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

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Via Videoconference
May 1, 2024
Commencing at 1 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, TAC Chair

Steve Shannon

TJ Litafik

Valerie Mudd

Tara Hyde

Eddie Reynolds

Mary Hass

MS. SCHUSTER: Looks like we still have two minutes or so.

MS. BICKERS: Yes, ma'am, and we are still clearing the waiting room.

MS SCHUSTER: Okay. How are we doing on voting members, Erin? Have you been able to spot folks?

MS. BICKERS: I haven't seen TJ or Eddie unless they snuck in recently on a big group on me.

MS SCHUSTER: Okay. So Steve and Val and Mary are on?

MS. BICKERS: Yes.

MS SCHUSTER: Okay, thank you. And our new board -- our new voting member, Tara Hyde?

MS. BICKERS: I have not seen her yet, I don't believe.

MS SCHUSTER: Okay.

MS. BICKERS: But I'm also not familiar with her login yet.

MS. SCHUSTER: Yeah, right.

MS. BICKERS: I know you sneak in on me under a different name.

MS SCHUSTER: Under a different name,

yes. I should explain to people, I'm not trying to sneak in, but I borrow a Zoom link from a friend, and so sometimes Zoom gets confused. So let's give it another minute or two since this is a different day.

MS. HASS: Everybody's derby crazy in Louisville, I'm telling you.

MS SCHUSTER: Yeah.

MS. HASS: Everybody in my family's gone to the races. It's pretty quiet around here today.

MS SCHUSTER: You know, it's hard to explain that to out-of-town folks, Mary, right?

MS. HASS: Yes, that's quite right. I was explaining it to some of Izzy's teammates up in Ohio, and told them about the bed races, you know, the Belle of Louisville race, and they're just going wow. I said, yep, it's a big to-do if you live in Louisville.

MS SCHUSTER: It is, absolutely. I see Eddie might be on, I see a BIAK logo. Are you on, Eddie?

MR. REYNOLDS: I am on, I am here.

MS SCHUSTER: Great, thank you.

MR. REYNOLDS: And they are having the bed races today as I left U of L.

MS. BICKERS: And, Dr. Schuster, your waiting room is clear.

MS. SCHUSTER: Okay. And we're --

MS. JOHNSON: Yes, I'm on one again today.

MS. SCHUSTER: All right. Well, I think we will go on and get started because we have a -- as usual, a long agenda, so welcome. I'm hoping that our newest BH TAC voting member will be joining us. You all remember at the last meeting, I announced that our good friend, Mike Barry, had passed away, and -- excuse me -- and the statute has PAR, People Advocating Recovering, as the nominator of someone in that field of work. And I got a letter from PAR nominating their CEO, Tara Hyde, so I'm hoping that Tara will be joining us shortly.

And I believe we have Steve Shannon.

MR. SHANNON: Right, I am on.

MS. SCHUSTER: All right. And Val Mudd? I'm pretty sure I saw Val already on.

MS. MUDD: I'm here.

MS. SCHUSTER: Yeah. And Mary Hass?

MS. HASS: Here.

MS. SCHUSTER: And Eddie Reynolds?

MR. REYNOLDS: Here.

MS. SCHUSTER: Okay. And has TJ Litafik from NAMI Kentucky joined us yet?

MS. BICKERS: Not yet.

MR. SHANNON: Not here yet.

MS. SCHUSTER: Okay. All right. Well, we have a quorum, so we'll go on, and the draft minutes were sent out. Could I get a motion from one of my voting members, please?

MS. HASS: Mary Hass will so move to approve the minutes.

MS. SCHUSTER: Thank you.

MS. MUDD: Val will second.

MS. SCHUSTER: And Val will second. Any additions, corrections, omissions, revisions?

(No response).

MS. SCHUSTER: Seeing none, all those in favor of approving the minutes, signify by saying aye.

(Aye).

MS. SCHUSTER: And opposed, like sign.

(No response).

MS. SCHUSTER: And abstentions.

(No response).

MS. SCHUSTER: Thank you very much. I think we sent out to everybody I had on my list that we need to adjust our November meeting date. I had scheduled us for November 7th, and Erin pointed out that that was in conflict with another TAC. That November meeting's always a little tricky because of Thanksgiving and I was trying to, quite frankly, give myself a little more time between our meeting and the MAC meeting, but we will go back to the second Thursday of the month. So it will be November 14th, at this regular time, one to three. So if you all will take note of that, that would be great.

MR. SHANNON: And, Sheila, Tara's on.

MS. SCHUSTER: Oh, great. Hi, Tara.

MS. BICKERS: And TJ has also joined us for the record.

MS. SCHUSTER: Oh, okay, great.

MR. SHANNON: So --

MS. HYDE: Hi, so sorry for being late. Thank you.

MS. SCHUSTER: That's all right, Tara. I had explained, Tara, that you were our new voting member representing People Advocating Recovery as their CEO, and we're very happy to have you. And welcome to your first meeting of the BH TAC.

MS. HYDE: Thank you.

MS. BICKERS: Actually, Dr. Schuster, if you don't mind, this is Erin. Guys, if you don't mind, please mute if you're not speaking. There's a lot of feedback and it's very hard for the court reporter to capture everything. Thank you.

MS. SCHUSTER: Yeah, thank you. And, TJ, I see that you're on from NAMI Kentucky, welcome.

MR. LITAFIK: Thank you.

MS. SCHUSTER: Yeah. And a happy May Day to everyone, I guess, as well as Derby week, and happy steamboat race, I think, is going on later on in Louisville.

So the first thing that we have is a report on the study on behavioral health rates, and I apologize, Erin, I don't remember who was presenting that.

MS. HOFFMANN: Dr. Schuster, this is Leslie. It was going to be Victoria. Victoria, do you want to just speak to that? We don't believe we're quite ready. Forgive us, we want to make sure that we've got this right before we share it. It is complete. Victoria, are you on?

(No response).

MS. HOFFMANN: I don't know that I hear her. So we want to make sure that it is correct for you, Dr. Schuster, and we are going to meet one more time internally with Commissioner Lee before we present that to you. So my suggestion earlier was if we can get that out to you before the next TAC, then that's what we'll do.

MS. SCHUSTER: Okay, and this is the report on the study that was done by the department where they were comparing rates across states and so forth?

MS. HOFFMANN: That is correct.

Victoria, did I hear you that time?

MS. V. SMITH: Yeah, can you hear me? Sorry about that.

MS. HOFFMANN: That's okay.

MS. V. SMITH: I was talking away. Yeah, we did get the -- we finished the report. We worked -- we've been working nights and weekends. The audit team has gone above and beyond. We believe we can wrap up both the PowerPoint that we were going to give to you guys and the written report in a couple of weeks. We've got it all completed, we just didn't have enough time to have executive team look at it and review it to make sure we've crossed all our t's and dotted all of our i's, but all of the research has been done and the report's been generated.

So we'll get that mailed out to you, I'll send it to Erin and have her mail that out to the TAC just as quickly as we can get the team to review it. And we do apologize that we don't have that to show you today.

MS. SCHUSTER: Okay. Well, I appreciate that. If you're going to send it

out in advance, then is it all right for us to circulate it in advance, and then you all can present at the July meeting, Victoria?

MS. V. SMITH: Yes.

MS. SCHUSTER: Okay. So actually, it's helpful, I think, for us to have the written information beforehand --

MS. HOFFMANN: Mm-hmm.

MS. SCHUSTER: -- so that if we have any questions, we can be prepared with those.

MS. V. SMITH: Yes.

MS. SCHUSTER: So you'll send us the report itself and then the PowerPoint as well?

MS. V. SMITH: Yes, we'll send you out the written report and the PowerPoint that will go with it. And then we will -- as soon as it gets approved, we'll get that out well in advance so that you'll have time to look at that. It should just be a few weeks -- a couple weeks that we would be able to email that out to you, and that would give you plenty of time to read through it and write down any questions or

any areas that you'd like us to dig further into.

And keep in mind, that this is phase one, so phase one includes the top 30 utilized services in Kentucky from the behavioral health fee schedule. And then, we fully plan on doing phase two as soon as you review phase one and give further direction.

MS. SCHUSTER: And what will phase two be, Victoria?

MS. V. SMITH: It will be the rest of the codes on the fee schedule. So we took the first 30 -- the top 30 utilized codes according to MCO encounter data for state fiscal year 2023. We ranked those services -- we ranked all the services on the fee schedule, and we captured the first 30 -- the top ranking 30 for phase one.

The report is just very labor-intensive. It's -- you know, we're not just looking at a fee schedule, we've got to read different state regulations and billing manuals and whatnot.

You know, a lot of times what we --

the code we might use for peer support, you know, North Carolina might use a different code. So we're not just comparing code to code. We have to really do a lot of research and digging and reading, and it's pretty time-consuming, but we're trying to match as close as we can apples to apples the definition, the unit of service, and the practitioner level or the provider level. We're lining all that up as much as we can, and then we're comparing those two rates. So we want to give a really good idea, apples to apples as much as possible. And if we can't line them up, then we call those unmatched services. So those are services that we couldn't match from state to state.

And we have -- you know, we have found some services that are provided in Kentucky are not provided in other states as a separate service and some interesting -- we found a lot of interesting information doing this study, so I think you're going to be pleased with the report. And if after you see the report, you want us to dig into a certain area or a certain service, we can

certainly dig a little further for you guys.

MS. SCHUSTER: Okay, that sounds great. And remind me, I know you did this across states. Did you do all states, did you do the southeast, how did you choose the states?

MS. V. SMITH: What we did was we did CMS region four --

MS. SCHUSTER: Okay.

MS. V. SMITH: -- excluding Tennessee because Tennessee is an MCO-only state, and then we added Ohio, Indiana, Virginia, and West Virginia because they touch us, you know, they're close to us.

And then we also -- you'll see in the report, we analyzed state populations and enrollment levels, so the beneficiary to population ratio. And we really tried to give you a very comprehensive look at these services, the way the states are providing them, and if they are comparable to Kentucky, then we compare those rates for you.

MS. SCHUSTER: Well, it sounds like we're going to get a lot of good information

about how Kentucky, you know, kind of stacks up vis-a-vis the other states aside from the actual rates themselves, but in terms of whether we're offering services or doing them individually and other states are not and that kind of a thing. And this is both --

MS. HOFFMANN: And, Dr. Schuster?

MS. SCHUSTER: Yes?

MS. HOFFMANN: I'm sorry. We welcome you to partner with us and do a deep dive and have questions for us. We want that interaction like we did before --

MS. SCHUSTER: Right.

MS. HOFFMANN: -- on the targeted case management. That works out really good for both parties.

MS. SCHUSTER: Yeah, well, I think -- and we're all -- there's lots of discussion going on right now about rates and so forth, so -- and this is both mental health and substitutes disorders, right, Victoria?

MS. V. SMITH: This is for all the codes listed -- all the services listed on the behavioral health fee schedule. So this

covers SMI, SED, SUD, and behavioral health services. And that is one of the issues we ran into, Dr. Schuster, is we might provide, and this is an example, peer support across all of our populations, and another state may only provide it to SUD and SMI, or maybe they only provide it to SMI, they don't provide it to any other populations. So that's also part of this analysis that we did so that you guys can get a look at just how flexible Kentucky is in the way we allow some of those services to be provided.

And, again, like Leslie said, if you guys see an area that you want us to dig deeper on, we would be more than happy to do that. We want to make sure you guys are really satisfied with the comprehensive analysis that we did. I think you'll see that we've gone above and beyond just comparing a rate to a rate. We really tried to give you as much information to explain that rate if it's higher or lower or comparable or what. We tried to give you as much information as we could to back up why the rate might differ in one state to the

next.

MS. SCHUSTER: Right. Well, it sounds it will get good attendance in July, which might be a vacation month, but people are waiting to get this information. And I actually think it's helpful to be able to get it beforehand, so --

MS. V. SMITH: And I do apologize, again, for not being able to present --

MS. SCHUSTER: Yeah.

MS. V. SMITH: -- today. We got it -- I got it done in the nick of time, but, unfortunately, it just didn't give our leadership enough time to review it as thoroughly as it needs to be reviewed. And so we're already setting up those meetings internally, and we'll get that taken care of, and we'll get this sent out as soon as we can, Dr. Schuster.

MS. SCHUSTER: Well, thank you, and I actually think that getting the material ahead of time where we can be prepared for questions and so forth is to our advantage. And so a delay of two months, I think, is not a problem, but we do appreciate your

efforts. I'm really looking forward to seeing this data.

Do any of the other voting members of the TAC have any questions for Victoria while we have her on?

(No response).

MS. SCHUSTER: Okay. Well, thank you so much.

MS. V. SMITH: Thank you, Dr. Schuster.

