providers who have a high percentage of that, their outcomes, their members have higher ER visits. They have higher admissions. They have higher

readmissions. And so, I mean, there's a balance to it I guess is what I'm saying.

And also, even, you know, we've been -- we're not -- we lack visibility into when individuals have been admitted, for example, like psych hospitals and PRTFs, and so we don't know. And we've asked providers to notify us so that we can help engage with discharge planning care coordination, make sure that they get, you know, the step-down care when they get discharged immediately, as quick as they can, so they don't, you know, get readmitted. So, I mean, there is a balance to it.

And I understand what you all are saying, but that -- we -- that has resulted in particularly, like with your peer support, psycho-ed, there's been a whole lot of money spent that actually did not help anybody.

MS. DOBBINS: Yeah. If I could respond. I can't find my raise my hand to raise it. I apologize; I couldn't find the icon. But, Stuart, as you say, that has been more of a concern on the substance --

MR. OWEN: Right.

MS. DOBBINS: -- treatment side, and, you know, for those of us -- for the organizations that are hiring peers who have a serious mental illness to provide peer support to other individuals with serious mental illness, you know, we're lucky if it pays for itself, very lucky if it pays for itself. We typically lose money on that, but we do it because it's a valuable service and it's meaningful to our clients. But we don't make money on it. And our class can't bill -- I mean, our peer specialists can't bill the volume of the substance use peer specialists, and yet, we get lumped into the same bucket. And I feel like that is unfair. I just want to put that out there.

And the other thing, Kelly, in terms of what you were saying, you know, your concerns, and I hundred percent agree with you. But don't you -- don't we all think, on some level, that some of this is being proactive because we know that there is a spotlight on Medicaid at the federal level, and that there could be cuts to Kentucky?

And so therefore, you know, the state is trying to get some handle and control on it before anything actually gets put upon us? Anyway, just putting that out there.

MS. GUNNING: I'd like to go back to Stuart.

MS. SCHUSTER: Sure.

MS. GUNNING: And, Stuart, if your companies know that there are certain providers in the substance abuse realm that are charging more and doing more and doing all of these things, then you surely have a way to target those individuals and go after them, not the consumers that are utilizing the services.

And secondly, what Kathy said, I don't think they have the sense to be proactive enough. I'm really starting to worry about that. I really don't know that they would be that way inclined. I think it's more of a kowtowing to managed care organizations and money, quite frankly, and not wanting to piss anybody off. And the reality is people's lives hang in the balance of all this.

MS. DOBBINS: Totally.

MS. GUNNING: My son was one of those people. There are lots of those people out there. And it's all semantics to the people in the suits that are sitting around saying, "Well, so-and-so over here, they're getting a little too much peer support for their SUD program for their IOPs. They're not utilizing professionals." I was dressed down by someone in Medicaid on another meeting the other day for saying it was always a clinical service always done by professionals. Well, then why did we train up a workforce of peer support specialists?

As for me and my programs through NAMI Lexington, we don't charge for any services. We don't bill Medicaid, we don't do any of it, and still, we're able to do it. So we're going to be able to find a way to serve our people one way or another, but you guys sure make it hard. You guys sure make it hard. And I am damn sad about our whole health and human -- I can't even say the word of it right now I'm so upset. Eric Friedlander. I'm upset --

MS. DOBBINS: Secretary.

MS. GUNNING: -- that they are doing this, the secretary of the Cabinet of Health and Family Services. There it goes, my brain's working again. Sorry, I get emotional, but this is ridiculous.

MS. DOBBINS: Well, I mean, we were providing peer support a long time before it was a Medicaid billable service, too. But what happened when it became a Medicaid billable service is it did become more professionalized. You know, it has been a really good thing for peer specialists to have that certification. And it is part of recovery. And their recovery enables other people to follow the path of recovery. Yeah. And it's a fairly inexpensive service, so if it's -- in most cases, at least for us it is. I can't speak for every provider out there.

MS. SCHUSTER: Yeah.

MR. OWEN: Yeah, and my point, it has value, but unfortunately, what we've seen is providers have exploited the lack of safeguards, and they have peer support

factories and that's all you get. You get a ton of peer support. You don't get the clinical. You don't get the actual clinical --

MS. GUNNING: Then go after the providers, Stuart.

MR. OWEN: -- outcomes.

MS. GUNNING: Go after the provider then, Stuart.

MR. OWEN: Well, I agree.

MS. GUNNING: You know who they are.

MR. OWEN: No, I agree. Here's the problem: There is frankly a lot of political pressure. I completely agree.

MS. GUNNING: Oh, of course.

MR. OWEN: When we have tried --

MS. GUNNING: Mm-hmm.

MR. OWEN: -- there's a lot of political pressure. Some of them are very well connected, and that's another part of this whole equation or whatever -- the whole landscape.

MS. GUNNING: I would respect that he would even admit that.

MS. SCHUSTER: Kelly, excuse me, I've

got a couple of people with their hands raised, and then we've got a move on because we've had this discussion --

MS. BICKERS: Dr. Schuster?

MS. SCHUSTER: -- with the MCOs about going after those people because they know who they are, and we've gotten nowhere with that. Erin?

MS. BICKERS: Dr. Schuster, Rita also is having problems raising her hand, so I just wanted to let you know --

MS. SCHUSTER: Yes, I was going to call --

MS. BICKERS: -- she's also in the loop.

MS. SCHUSTER: I was going to call on her next.

MS. BICKERS: Thank you.

MS. SCHUSTER: Rita, you were trying to ask a question.

MS. HARPOOL: Yeah. Actually, I guess maybe it's kind of a recommendation if the TAC could take this to whoever. Pre-pandemic when we would need to do these authorizations, say for TRP, and it got --

would be denied, we would then do a doctor to doctor --

MS. SCHUSTER: Mm-hmm.

MS. HARPOOL: -- discussion. And I would like to suggest that maybe if it gets to the level of doctor-doctor, that the MCOs ensure that the -- in my case, I was speaking with a psychiatrist, so make sure that the doctor that we are discussing these services with are actually in the state of Kentucky and licensed in Kentucky. Because the doctor that I had to speak with was in Florida and didn't even know what TRP was. He asked me what it was.

MS. SCHUSTER: Oh, okay. So he didn't know enough about the service to discuss it with you.

MS. HARPOOL: Correct.

MS. SCHUSTER: Yeah, okay.

MS. HARPOOL: Yes.

MS. SCHUSTER: Yeah, good point. Krista Brinly has her hand up.

MS. BRINLY HENSEL: Good afternoon. Thank you, Dr. Schuster. I just appreciate the venue to have the conversation, so I

would say that first. And I absolutely -- it's heart breaking to hear -- I forget the woman's name whose children were impacted by mental health, so my heart goes out for those situations.

I do really struggle with accusations around it's just a financial thing. I would tell you, as the Kentucky leader for United Healthcare, we are incredibly mission driven around helping people live healthier lives and helping the healthcare system work better for everybody involved.

We do have grave concerns around the delay in diagnosis around 11 years. I have equal grave concerns around the amount of time it takes for evidence-based practice to fully be adopted by various practitioners. And that's part of our role in the system is once scientific evidence is out there, help through care coordination, have conversations with providers around specific cases.

I will tell you, without authorizations currently in the BH space -- which is an anomaly quite frankly. I

believe we are the last state to still have an auth waiver in place from a public health emergency that ended two years ago. When we try to engage with providers around a collaborative conversation around care, only 20 percent of the time do we get engagement from a provider's office. But when we do, over 90 percent of the time, something around the treatment plan is adapted to be more in line with evidence-based care.

So I just want to put that out there in a fact base. This is not purely a financial thing. Where our passion comes from is the ability to engage in collaborative conversations with providers. I believe there are times when patients, either on purpose, or for whatever -- on accident, they're not in the condition to be able to tell you other providers they may be seeing, other medications that they may be on, and that is also access to data that we have that is oftentimes helpful in those collaborative conversations around updating or adapting a care plan.

