DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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THURSDAY, SEPTEMBER 12, 2024
2:00 P.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Sheila Schuster, Chair
Steve Shannon
TJ Litafik
Valerie Mudd
Tara Hyde
Misty Agne
Mary Hass

MS. BICKERS: Good afternoon. This is Erin with the Department of Medicaid. It is not quite 2 o'clock and we are clearing out the waiting room so we will give it just a few minutes before we get started.

Dr. Schuster, it's 2 o'clock and your waiting room is clear and TJ is joining us now. So ready whenever you are.

MR. SHANNON: You are muted, Sheila.

DR. SCHUSTER: Thank you, Steve.

Erin, did you see Mary Haas or Tara Hyde?

MS. BICKERS: No, ma'am. I will keep an eye out for them.

DR. SCHUSTER: Okay, great. But we have a quorum, so thank you very much.

And good afternoon, everyone. This is where the PA system comes on the plane and says this is the BH TAC, if you are on the wrong plane, you still have time to depart. But we are glad to have you on.

I am Sheila Schuster, Executive Director of the Kentucky Mental Health Coalition and chair, and we welcome you all.

Let's see. Let's have the voting members -- Steve, I see you first. Would you introduce yourself, please?

MR. SHANNON: Yeah. I'm Steve Shannon, the Executive Director of KARP, Association 1114. Glad to be here.

DR. SCHUSTER: Great. Thank you very much. And I think Val, I saw you next.

MS. MUDD: I'm Valerie Mudd. I am with NAMI Lexington, and here participating as the consumer voice for people who are living with mental illness like myself.

Misty?

MS. AGNE: Hello. I'm Misty Agne. I am a manager at Frazier Rehab, representing the brain injury and stroke patient populations, and a provider.

DR. SCHUSTER: Great. Thank you very much. And TJ?

MR. LITAFIK: Hello. TJ Litafik, NAMI Kentucky.

DR. SCHUSTER: Great. Glad to have you.

And I didn't hear from Mary or Tara so they may be on, but we do have a quorum. So the minutes of our July 11th meeting were sent out in advance and I would entertain a motion for one of the voting members of the TAC for their approval.

MR. SHANNON: So moved.

MS. MUDD: I'll second.

DR. SCHUSTER: Val, all right.

Any additions, corrections, omissions?

MS. BICKERS: My apologies. Can we have all voting members on camera, please?

DR. SCHUSTER: That's right. That is the open records.

MR. LITAFIK: It keeps wanting to put me in driving.

DR. SCHUSTER: We saw you briefly. There you are TJ.

All those in favor of approving the minutes signify by saying, "aye".

TAC MEMBERS: Aye.

DR. SCHUSTER: Thank you very much.

We sent in a recommendation to the MAC at their May meeting and when we met in July, we had not yet received the reply. I think it actually came after the July meeting. And I circulated that to the voting members and to the others who typically attend these meetings and I am wondering if you all feel like our question was answered. We had made the recommendation that Medicaid provide written guidance to providers about the pre- and post-payment audit procedures and how each MCO is implementing the process. What we got back was the information based on the language and the MCO contract about what the MCOs are supposed to do, and the fact that providers would be given 45 days to submit the documents.

I would like to open it up for a minute and Tara, welcome. I see that you

are on. Thank you.

MS. BICKERS: Dr. Schuster?

DR. SCHUSTER: Yes.

MS. BICKERS: Mary has also joined us for the record.

DR. SCHUSTER: Right. Thank you very much. So I would like to open up for a minute or so. Not only to the voting members of the TAC but to others in attendance who are providers to see whether it gave you enough information to know what to expect in the case of a pre- or post-payment audit, and if there is additional information that you would like to get from DMS.

MS. GRIMES: Yeah. Could I have a copy of that?

DR. SCHUSTER: Yes. I sent it out to everybody that is on my list. Do you have a copy of it there, Erin?

MS. BICKERS: I don't. But if you give me just a few minutes I can pull it up.

DR. SCHUSTER: Okay. It was sent on July 12th.

MS. GRIMES: I am a provider and I don't remember seeing that, and that would be very helpful to me.

DR. SCHUSTER: Yeah. I don't think -- just to clarify, I don't think that DMS sent it out to providers. They sent it back to the BH TAC.

MS. GRIMES: Okay.

MR. SHANNON: And Sheila, Kathy Adams has her hand up.

DR. SCHUSTER: Kathy?

MS. ADAMS: Hi, Sheila. I guess I'm a bit confused by the response. Because it says that DMS will prepare written guidance in the form of provider education. So I'm hoping that the language they gave us isn't all they are going to give us. Does that make sense? I'm hoping they are going to give us additional information and that they are just cut and pasting what they already have available in this letter, but that there is more to come, but perhaps we need to make sure there is more to come.

DR. SCHUSTER: Okay. That is

very helpful, Kathy. That was kind of my feeling as well, because we were specifically asking for written guidance in the form of provider information. And getting the contract language with the MCOs, I'm not sure. In fact, we asked about how each MCO is implementing the process. I mean, part of what I think we were looking for was some guidance, as well for providers if they feel like an MCO is not following those guidelines. They lay out the parameters in terms of how the MCO will notify the provider in two days through multiple modes of communication, and the specific reasons for the review and so forth, and I -- my impression from providers is that they're not always getting that notification.