MS. SCHUSTER: So our next item is one that actually came up at our last meeting when we started talking about audits, and then got into a lot of questions. And Veronica Judy Cecil had given us a little bit of background which a lot of us were not familiar with. So we submitted a series of questions to DMS, and I am here without my questions, so who's going to be responding from DMS?

MS. DUDINSKIE: Hi, Dr. Schuster. This is Jennifer Dudinskie, the division director for the Division of Program Integrity.

MS SCHUSTER: Yeah.

MS. DUDINSKIE: And I am going to speak to your all's questions today. Actually, I'm going to share my screen in just a second, I actually prepared a short PowerPoint, I want to be respectful of your all's time. There's just a few things I kind of wanted to go over and share with you all, and then I'll get into answering your questions. And I've already sent this presentation to Erin and Kelli, and they will be emailing this out to you all so that you can have a copy of it. If anything else comes up, you know, it's got my contact information and you all can reach back out.

MS SCHUSTER: Wonderful, thank you very much.

MS. DUDINSKIE: You're welcome. Let me screen share with you here. Let me know when you all can see that. Okay, good.

MS SCHUSTER: Yes, we can see it now.

MS. DUDINSKIE: Great. Okay, so I just wanted to talk a little bit first about why we do what we do in Program Integrity. We are charged by the Social Security Act to establish a Program Integrity program that

does require us to conduct audits of individuals and entities that we pay, and it also requires us to identify overpayments of those individuals and entities. So that's kind of our charge and why we do what we do. And you can look at that at your leisure if you're interested in what the specific language of that is.

I will say that we do have to report information to CMS on a regular basis on numbers as to how many providers we're auditing, at times even broken down into specific provider types for specific services, that sort of thing. So just so you all are aware, we are closely monitored by CMS on that, and we do have specific requirements we have to meet.

I wanted to talk a couple minutes about targeted case management specifically because there's been so many questions surrounding targeted case management auditing process over the course of time with this particular TAC. And so just as a reminder, we had a single state audit in fiscal year 2019 that identified that we

failed to timely perform and monitor managed-cares specific with the TCM audits. So CMS required us to develop a corrective action plan to address the findings. We submitted that plan which was approved by CMS, and so we are continuing on with the plan that we had submitted at that time.

It is -- it's -- CMS viewed this as our current process, so it's not something that has an end date to it. It is something that is ongoing from now until they tell us otherwise. I will say, if we noticed patterns of significant change and that we were seeing such a vast improvement of the services, we might try to revisit that with CMS, but at this point in time, we have not seen that type of improvement. We are still getting a lot of findings on the TCM audits which is why we continue doing what we do.

In addition to that single state audit, we did also have audits by the APA office. We have to go through that process each year as well. We have to explain what we've done, give them samples of what we've done, and they give us feedback as well.

And we've been doing well with that portion, the part that requires us to show them what we're doing and how we're doing it. But we do continue to have to do that on an annual basis.

So the targeted case management audit process, just to kind of go briefly through this with you all, on the 15th of every month, there is a report that's generated that identifies fee-for-service and MCO TCM claims that were billed in the prior month. What we do is we take a random -- randomizer that generates numbers for us to select three TCM single claim audits per month. So that's one claim per month, a total of three of those. And then, that's for each MCO, so that ends up being a total of 18 claims. So that's what we will look at. We do the fee-for-service, as well as the MCO.

We mail the audit letters to the providers requesting that they submit the documentation to support the claim. They're given 30 days to submit those records to us. If we don't receive it in the 30 days, what we do is we just issue a second notice, we

give them an additional 30 days to get it into us.

At that point, if they do not submit the records, then we do deem the claim an overpayment and we issue a demand letter for recoupment. And the provider does, of course, get due process rights with that. If the records are provided, we review them, they have to be validated in a specific way, and we have to look at the assessment, the plan of care, the contact, BHDID credentialing, and in addition to just verifying the billed claim.

So we do all of that for each of those claims. If no overpayment is identified, we just issue a letter back to the provider letting them know the results, that we're fine and there's no overpayment identified. If we do identify that overpayment, we do issue the demand letter, and again, due process rights apply for the provider.

If the DC -- DMS TCM review results in a finding of a deficiency, we mail a notification letter to the MCOs, and require

them to conduct a one-year look-back of the TCM claims by that provider. We would like to note, that initially when we started this process, we did include a two-year look-back. But partly because of some of the feedback that we received in this TAC meeting as well as some other feedback, we did reduce that two-year look-back to a one-year look-back. So the one-year is what's required now.

MCOs have 180 days to complete their review. They can always request an extension if they are having trouble meeting that, and we grant extension requests for those. And then the MCOs are responsible to identify any overpayment that they identify in their review as well as going through their due process rights system for the provider. So if we identify the overpayment, we take care of those letters and work with the providers. However, when the MCOs, if they are requested to do an extended review, they handle that and they just report information back to us.

So that was all on TCM. Does anybody

have any TCM questions before I kind of move into the prepayment review process?

MS. SCHUSTER: Yeah, Jennifer, there was a question in the chat about who sends the letter. Does that come from DMS, or does it come from the MCO? Can you back up a slide or two and I'll show you where it is?

MS. DUDINSKIE: And thank you, I can't see the questions in the chat while I'm presenting. So basically --

MS. SCHUSTER: Yeah, the audit letter is mailed to providers requesting documentation. So does that letter come from DMS, or does that letter come from an MCO?

MS. DUDINSKIE: It comes from DMS if it's in that initial claim review. So that monthly process that we follow, if we are doing the audit, that letter will come from us. If we pass information onto the MCO and tell them that they have to do a one-year look-back, at that point, the MCO would be issuing the letter.

MS SCHUSTER: So is the provider --

I'm trying to figure out what the provider is told along the way. If you send that initial letter, do you say this is part of the -- of your DMS monitoring or, you know, whatever?

MS. DUDINSKIE: The letter that we send, it's clear that it comes from DMS. And it's them having to submit the records to us, and then when we have completed our review, they will get a letter from us.

So what can be expected on the provider end is if they receive a letter that tells them there were no findings, then that process is done for them. If they get a letter that identified an overpayment, they can most likely expect that we are then going to in turn ask the MCOs to do a longer look back period, and that correspondence will come from the MCOs.

MS SCHUSTER: Okay. Kathy, you've got your hand up and you had asked that original question, I think, in the chat. I don't know if that answers your question.

MS. ADAMS: Yeah, I had a follow-up question. Thank you, Sheila. Kathy Adams

with the Children's Alliance. So if you all are doing 18 single claim audits on TCM a month, for the MCOs that equals 216 for the year. So do we know out of those 216 audit records resulted in deficiencies, so the MCO then had to go and request a year's worth of records?

MS. DUDINSKIE: I do -- I don't have that information with me or in front of me right now, but we do track all of that.

MS. ADAMS: That information would be very helpful to see, you know, how good or how bad are we doing. If we're auditing 216 records initially, what percentage, how many of those require a year's worth of look back? That information, to me, would be very helpful for providers to have to give them an idea of why they feel so inundated with TCM audits. That might help explain things, so thank you.

MS. DUDINSKIE: If you all could send us a formal request of what data you want so that I don't have any question about what it is you're wanting to see, we will be happy to get that data together and present that

to you all or send it to you, however you all want it.

MS SCHUSTER: Okay, thank you very much, Jennifer. I'll work with Kathy and any other providers that have specific questions so we can get that data. Thank you.

Was there any other question about the TCM audits because TCM is -- as Leslie pointed out, has been a topic of great study by this TAC over the years.

MR. SHANNON: Here's another question, Sheila, from the --

MS. SCHUSTER: Oh.

MR. SHANNON: -- Boys and Girls Club Haven. Does the MCO also have to give 30 days to submit requested records?

MS. DUDINSKIE: Their time frame -- I don't know that we necessarily dictate their time frames. What we dictate is how many days they have to submit their findings to us. We allow them to use whatever process they have in place. I will say that generally, what we recommend is to allow at least a 30-day turnaround time.

And I know I've said this on this TAC meeting, as well as some others -- other meetings before as well, if a provider feels as though they're not getting enough days to provide those records, they have every right to request an extension. If that is not going well with conversations with the MCOs about that, then at that point you can reach out to us either as a provider complaint with the DPQO area, or you can reach out to Program Integrity, and we can kind of assist with that.

But really, at that point, we consider that turned over to the MCOs for the MCOs and providers to work together. But again, happy to help if we need to.

MS SCHUSTER: Bart, you've got a question.

MR. BALDWIN: Yeah, just got a clarifying question -- a quick comment and then a clarifying question. In terms of the response times, I'm hearing very routinely eight days, 12 days turnaround time, not -- initially, not even 30 initially, but a eight-day, and I don't know, so that's just

food for thought or FYI for you all. That that's a pretty routine -- not always, but pretty routine thing we're hearing.

MS. DUDINSKIE: We don't know that unless you all provide us specific examples. Share letters with us, share the correspondence with us, and if that is a concern, then I would encourage you to send that information and share it with us.

MR. BALDWIN: Sure, absolutely. And my clarifying question on this, on the TCM audits, the way you described it, Jennifer, was DMS had an initial audit, and then, if necessary, it triggered for the MCO to do one if there is a finding. My question is do the MCOs -- is there a requirement for them to do audits outside of that process that's not triggered from the DMS? Does that make sense?

MS. DUDINSKIE: Yes, it does make sense. For TCM, no. Like the RTCM process is geared from -- like, we are the starting point of that, and then we hand over to the MCOs what they need to review. Now, that doesn't mean that they can't initiate it on

their own.

MR. BALDWIN: Okay.

MS. DUDINSKIE: It's that we're not requiring that. They may require that as part of their process and part of the audits that they conduct on a regular basis.

MR. BALDWIN: Okay, thank you.

MS. DUDINSKIE: Sure. Any other questions before I move on to prepayment?

(No response).

MS. DUDINSKIE: Okay, so I know you all were interested in how prepayment reviews work. And that process recently changed in DMS, and then us working with the MCOs. So effective in January of this year, we required the MCOs to submit prepayment policies and procedures to us for review, and we approve those before they implement those.

Now, when there is a sustained level of a high payment error rate, or an MCO reviews data they identify some type of problem, they then may request approval from DMS to implement a specific prepay on a specific provider. They do have to send

that to us, and we do have to review and approve. The information that we require them to submit to us is there on this slide. So they have to provide the specific information to us for a review, and then we have five business days to review the request. We can approve or deny the request. Sometimes we might have additional information that we ask, but we work in that five-business day time frame, and then we work to generate either an approval or a denial.

If we do grant an approval, then here is the process that the MCOs have to follow: They must issue notice to the provider in writing within two business days in advance of the prepayment start date. And they are required to use multiple means of communication. And then that notice has to identify for the provider the reason for review, the description of the documentation that they are going to require the provider, how they want it submitted, the time frame that they will return back the documentation and results of their review, the length of

time of the prepay, contact information for questions that providers may have, and then information on how to request the prepay removal. All of that has to go to the provider, again, two business days in advance of the prepayment.

And then the provider is given 45 days to submit documentation. Claims that occur on or after day 46 may be denied by the MCO if that documentation was not submitted. And then, of course, there's going to be an appeal process that's specific to the contract and internal policies and procedures with the MCOs. The contract may extend the prepayment review period if it's determined necessary.

If a provider has a sustained 90 percent error-free claim submission for the 45 days, the MCO has to then request permission from DMS if they want to continue prepayment. So they would have to ask us again, and they would have to provide reasons for why they wanted that extended. And then, once the provider is removed, the MCOs notify us of that information. The

MCOs do have to submit an annual report to us as well that provides a listing of all the providers that were placed on prepayment during a calendar year.

So that was on prepayment. Are there questions about prepayment before I talk about post payment?

MS. BROWN: I have a question; this is Missy Brown with Community Care.

MS. SCHUSTER: Yes, go ahead, Missy.

MS. BROWN: Is this any prepayment review because we were getting a lot of peer support prepayment audits, and they were giving us four days to get the records to them.

MS. DUDINSKIE: So again, this is the prepayment process that started as of January 1st of 2024. So anything that would've occurred before January of 2024 may have been different, but this is the process for any prepayment as of January 1st.

MS. BROWN: Okay, and these have been since January 1st, so we just need to let Medicaid know that we're getting these prepayment requests from an MCO and limiting

us to four days?

MS. DUDINSKIE: You need to send that to -- like I said, you can send that through the provider complaint process.

MS. BROWN: Okay.

MS. DUDINSKIE: We will -- when you send that in through the normal complaint process, Program Integrity will be notified as well, so.

MS. BROWN: Okay, thank you.

MS. DUDINSKIE: Sure. Anything else on prepayment?

MS. SCHUSTER: So January 1st, Jennifer, was the start of this new process as I understand, and then --

MS. DUDINSKIE: That's correct.