So I just want to continue to have

conversations around how do we improve the lives of Kentuckians holistically, both from a medical and a behavioral perspective, and I really want to keep conversations like this very fact-based and grounded in what's best for Kentuckians. Thank you.

MS. SCHUSTER: All right. And the last one is Nina.

MS. EISNER: Quick question for Stuart. Did I understand you to say that hospitals had not been notifying you when patients were admitted, or did I misunderstand that?

MR. OWEN: Yeah, we have had some. We have had some where we have asked, and they have not.

MS. EISNER: That's interesting.

MR. OWEN: Yeah. And that's the frustrating -- because we -- like I said, we want to help engage. We want to get the, you know, discharge planning going, care coordination, make sure they get the appropriate step down. But some absolutely have not.

MS. EISNER: Okay. Thank you.

MR. OWEN: Sure thing.

MS. SCHUSTER: And, Val, I'm sorry, I missed you. We'll have you wrap this up here.

MS. MUDD: Yeah, that's okay. I did want to remind everybody that peer support is an evidence-based practice, you know? And I don't remember which meeting I was in, but I was told that psychoeducation was never an approved service for peer support, you know? And if it was never approved as a -- if psychoeducation was never approved for peer support folks to do, you know, I just question why we were ever, ever doing it. I don't know. I don't know. That just bugs me, you know, because --

MS. SCHUSTER: Yeah.

MS. MUDD: -- I don't know.

MS. SCHUSTER: Well --

MS. MUDD: But we are evidence-based. You know, we're doing real stuff. We're not just out there lollygagging and just, you know, talking to folks and, you know -- evidence-based. That's the best thing I can say --

MS. SCHUSTER: Yeah.

MS. MUDD: -- is we are doing --

MS. SCHUSTER: Yeah.

MS. MUDD: -- evidence-based stuff.

MS. SCHUSTER: No, I think that's exactly right. And I think the -- certainly, there are many, many accounts of the peer supports being crucial to the person particularly dually diagnosed and getting them into the system and doing that, you know, support that they -- that only they can do. So I do appreciate that, Val.

I also -- actually, somebody told me recently that psycho-ed is not even in the state plan. So I guess I have a lot of questions about psycho-ed. And I -- you know, as a licensed mental health provider, I would not see it as something that one needs to have a master's or a doctoral degree and have a license to be able to do in the way it's defined. So I just -- you know, I'll just throw that out there.

So as always, we have lots of input, and lots of -- so one last question: Is psycho-ed approved for CSAs? And I don't

know the answer to that.

MR. SHANNON: Leigh Ann Fitzpatrick answered that and it's a no.

MS. SCHUSTER: I can't hear you, Steve. Somebody says it is for 2015, but not for 2027. Oh, Leigh Ann says no.

MR. SHANNON: Yeah.

MS. SCHUSTER: Yeah. Okay. I hope that answers the question.

All right. Where are we in our agenda? So I have lots of notes. And, Erin, I will work on you to make sure that we capture all of this to pass it along.

The current status of House Bill 789, that's the infamous MAC and BAC bill. If you will remember, the BAC is the Beneficiary Advisory Council, and this was supposed to be an open process of coming up with this language and sharing it with the MAC hopefully and so forth, and none of that happened.

So it was filed, as you can tell, very late in the session. Representative Moser is the sponsor of it. You can tell by the 789 that it was very late in the

session, and it has not moved. So the statutory establishment of the BAC is not going to happen. And I'm not quite sure what the next step is on that. I don't know if there's anybody from DMS who's on who wants to answer that question about what the next step is.

MS. CECIL: Hi, Dr. Schuster.

MS. SCHUSTER: Yeah.

MS. CECIL: It's Veronica Judy-Cecil with Medicaid. Yes. So if the legislation doesn't get out, and as you have astutely pointed out, it probably won't. Our only next step could be regulations -- filing regulations because we are required by the federal law to implement, and if we do not have the state statutory authority, we'll have to then file regulations for regulatory authority. So we are in the process of trying to create those right now so we can quickly file not too long after the session once we're confirmed that there is no state statutory changes.

At that point, it's going to look extremely similar to what you see in the

legislation for the BAC. For the MAC, it's a little bit trickier because there is a state statute that, you know, has the -- constitutes the MAC and its membership. We will likely just implement any of the federal differences between that. So for example, you know, it requires nonconsecutive terms, things like that. So anything in the federal law that's not currently in the state statute, we'll implement for the regulation as well.

MS. SCHUSTER: So the MAC changes that would be done would be those that are in the CMS final rule, right, Veronica?

MS. CECIL: That's correct. That's correct. And of course, that means, you know, it'll go through the regulatory process so folks will have the opportunity -- I'm certain we'll probably have to do an emergency in addition to the ordinary to make sure that it's in effect at the time that we're required to comply with the federal law, which is July 9th.

MS. SCHUSTER: Okay. So we will wait and see. Is there any thought that there

might be changes at the federal level that would change or do away with that CMS final rule?

MS. CECIL: I think it's unpredictable. I do not -- yeah.

MS. SCHUSTER: Okay.

MS. CECIL: I do not have that crystal ball. It really is --

MS. SCHUSTER: You don't have that crystal ball?

MS. CECIL: It --

MS. SCHUSTER: We all wish --

MS. CECIL: Yeah, it's very difficult.

MS. SCHUSTER: We all wish we had that crystal ball, yeah.

MS. CECIL: Correct. But, you know, keep in mind, so they -- they would have to pass something in Congress, or they'd have to promulgate a federal final rule to change -- a federal regulation to change that. And if they haven't started that process, that also, I think, you know, takes a lot of time to get through. So we're just focused on moving forward until something changes in

the law or regulation that requires us to do something different.

MS. SCHUSTER: Okay, thank you. So there are some very interesting bills in the General Assembly. There are some things that are moving, some of which we are happy about, and some of which we're not very happy about, or some of us are not very happy about. And, Steve, I wondered if you could tell us first about House Bill 695 because that's the biggie in terms of Medicaid.

MR. SHANNON: Can you hear me okay?

MS. SCHUSTER: Say it again.

MR. SHANNON: Oh, I guess you can't. That was my question. I don't know why.

MS. SCHUSTER: I don't know what's the matter with your -- is everybody else having trouble hearing or understanding Steve? Yeah.

MS. HASS: He does sound muffled.

MS. SCHUSTER: Yeah. Somebody said, you know, you might want to call into the meeting with your phone. Try turning off your video, Steve, when you're talking.

MS. DOBBINS: Good idea.

MS. SCHUSTER: See if that helps. You there?

(No response).

MS. SCHUSTER: He might be trying to sign back on and see. Let me go on and talk about some other Medicaid related legislation.

Senate Bill 13 is Stephen Meredith's bill that he does every year to limit the MCOs to three. And it passed the Senate unanimously, was not taken up in the House. But it has now been added to House Bill 9, which is an interesting bill. House Bill 9, if you all will remember up until, I guess, two sessions ago there was a legislative committee called the MOAC, the Medicaid Oversight and Advisory Committee, and Stephen Meredith ran that committee, and they would take up all things Medicaid. And a lot of us testified to that committee over the years. And then, for some reason, and I'm not sure I remember the reason, they did away with it.

MR. SHANNON: Yeah.

MS. SCHUSTER: Well, now they've decided that it's -- are you there, Steve?

MR. SHANNON: Well, I hope so. Is it any better?

MS. SCHUSTER: Yeah, it's a tad better, but not a lot.

MR. SHANNON: Dang it, I'm sorry.

MS. SCHUSTER: Yeah. So try turning just your video off and see if that's any better.

MR. SHANNON: Is that better?

MS. SCHUSTER: Yes.

MR. SHANNON: Is it really? Well --

MS. SCHUSTER: Yeah.

MS. DOBBINS: Yeah, it's a little better.

MR. SHANNON: Yeah, okay.

MS. SCHUSTER: So talk about 695 first, and then we'll go to House Bill 9.

MR. SHANNON: Sponsored by Adam Bowling, the vice chair of Appropriations & Revenue, and the co-sponsors are Petrie, the chair -- and you can't really understand me. Yeah, I'm sorry.

MS. SCHUSTER: Yeah. Okay. Let me

do my version of it then. So 695, as Steve was saying, was put out there by the chair and vice chairs of House A & R, so Petrie, Bowling, and Bray. And, you know, our first look at it was like, wow, the legislature is taking over the running of the Medicaid department. And then, they had a meeting, and there were many, many reassurances made that they were not taking over the running of Medicaid, and there was quite a bit of discussion at that meeting, which was for discussion only. And a couple of people testified: Emily Beauregard from Kentucky Voices for Health, and Joe Dan Beavers from LifeSkills DMHC, Dustin Pugel from KY Policy, and then the secretary also testified.

And so they waited a week and came back with a committee sub that did change some pieces of it, and they talked from the very beginning that this was a companion bill to House Bill 9, and that's what I started to tell you about. House Bill 9 creates the Medicaid Oversight and Advisory Board, the MOAB. And instead of just having

the legislators, it has legislators, it also has the budget director. It has the state auditor. It has the Commissioner of the -- of Medicaid. It has the chair of the Medicaid Advisory Council and some other people. And they are looking at the MOAB as being kind of the guiding light for what would happen with Medicaid going forward.

I think this was done in large part -- well, for two reasons, probably. One is that you may remember that the legislature, which is predominantly republican, got very upset with the governor, who is a democrat, about a couple of regulations and a couple of things that came out of the cabinet that they were not happy about.

One of those was the expansion of adult services in Medicaid to cover vision, dental, and hearing, and that went into effect a couple of years ago. And when it came to the administrative reg review subcommittee, the legislators were up in arms about it because they said, "How are you going to fund this?" And they said,

"Well, we have money from the drug rebates that we get, and so that's how we're going to fund it." And the legislators said, "You can't use those funds because we have not authorized you to use those funds." And Medicaid essentially said, you know, "Yes, we think we can. And so we're going to do that." And so they have done that. And that reg has been found consistently deficient. And so if you look in the last couple of legislative sessions, Senator West does a Senate Bill 65 to talk about all of the deficient regs because that battle continues.

I think the other battle came up around the crisis services and the contract that was let by the cabinet in the millions of dollars that was not authorized by the legislature. And again, they said, you know, "How are you doing this?" And they said, "Well, we have money available." So there's been a difference of opinion to say the least between the legislators and the administration about who has the authority to make these changes in Medicaid. So 695

kind of systematically goes through a whole bunch of issues. What happens to that drug rebate money? And they changed it to make it still available to the cabinet at least through the two years of this biannual budget. I think they're going to change that language when they get to the budget session in 2026.

They also actually put in there that prior auth for all behavioral health services would start. Originally, it was 90 days from the date of the law going into effect. They recently changed that to 180 days. And they're doing it with a kind of hatchet approach, so there's none of this nuance that we just talked about in the recommendations from the cabinet. They're just saying all behavioral health services that were originally PA'd are going to be PA'd as of that date. And Steve, in particular, and some other people have worked very hard with Representative Bowling to try to get a more graduated approach to that, but that has not seen -- found itself into the language of the bill.

There also is new language that is of great concern to people on waivers, and also to the long-term care facilities, that calls for a feasibility study on the management of long-term care services, and certainly that could be interpreted to include all the waiver services. And I think the concern is as you will recall at the BH TAC meetings, particularly Mary Hass has raised these issues in the past when there's been a study, whether it's about rates or about the way waivers are done, very often the studies are not very open to input from the people that are most affected, meaning the waiver participants, their families, their caregivers, and even their providers. We've had lots of instances of angst among those groups, so there's a lot of concern about that particular part of this bill as well.

I think those are the major points in 695. And it is poised --

MR. SHANNON: Sheila, can you hear me now?

MS. SCHUSTER: Yeah.

MR. SHANNON: Can you hear me?

MS. SCHUSTER: Yeah.

MR. SHANNON: I changed computers. The other piece is there's directive to look at services that increased by 10 percent expenditures or units. So they're going to -- you know, so this goes back to the point of let's identify specifically maybe who needs, you know, some attention and do that as well, and that's in there.

It also, you know, if there's any increase in Medicaid, it has to go through -- the General Assembly has to know that, and I think that's your point earlier in the reg and the crisis services. But it's a shift in my opinion to oversight by the General Assembly of a Medicaid program with concerns about, one, we all believe pending federal changes whatever those may be, as well as increasing the Medicaid budget itself. So I think that's what's that.

There's an expectation --

MS. SCHUSTER: And also --

MR. SHANNON: -- that it will pass, right, Sheila? I mean, there's no doubt it will pass.

MS. SCHUSTER: Yeah. It puts the caps in on psycho-ed and peer support specialists. I mean, it really gets into the weeds.

MR. SHANNON: Yeah. The Senate took that language out.

MS. SCHUSTER: Oh, okay. Good.

MS. HYDE: Oh.

MR. SHANNON: The Senate version removed that specific psychoeducation language that was in there.

MS. HYDE: Wow.

MR. SHANNON: Yeah. But, you know, so we'll see what happens, but it's still -- the letter -- the November 1 letter is still included in that, so that's gone right now in the Senate version. And, you know, procedurally the House can agree with the Senate version, or they can go to a conference committee and discuss those changes.

But again, this all has to happen by midnight Friday or they lose the ability to override a veto, which I anticipate in this bill. So it's -- and this is a companion

bill to House bill 9 that creates the Medicaid Oversight Advisory Board modeled after the Public Pension Oversight Board that really everything goes before will go before this -- the MOAB just to make -- you know, before it gets into a budget even. So the MOAB, which has legislative members, and again, I was on the advisory board as well as some other folks on that board as well who know what it looks like. And they'll have to seek approval.

MS. SCHUSTER: Yeah.

MR. SHANNON: That's kind of how it works out in the Public Pension Oversight Board with the same thing.

And, yes, and the PA language is new members it looks like will have access to --

MS. SCHUSTER: Oh, that's right.

MR. SHANNON: -- behavioral health --

MS. SCHUSTER: Yeah.

MR. SHANNON: -- will have 90 days before a prior auth, which is again, not what the secretary's talking about. This is what's in the bill. And existing will have 180 days before a prior auth kicks in for

those services and it's all services. They don't break down which services it is, it's just prior auth for behavioral health.

You know, one take away is behavioral health is really -- apparently is under the microscope and concerns about that spend.

MS. SCHUSTER: Yeah. Yeah.

MR. SHANNON: That it's not -- I don't think it's driving any Medicaid shortfall. The long term -- the managed long-term service supports, you know, what does that look like? What's going to be included in that, and what happens with that, you know? And a feasibility study, and I've said this, you know, almost every answer is yes to feasible. It doesn't mean it's feasible, you know, easily. Is it effective?

MS. SCHUSTER: Yeah.

MR. SHANNON: Does it meet people's needs? I think is what, you know -- I think Kelly kind of touched on that earlier.

MS. SCHUSTER: Yeah.

MR. SHANNON: So we anticipate it passing, right, Sheila? Bart, right?

MS. SCHUSTER: Yeah. Yes, I think it will. And the MOAB bill, the House Bill 9 Meredith put in his three MCO limit. He also put in his 340B pharmacy bill.

MR. SHANNON: Mm-hmm.

MS. SCHUSTER: And I don't know what they're going to do with that, Steve, whether that's going to go into a conference committee because some of that is language that other people don't like.

MR. SHANNON: Right.