MS. SCHUSTER: -- each of the MCOs had to submit to you what they were going to do in terms of conducting these prepayment audits, and you all approved that general process, right?

MS. DUDINSKIE: That is correct.

MS. SCHUSTER: And then we have all of these different -- all of these different pieces here.

MS. DUDINSKIE: And we had --

MS. SCHUSTER: Go ahead.

MS. DUDINSKIE: -- the process first -- processes and procedures, we reviewed that first, which is, you know, I guess that, you know, laid out their plan for how to conduct it. And then on top of that, they have to send us notice of who they plan to put on prepayment review, and we review each of those individually as well.

MS. CECIL: Yeah, and if I could just interject --

MS SCHUSTER: Are those policies -- are those policies and procedures available to us?

MS. DUDINSKIE: The -- each of the MCOs' policies and procedures?

MS. SCHUSTER: Yeah.

MS. DUDINSKIE: I would think that that would be part of their manuals that they have online. I mean, I don't think it should be anything that you can't access.

MS SCHUSTER: Okay. I'm sorry, Veronica, you were going to say something.

MS. CECIL: No, that's okay. This is

Veronica Judy Cecil, Deputy Commissioner for Medicaid. And I -- just so everybody understands the nuance of prepayment, so keep in mind, that if it's prepayment, they are asking for documentation prior to approving or denying the claim. So the longer it takes for them to request and you all to submit documentation back means it takes them a long time to actually process the claim.

Now, we'll take back the concern about four days. Certainly, that seems like a little bit of an unreasonable time frame to turn around. But they're probably doing that to try to keep the process moving so that they could try to get that claim processed as quickly as possible and you're not waiting for the claim to be approved or denied. So just keep that in mind because this is prepayment.

But we'll take that back and certainly have conversations about it. And do want to make sure that it's a reasonable amount of time for providers, you know, as you all go through those reviews.

MS SCHUSTER: Thank you, I think that's really helpful. I'm struggling with -- so if it's prepayment, is the audit looking at a tendency on the part of the provider to be submitting claims for services that shouldn't be covered or are being delivered by people that are not qualified to do them? I'm trying to figure out what the -- what's on here.

MS. CECIL: Yeah, it could be --

MS. SCHUSTER: All of the above?

MS. CECIL: All of the above, yes. It could be, you know, a concern about medical necessity, it could be a concern about a particular provider delivering the service and the appropriate level of practitioner. It could, you know, be around the code itself and ensuring that, again, the services are supported by the documentation.

And prepayment, again, generally only happens if there is an identification of a problem. So they don't just go out and do prepayments because they can. They do it because it has actually identified an issue

that they really feel like they need to have that increased interaction with the provider to try to get the claims back to, you know, in shape for just submission without a prepayment.

MS SCHUSTER: Okay, thank you. Kathy, you had your hand up.

MS. ADAMS: Yeah, thank you. First of all, thank you to DMS for instituting a policy as of January 1st. I think that is most helpful, and I do think it's very important that providers understand the process.

We have members that are unable to get out from under the prepayment audit, and that it's going months they don't hear back from the MCO and they're not getting paid for months. And that's a concern. I mean, if they're doing something wrong, it seems like the result of the audit would be until you start doing this or stop doing that, you shouldn't be providing these services because we're not going to pay you. So that's a big concern is whether or not there is feedback going from the MCO to the

provider as to what they need to do to get out from under this prepayment audit and not get paid for the service.

But the other big concern is the process after you receive notice from an MCO that you are under a prepayment audit, and that is I'm hearing from members that they're not providing an ample amount of time for them to provide the records. And then when there are violations, from what we perceive on the MCO side, like not providing ample time -- I had two others that came to mind as to why -- oh, they didn't -- let's say they didn't give them the two-day advanced notice before they stopped payments, but any of these things that the MCO isn't doing that our members then submit to DMS, they don't get a response back.

So then they don't know, well, do I still have to give them all this information within 14 days? Or, you know, if the MCO didn't give them the two days, but yet the MCO stills starts taking the money. I guess, that back-end piece as to how the provider gets feedback from DMS on what they

need to do when they feel the MCO has violated their requirements regarding a prepayment audit.

MS. DUDINSKIE: So if you're not receiving a response back from DMS, I mean, that surprises me. Our compliance branch does a really good job of responding to providers, but if you are having a hard time getting a response, then, you know, you can check back with the compliance team wherever you submitted it. You can also feel free just to reach out to me, and my contact information is at the end of this. Again, my name's Jennifer Dudinskie; I'm the division director from Program Integrity. But if you're having a problem with that, I'm happy to reach out to them and try to help if you feel like you're not getting a response.

I mean, it does take some time. Please understand that if you send us a complaint, we're going to look into it. So we are going to have to have conversations with the MCO, we're going to have to ask them to allow us to take a look at what

correspondence has been with the provider. Probably somebody from the compliance team is going to be asking the provider to provide that information as well.

So, I mean, it could be that it takes a little bit of time, but you should be hearing back from DMS. And if you're not, please let us know because we really pride ourselves on providing good customer service to providers and providing responses back. And so I'm happy to help facilitate that if you feel like that's being missed somehow, then let us know.

But again, in the prepayment process, keep in mind that, you know, you're supposed to -- all of this information that I've shared with you, that's what you're supposed to get from the MCO. If you're not getting that, then, of course, let us know.

And then know that if -- you know, if they are not releasing a provider from prepayment after that specified amount of time and they're wanting to increase that time, you know -- so again, on this slide, if the provider sustained that 90 percent

error-free claim submission for 45 days, they should be coming off prepayment unless they come to us and ask or provide additional information or there's some other issue, then they have to come back to us and ask to keep that going.

So, you know, keep that in mind as well, but you should also be getting feedback with the MCO. They should be working to help identify what the problem is, if the provider is trying to fix a problem that they don't understand or something of that nature, they should be working to explain that to providers and help provide -- I mean, the goal is to get off of prepayment, I realize. So that should be the goal on the MCO's behalf, on the provider's behalf, and DMS as an assisting provider, so that is the goal. It's to fix the problem and to move on.

But again, my contact information will be on the last slide, and I can put it in the chat after all of this as well, but, you know, reach out to me if there's something that's not going well.

MS. SCHUSTER: Thank you, Jennifer, and how does -- who determines if the provider has a 90 percent error free claim submission rate for 45 days?

MS. DUDINSKIE: I think that is a collaboration between what DMS sees in claims review and what the MCO is providing. I'm not directly involved with looking at that, but my understanding is it would be, you know, a combination of both entities looking and verifying that.

MS. SCHUSTER: So there was a question -- and again, I think we're back on this issue about time frame. Is there a time frame during which the MCOs and DMS are looking at the documentation and a provider could expect to hear back?

MS. DUDINSKIE: So okay, let's look at all the time frames in the prepay. So again, after it leaves us, if we've granted permission, they have to notify the provider with that two days in advance business days notice which I understand might be a concern from some of you. And then at that point, they have to provide all of the detailed

information.

That notice should include the time frame for the documentation, not only submitting the documentation for you, but the time frame for reviewing and returning, the length of time of the prepay -- so, you know, please understand, the length of time of a prepay could be different. And we do review and approve that, but they -- different MCOs might have different prepay time frames, but that should be communicated to you in that correspondence that they're sending. They should also give you the contact name of somebody that can directly answer your questions and that you can easily get to. And then, again, information on how to request the prepay removal.

So it's all going to be case-by-case base specific. As far a specific time frames, providers are going to have the 45 days to submit the documentation. And again, if that documentation is not received in that 45 days, then the MCO does have a right to recoup. But within the 45 days that those records are presented, then

again, you would -- I would have to refer you back to that initial correspondence from the MCO that said how many days they expected it was going to take them to review that information and get a response back to you.

And then if you're not getting that -- if a provider is not getting that, then at that point they need to reach out to the MCO first, of course. And if that's not going well, then reaching out to DMS for us to help kind of facilitate that process of communication with the MCO.

MS. SCHUSTER: Okay.

MR. SHANNON: Sheila, this is Steve Shannon. It looks like MCOs in the comments are saying 30 days to respond.

MS. SCHUSTER: Instead of the 45 that's on the slide?

MR. SHANNON: Yeah. Yeah.

MS. DUDINSKIE: Okay, I can check that. I believe it's 45, but that's something I can easily verify.

MS. SCHUSTER: Yeah, I see here United Healthcare says we have 30 days.

MR. SHANNON: Yeah.

MS. KOENIG: Steve --

MR. SHANNON: And this was effective 1/'24 --

MS. KOENIG: -- that was specific to the TCM audits.

MR. SHANNON: -- right?

MS. DUDINSKIE: Yeah, TCM is different. If we're looking at TCM, that time frame is 30.

MR. SHANNON: Okay, that's confusing for providers I suspect. But this plan, the prepayment, was -- these are effective January of this year, right?

MS. DUDINSKIE: Yes.

MR. SHANNON: Is it for audits after that period or services after that period?

MS. DUDINSKIE: No, it means that as of January 1st, this is the process they have to follow --

MR. SHANNON: Okay.

MS. DUDINSKIE: -- with prepay.

MS. SCHUSTER: Okay. So the time frame may be 30 days on the TCM and 45 days on the prepayment; is that possible?

MS. DUDINSKIE: Yes, it is.

MS. SCHUSTER: Okay, so that's one of the confusions -- confusion points.

MS. DUDINSKIE: But you should always follow the number of days that's in the letter. The provider should always follow the number of days that's specified in the letter. The letters should always specify the days.

MS. SCHUSTER: So, Jennifer, if somebody gets a letter, and it doesn't have all of those things in there that it's supposed to have, I mean, I guess I would assume from a provider's standpoint that the clock doesn't start -- I mean, they need to notify you that --

MS. DUDINSKIE: Well, that's something that they need -- I would advise going directly to the MCO and stating, "We're aware that this information should be in the letter, and it isn't." And then on top of that, if they feel it's necessary to loop us in, can do that as well, but yes --

MS. SCHUSTER: Okay.

MS. DUDINSKIE: -- I understand the

point that you're making.

MS. SCHUSTER: Yeah.

MS. DUDINSKIE: Theoretically, they should have all of the information in place before the clock starts.

MS. SCHUSTER: Yeah.

MS. ADAMS: And I think the biggest concern is that providers feel that MCOs, if they don't follow the rules, there's no repercussions, they're not going to pay them. It's a prepayment audit, and so the provider really doesn't have much leverage, you know? It's like, okay, so if you get a letter, and it doesn't have this information, the provider still has to do everything and submit records, etc.

MS. DUDINSKIE: Okay, so a provider still has rights, correct? I mean, you still have rights as a provider. I would say if the information is not contained in the letter that should be there, at that point, it's the provider's responsibility at that point to reach out and advocate for themselves and the information that they don't have to meet whatever the requirement

the MCO has.

Now, in terms of the -- I don't know if you meant the provider has no choice or nothing's going to happen with the MCO. From an oversight perspective with DMS, if we are getting complaints against an MCO and they are not following the procedures, we have an internal process that we follow for the MCOs that is a, you know, graduated process of what actions we take based on a noncompliance issue. So we do hold the MCOs accountable for not following policy and procedure the way that they are supposed to follow it.

And there's some more information about that later in this presentation that will kind of walk you through what happens, because that was one of your all's questions is what -- basically what happens to an MCO if they don't follow the process, so that's in here.

MS. ADAMS: Thank you.

MS. SCHUSTER: Yeah, and Deputy Senior Advisor Veronica Judy Cecil says put all of that information in your provider

complaint letter, you know? Put a copy of the letter, put documentation of your attempt to get clarification from the MCO and so forth because DMS cannot -- and we know this, it's just people get upset so they just send stuff and call you and so forth, but you all need to have information that can be verified.

MS. DUDINSKIE: Yes, thank you. We -- I mean, I hear a lot of complaints, but if you all don't provide us with the specific documentation, it makes it really hard for us to help you. It's basically your word against their word, right? So give us everything. I mean, share with us on the complaint form and attach what you need to attach as far as the documentation you've received from the MCO, hard copy, emails, whatever. The more information you give us, the better we can help.

MS. SCHUSTER: Okay, that's a helpful reminder. Thank you.

MS. DUDINSKIE: So I'll move on to post payment review now, and explain the process for this. It's going to vary a

little bit more because prepayment is very specific to prepayment. Post payment reviews could be a whole variety of things, so this is just a general process that's followed for post payment.

So we conduct post payment reviews to identify services are billed in accordance with the policy and regulation. Of course, MCOs are going to be conducting post payment reviews as well. We do post payment reviews on all provider types. There's some listed there, but, of course, that's not everything. Any payer, as I kind of said at the beginning in our charge, is anybody that is paid is subject to an audit. And so we do reviews of all different provider types.