MS. SCHUSTER: So big changes coming with Medicaid for sure because it looks like 695 is going to go, and probably some version of House bill 9 is going to go.

MR. BALDWIN: Sheila, can I just make one quick comment on --

MS. SCHUSTER: Yeah.

MR. BALDWIN: -- 695? One of the things that -- on the -- specifically what Steve was talking about with the 10 percent increase, one thing that I think we're going to have to be really diligent about with the MOAB and even implementation of 695 is the context of why there is an increase.

Because I know that of a -- one of those particular codes that falls under this is due to a lot of efforts and some changes in policy to make -- to get providers to become Medicaid providers. So part of that growth is just increased access to the service.

And I worry about some of those, and specifically the ABA is what I'm talking about, but that has worked for years to get some changes so that more providers would become Medicaid providers. And so if you just look at the trend line, you can't make the assumption that this is an overutilization or there's something nefarious going on here.

MS. SCHUSTER: Right.

MR. BALDWIN: It's the access was not there, now there's an increase of access. But that's one of the things that I think we'll really need to pay attention to under the MOAB is that legislators understand the reasons behind this and don't just look at it as like, oh, here's a trend line. We need to address this trend line and flatten it.

MS. SCHUSTER: Yeah.

MR. SHANNON: Right.

MR. BALDWIN: Because all increased spending is bad, you know, which is not the case.

MR. SHANNON: Yeah. Good point.

MS. SCHUSTER: Did the --

MR. SHANNON: It says utilization rates or expenditures. So --

MR. BALDWIN: Yeah.

MS. SCHUSTER: Yeah.

MR. SHANNON: -- you know, if you go from 10 to 11 providers and they see more people, then the increase of 10 percent, it may really be a good, good thing, right?

MS. SCHUSTER: Yeah. Steve, did they take out the scorecard for behavioral health services or did they leave that in?

MR. SHANNON: No, the scorecard is in there as well.

MS. SCHUSTER: Oh.

MR. SHANNON: Yes. Yeah.

MS. SCHUSTER: Yeah, again --

MR. SHANNON: And it's interesting -- yeah. I'm trying to find it, but it is --

MS. SCHUSTER: Well, behavioral health has been a target, and that's because of the --

MS. SANBORN: Well, so the scorecard piece, they changed it to the cabinet is to develop --

MR. SHANNON: Yes.

MS. SANBORN: -- the scorecard versus the MCOs.

MR. SHANNON: Yeah. The cabinet may collaborate with Medicaid managed care organizations on the development of behavioral health substance use disorder services scorecard. So it's just not solely the MCOs now.

MS. SCHUSTER: Yeah.

MR. SHANNON: And that's the Senate committee sub right now, you know?

MS. SCHUSTER: Yeah. And --

MR. SHANNON: And there's a thing in the comment that the MOAB, the Medicare Oversight Advisory Board language has been added to two Senate bills by the House. So they have multiple ways to get to the MOAB in case House Bill 9 doesn't get through the

process.

MS. SCHUSTER: Yeah. I think they definitely want it to go. In the interest of time because we have lots of other things --

MR. SHANNON: Yeah.

MS. SCHUSTER: -- I will send out to you some other things. For those who provide treatment for LGBT individuals --

MR. SHANNON: Mm-hmm.

MS. SCHUSTER: -- there was a terrible addition to House Bill 423 yesterday that would prohibit any Medicaid payment for services for gender affirming care for adults. You know, the other stuff on trans has all been about youth, but this is adults, and that bill passed committee and will probably pass the Senate and go back over to the House for concurrence. So there's some really bad stuff happening in that vein as well.

And some good bills that we were hoping, like a revamp of nonemergency medical transportation did not go any place, and some other bills. So we'll send that

out in a little bit. Thank you, Steve, and Bart, and Karen, for your information.

MR. SHANNON: Yeah. And isn't that bill 425? The transgender bill?

MS. BROSNAN: Are you referring to 495?

MS. SCHUSTER: It's 495.

MR. SHANNON: 495, yes.

MS. SCHUSTER: 495. I was thinking of the prior auth bill, which was 423.

MR. SHANNON: Right.

MS. SCHUSTER: Yeah. Yeah, thank you, Hannah. It's 495. So you could look for that there, but that was a very bad addition with the committee sub and no transparency. I mean, Hannah was there to testify against the bill, and then this boomerang got thrown in there and it's very difficult.

So status update on 1915(I), the SMI waiver, SPA. Any update on that?

MS. DICKINSON: That would be me. Good afternoon, everybody. Hi, Sheila.

MS. SCHUSTER: Hi, Tanya.

MS. DICKINSON: Hi, Steve. Haven't

seen you guys --

(Inadvertent interruption).

MS. SCHUSTER: Leigh Ann, I think you're -- yeah, thank you.

MR. SHANNON: Yeah, she's got it.

MS. SCHUSTER: Tanya, you're going to give us an update on the 1915?

MS. DICKINSON: I was.

MS. SCHUSTER: Okay.

MS. DICKINSON: Ann's sorry --

MS. SCHUSTER: Yeah.

MS. DICKINSON: Ann Hollins was sorry that she couldn't be here today, but she left me a list of points -- bullet points for updates. And I've been working with her on the 1915(i) project, and so it gives me something to -- some new challenges that I'm really enjoying.

But for right now, at present, we're still waiting on CMS approval for the 1915(i) state plan. They've stated we're -- CMS has stated that we're on the path to approval. We've made technical edits, and current status is that it's still under review. So should be soon, and we've been

saying should be soon for a while.

The proposed regulations from Medicaid are now available on the LRC's webpage. If you'd like, after we're done, I can put the link into the chat. There are five of them, and there's a feedback process, a hearing process that people can comment on them. And we would encourage that. We can -- BDID continues to work collaboratively with DMS to develop and refine our provider education and certification processes, and we've been meeting weekly to develop the training and competencies we want our providers to have with our targeted population.

We're also looking at a streamlined approach to give credit for trainings that are like those in the 1915(c) waivers --

MS. SCHUSTER: Good.

MS. DICKINSON: -- to have a little bit of -- to have a little bit of, you know, economy of scale, if you will.

MS. SCHUSTER: Right. Right.

MS. DICKINSON: We've completed the eligibility thresholds for our functional

assessment tool, inter R-A-I or interRAI community mental health and crosswalked the domains in the assessment tool to the services.

We're partnering with UK's Human Development Institute to obtain staff to assist with administering the RISE program.

We continue to work collaboratively with KHC and the continuum of care providers, KHC being Kentucky Housing Corporation, on housing supports and their existing processes, data integration, enrollment with Medicaid, all of those things. This will be new to those kinds of providers.

And we continue to work on Needham system changes for processing the eligibility, enrolling providers, and payment for services rendered.

Listening to myself, that -- there were a whole lot of acronyms. If I said something -- if I wasn't clear on something let me know, but that's where we are. In other words, we're rolling. We are about where we want to be, but we're waiting for

that crucial CMS approval before we can really lock some things in.

MS. SCHUSTER: Yeah. Well, it is very encouraging to hear that we're under review and on the way and should be soon. So -- and if you would put that link to the --

MS. DICKINSON: Yeah.

MS. SCHUSTER: -- regs in, Tanya, that would be very helpful. Thank you very much.

MS. DICKINSON: I can't talk and go to the Internet while I'm on a Zoom all at the same time.

MS. SCHUSTER: Yes, that's all right.

MS. DICKINSON: So I'll have to wait until we're done.

MS. SCHUSTER: Yeah, thank you. Are you doing the status update on the reentry waiver, or is that Angela?

MS. DICKINSON: Nope. Just the 1915(i).

MS. SCHUSTER: Okay. Thank you so much, Tanya.

MS. DICKINSON: Yes, ma'am.

MS. SCHUSTER: It's good to see you.

MS. DICKINSON: Thank you, guys.

MS. SCHUSTER: All right. And the reentry waiver?

MS. SPARROW: Although I'll let her do that if she wants to.

MS. SCHUSTER: We like it when you do it, Angela.

MS. DICKINSON: No, no. You go ahead.

MS. SCHUSTER: You're good at it.

MS. SPARROW: She does a great job. Again, yes, good afternoon, everybody. Update on reentry 1115: Again, we continue to meet with our justice partners routinely around program design. Again, still working through many of those things in terms of defining services, operational policies/procedures. So again, that work does continue.

We are also -- and I should back up to say, we have not received any response from CMS on the deliverables that we submitted last fall. So that's our implementation plan, our monitoring

protocols, our reinvestment plan. We continue to keep that, again, on the agenda, asked if there's any feedback if they need anything from us, and ensured again, if there's any questions or if they need anything, they'll let us know.

We are continuing again some discussions around the pharmacy 30-day supply service benefits. Again, what does that look like and some of those impacts. We are drafting system requirements. There will be, again, significant -- not significant, but there will be lots of systems that will require some changes. Our eligibility, again, how we're identifying the reentry population, when they're eligible for services, etc. So our claiming billing system changes, pharmacy, again, MedImpact, so lots of systems drafting those requirements again, and working with and pulling in our managed-care partners to have those discussions as well. Impacts to their systems, drafting out those timelines for deployment, and what that looks like.

Again, we do continue to also work

with our independent evaluator that we're required under the demonstration to have and their evaluation design. So getting them familiar with the program, and we'll start introducing the evaluator to our partners to participate in some of those activities.

We, again, do also continue to work with participate in learning collaborative, the NASHP HARP learning collaborative, with other states. So that, again, is a good, great opportunity to take advantage to hear from other states, to hear some of the same challenges and barriers that they're facing. How are they addressing those? Again, kind of working through those lessons learned, so getting that feedback, addressing some of those concerns. So again, those are all good things that are occurring.

We continue again to target October as implementation date. So again, marching towards those system changes, deployments, readiness, training, onboarding, again, schedules, and so that is still the target date.

MS. SCHUSTER: Great. Thank you.

MS. SPARROW: Lots of work.

MS. SCHUSTER: Thank you, Angela. And just a reminder for those of you who are particularly interested in that reentry, Steve chairs the reentry TAC, and you can get direct updates from Angela in even more detail. And it meets the same day as the BH TAC, but it meets at 9 o'clock in the morning. And that Zoom link is on the DMS website, and that's a good TAC for those of you who are working with or concerned about our incarcerated folks. So thank you very much, Angela. Appreciate that.

I have on here any follow-up on audits from the MCOs. Does anybody have anything they want to share?

(No response).

MS. SCHUSTER: Well, that's a first.

MR. NIYIRAGIRA: This is Gad with the Children's Alliance.

MS. SCHUSTER: Yes.

MR. NIYIRAGIRA: I can share that House B 787, which we talked about last time, got tacked onto House Bill 785, which passed out of the health committee. And

Senate Bill 153 has gotten an amendment, which is that combined House Bill 785, which was also passed out of the health committee yesterday.

MS. SCHUSTER: Okay. And tell us what's in that bill because not everybody that was on the KMHC meeting got --

MR. NIYIRAGIRA: Yeah. It's -- so the original House Bill 787 was to reform the audit and appeals process to standardize things for our -- yeah, for our MCOs to make sure that providers get, you know, a fair shake on the notifications, and -- oh, gosh. Yeah, I can share the original language here in a second into the chat. It's a bunch.

MS. SCHUSTER: Yeah. Yeah, I know it's very comprehensive. So it's been attached to 785, House bill 785, and also attached --

MR. NIYIRAGIRA: It's now been attached, yes, to SB 153.

MS. SCHUSTER: Yeah, and SB 153. Great, so you're still alive.

MR. NIYIRAGIRA: We are, fingers crossed.

MS. SCHUSTER: Yes. Okay, great. That's great to hear, and we will keep an eye on now 785 and Senate Bill 153. Good to hear that. Thank you.

MS. TURNER: I will say from the provider end of things, we continue to get multiple audits. We just had one. And we have had four previous ones from the same MCO that we've never gotten feedback from those four. So we had four within the last maybe 18 months, and now we have another from the same MCO, and it just feels like an exercise in futility, you know? We keep spending the time to copy the charts, to mail them, to do all the things --

MS. SCHUSTER: Yeah.

MS. TURNER: -- and there's not even feedback.

MS. SCHUSTER: Yeah. And I think that's been one of the big frustrations. Thank you for sharing that, Susan. I'm sorry to hear that, but that has certainly been one of the big frustrations, and hopefully, if this language that was in 787 could get passed, that might put some teeth

into it. I think DMS has tried very hard to ride herd on this, but I think we need to tighten this up. So thank you very much for sharing that.

MS. RITTENHOUSE: I would echo that as well. And I would also add that we are continuing to appeal results from some audits where they don't understand Kentucky regulations, specifically around targeted case management. They're telling us that we don't have the right number of contacts because they're not counting a guardian as an allowable contact for a child. And they're asking us to reimburse that money, and that's happening continually with two of the MCOs and has been.

So I echo an earlier comment when we were talking about authorizations. We need to have individuals that are working with us that understand Kentucky regulations or live in Kentucky, and that we're not held accountable for other states.

MS. SCHUSTER: Yeah. Good point, Susan, thank you.

MS. SANBORN: Sheila, this is

Michelle with the Children's Alliance.

MS. SCHUSTER: Yeah.

MS. SANBORN: And I just wanted to let you know that there are several provisions in House Bill 787 that are already in statute for pharmacy records. And so I've been asking in regards to House Bill 695 that if we're going to move forward with prior auths and if we don't want to include 787 for whatever reason, that to at least include what's in statute already for pharmacy records for behavioral health and medical records.

So, you know, I don't know, but there's clear provisions already in statute that we should at least be communicated with. We should be given time. We should not be doing recoups until after appeals are going through. So I just think there are some -- just some basic standards that need to be implemented for our records just like they are for pharmacies.

MS. SCHUSTER: Yeah. Good point, Michelle. Thank you. And we will hope that either House Bill 785 goes, or Senate Bill

153 goes and we get that in there. Thank you.

MR. BALDWIN: And, Sheila, just for context, Senate Bill 153 is a very similar bill to 787, but it addresses prepayment audits.

MS. SCHUSTER: I thought that was it. I was trying to remember what --

MR. BALDWIN: Prepayment reviews. I'm sorry, not prepayment audits, but prepayment reviews.

MS. SCHUSTER: Yeah.

MR. BALDWIN: Audits are on the other side after payment, but this is on the prepayment review side.

MS. SCHUSTER: Yeah.

MR. BALDWIN: So there's a lot of trying to address a lot of the same issues.

MS. SCHUSTER: Yeah. Who's carrying that, Bart?

MR. BALDWIN: It's Senator Craig Richardson.

MS. SCHUSTER: Okay.

MR. BALDWIN: He's a freshman senator that took Senator Westerfield's spot.

MS. SCHUSTER: Okay, good. Well, we will hope that they make it to the finish line, or over the finish line. Thank you.

MS. BICKERS: Dr. Schuster, there --

MR. SHANNON: Valerie Mudd has a question.

MS. SCHUSTER: Oh, I'm sorry. Val?

MR. SHANNON: Well, it's in the comments.

MS. SCHUSTER: Oh.

MR. SHANNON: So are the audits going away when the pre-auths go back in place?

MS. SCHUSTER: That's a great question. Maybe that ought to be one of the ways that we know that the PAs are doing something. I don't know.

MS. SANBORN: So I've been told the answer is no, that audits will always be with us, which is why I've been fighting for just some standardization. We're not opposed to audits. We're opposed to 20 audits in 3 days with 15 days or less to respond with no response months later. And we're opposed to them taking our dollars without an agency being able to appeal.