Sometimes we'll receive a complaint or an allegation of fraud, waste, or abuse. Those come in various channels, they can be against various different things, they can be very specific, or they can be very generalized. So depending on the language contained in the complaint or the allegation, that is going to kind of drive what we look for in a post payment review.

So we take a look at it. We first take a look and see if it's a provider who's being reviewed by a law enforcement agency. If that is the case, then we work with law enforcement agency to see if it's something they want us to look at or if they prefer us not look at it. Then we establish a certain time frame for the review and the specifics of what we're going to look at. You know, are we looking at one thing, are we looking at two things? We identify what that's going to be, so we establish a framework for the review.

After we do that, we do a data request. So we run data, we obtain a sample size that's always conducted using a randomizer. And then at that point, once we've selected who we're going to review, then we would move on and do a records request letter. These typically are 30 days, so -- and I hear you all about some of maybe the confusion because we have different time frames for different types of audits. But the letter should always outline the specific documentation that we

need, the submission instructions, and then the due date.

As always, if there's questions, there will be contact information in the letter so that the provider can call and ask questions if they're unclear, or they feel that something's too large to submit a certain way, or they need some additional time. Any of that can be discussed via phone call or an email. If records are not received by the due date, we send a second request letter, allow an additional 30 days.

At that point, of course, if we don't receive the records, very similar to the TCM process, if we don't receive them, the claims are considered an overpayment. We issue a demand letter to the provider, and then they get the due process rights with that.

Upon our completion of an audit -- and I will say in terms of time frames on a post payment review, and this is specific to DMS when we are looking at records -- we do not always get -- we do not give a time frame for review in our letters that ask for

records. And that's simply because it is very hard to determine how long a review is going to take. Sometimes we get the records back, it's a very easy review, we're done in a couple of days. Other times, it might be that we're looking at a lot of very specific detailed data, we're looking for very specific things in the records, the records may be voluminous, it's going to take us longer. However, at any point, a provider can call in and, you know, you can always request a status update if we're still reviewing, that sort of thing.

When we do complete the audit, we do issue a findings letter to let them know if there was anything we identified, if we didn't identify anything, if we had some form of provider education we wanted to relay to the provider, or if there was an overpayment, we would identify that in the letter as well. If we identified an overpayment, that will be in the letter. We set up an accounts receivable, and the provider's expected to pay back that overpayment. Of course, they're going to

get their due process rights with that. So there's some room for that process, but we do set up that accounts receivable, and it's expected that the provider would pay back that money.

Are there questions on post payment then? Because next, what I'm going to move into are your specific questions that you sent in and asked us.

MS. SCHUSTER: Jennifer, just a question, when you send the letter to the provider, does it say what the charge is or what the concern is that's been raised that you're looking to investigate? You mentioned fraud, waste, and abuse, those kinds of things.

MS. DUDINSKIE: We do not generally give information specific to what the allegation is. Sometimes there might be information in the letter that, you know, where the provider might be able to kind of tell based on what we're asking to look at. But, no, we don't necessarily divulge what the specific complaint was.

MS. SCHUSTER: Hm. Do they get a

copy of your findings letter afterwards?

MS. DUDINSKIE: They get a letter which details the findings. They don't get a copy of the report if that's what you're asking. That could be requested with an open records request, and then, of course, anything that we can release to the provider, we would release upon an open records.

MS. SCHUSTER: Hmm. Any other questions of Jennifer about post payment review?

MR. MARTIN: Dr. Schuster, this is Barry Martin.

MS. SCHUSTER: Yeah, hi, Barry.

MR. MARTIN: I think we got our first ones today because we're still babes in the woods. And actually, it was on two 15-minute charges for peer support. Kind of seems like that's a little on a waste of time to ask for prepay reviews on two charges like that. I guess I'm just saying that as a -- I guess, as an example of some of the things that is frustrating to providers.

MS. SCHUSTER: And that was on a prepayment, I assume, Barry?

MR. MARTIN: Yes.

MS. SCHUSTER: Yeah. Yeah, and I mentioned and CommuniCare mentioned that they were getting lots of audits on peer support, so I'm wondering if there is a misunderstanding about peer support or what's being charged, just curious.

I guess that's the other question, Jennifer, if -- and I guess you would see this -- well, I don't know that you would see what the -- do you have any way of analyzing the audits that are -- who's being audited and for what so that you can kind of go backwards and identify, here's a provider community that obviously very large, and there seems to be a consistent problem around X. In this case, it might be peer support. Do you ever do that?

MS. DUDINSKIE: We do. We do.

MS. SCHUSTER: And then would you give information back to something like the BH TAC about that?

MS. DUDINSKIE: So it -- that

depends. It depends on where the information came from. It would depend on if we felt like it was something that needed to be brought to the TAC's attention. I mean, there's a lot of different factors there, but certainly, we look at, you know, regions, we look at certain areas. When we get complaints, sometimes they're specific to a broad area or, you know, sometimes they're very specific to one provider or, you know, sometimes it's in this area this is happening.

So we have to look at the complaints as they come in, and our first response is always to look at some data to see if there's data to support what the person is alleging or what the complaint is. We do start with a data analysis before we proceed to any type of record review.

MS. SCHUSTER: Mm-hmm.

MS. DUDINSKIE: I mean, we do go through a process of some form of verification because we don't want to waste our time or a provider's time on asking for records or information when we don't have

any -- there's no validity to a complaint, right? So we do a little background work before we get to the point of asking for records.

MS. SCHUSTER: Yeah, and I guess Barry's question was if the focus is two 15-minute charges on peer support and they're having to produce X number of records, it seems like overkill.

MS. DUDINSKIE: Well, and in that case, what that says to me is there might be some concern over peer support in general, and either an MCO or DMS is taking a look at some of those claims to see if there is anything to support what we're either seeing or what we're hearing. Does that help?

MS. SCHUSTER: Yeah, I think it does, and I guess, you know, I'm trying to be proactive here.

MS. DUDINSKIE: Right.

MS. SCHUSTER: You know, to, you know -- and encourage you all to use -- because you have the data, we don't.

MS. DUDINSKIE: Right.

MS. SCHUSTER: I mean, we have the

anecdotal data, but if there's an issue -- this is how the TCM issue got raised years ago. One of the MCOs -- that's when we were meeting in person -- one of the MCOs said, well, there's no reason for anybody to have targeted case management after six months or whatever and argued that it was detrimental almost, and there was such an uproar about it. That's when Commissioner Lee said, "Well, let's get the data and find out if it's helpful or not."

I guess my other question just while I'm asking questions is do you all look by MCO? In other words, if there's MCO X, and almost all of their prepayment audits are around peer support let's say, and you're not seeing that same thing from the other MCOs, do you address that at all? I guess I'm curious about are there some biases in what the MCOs are looking for?

MS. DUDINSKIE: We did look at that. We do look at the different types of cases that each MCO is doing there that -- we do have meetings with them as well to get an idea of what each one will -- what they're

looking at, information sharing. There is a lot of information on, you know, we're seeing this, are you all seeing this?

MS. SCHUSTER: Hm.

MS. DUDINSKIE: So that kind of information does exchange between MCO to MCO, MCO to DMS. And certainly, if we saw patterns, we would ask questions. We get monthly reports from them based on what cases they're reviewing, what types of things they're saying. When we see patterns or things that look curious to us, we do ask questions.

MS. SCHUSTER: And again, I guess I would urge you all to think in terms of that third leg of the stool if you will. If there's some of that information that would be helpful to the provider community as a whole, and I'm going to pick on peer support since it's come up twice. You know, if there's some issue about either the way it's being billed, or who's doing it, or whatever that seems to be getting lots of providers audited, you know, we're trying to not tie up funds, and not tie up fax machines and

Xerox machines and all of that kind of stuff, and the MCO time and your time.

MS. V. SMITH: Right.

MS. SCHUSTER: So if we can proactively look at an issue, let's try to do that as well.

MS. DUDINSKIE: And I agree with that, and I will say that, you know, there's going to be some level of review on our part before we reach that stage.

MS. SCHUSTER: Sure, sure.

MR. MARTIN: And I'll keep track of it. I guess what kind of alarmed me was it's two claims of 15-minute peer support. It's not like it's, you know, 15 claims or it's 15 units. It's just individual two units on two different patients, I believe, so that's what concerned me.

MS. DUDINSKIE: They keep --

MR. MARTIN: I understand what you're saying, and I understand peer support is running rampant, and I think we should work on that, and we should help develop some good guidelines for it. Believe me, I want us to police ourselves as much as you guys

policing it to keep that from happening.

MS. DUDINSKIE: Appreciate that, thank you.

MS. SCHUSTER: Well, and we feel like peer support is a valuable service, so we don't want it to get --

MR. MARTIN: Yes.

MS. SCHUSTER: -- truncated or overly, I guess, scrutinized because of a few, you know, misunderstandings or bad apples out here. Because we -- and that's how we felt about targeted case management quite frankly. And I'm not saying that it is not billed inappropriately at times, but, you know, we really like our peer support specialists in both mental health and substitutes disorders and, you know, want to see those services done correctly by the right people and then reimbursed.

MS. DUDINSKIE: Well, and us too.

MS. SCHUSTER: That's what you want too.

MS. DUDINSKIE: Yes.

MS. SCHUSTER: Right, right. All right, thank you, Barry, for bringing that

up.

MR. MARTIN: You're welcome, thank you, all, for listening.

MS. DUDINSKIE: Okay, if you're ready, I will move into your all's questions and --

MR. SHANNON: There's another question from Kathy Adams --

MS. DUDINSKIE: Okay.

MR. SHANNON: -- in the chat before we move on.

MS. DUDINSKIE: If somebody can tell me what the question is, I can't see the chat right now.

MS. SCHUSTER: Kathy, want to ask your question?

MS. ADAMS: Yeah, I just wondered if there was a way for a provider to know if the -- if they get a request for a prepayment audit, that DMS has approved that? And if MCOs were requesting prepayment audits without DMS approval, would DMS know that?

MS. DUDINSKIE: Well, I mean, we wouldn't know unless we were alerted to it.

In terms of the provider knowing, if you suspect or, you know, if a provider thinks that maybe we don't know, then that falls more I would think to the complaint process. You would, of course, have to provide some justification for why you felt that way, or if you felt like the process was not being followed.

I've shared the process with you, so if you're not seeing the process being conducted in that manner -- now, they do have to tell us who all -- remember, they are required to submit an annual report that identifies all of the providers that they put on prepay, but, like, on a day-to-day basis we might not know if they didn't submit one. Does that make sense? I mean, we will get that report at the end of the year, and then we'll be able to look at that and compare that list to what came through as a request. But, I mean, is it possible that one slips through the cracks and that they don't submit it? Sure, anything's possible.

But like I said, what you have

available to you in forms of your tools are now that you know what the process is, and you'll get this document, making sure providers know what the process is, if there's something that is not in accordance with that process, that they reach out to the MCO and they reach out to us. And if something just feels off, of course, you always have that complaint process to fall back on.

MS. ADAMS: Thank you.

MS. DUDINSKIE: Mm-hmm.

MS. SCHUSTER: Yeah, very helpful.

MS. DUDINSKIE: Okay. So --

MS. SCHUSTER: Okay, we had a couple of questions for you.

MS. DUDINSKIE: You had a couple, yeah. I'll try to keep -- I know you all have a long agenda. So you asked about the different types of audits that MCOs conduct on providers, the purpose of each type, and which audits must be preapproved by DMS.

So I've gone through the two types of audits today: The prepayment and post payment. Really the prepay audits are what

they have to seek approval in advance of. So prior to them initiating that process, we do have that approval process in place.

The post audit is different. They don't have to get approval for us to do any post pay audit. That can result, you know, through billing practice reviews that have been identified. They might receive a complaint, much like our process. I'm sure that each MCO's process is rather similar for post pay, and that they see something, or they've received the complaint, and they're going to conduct that post pay. Now, they do notify us of their post pay audits. They do have to report it to us, but we are not approving those.

And then, I've just got some information there on what post pay audits might be. It could be data mining, it could be a provider has been an outlier in a certain area, it may be that DMS has requested them look at something specific. That could be a specific provider, or it could be a specific issue, it could be either. So I won't say that we never ask

them to conduct a post pay. We might, but typically they're self-generated by the MCO.

Anything on that one before I move on?

(No response).

MS. DUDINSKIE: Okay.

MS. SCHUSTER: Your previous slides are very helpful on that.

MS. DUDINSKIE: I was hoping that it would be, and like I said --

MS. SCHUSTER: Yeah, thank you.

MS. DUDINSKIE: -- you all will get this, so then if you have additional questions, you can come back.