MR. SHANNON: Right.

MS. SANBORN: Then months later, once they win the appeal, they have to get their money back. It's like, why do you get to take the money while --

MS. SCHUSTER: Right. Yeah.

MS. SANBORN: -- during the appeal process? Wait until they lose the appeal --

MS. SCHUSTER: Yeah.

MS. SANBORN: -- and if they lose it, then you need to take it. I mean, I'm for that, but at least give people the opportunity to appeal and respond. And not 20 times in 3 days with 600 and something, you know, files, so.

MS. SCHUSTER: Yeah, exactly.

MS. MUDD: And I'd just be interested to see if the audits are like lowered -- the amount of audits go down extremely smaller when the pre-auths go back into place. I'd be interested to see that.

MS. SCHUSTER: Well, one can only hope, Val, and we will keep an eye on that. Good question.

1915(c) waiting lists: And I don't

know who's reporting on that.

MS. STALEY: Hi, this is Sherri. I'm here for Leslie today and have the waitlist numbers. There are only three of the waivers that currently have a waitlist: The HCB, and the Michelle P., and the SCL, of course. The HCB waitlist is 3,256.

MS. SCHUSTER: Yeah.

MS. STALEY: The Michelle P. is 9,638. And SCL is 3,566. So total, that's 14,502 on all of the waitlists, and those are unduplicated. Those numbers are from 3/10.

MS. HASS: This is Mary Haas. Is it possible -- I'm going to be serving on a couple Medicaid forums and a roundtable discussion. Can you send out through Erin or whatever the total number of individuals on each one of those waivers, and then the waitlist numbers? That would be very helpful to me.

MS. STALEY: Yep. I have a little table. I will get that over.

MS. HASS: Thank you so much.

MS. STALEY: Sure.

MS. SCHUSTER: Sherri, did I take these numbers down wrong because a quick count in my book looks like it's over 15,000. I've got HCB --

MS. CLARK: What she gave you, she -- the last number she gave you is unduplicated. So if you do count all of those up, you will see that it is more, but there are many individuals that are on multiple waiting lists. So we let you know the unduplicated number.

MS. SCHUSTER: Oh, all right. I see what you're doing. So you're giving us -- the numbers that you gave for the waiting lists include duplicated numbers.

MS. CLARK: Right, but we let you all know the unduplicated, which --

MS. SCHUSTER: Okay.

MS. CLARK: -- is going to be less because of the --

MS. SCHUSTER: Right.

MS. CLARK: -- individuals that are on multiple.

MS. SCHUSTER: Okay. Because I looked at it and I'm like, no, it's over

15,000 -- it's over 16,000. Okay. That makes sense. So the number of unduplicated, the number of individuals counted only once is 14,502, Alisha, Sherri?

MS. CLARK: Yes.

MS. SCHUSTER: Yeah, okay. Yeah, we would be interested in getting those total numbers. I had asked Leslie for it for something I was -- oh, it was an interview on television, and that was probably two weeks ago, and I think it was in the 33,000 range, Mary, of total number of people on all of the waivers.

MS. HASS: Okay. Thank you, Sheila.

MS. SCHUSTER: But we will get the absolute numbers from Sherri. That would be great, Sherri. Thank you very much.

MS. BICKERS: And, Dr. Schuster, Rita put in the chat she would like to speak.

MS. SCHUSTER: Yes, Rita?

MS. HARPOOL: Hi. Okay, I'm trying to get some -- I guess, hopefully, I can get some feedback about what's happening with this situation. I found this information out last night and I was pretty shocked.

I am in the process of trying to become an SCL provider. And I've been in that process for quite some time, turned in my packet in September. Actually, it was September 17th, 2024. And I'll preface this with, you know, the governor had approved -- I don't have the numbers in front of me -- a certain number of slots, and part of those slots were opened up during the current fiscal year, I guess.

MS. SCHUSTER: Yeah, they were in the budget -- they were in the budget from the legislature, Rita.

MS. HARPOOL: Yes.

MS. SCHUSTER: That was not from the governor.

MS. HARPOOL: Okay.

MS. SCHUSTER: Yeah. Yeah, in the budget.

MS. HARPOOL: In the budget.

MS. SCHUSTER: Right.

MS. HARPOOL: And then, I guess there's going to be some of the slots will be in the budget the next year --

MS. SCHUSTER: Yes.

MS. HARPOOL: -- is that how that works?

MS. SCHUSTER: There were some approved for the first year of the fiscal year, and then some for the second year of the fiscal year.

MS. HARPOOL: Right. And the article I was reading said, you know, they didn't want to put them -- put them all out there at one time because they wanted to avoid overwhelming providers. So maybe the article I'm reading is a little off, I don't know. But last -- when I turned in my packet in September of 2024, I was told that there were ten packets in front of me. Yesterday, I inquired -- this is now six months has gone by. I inquired how many packets are in front of me, and I was told eight. So if I do the math on that, it will take me two-and-a-half years to become an SCL provider. And that seems extraordinary to me.

MS. SCHUSTER: Yep.

MS. HARPOOL: Is that normal, or --

MS. SCHUSTER: I don't know. Do we

have anybody from Medicaid that can respond to Rita's question?

MS. CLARK: I don't know if we have anybody from the Department for Behavioral Health on here or not. But what I can do is -- because the Department for Behavioral Health is the operating agency for the SCL and Michelle P. waiver programs, but if you would like to send me the emails of where you followed up with them, and, you know, stating that there was ten, and then -- you know, kind of a timeline, if you don't mind, I'll be more than happy to send that to their director, Crystal Adams, and follow up with her.

MS. HARPOOL: Okay.

MS. CLARK: And I can put my email address in the chat here. Let me just get it open, and then you can send that directly to me, and then I will forward it on to BDID and follow-up. Is that okay?

MS. HARPOOL: Yeah, that'd be great. It just -- I mean, that was -- like I said, I just found that out last night and I'm --

MS. CLARK: Okay.

MS. SCHUSTER: Yeah.

MS. CLARK: And I just put that in there.

MS. SCHUSTER: Yeah, so there's her -- there's Alisha's email, Rita, in the chat there. Thank you, Alisha. And keep us posted, Rita. Let us know next meeting --

MS. HARPOOL: Okay, thank you.

MS. SCHUSTER: -- how much progress you've made, okay? We want more providers, obviously. Yeah. Okay.

MS. CLARK: And just -- and if you want me, Dr. Schuster, just to --

MS. SCHUSTER: Yeah.

MS. CLARK: -- kind of -- also, I'm not sure what article she was reading, but we release those slots kind of over a period of time, right? And, you know, I'm not sure in what context they were talking about overwhelming providers, but you don't want to create a bottleneck at the beginning because everybody has to receive that assessment. And so, you know, because that is the first step in the process, and so we've got to make sure that we've got

enough, you know, assessors and all of that, and then once they meet level of care, that's when we can also -- then they can pick and choose who their case management provider is and all of their other providers.

MS. SCHUSTER: Okay. Thank you. But all of the -- have all the slots that were allocated in the first year of the biennial budget --

MS. CLARK: Yes.

MS. SCHUSTER: -- been filled, Alisha?

MS. CLARK: Yes.

MS. SCHUSTER: I thought they had. Okay.

MS. CLARK: They were all released -- capacity was released for all of those slots, and -- excuse me. For all of the waivers, those were completed I know it was before the end of October of 2024.

MS. SCHUSTER: Okay. Yeah. Mary, Sherri just put in the chat the table of the waiting list numbers for you.

MS. HASS: Okay, and did she put the

total number of folks being served --

MS. SCHUSTER: No, we don't have -- no, we don't have the total -- yes.

MS. STALEY: Yes, it is. I put it on there.

MS. SCHUSTER: Yeah, I'm sorry, it's on there.

MS. HASS: Okay.

MS. SCHUSTER: It's got funded slots and filled slots.

MS. HASS: Okay.

MS. SCHUSTER: And remind me, Sherri, what the reserved -- why the reserved are there?

MS. CLARK: So let me -- do you want --

MS. STALEY: Go ahead, Alisha.

MS. CLARK: -- me to do that? No, that's okay. Sherri was actually covering because I know there were lots of us in different meetings today.

So, you know, the funded slots, obviously how many is funded. The filled slots, those individuals are enrolled. The reserved slots are where they have been

given capacity. They could be waiting on an assessment. They could be waiting on Medicaid eligibility. Those -- there are individuals that are in this category that may have received an assessment but received a denial of level of care. So some of these individuals have chosen to go through the hearing process, and technically, that slot is going to be theirs until that hearing process is complete and we receive a final order one way or the other.

MS. SCHUSTER: Okay. So it's held for them until a final determination is made after review and appeals and so forth? And if they end up not qualifying for it, it would go then to the next eligible person, I assume?

MS. CLARK: Yes. And also, you know, there are, I think -- I would have to just confirm, but I'm pretty sure that within that, there are individuals that those slots are theirs. They might be out of services right now. They are not deceased or anything like that. They may be in hospitalization or different areas, but that

slot is still theirs.

MS. SCHUSTER: Okay.

MS. CLARK: So we can't give it away just yet to another person.

MS. SCHUSTER: So what is the available slot category?

MS. CLARK: The available slots are what's available that can be released. We look through that. They're -- we do try to hold back a few slots because we have learned over the years that sometimes we have to give slots back to an individual. Maybe they were closed because, you know, it didn't appear that the process was going through like it normally should. There may be times somebody got closed out, but they were still waiting on the MRT process. So if we can determine through research that an individual was doing everything that they were supposed to do, we will give that slot back to that individual since it was not any fault of their own.

MS. SCHUSTER: Okay, thank you. All right. Thank you for putting that table there, and we will send out what was in the

chat to everybody. I'll send it out to everybody who's on my list, and if you're not getting direct communications from me, you can send me an email to KYadvocacy@Gmail.com. It's an easy email to remember. Thank you.

MS. AGNE: Sheila?

MS. SCHUSTER: Yeah.

MS. AGNE: Dr. Schuster, I'm sorry, this is Misty. I have a question. How long -- and this is for Alisha. How long are those individuals permitted to remain on that reserved list?

MS. CLARK: It really varies. You know, it's until they get enrolled, or their slot is then given to another individual. Once that slot is no longer theirs, it's -- you know, it would remove -- it would be changed from the reserve to the available, but once they get, you know, eligibility -- so you have to get waiver level of care approved, and then you also have to be financially eligible through Medicaid. And that's when they're enrolled that they would go to that filled slot.

So it's really -- it's a variation of -- you know, I don't want to say, you know, it's 30 days or 60 days because it -- depending on SSI sometimes can take a little bit. The MRT process can take a little bit. You know, if all is well and good and the happy path, I think we did some statistics that, you know, they were getting services out within about like 58 to 62 days, but that is not, again, the case with everybody depending on just the whole financial eligibility part.

So there is no hard and fast number that I can really give you, Misty. If that makes sense.

MS. AGNE: Thank you. I appreciate that insight.

MS. CLARK: Yeah, you're welcome.

MS. SCHUSTER: Yeah, that's helpful. Thank you. Mary, you have some questions about the ABI waiver and access to therapy services?

MS. HASS: Yeah. We're still somewhat in this holding pattern, whatever. People -- the way I understand, I'm being

told from providers and family members that if you were already in the waiver, you are still getting your therapy services as before. But if you are newly enrolled into the ABI waiver, then you are now having to go through the state plan, which limits your availability to be able to acquire those specialized therapy services that a lot of our folks desire.

And so anyway, I know one of the providers called me, and he said he was still having difficulty being able to access the therapy services that he felt his client needed. So that's kind of we're still here.

And the other problem is the PDS services. A lot of our folks, because of the limited availability of residential providers, that they would choose to do PDS, but I think we're still in a holding pattern on being able to get PDS services.

I don't know if anybody can address that or not, but that's what I'm hearing from a lot of family members that they have wanted to do PDS, but that they're -- especially in the Louisville area, that

there's not case management or -- I use that, but support broker or whatever availability.

MS. SCHUSTER: Is there anybody that can respond to that?

MS. STALEY: I think Misty Wright is on and is going to talk about PDS.

MS. WRIGHT: Good afternoon, everybody.

MS. SCHUSTER: Yes.

MS. WRIGHT: We have an ongoing interest list for PDS, so when these documents are actually sent into us the person's name goes on this list. They're not removed from the list because we do --

MS. HASS: I'm having a difficult time hearing her.

MS. WRIGHT: Let me see if I can make that any better. Give me just a moment. Is anybody else having an issue with that as well?

MS. SCHUSTER: It could be a little bit louder, Misty.

MS. WRIGHT: Oh, that's not something I'm usually accused of, everybody. All

right. Let me just speak a little louder. Is that any better?

MS. SCHUSTER: Yeah, I think that's better.

MS. WRIGHT: All right, there we go. Okay, so we have an ongoing PDS interest list, so when we get the PDS documents, the person's name goes on that list, and they're never really removed from it. We do mark them as the fact that they've gone active for those services.

So using that interest list, I currently have the overall numbers as we have had 986 people actually move off of that list into active services. 247 people have shown no interest in PDS once they've been contacted, or if for some reason maybe the waiver had closed and they're off that list now. We have 898 individuals that are actively being tracked for PDS services. 472 of those are currently receiving traditional services. Of those that are remaining, they've either chosen not to do the traditional services because they're remaining -- waiting to have an individual

actually be their PDS provider that is not currently certified to do so. A few of those, we have actually not been able to communicate with despite numerous attempts. And a few of them are truly waiting for a service provider in their area.

And, Mary, I will let you know after the last Behavioral Health TAC when we started going into this, I only have two individuals listed on the PDS interest list. So if you could please share with me the organizations and/or the people just to make sure that we're getting all of those forms that we need to get, I'd be more than happy to look into that for you.

MS. SCHUSTER: Do you want to put your email address, please, Misty, in the chat as well?

MS. HASS: Yeah.

MS. WRIGHT: Absolutely.

MS. HASS: Yeah, that'll be helpful. So what you're saying, you are wanting what areas that people are having the difficulty in acquiring the PDS services. And what I cannot tell you 100 percent are they already

getting some traditional services? I would say possibly, yes, but I don't know that for a fact, and I don't want to say anything that's not right. But, yeah, send me the email and then we'll go from there.

MS. WRIGHT: It's in chat. And that's the thing I want to know. I want to make sure that we're getting the lists that we need to get from the people we need to get them from. I don't want us thinking we're receiving everything, and there may be a kink in the chain somewhere that we need to straighten out.

MS. SCHUSTER: Misty, I had a question. When you say that -- I can't read my writing -- 986 have moved off and have gotten PDS services. What's the timeframe for that? Is that this past year? Is that the last six months? Is that two years?

MS. WRIGHT: So the creation of this list started in March of 2023, and that's been since then.

MS. SCHUSTER: Okay.

MS. WRIGHT: I can do more numbers on how many come off within each year. We can

do it by calendar year if you'd like, but that's been overall since March of 2023.

MS. SCHUSTER: Okay. That's very helpful.

MS. WRIGHT: And this list is an ongoing list. It's not really --

MS. SCHUSTER: Right.

MS. WRIGHT: -- like a true waiting list. It's not like the next person on the line would get a service if somebody else comes off of it. It's truly an interest list, like we don't want to lose these people in a flow -- a backflow, so we keep their stuff together so that we know to reach out to them. Because if we get somebody who's a PDS provider in that area, at least we'll know who all is interested in that area.