So the history and purpose of the prepays, I kind of feel like I've talked a lot about that today. Historically, you know, prior to this new process that we implemented as of January, they did not necessarily have to notify us of their prepay intentions, that we did see an increase in the prepay and received a lot of provider concerns about prepays, so we put this process in place to help with that. It is relatively new, you know, we're at

May 1st today, so it is a fairly new practice, so I think it's going to take some more time to see the success of that.

Prepays do generally occur following some form of a post pay or some type of data review situation that the MCO is engaged in, or that they have had some type of unsuccess in changing a provider's billing behavior. So it may be that they've tried to educate the provider, it's not working, so they request to put a provider on prepay. MCOs might see a pattern of inconsistency, data analysis, I've kind of talked about that already, or the error rate is high. That could be another reason.

So they are meant to be an educational platform, spoke about that earlier. The intent is to change that behavior or get the behavior in the right direction if there's a misunderstanding, and make sure that we align everything in terms of the contract, the regs, coding/billing guidelines, all of that. So the goal of prepay is to correct some form of behavior that is incorrect for whatever reason.

I'm just going to move on, Dr. Schuster. If there's a question or something, just stop me.

MS. SCHUSTER: Yeah, that's fine, thank you.

MS. DUDINSKIE: So this question: Are MCOs required to get permission from DMS to perform certain types of audits? If so, which ones are MCOs required to get permission from DMS to perform certain types of audits on certain providers? Why is this? Why are the criteria that DMS uses to give permission or to withhold it? Does the permission come with some parameters such as the service, etc., the number of records, the time frame?

So they do have to engage with us and get approval on the prepays, we've already talked about that today. If there is a provider that is being investigated or audited by any type of law enforcement agency, they do have to get permission to move forward with anything in regard to that provider. What I can say about that is maybe it's an issue where they want to look

at something, but they know the investigation is related to something totally different, and they want to get permission to look at the provider for that. Sometimes they will reach out and ask, sometimes law enforcement agencies give the green light, sometimes they say, no, we don't want you to interact with this provider at all. So there are times when we provide that feedback.

There are also times when we do provide conditions or parameters on approvals. Sometimes it's -- sometimes it's at the request of a law enforcement partner, which is kind of related to the point I had above. Sometimes that might be due to if they want to conduct the audit they can but exclude this specific rendering provider. Or we might provide any type of guidance, like, you can look at this code, but we don't want you to look at this code right now.

So, yes, there are circumstances, and generally, if we do give a parameter, there is a specific reason for it. Maybe it's

something that we are already looking at and we don't want to duplicate. We don't want them to duplicate what we're doing, or we don't want to duplicate what another entity is doing. So we do take those things in consideration.

Does DMS --

MS. SCHUSTER: Yeah, Ramona asked if the PowerPoint will be sent out, and, yes, we'll send it out, Ramona, to everyone that I've got on my list, and Erin and Kelli. So it is very useful to have this, thank you.

MS. DUDINSKIE: Does DMS direct MCOs to conduct certain types of audits? Does DMS direct MCOs to conduct certain types of audits of specific providers? What are the criteria? And are there specific questions, and is the provider notified? Trying to move along quickly here.

DMS does direct the TCM audits. We talked about that earlier, and quality review audits. Sometimes they're generalized, sometimes they are for a specific provider. And those types of audits require a one year look back.

DMS sometimes receives referrals from law enforcement that may result in some direction from DMS to request the MCOs to conduct a specific audit. If it is directed by DMS, providers are not necessarily notified that DMS made the request. We just submit that onto the MCO, and then the MCO handles it the way they would do any other audit and they just require -- we just require them to report back to us. So there are times when we provide instructions, but have them conduct the audit, and then they provide follow up to us.

How is it determined how many records have to be provided and the time frame of the audit period? Do these metrics vary depending upon the type of audit? Is there a number of records or time frame that DMS would consider excessive? If so, would the complaint form be used to report these concerns to DMS?

A minimum number of records for you is 20 unless the audit is for TCM. For TCM, the minimum number of records is 50, but keep in mind, that's a one year look back.

Now, if MCOs do not have that many in their universe, so either the 20 or the 50, if they don't have that many, they tell us that. They tell us how many records are in their universe, and then we adjust that accordingly. Typically, in that case, let's say they had 15 records, but not 20, we would say, okay, go ahead and do the 15. So that's how that works.

If the number of records does appear to be excessive, the MCO dispute inquiry form, that provider complaint form, can be used to bring awareness to the department. But again, we do recommend that you try to work with the MCO first, and if that conversation doesn't go well, then come to us. MCOs do have the flexibility and capability to work with each provider. We make that clear to them all the time. And then they know that if we are dictating something and something comes up, they know that they should be coming back to us and letting us know if there is a problem or an issue and collaborating with us to come up with some type of solution.

What is the relationship between a prepayment audit and withholding -- withholding payment for a service? May the payment be withheld until the conclusion of the audit?

So prepay audits withhold the payment until the review of that documentation has been submitted and reviewed and assured that the billing is done properly. Then there will be a payment or a denial upon the conclusion of the audit process that should be communicated to the provider. MCOs are not permitted to unnecessarily extend the review time, we talked about that earlier. They have to come back to us if they want to extend the time frame. They should be promptly reviewing the documentation and trying to settle it expeditiously. If not, that's when you all should have the providers reach out to us.

There's a question about extrapolation. We do not extrapolate, and the MCOs are not allowed to extrapolate either. So whatever is identified as an overpayment, should be the exact

overpayment, not an extrapolated one.

Are all --

MS. SCHUSTER: I think the question there, Jennifer, if I remember was a provider reporting that they, I don't know, had to submit 50 records, and the MCO got back and said, well, we only looked at 7 of them, but we've decided all 50 of them are in error or whatever, and we're withholding it all. And I think that was the extrapolation that was going on.

MS. DUDINSKIE: Okay, if that is the case, then I would appreciate that being shared with me.

MS. SCHUSTER: Okay.

MS. DUDINSKIE: They have to review the records and determine that overpayment accurately. There's --

MS. SCHUSTER: So they have to determine that the overpayment occurred. They have to review every record that's submitted -- that they requested and is submitted to them, and then they have to determine how many of them reflect an error.

MS. DUDINSKIE: Yes, they can't just

make an assumption if eight did --

MS. SCHUSTER: Okay, well, I think that was the -- I think that was what was shared at the last meeting, so --

MS. DUDINSKIE: Okay.

MS. SCHUSTER: -- and I don't remember who shared it, but it sounds like they need to use the complaint form and get that information to you.

MS. DUDINSKIE: Yes, ma'am.

MS. SCHUSTER: Yeah, thank you.

MS. DUDINSKIE: Sure. And are all behavioral health services subject to a prepayment audit? Any Medicaid service is subject to a prepayment. Just like any provider is subject to be audited, any service is subjected to a prepayment.

And is there a way DMS can ensure that different audits conducted by the same MCO in the same time period on the same provider are coordinated? Providers expressed concerns that they have multiple audits going on at the same time by the same MCO with little indication that there is any coordination between the different entities

that are conducting the audits. The different entities aren't talking to one another, and they are all requesting different records at the same time, which overwhelms the provider.

So DMS, we do allow the MCOs to manage their own audits. We don't manage that. Like I said, we get a report, but that would -- it would be very difficult for us even to look at each MCO report on a monthly basis and cross reference all that especially since we're getting it on a timeline, right? So our reports are monthly but we're getting the data from the previous month.

So, you know, we can take a look at this. We have kind of talked internally about is there another way to take a look at this and see and decrease the burden? It's a challenge for us just like it's a challenge for the providers because we do have -- you know, we have six MCOs. That's a lot, that's a lot to coordinate. We do understand that on the provider's behalf as well.

Again, the first step would always be go to the MCO, be upfront about, you know, you've got this many audits, ask for some additional time. If that's not proving successful, then come back to us. Let us know if you're getting -- if the provider is getting multiple requests from MCOs, the same type of information, then do make us aware of that. You know, we certainly are open to conversations about ways we can improve that. We just haven't found a way to do that yet. We do realize that it can be a burden on providers, so always willing, if there's suggestions, we can take that back and discuss it further internally. It's a challenge.

MS. TURNER: I do just want to quickly say that my agency has had, like, five requests from the same MCO in the course of just, like, I don't know, six or seven months. And we did request -- we got our last one we were allowed eight days to submit. We did send a request for an extension, and we received four days extension.

MS. DUDINSKIE: Okay, again, things like that, send that -- you need to elevate that probably to DMS level so we can take a look at those time frames and have discussions with the MCOs about it understanding that four days might not be an appropriate extension.

It has been recommended that a given provider submit the MCO provider complaint form to bring DMS's attention to concerns about the MCO behavior in regard to audits or issues. This was suggested with regard to the prepayment audits being conducted by MCOs. When information about audits needs to be included in the complaint form when it's filed, what would be the expected length of time for review? It's not uncommon for a concern with specific information to be provided to DMS by a provider with no response received for months.

And I know we kind of talked about some of these things earlier on in the conversation today. So provider complaints can be submitted with any concern that's

excessive in number of audits, if the request time is unreasonable, and again, what I stress is please send us as much information as possible. A lot of times, on meetings such as this one or others, we get these complaints, we ask for the follow-up with the specific information, but it never comes. We cannot help you if you do not provide us with the specific information because we have to have the specifics to address the issue. At a minimum, we need to see the audit letters you're receiving, we need to see those time frames. We need to see the volume of claims that are requested so that we can compare the amount of records they're asking for the time frame -- within the time frame that they're asking. We need to see all of that so we can see if it is reasonable or not because you're telling us that, but we need to see the documentation that supports it. And whether it's a letter or an email or what have you, or even documented conversations. If you don't have it in writing, document the date and time you had the conversation, who you had it

with, as much information as you can document, and document that in an email or in a letter to us, either way and submit that with the complaint form.

As I said earlier, the contract monitoring branch they work very hard and they're very responsive. Typically, I would say that they are 30 days or less. I did mention earlier, sometimes it takes us a little while to navigate and get to the bottom of an issue, so there could be some time frames that are over that, but hopefully, they'll be communicating that to you. But again, if that is a problem, reach out to me and I can work internally with that team as well to try to see what might be going on there.

And then, almost to the end, this is the last question: In instances where an MCO doesn't follow their own appeals process -- or procedures as outlined in the contractual requirements with DMS, is it appropriate for the provider to bring this to the attention of DMS and expect the MCO to be held accountable? What process should

a provider use to notify DMS when an MCO does not follow their own appeals process? What are the possible consequences for the MCO in this situation? Would the action taken by the MCO against the provider be modified or negated if the appeals procedures were not followed?

So again, the complaint form for the contract monitoring branch, it is appropriate for you to reach out to us on that. That's the way to reach out to us. MCO contract does dictate the MCO appeals process and requires them to follow it. If they don't follow that process, we do have an actions of noncompliance. We have a process for that. As I mentioned earlier, we have an internal process of following complaint reviews, and then, we have a variety of noncompliance options that we can follow. So it could be that we issue a letter of concern, we could require an MCO to submit a corrective action plan, or there's a variety of different penalties that we can utilize with the MCOs as well. And it kind of depends on what the

infraction is, what the situation is, if it's a first-time occurrence, if it's happened before and it's a repeat occurrence. There are lots of factors that play into what action we take, but we do take those actions regularly.

And then the MCO would be required to correct it if it wasn't completed properly. So we do -- not only do we, you know, inform them of what the, I guess, wrongdoing was, for lack of a better term, or whatever the issue was, and they are required to correct it, and they have to provide that feedback back to us as to how they corrected it, the time frame they corrected it. So we do require a lot of documentation.

And then the last slide is just my contact information. This will be in the PowerPoint that comes out to you all. If you do need to reach out to me, that's my email address, that's the best way to get to me. I'm very responsive to email, so I will certainly get back to you if you reach out to me. And generally, just so you know, my response -- my typical response, I will

acknowledge that I've received your email, and I will let you know that I will get back to you. I don't promise time frames, but I will -- I do keep communication, and I will be sure to give you an end result.

So with that, that's all I had for you all. If there's some additional questions, I'm happy to take those now, or you could always email me.

MS. SCHUSTER: Well, I appreciate it so much, Jennifer, and we all do, and having the PowerPoint. I will also let you know that there was an email put in the chat, that's ProviderMCOinquiry@ky.gov which also is a way to move things along, I believe.

Bart, do you have a question?

MR. BALDWIN: Yeah, just real quick, Jennifer. Thank you so much for answering the questions and providing the information and the overview today. Just so -- I have lots of clients that work in this space and are Medicaid providers and behavioral health, so we really appreciate that. My quick question just for clarity, is the Contract Monitoring Branch, is that within

the Division of Program Integrity, or is that parallel to you, or is that within you? I'm just trying to get clear on how that's set up.