MS. SCHUSTER: Yeah. I would be very interested in seeing -- you know, I've asked Leslie at various times to tell us if she can the kind of average wait time for PDS services in each of the waivers, and you probably have a way to do that off your list.

MS. WRIGHT: I can, but I'm going to go ahead and tell you since it's not a true waiting list --

MS. SCHUSTER: Yeah.

MS. WRIGHT: -- that timeframe really doesn't -- the data flow in that isn't something that I would be wanting to stand -- that's not a hill I want to stand on because it's based on so many things. It's based on the list getting to us. It's based on the person could have been on there for four years now, and they just keep saying no to somebody else doing services because they have one individual who they want to be their PDS provider.

MS. SCHUSTER: Mm-hmm.

MS. WRIGHT: So we have a lot of reasons that people have stayed on this list.

MS. SCHUSTER: Yeah.

MS. WRIGHT: And I really don't -- I feel like if we treated it like a waiting list and we give it those fast, hard numbers that we do for the waivers themselves, we're not going to get accurate reflection of true

waitlist type style times. Does that make sense? I'm sorry.

MS. SCHUSTER: Yeah, it does. I keep hearing these stories about people waiting for years to get PDS. That's why I keep trying to figure out what's going on.

MS. WRIGHT: Well, and I looked at that.

MS. SCHUSTER: Because the numbers I've gotten from Leslie the one time I think -- or maybe twice she gave me some, you know, were certainly within I don't know 50 days or 60 days or something, and it seems so at odds with families that call me and say, "I've been waiting for six years for PDS."

MS. WRIGHT: Well, now I probably was the person who provided her those numbers to give you previously, so I can say that that's probably why it doesn't add up.

MS. SCHUSTER: Okay.

MS. WRIGHT: Is, you know, I give you the fast, hard numbers, but it's not going to really add up for the reasons. And if we have groups, individuals, providers that you

all really want to look at specifically, I'm more than happy to look at that. And we may find that maybe a provider is not getting those forms to the right place --

MS. SCHUSTER: Yeah.

MS. WRIGHT: -- and that's why they're not on our list. Because Mary had mentioned that she had I think there was upwards of over 300 on the list the last time. And I was completely shocked when I went out and looked at the data and I had four people since March of 2023, and only two of them are on there and both of them are actually doing the thing that I had mentioned where they're staying on that list because they want a specific person to qualify as their PDS person, and that's not been able to happen for them yet.

MS. SCHUSTER: And it hasn't happened because the person doesn't qualify?

MS. WRIGHT: That's the reasons in my notes is the person that they're wanting to become that has not yet met qualifications to do so.

MS. SCHUSTER: Ah, okay. Yeah, much

more complicated than just looking at a list and counting the days or the months or the years or something.

MS. WRIGHT: Yes, ma'am.

MS. SCHUSTER: Okay. Thank you. That's very, very helpful. Appreciate that.

Status of the Medicaid unwinding and recertifications.

MS. CECIL: Hi, Dr. Schuster. I'm not going to share my slides, but I will send them to the TAC members and then we'll post it on our website just as a kind of high-level given the time. We're still staying around 1,450,000 individuals enrolled. As far as renewals go, we still are maintaining an extremely high approval rate, so yay.

MS. SCHUSTER: Good.

MS. CECIL: We're excited to have that, obviously.

MS. SCHUSTER: Yeah.

MS. CECIL: So that approval rate is staying up in the 80 percent, and the majority of those are by that automatic renewal --

MS. SCHUSTER: Right. Right.

MS. CECIL: -- instead of having to go through an actual manual kind of redetermination. I know a lot of folks primarily are interested in child renewals, and as a reminder we've been automatically extending children for 12 months. They have not had to go through a redetermination.

MS. SCHUSTER: Right.

MS. CECIL: Those began with July renewals, so in May, as May approaches, in June, as those renewal packets go out and those renewal notices go out, we want to make sure folks understand what's happening.

We have been working on a campaign around the restart of renewals. We've developed a lot of materials. We've been working with providers, and we've been working with our FRYSCs on the development of those materials. I think right now, we have some advocates and some others looking at those, and then once we finalize those, we're going to start the campaign. We're going to be really focused on schools and trying to get through to parents that are,

you know, in the schools, the children that are in the schools.

MS. SCHUSTER: Right, right.

MS. CECIL: Trying to get information that way. But we're going to have postcards that we're going to mail ahead of time to let folks know child renewals are starting. So we're going to do all we can to make sure people understand that that's going to start again.

I think our biggest concern is that folks don't understand that children have a higher -- most children have a higher federal income level that can make them qualified than their parent. So, you know, that's the other kind of education is just asking those parents or guardians to go through that redetermination. Just respond, let us make that -- make that determination of ineligibility rather than just presume that, you know, the child may no longer be eligible. So that's going to be our primary focus going forward.

MS. SCHUSTER: Yeah. Thank you. All right. That's great. We appreciate it.

We'll look for your PowerPoint.

Do we have any recommendations for the MAC?

(No response).

MS. SCHUSTER: I don't have any myself and I don't know that anything's come up specifically.

We have a couple of things we want to come back to the SUD approvals or non-approvals for -- you know, the approvals by the MCOs for SUD residential, and we will put that on the agenda. And also, the behavioral health needs assessment. We heard that a month ago, and there were lots and lots and lots of questions. And Leslie said that they are reworking that and will come back the next TAC meeting for that. Is there any new business to come before the TAC?

(No response).

MS. SCHUSTER: Are we all talked out? Probably.

MR. SHANNON: We're all talked out, Sheila.

MS. SCHUSTER: All talked out. All

right. Any formulary issues? That's the other thing that we always want to know on old business.

(No response).

MS. SCHUSTER: Okay. I guess that's good news that we don't have any there.

So the next MAC meeting is in two weeks. It's morning, 9:30 to 12:30 on March 27th, and then our next BH TAC will be May 8th. So it will be after the Derby. You all could all do your Derby betting and so forth, and I will look to see you then.

I will work with Erin to make sure we have all of the input, and we'll forward that to the -- to Angela and to Secretary Friedlander the feedback on the PA recommendations from the cabinet. Oh, Nina, has her hand up. Nina?

MS. EISNER: Yeah, just a quick thing. Can we ask the cabinet to ensure that there is training or retraining on the prior authorization process prior to its implementation either by them or the MCOs whatever they direct?

MS. SCHUSTER: Yes. I have that in

the notes because somebody else --

MS. EISNER: Perfect.

MS. SCHUSTER: -- had brought that up because it's been --

MS. EISNER: Thank you.

MS. SCHUSTER: -- five years or so since people have done that.

MS. EISNER: Yes.

MS. SCHUSTER: We need to do that.

MS. EISNER: Thank you.

MS. SCHUSTER: All right. Anything else to come before the body?

(No response).

MS. SCHUSTER: All right. So we kind of made it by 4 o'clock. Thank you all very much. And thank you for your participation in the discussion and your many good questions and so forth. And I will do --

MR. OWEN: Speedy healing to you, Dr. Schuster. Speedy healing to you.

MS. SCHUSTER: Oh, yes. Hopefully I won't look quite so beat up the next time you see me.

MR. OWEN: No, you're fine.

MS. SCHUSTER: All right. So I'll

see some of you who tune into the MAC, and it's well worth your time, I think, because it's a different level of -- a different range that's much broader, but it also -- you hear directly from the Medicaid commissioner and staff. We will have an update, a biannual update on maternal and child health, so those of you who are interested in that space we will have that at the next MAC meaning.

So thank you all very much. And, Erin, thank you as always for your help. And I wish you all enjoying sunshine. I guess it's still sunshine out there so -- and living through the end of the session before the veto days. Bye-bye.

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

MS. SCHUSTER: Bye-bye.

(Meeting adjourned at 4:06 p.m.)

* * * * * * * * * * *

CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim 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 21st day of March, 2025

Tiffany Felts, CVR