MS. DUDINSKIE: Yeah, it's in a different division. So I'm the Division of Program Integrity, that is a different division, but we do work very closely with them just because a lot of the things that come through with prepayment or with post payment audits, that sort of thing, that really is a program integrity function. So we work really closely with them, but the Compliance Branch is actually a separate division.

MR. BALDWIN: Okay, just a lot of overlap, but a lot of coordination it sounds like.

MS. DUDINSKIE: The Division of Program Quality and Outcomes, they are a part of that branch --

MR. BALDWIN: Yeah.

MS. DUDINSKIE: -- or that division, I'm sorry.

MR. BALDWIN: Okay, great. Thank

you.

MS. SCHUSTER: Well, this has been a wealth of information, and what we'll do is to make sure you all get the PowerPoint. I also will send out to you again because we have that provider complaint form and I think I sent it out generally before, but we will also send that out to you. And we appreciate all the time and effort, Jennifer, that you've put into this. That's really, really been helpful. And your willingness to give us your email address.

MS. DUDINSKIE: You're very welcome, my pleasure.

MS. SCHUSTER: Thank you. We're going to have to move along quickly here. I know that Veronica Judy Cecil needs to get off before probably we're going to get to her on the agenda. She did put in the chat that, and, Veronica, you'll send your PowerPoint and also the link to the recording of your last stakeholder meeting.

MS. CECIL: Yes, I most definitely will do that.

MS. SCHUSTER: All right, thank you

very much. And that's on the unwinding, and we're still going strong on the unwinding. So all of you all as providers, keep reminding your folks that if they get that request for information because they're going back and recertifying people and, you know, covering them for that period that they were not covered. And I think your emphasis now is you're going to be taking on a lot of child cases; is that right, Veronica?

MS. CECIL: So the -- just our first round of unwinding and restart of renewal cases ends in May, so May renewals will end all of the ones we had to implement as part of unwinding. Our child renewal cases, if people remember, the flexibility we implemented was we automatically renewed them and pushed them 12 months continuous coverage. Those will actually start in September is when they'll start coming around and children may be up for their first renewal since the end of the public health emergency, and they will have to go through an actual renewal for

redetermination of eligibility.

MS. SCHUSTER: Okay. Yeah, that's very helpful. So we will look for your slide deck. As always, very educational, and we like to track the progress that you all have made, so we appreciate that. Thank you.

MS. CECIL: Thank you.

MS. SCHUSTER: A status update on the 1915i SMI -- I call it waiver, it's actually the SPA. And for those of you who were not aware the department sent out a 19-page response to the comments, and it was sent out last Friday. I don't know, Leslie, are you reporting on this?

MS. HOFFMANN: This is Leslie, Pam should be on. If she's having trouble --

MS. P. SMITH: I'm -- yeah, I'm on.

MS. HOFFMANN: -- getting on, I can take it.

MS. SCHUSTER: Okay.

MS. HOFFMANN: Pam, I just thought you might want to --

MS. P. SMITH: I'm on, can you all hear me?

MS. HOFFMANN: -- while you're on, you can do --

MS. SCHUSTER: Yeah, Pam's on.

MS. P. SMITH: Yeah, I was going to ask Dr. Schuster, if you don't mind, I can give -- I'll give updates on this one and on 10, and then I actually can give something on 17 really quick because I am traveling on the way back from Nashville, so -- from a conference.

MS. SCHUSTER: Okay.

MS. P. SMITH: So the 1915i, yes, we did send out the response to public comment on, let's see, last Friday. And so it also indicates on there, I think it's the last column of the public comments, it indicates if that comment, if it resulted in an update to the SPA. We're not going to post it again until we get the approval from CMS just to avoid any confusion or multiple versions if somebody were to save it, but certainly, if there's questions, people can, you know, email us, and we'll -- we can, you know, we'll still answer questions.

But we submitted the SPA on the 30th

to CMS, so it is in CMS's hands now. We had a pre-meeting with them on the 26th and they are very excited to get it. We were very excited to submit it, so now we are waiting. The next step will be a 15 -- about -- and I don't know that it will be exactly 15 days, but about a 15-day call we will have with CMS after -- from the 30th since they received it.

So we're looking forward to that and working with CMS. And then, you know, we are forging, you know, on ahead looking at, okay, now the regulations, what we need to do to get, you know, the providers, all of the steps that we can do between, you know, now and until we actually receive, you know, official approval from CMS. So we're very excited about that and the progress that we've made moving forward.

So I'll pause first and see if there's any questions about that update first before I move on.

MS. SCHUSTER: Yeah, Pam, that's great information and not what I was expecting. I had heard, you know, via the

Frankfurt grapevines that there had been comments made that CMS was getting a number of these 1915(i)s submitted, and they were going to have some kind of group call with the states that were submitting them and that they might be looking at revising their guidance.

MS. P. SMITH: Well, that grapevine knows different information than I do --

MS. SCHUSTER: Oh, well, that's --

MS. P. SMITH: -- so that is not what we have heard.

MS. SCHUSTER: -- wonderful. Well, that's -- I'm very excited about that because when I heard that, I thought --

MS. HOFFMANN: Dr. Schuster, this is Leslie.

MS. SCHUSTER: Yeah.

MS. HOFFMANN: They have been doing that related to the reentry for the waiver.

MS. SCHUSTER: Well, I knew that.

MS. HOFFMANN: The 1115s they had so many.

MS. SCHUSTER: Yeah.

MS. HOFFMANN: Yeah. We've had two

joint meetings on those, and I would just mention real quick, Pam, that CMS is very excited that we're a state --

MS. SCHUSTER: We may have just lost Leslie.

MS. P. SMITH: I was going to say, I don't hear -- I think we -- I didn't know if you lost me, or you lost Leslie.

MS. SCHUSTER: No, I think we lost Leslie. Maybe she'll come back on.

MS. P. SMITH: Okay.

MS. SCHUSTER: So the word that you have, Pam, is that there were -- were there a few changes made?

MS. P. SMITH: There were a few changes, I believe there were about four changes that were made. A lot of them they were more kind of clean up. Like, there was some language referencing support broker that I think it had gotten -- that needed to get updated to say case manager since there's not a participant directed option --

MS. SCHUSTER: Right, right.

MS. P. SMITH: -- in this waiver. And I don't have the other ones, I

apologize, I don't have them in front of me, but like I said, it does -- there is a specific column on the public comment that does --

MS. SCHUSTER: Yeah, yeah. I went through I saw, and they were mostly -- so the eligibility has basically remained the same -- the eligibility criteria for --

MS. P. SMITH: It has, yes. The eligibility criteria remained the same.

MS. SCHUSTER: For both the overall SPA, and then also for the separate eligibility for the --

MS. P. SMITH: Specific services.

MS. SCHUSTER: -- housing?

MS. P. SMITH: Yes, so all of that has remained the same. And what I tell everybody is remember this is the first, you know, this is our out of the gate as we, you know, begin the first step in this very important waiver, and does not mean that we won't change things and revise things going forward because, you know, that's the whole entire quality improvement process. And we, you know, we will -- but, you know, getting

it on the ground and started, most important step, and I'm sure we'll have lessons learned that we decide, you know, things that we want to improve and change as we roll it out and, you know, as we implement it, so.

MS. SCHUSTER: Yeah, all right. Well, that is really good news. That was much better news than I had -- so that grapevine in Frankfurt was erroneous, and as Leslie started to say that must've been still the information about the reentry waivers, so --

MS. HOFFMANN: Dr. Schuster, this is Leslie again, I apologize, I lost connection as I was speaking. So, yes, we've been working on streamlining our reentry which I can give information about that at a later date since we're running late, but what I wanted to say was CMS is very interested in what Kentucky is trying to do with two authorities through an 1115 and an (i) trying to meet the holistic care of the members here in Kentucky. So they're excited to be working with us on this

initiative.

MS. SCHUSTER: Right, right. Well, that's good news all the way around. Thank you.

Pam, you were going to talk about --

MS. P. SMITH: Yeah, the waitlist, I think, is the next --

MS. SCHUSTER: -- the waitlist, yeah, No. 10.

MS. P. SMITH: -- so I'm going to skip down.

MS. SCHUSTER: Yeah, thank you.

MS. P. SMITH: So right now -- so we have four waivers right now with a waitlist. I don't have the -- most of these individuals are receiving -- for ABI LTC, if they're receiving services on another waiver, most of them on the ABI acute, a couple on HCB, but there are ten right now on the ABI LTC waitlist. SCL, there are a total of 3,493. The majority of those, 3,423, are on future planning. Michelle P., it is up to 9,076. We are continuing to allocate months -- or slots monthly. Our partners, VDID, as the operating agency, do

that, and they allocate about 75 slots a month.

I've talked before about kind of the interesting phenomenon that we -- when we allocate slots, about 50 percent of those we end up, you know, going back into the -- after we wait, you know, the required amount of time to, you know, locate people, to allow people to respond, to let, you know, all the steps to happen, we still have about 50 percent of the slots where they go back into the pot of slots that can be reallocated. And then, HCB, we are at 2,189.

Now, one thing, and actually, it is as of today, May 1st, our waivers -- the new waivers became effective with the unwinding from Appendix K. So we are working to -- that means our waiver years are going to start over, so earlier than what they typically would've been. So we're going to be on a new waiver year clock. They're all going to be starting on May 1st which means all of those vacated slots that were kind of hanging -- you know, that were out there

waiting to see, you know, that the individual, you know, maybe had stopped services because either they chose to, or, you know, they were in the hospital, you know, something happened where they had been out of the waiver for 60 days. So that slot was vacated and was essentially still assigned to them even though they weren't using it. Those normally don't get reallocated until the start of the waiver year which, you know, with each waiver had its own unique waiver year.

Well, since today begins the -- you know, since it's May 1st, all of the waiver years starting over, we're going to get to reallocate those slots. So what does -- that means that we have enough that the ABI LTC waiting list will be cleared. HCB, I believe we may have -- still have some individuals left on that waiting list, I don't have the count. And then, you know, as far as SCL, Michelle P., we talked about Michelle P. We're continuing to allocate monthly for Michelle P., have been -- for several years now we have been doing that.

And then SCL, you know, we allocate based on emergency basis.

And at any point in time, anyone, whether you're not on the waitlist yet, or you are on the waitlist, and even in the future planning category, you can request an emergency allocation to be evaluated. So I'll hope -- we'll send out more information about that.

Another thing that I want to say that's not really related to the waitlist, but since today is May 1st, there's been a lot of confusion about some of the changes. For example, LRI and therapy services in particular -- and I know, Mary, you have this on the agenda. We are communicating to the providers. We realize today is May 1st, however, as we said in the recordings about its appendix K unwinding, as well as what we've been speaking about for several months, do not change anything until we send you further guidance. There's going to be trainings that come out for the ABI, the change to the state plan therapies. There's going to be trainings that come out, there's

going to be a transition plan that comes out.

Same thing with the -- for PDS or participant directed services for the legally responsible individual exception process, there will be trainings, and there will be a timeline that is sent out. So as of today, nothing changes, everybody should continue as is. If your plan ends today or in the next week or before that guidance comes out, you should continue as is. So that means you would do a new therapy plan through the waiver provider just like you are today in ABI or ABI LTC. It means that no employee should stop work or that nothing should change in the participant directed programs.

We are continuing to see more therapy providers, the ABI providers, sign up as independent therapy providers or as a multispecialty group provider, so we've seen even more providers sign up and get their numbers. If anyone is having trouble with that, they've been reaching out to us, and we've been working with Jennifer's great

team in program integrity and in provider enrollment, and they've been working individually with those providers to answer questions and to help them to onboard.

And then, Mary, I'm not sure, I think this -- the last part of ten I think is what you and I were -- was that ABA intervention plan implementation? I need more details about that. That was the one we were trying to remember exactly what it was when you and I talked last and neither one of us could remember what it was, and then when I saw it on here, I'm like, that's what it was. So I just need a little more information about what that item is.

MS. HASS: Pam, this is Mary. I'm doing a survey of all the providers because I did not know exactly that you all were going to have a transition and another provider sent me that letter that went out on May 25th. You answered one of the questions the providers had, they had a meeting on Friday. And what happens with someone who is being certified this month? And I think the way I understood you say is

that you just go on as usual because one of those people is my sister. Um, so --

MS. P. SMITH: Yes, they should continue as normal -- as usual.

MS. HASS: Because they have not gotten anything, like, when they request the -- because she was certified. She got the thing that she was recertified, but her plans have not been approved, and usually we get that about the same time, so I will speak to her therapist and say, as of right now, they continue on.

MS. P. SMITH: Yes.

MS. HASS: One of the questions the providers were having: What's the status on behavior counseling? Is that also going to have to be gotten through the state plan also?

MS. P. SMITH: So it has been an expanded state -- that service has been an extended state plan service since the waivers began. So there has been no change in, like, counseling. The counseling that is offered through brain injury, when you look at the definitions in the waiver, and

you look at the requirements, you know, what -- it's different than what the state plan is. It's very much -- it's different than therapy when you look at how it is structured in the waiver and how it is structured in state plan. But there's not -- you know, we did not do any specific communication around those services because that's not a change. That has been in effect literally since the waivers were written. That's how those services have been administered --

MS. HASS: Okay --

MS. P. SMITH: -- and expected to be held -- done.

MS. HASS: -- that's one of the things -- maybe if you would send some guidance out to the providers because that was one of the things -- and I'm only the messenger here. So that was one of the things --

MS. P. SMITH: I know.

MS. HASS: -- they were concerned about. Again, you know, like I said, 'cause I didn't even know until another provider

shared that letter of the 25th of what was exactly going on. So I think many of the concerns I'll be happy to see because surveying I have a graduate student who's working on the surveys is that one of the questions that they have not -- one of the questions -- the one thing is where do we go? That's one of the questions I have because the person who's providing the therapies right now has stated to me they will no longer provide those therapies and it will be very cumbersome to expect her to get them at a hospital.

I don't think it'll be -- and then the two other ones -- so I think maybe -- and again, this is only a suggestion or that you then, you know, say or in that guidance with the behavior counseling and supports is that who are the folks that we anticipate -- and that might be something you're already thinking about doing. But I think that's one of the biggest unknowns is where folks are going to go because it's going to be very unrealistic to think that being able to transport these folks when they've had the

luxury of the therapist coming to them, working with them in their environment and their surroundings which you will not get if you have to go to a hospital or a standalone therapy entity that -- those types of things will, to my knowledge, is what's giving me the biggest heartburn. Because when we started in 1998, it was really intended to be a rehab waiver, and so it gives me pause to think that that will not continue.

So I pray that, you know, that we can work through this and that we can still keep that integrity and the intent of when the waivers were first started that they be a rehab waiver, so we'll see how it goes with the guidance. And, you know, so I'll tell people to hang tight, but those were questions that were brought to me, and I did say we were having the meeting today and that I would pass them along.

MS. P. SMITH: Well, and like I said, there is no -- has been no change in the behavior of the counseling and those services. There has not been any intended change in those services.

MS. HASS: So then the person that she's currently receiving the counseling from, there should be no interruption in that service?

MS. P. SMITH: As long as it continues to meet the service definition in the waiver, then there should not be.

MS. HASS: It has been for two years, so I assume it will be. So that -- that would be my point. So anyway, okay, thank you, Sheila; thank you, Pam.

MS. SCHUSTER: Yeah, very helpful.

MS. P. SMITH: Okay, and then really quick, Dr. Schuster, I will say on 17, about the consumers and family members navigating medicated and waivers --

MS. SCHUSTER: Right.

MS. P. SMITH: -- we have just recently formed a cross-cabinet workgroup that's taking a deep dive into the eligibility processes. Part of the desired outcomes of that workgroup is development of resources and tools, as well as looking at, you know, really taking a case beginning to end and looking at everything an individual

has to do to navigate the eligibility process and all of the rules. And where can we streamline things? Where can we make things easier? What kinds of resources can we develop?

And then, you know, as I mentioned, I sent you all of the ones we have today related to waiver. We are looking at reviewing those and revising those. But I will put in the chat the waiver help desk, the email, and the phone number that anytime anybody has, you know, a question specific to waiver, they can reach out to the help desk.

The individual, you know, they may not have -- if they don't have the exact information or cannot answer the question, they will capture everything and make sure it gets to the right person. So a lot of times they can answer the questions, but if they can't, they have -- you know, they have escalation points and they can make sure that we get the individual connected to whoever needs to answer those questions or who would be best to answer those questions.

MS. SCHUSTER: Okay, that's very helpful. I've been farming out the documents that you sent to a number of the other TACs and to a number of organizations and individuals, so I'm trying to gather some feedback in terms --

MS. P. SMITH: That would be -- if you would share that with me when you get that --

MS. SCHUSTER: Yeah, absolutely. Okay.

MS. P. SMITH: -- that would be very helpful because we, you know, obviously want them to be user-friendly, and to be, you know, helpful so.

MS. SCHUSTER: Right, yeah. All right, thank you very much, Pam.

MS. P. SMITH: All right, thank you all so much.

MS. SCHUSTER: Appreciate it, yeah. Leslie, you want to give us a quick update on the reentry waiver?

MS. HOFFMANN: Sheila, this is Leslie, and I actually have Angela on. I believe she's going to give the update.

MS. SCHUSTER: Oh, great. Hi, Angela.

MS. SPARROW: Good afternoon, everyone. Again, just try to do a brief update. We did receive some information from CMS just really recently as of this week. So what we've learned this far again is that they are still planning to move forward with the bundled approval approach for states. And so, right now, again, Kentucky is being considered in that initial first group of bundled approvals, and that could be as soon as before July 1st, which is exciting. And again, you know, what we had hoped for for a quite timely approval if we really again kind of stayed in the guardrails of the letter and request.

And so they've set some updated information that we're reviewing. We've got to review our budget neutrality again, and again, kind of a template that they've provided to make sure that we stay within that and meet all of those requirements. And so we're just again as of this week received that, going through that

information, collecting our questions so that we can have some discussion and negotiation. So I would say again we've really kind of approached that negotiation phase with them and may move quickly in terms of the approval.

So again, we just always keep everyone in mind, even when we receive an approval, that does not mean that's a go-live effective date. So again, we're anticipating at that point in time that we do receive that, it's 180 days that the state has to submit our implementation plan. We are planning and hopeful again through the work that we're doing that we can do that before that time frame.

And then, of course, once that's submitted to CMS, it is their -- back in their hands for an additional review. And once the implementation plan is approved, then the state can move forward with the actual implementation and go live.

So again, it's just one step forward in the process, and we're thankful for that, so we'll keep you updated. Hopefully, again

we'll have some more responses in conversation with them very quickly.

MS. SCHUSTER: Well, that sounds like good news, Angela.

MR. SHANNON: Yeah.

MS. SCHUSTER: We meet again in mid-July, so it's possible that we'll have an approval by then. Is that possible?

MS. SPARROW: It is, yep. Well, fingers crossed. That's, you know, that's -- anyways what we're hopeful for and the direction we're headed. So we've got to work through the negotiations, and again, it's a quick time frame to do that, but we absolutely are, um --

MS. SCHUSTER: This is such a huge, huge step forward for our people who are incarcerated and have particularly substitutes disorders, but also, mental health issues to be able to provide those services. And Steve will faint that he'll have a reentry TAC that actually will have something to talk about, so that's great.

MR. SHANNON: Right. That'd be nice.

MS. SCHUSTER: Yeah, thank you, thank

you very much. Leslie, since you're available, do you want to tell us what's happening with mobile crisis, please? Thank you, Angela.

MS. HOFFMANN: Yes, ma'am. What I have to say today might not be what you want to hear since the general assembly did not fund our waiver -- our mobile waiver -- I'm sorry, our mobile crisis program, we had to take a step back. We are reevaluating things, like start dates and how we will fund going forward, so give me just a little bit of time, Sheila, and I can give you more information about that, but that's kind of our answer for today.

MS. SCHUSTER: Okay. So there's no -- I thought I heard something about being hopeful that it would happen sometime between November and the first of the year.

MS. HOFFMANN: Yeah, so we were thinking October to January looking more at January of 2025, but I don't want to give any specifics out today until I can get just a little bit farther down the road with finances and to figure out how we're going

to move forward and the different options that we do have.

MS. SCHUSTER: Okay.

MS. HOFFMANN: And we're working on that as we speak.

MS. SCHUSTER: Oh, I'm sure. We were all concerned about the budget items not being in there, in either the House or the Senate or the final budget. So any questions from anyone on that?

(No response).

MS. SCHUSTER: I don't know if Jonathan Scott is on, he's really done a great job on the BHA reg.

MR. SCOTT: Hello, Dr. Schuster.

MS. SCHUSTER: Oh, hi, Jonathan. Oh, I thought I was praising you in absentia. Nice to see you. We do appreciate all of the many meetings that you've had and all of the revisions. Do I remember is this going before ARRS in May?

MR. SCOTT: That is the hope that it will be on the May 14th meeting of ours.

MS. SCHUSTER: Okay. And what's the actual start date for it? I've forgotten at

this point, Jonathan.

MR. SCOTT: At this point, we would be contemplating a June effective date. It would go -- after ours, it would go forward to -- the bulk of the regulations would go forward and would be seen on the agenda of the June health services interim joint committee.

We are pushing some provisions of the BHA out to July 1st, 2025. We're also adding some extended timelines for the amount of time that folks are going to be able to be BHAs depends on the type of graduate program they're in, whether that's a less than 60-hour master's program, a more than 60-hour master's program, and then there are a few direct doctoral students that we also wanted to make sure we're accommodating.

MS. SCHUSTER: Okay, so we're looking at a year from now, you know, assuming that the reg goes along without any hiccups?

MR. SCOTT: Yes.

MS. SCHUSTER: Yeah. Any questions from anyone? This has been a topic of

discussion here.

MR. SHANNON: Yeah, Jonathan, can we get a copy of the final version that will go before ARRS?

MR. SCOTT: Yes, yes, I will send it to you. I'm going to -- I will send you the final version. It's drafted, we're looking at just a couple more dotting of the i's, crossing of the t's, have a little bit more feedback that we might listen to, but hopefully, I can get you a copy of that this week.

It's going to be a change to 15005, which is the definition reg, and then it's also going to be a change to 1044. And so it's going to look a little bit different because it's an agency amendment, so I may also try to send you kind of a draft version of what it's going to look like just in the document as well.

MR. SHANNON: Okay.

MR. SCOTT: It could be a little bit tricky to read.

MR. SHANNON: All right, appreciate it.

MS. SCHUSTER: Yeah, that would be very helpful, Jonathan. I'd like to be copied on that as well.

MR. SCOTT: Perfect.

MS. SCHUSTER: But we do appreciate your work and the collaborative nature of your work. I think you've reached out and heard from people that you hadn't thought that you would ever hear from about this.

MR. SCOTT: I've enjoyed it, it's been good. It's been a good series of discussions.

MS. SCHUSTER: Good. All right. Well, thank you. Is Justin on to report from the website dashboard on provider patient no-show data?

MR. DEARINGER: Yes, ma'am, how are you?

MS. SCHUSTER: Fine, how are you, Justin?

MR. DEARINGER: Good. I think I gave Erin some information from that. Erin, do you have that?

MS. BICKERS: Sorry, I can't even unmute myself. Yes, I'm sorry, I'm trying

to get my other screen to share. My apologies.

MR. DEARINGER: So we have a bigger report, but the information got kind of crossed up, so this is just a few snips from the overall larger report. Of course, everything's kind of real time in the no-show data, you know, portal, but so -- so far, we've had 89,941 no-shows reported, and I think this was '23 and '24. 64,573 of those were no-shows with no reason. So that left us with a 72 percent rate of no-shows that had no reason for the no-show.

Of those, the top providers were occupational therapists, I had 11,500; optometrists, 9,288; dentists, 6,500; physicians' group, 6,100; and primary care/rural health which are -- kind of had to share a provider type with 4,292.

MS. SCHUSTER: And those were the numbers of providers in those designations that reported no-shows?

MR. DEARINGER: That's correct. Well, that was the number of no-shows --

MS. SCHUSTER: That was a number of

no-shows --

MR. DEARINGER: -- reported by those providers.

MS. SCHUSTER: -- by those providers, okay.

MR. DEARINGER: Yep. So we took this, it's kind of an interesting graphic. We took a look at -- we mapped all the different no-shows from highest to lowest. Well, not highest to lowest, but from highest to -- like the highest 25 and kind of put them together. And so this is -- or 25 to 45. I can't remember what they did, but this map shows where they were mostly located, and as you can see, most of the no-shows occurred in the Louisville area.

MS. SCHUSTER: Hm.

MR. DEARINGER: Louisville Metro area.

MS. SCHUSTER: Yeah, by far it looks like.

MR. DEARINGER: So as you know, you know, we're reviewing some possible reduction methods. One of those, we're still working with community health worker

services, and as that gets up and going, some of the things that they're working on working with the Department for Public Health to work with community health workers on educating patients on the importance of calling and rescheduling appointments. For community health workers, calling no-show patients and determining what specific reasons -- you can see, we have a 76 percent don't know why they didn't show up.

And then also, assistance in appointment scheduling. One of the issues that came out was for some of the -- 23 percent that were reasons, conflicting appointments was an issue, or too many appointments in a confined amount of time. And so community health workers can assist in scheduling appointments and prioritizing appointments, and canceling appointments and rescheduling appointments. They can also assist in transportation services, which targeting an area where we're lacking which is the Jefferson County area, that should be fairly easy to do.

MS. SCHUSTER: Right. Yeah, it's a

pretty concentrated area to be looking at.

MR. DEARINGER: So -- absolutely.

MS. SCHUSTER: Yeah.

MR. DEARINGER: Looking at the next slide there, we have, you know, we're still working with some providers, and we've got some -- as we work on the new billing system, we're going to do some outreach -- provider outreach through the MCOs in the future to provide the importance of provider participation and outreach to patients, whether they use CHW services, whether they use somebody in their office, to really bolster that 73 percent number and try to determine exactly why people aren't showing up so that we can get them assistance and educate patients on how important it is to make those appointments or reschedule those appointments.

And then, the last thing there on that slide is we've -- or on the next slide, we've got several projects that we're looking at various ways and reaching out to other states, some workgroups, no-show workgroups, that we're trying to get

information and data on what other states have done to reduce those no-show rates and to increase provider participation, and patient, you know -- a reduction in patient no-show status.

So hopefully, in the future, we can have some more ideas to float out on some changes. A lot of those meetings, we're supposed to have some recommendations pulled together before January 1st of 2025. And once we get a more compounded report put together, we'll make that available as well.

MS. SCHUSTER: Justin, obviously behavioral health providers were not in your top five or whatever we're particularly interested in. You know, it seems to me that reaching out to providers to reach out to their patients, but we also need to reach out to providers to get them to report to the no-show portal, right?

MR. DEARINGER: That is correct. So it's -- we've had a little -- again a little difficulty trying to piece together because as you know, our provider types are broken down and it's hard to piece out which

providers or -- you know, we've kind of got to do it by codes --

MS. SCHUSTER: Right.

MR. DEARINGER: -- and then try to see what codes are billing which way so that we can really pull out the behavioral health pieces. It's difficult to do because we have physicians that do behavioral health, we have physicians' assistants, APRNs, you know, we have therapists, we have all kinds of different people doing different behavioral health services.

MS. SCHUSTER: Right.

MR. DEARINGER: And then, you know, rural health clinics and FQHCs, and so trying to piece that together with which ones no showed for what reasons is a little more difficult, but it's something that we have discussed and something we're working on as well.

MS. SCHUSTER: Yeah, that would be great. Because way back when, you know, this is before you got the dashboard set up and I don't know that you were the one that reported. I mean, this was a couple years

ago there -- it seemed like there was a subset of behavioral health patients that you had some data on. So --

MR. DEARINGER: I'd have to go back and look and see if I can find that. I know we've had some -- again we're working on trying to pull those individuals out, and to pull those actual behavioral health appointments out --

MS. SCHUSTER: Right.

MR. DEARINGER: -- and see how many of those appointments were actually no-shows. Again, it's a little more difficult because behavioral health doesn't have its own set provider type like a dental or optometry would, so it's spread across multiple provider types, but we're working to see what we can do.

MS. SCHUSTER: Yeah, and Valerie Mudd, who's our consumer rep here, has suggested that getting a call to remind people about appointments is really helpful. And I don't know how many providers have the staff or the wherewithal to do that as well.

So Erin has your slides, Justin, and

we'll send those out to folks; is that all right?

MR. DEARINGER: Absolutely. If you have any questions or anything --

MS. SCHUSTER: Okay, because there was a --

MR. DEARINGER: -- I'll put our division email address in the chat.

MS. SCHUSTER: Great. There was a request in the chat, so thank you very much, and thanks for that report. Yeah, Dr. Theriot says it's better if a person calls and not a machine. Yeah, I agree with you, Dr. Theriot.

I want to just for a second, under new business, we are looking at this issue of how do consumers and family members navigate their way through Medicaid and then find their way to the waivers. So I'm going to be sending out some of Pam's documents and getting some feedback on those.

We also had another new business item that I wanted to bring to the department's attention, and this came from several provider groups about one of the MCOs

sending a letter, just a blanket letter to their providers saying that they were cutting all behavioral health reimbursement rates by 25 -- 20 percent, which as you can imagine came as very unwelcome news. And I guess I'm curious about is that okay? Do MCOs have the absolute right just to send blanket letters to their provider networks and say, you know, across the board all the behavioral health rates are going to be cut by 20 percent? Does anybody from Medicaid want to field that question?

MR. DEARINGER: Well, this is --

MS. HOFFMANN: Dr. Shuster --

MR. DEARINGER: Go ahead.

MS. HOFFMANN: -- this is Leslie. I think if Jennifer's still on, she might be able to start the conversation.

MS. SCHUSTER: Yeah, I don't know.

MS. PARKER: I don't think she's still on. This is Angie Parker, director of quality and population health. A lot of it depends on your contract with the MCO.

MR. SHANNON: Right.

MS. PARKER: And you also have to,

you know, make sure you review your contract that you have with that MCO. You do have -- you can negotiate that with the MCO as well. You do not have to accept it, but in general, yes, they can send that to the providers that they are changing your contract. They have to give you 30 days notice.

MS. SCHUSTER: Okay.

MS. PARKER: But they should provide in that where you can discuss this with them, any notification.

MS. SCHUSTER: So that should have been in the letter right, Angie?

MS. PARKER: Yes, ma'am.

MS. SCHUSTER: Okay, I have not seen the actual letter, so we'll need to go back and -- and it's -- I'm hearing this from the psychological association and the social workers, so I wonder if it's going out primarily to, you know, private providers -- individuals because I don't think we've --

MR. BRENZEL: If I may, this is -- if I may, this is Allen Brenzel, I apologize. I was -- what we're aware in Department of

Behavioral Health is a letter went out from a provider to non-par providers suggesting that until their contracted they had previously paid their full rate, but that they were going to pay a decreased rate until they became in-network providers. And that may be -- it would be I think important to figure out who got the letter and what were the terms of the letter.

MS. SCHUSTER: Oh, okay, that's very helpful, Allen. I had not understood that. So you're saying that it went out to providers who are out of network.

MR. BRENZEL: That they would -- that was -- that's our understanding in behavior health. We were part of a meeting where one of the MCOs had suggested that they had considered that move. I was not aware that the letter had gone out but that they had an issue where providers were not incentivized to join their network if they could receive the full rate without joining the network. And so that they had made some decision to not pay the full rate and decrease it by a percentage until they had joined and

until --

MS. SCHUSTER: Okay.

MR. BRENZEL: -- they had become part of their network.

MS. SCHUSTER: Okay.

MS. HOFFMANN: Sheila, this is Leslie. I did see a letter that Jennifer and I were cc'd on, and I believe there was a small paragraph that talks about if you are in disagreement with the amendment, there's a small section in the letter, if I remember correctly about four paragraphs down --

MS. SCHUSTER: Okay.

MS. HOFFMANN: -- I did see language in there. I can't speak to what Dr. Brenzel's saying, but I did see a letter that Jennifer and I were cc'd on.

MS. SCHUSTER: Okay. Yeah, I'll check. The one letter that was discussed with me came from a provider who I think was in-network, so I'll have to check that. So --

MR. BALDWIN: Yeah.

MS. SCHUSTER: -- there may be

several different -- Bart, you have something to add here to this mystery?

MR. BALDWIN: Yeah, yeah, just you know, I would. So yeah, the one I'm aware of is they were in-network, and they were a multispecialty group. So it wasn't an issue of being non-par or not, they were in-network and had been in-network -- sorry, was getting a phone call. And was not just an individual practitioner, so -- and it was a 20 percent, and -- which, of course, I encouraged them to fight and push back on that reduction.

And I think that -- so obviously, that's an individual provider issue with their MCO and with their contract etc., but I think and the broader issue is with our current environment, you know, the lack of providers and lots of providers having waiting lists to receive services, to get services, to bring new people in, and I don't mean SCL and the Michelle P. waiting lists --

MS. SCHUSTER: Right.

MR. BALDWIN: -- I mean, pick a plan,

bill MCO, you know, services.

I think it raises an issue. That kind of reduction, you know, obviously, the provider can accept which is highly unlikely because we talked about rates already, you know? A 20 percent reduction is unsustainable, but for those, if they pulled out of network and stopped serving that MCO clients -- or members, then those members who are currently receiving services will stop. Because if they go to another provider that is taking -- is in-network for the MCO, they'll be put on a waiting list.

So I think the bigger issue is access to services for the members, in addition to the obvious with the provider negotiations. But, you know, 20 percent's a huge reduction, and so I think if the provider's left to not doing that, then those current patients will be left without services. And all practical purposes, you know, for all practical purposes --

MS. SCHUSTER: Yeah.

MR. BALDWIN: -- they're just going to apply somewhere else and be on a waiting

list.

MR. SHANNON: And, Bart, this is Steve Shannon. If I remember correctly, when I heard there was really no communication prior to this letter, right?

MR. BALDWIN: No, this was pretty -- the one that I'm familiar with was pretty much an out of the blue, here's a letter, we're going to reduce your rate by 20 percent below the Medicaid fee schedule.

MR. SHANNON: Yeah.

MR. BALDWIN: So, yeah, it wasn't a -- and that's, of course, when I encouraged, well, find what precipitated this. Is there --

MS. SCHUSTER: Right.

MR. BALDWIN: -- it wasn't as a result that I'm aware of from an audit or an egregious waste, fraud, and abuse, or anything like that that would precipitate this type of move.

MS. SCHUSTER: Yeah --

MR. SHANNON: Yeah.

MS. SCHUSTER: -- and I think it's one of the larger MCOs, one that has a good

number of Medicaid --

MR. BALDWIN: Yeah.

MS. SCHUSTER: -- members.

MR. SHANNON: Covered lives, yeah.

MS. SCHUSTER: Yeah, covered lives, so it's going to be a real, real issue in terms of access to services.

MR. BALDWIN: Yeah.

MS. SCHUSTER: So I think we will carry this over. You know, each of us could go back to people and encourage them to fight it and so forth, but let's put this on the agenda for our July meeting as well.

Do we have any recommendations for the MAC for their May 23rd?

MR. SHANNON: I don't know about some recommendations, Sheila, but we had a lot of conversation today about the pre and post payment audits. It was great information that was shared and great PowerPoint. I mean, is it a recommendation appropriate for -- can that be synthesized to a single page so providers can get quick access to it and what are the expectations?

MS. SCHUSTER: So would your

recommendation be that Medicaid develop a provider letter?

MR. SHANNON: A provider letter or provider guidance?

MS. SCHUSTER: A provider guidance -- provider summary?

MR. SHANNON: Yeah, yeah.

MS. SCHUSTER: Of pre and post --

MR. SHANNON: Sure. It sure seems like a lot of people did not know the details. You know, I'm still struggling: 30 days, 45 days, 30 days just seems like an opportunity to be confused, but having it down in writing, and I think that will help maybe address some of the questions we have about audits.

MS. SCHUSTER: Well, and I think the fact that there is now a -- each MCO has to have an approved set of procedures --

MR. SHANNON: Yeah.

MS. SCHUSTER: -- to know, and that's new since January 1st. So, yeah, you want to make that in the form of a motion, Steve?

MR. SHANNON: I will move that the recommendation from the BH TAC to the MAC is

Medicaid develop provider guidance relating to the audit process, pre and post audit process.

MS. SCHUSTER: All right, do I have a second from one of the voting members of the TAC?

MS. MUDD: I'll second.

MS. SCHUSTER: Thank you, Val. And all of those in favor of sending that recommendation to the MAC, signify by saying aye.

(Aye).

MS. SCHUSTER: All right. And opposed, like sign.

(No response).

MS. SCHUSTER: I think it passed unanimously. Thank you, Steve, I think that's a good recommendation for us and a good follow-up from this.

We are way over time, and I appreciate all of you hanging in here with us. I think it's been a good meeting. I guess it's good that we didn't have our report on the study of behavioral health rates because we would be meeting far into

the evening. I'm a little bit ambitious about the length of our agenda I think.

So I will adjourn the meeting by acclamation since we're over time, but our next meeting is July 11th and we will have the study on the behavioral health rates. And we will get out to you all and also make sure that you get the information from the chat because Pam also put in the email address and the phone number for the waiver help desk which is a helpful thing.

And so I thank you all, and I hope you all pick a winner on Saturday -- well, actually on Friday for the Oaks. You know, we've gotta support those lady horses, and for the Derby. So thank you, all, and thanks to Erin and Kelli for your help, and thanks to the DMS staff who have hung in here and have presented such good information for us. You all take care.

MR. SHANNON: Thank you.

MS. SCHUSTER: Meeting is adjourned, thank you.

(Meeting adjourned at 3:22 p.m.).

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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 May, 2024

Tiffany Felts, CVR