MR. SHANNON: Yeah. I thought we were trying to hope to get some guidance of how a provider can respond to the audit and what recourse do they have in the process.

Is that correct; Sheila?

DR. SCHUSTER: That is what we

had talked about. And I don't -- maybe we didn't ask it in such a way that that was clear. And to your point, Kathy, it has been two months, now, since they sent this original response and we've not gotten anything else.

MS. ADAMS: And I do think that what they provided seems to be specific to prepayment audits. And I think we need additional information regarding the entire audit process and then, again, who do you reach out to when there's problems? I know they have got that complaint form, and I know that Jennifer Dudinskie, when she gave her presentation, was kind enough to offer up her assistance. So, yes, I'm hoping we would get additional guidance from Medicaid on the audit process, because -- I have more to say, but our members continue to be inundated with audits, and just the difficulty in when you try to file an appeal, and we've got examples where the MCO doesn't follow the rules. They are required to respond to an appeal within 30 days. They can ask for

another 15 days on that, but we've got examples of them not responding for 60 days or more to an audit request, and there are no repercussions for the MCOs when they don't follow the appeals process. But if a provider doesn't follow it, they lose their appeal.

MR. BALDWIN: And Sheila, if I can jump in. This is Bart, real quick.

I think the other piece is a lot of what we received recently on the audits for Medicaid was around when Medicaid does an audit. That is, at least, my experience with our clients. That is a rarity. It is really the MCO audits and when they don't follow the -- the 30 days, I've been continually hearing that the provider has 30 days to respond, and they tell that to the MCO and it is basically ignored. So now you have 12 days or you have 8 days. So being able to contact someone at Medicaid to help get that resolved -- and then we don't hear from Medicaid for months on end either. So I think it's really about the MCO audits and

what is the recourse for, you know -- I'm being repetitive here, but the recourse for the provider when the procedures are not being followed? Bottom line.

DR. SCHUSTER: Yeah. Yeah.

MR. BALDWIN: Thank you.

MS. TURNER: Can I jump in here as a provider?

DR. SCHUSTER: Yes.

MS. TURNER: So in this -- and I realize this is directed at prepayments. If the MCO provided a claim on these submitted documentation lacks evidence to support the service or code, I have on my desk a recoupment request where WellCare is asking -- or trying to recoup on months worth of therapy services because the date of birth is not used as the identifier. So at our agency, the only requirement is we use a valid identifier. So in our agency, we use the name and the social. So to me, that also needs to be addressed. Timelines are an issue.

We've had three or four audits since August the 16th, all of them have

had seven- or eight-day turnaround times, and then also, just like Kathy was saying, the timelines for them to follow through -- I have an example of one where we did an appeal, and we didn't hear back for seven months.

MR. OWEN: Stuart Owen from WellCare. Who was that who was speaking? I'm sorry. Was that Susan?

DR. SCHUSTER: That was Susan.

MS. TURNER: This is Susan Campbell Turner with Children and Family Counseling.

MR. OWEN: And those were all regarding WellCare; is that correct?

MS. TURNER: The one about the date of birth was WellCare, and we also had three or four audits from WellCare since August the 16th; yes. The one about the seven months was actually not WellCare, so --

MR. OWEN: Okay, good.

MS. TURNER: -- congratulations.

MR. OWEN: A little bit of information there. So that particular

audit that we've done, it's ending September 23rd, and it should be -- we definitely get 15 days, I believe we agreed to do an 8-day extension as well. And I know that there is an option to do remote. There are several options, but one of them is to do remote, that if you permit -- it's our vendor -- access to your system -- your EMR system -- they can actually do it. They can pull it. They can do the legwork, so to speak. That is definitely an option out there. But you can ask for an extension, as well. But it will end September 23rd.

MR. SHANNON: What will end September 23rd?

MR. OWEN: This particular audit. This particular audit, medical record audits of behavioral health providers. And it's with a vendor named Datavant.

MS. WILLIS: Is this the risk analysis?

MR. OWEN: Yes. Risk adjustment. You know, basically, it's

critical to capture all the diagnosis, you know. That's one of the things in care management, for example, making sure that that we capture all the diagnosis for all the members. So we understand the acuity and we can refer them to case management, for example. So it's critical to know that.

MS. ADAMS: And Sheila, what Stuart is speaking to, is the information that the Children's Alliance has gathered from their members on this particular audit. I don't know if you are ready for me to talk about that yet. You may want to get a little further down, I'm not sure, but just let me know when you are ready for me to, kind of, respond to Stuart about this current audit that is going on with WellCare.

DR. SCHUSTER: Well, let's go on and do that. That's number five on the agenda, follow up on audits.

And Kathy, I know that you had gathered some data, and I see that Jennifer's on from Pathways, and has also

been in touch --

MR. SHANNON: They had the same situation.

DR. SCHUSTER: Same situation, yeah.

Kathy, do you want to talk about your data while Stuart is on here?

MS. ADAMS: Yes. That would be wonderful.

So the Children's Alliance started hearing from members in, I guess, around August 19th, 20th, around that timeframe, that they were receiving all these audits from WellCare. And so the Children's Alliance reached out to who we work with -- the WellCare reps. We gathered some information, expressed our concerns, and that's when we were advised that folks could have a 15-day turnaround instead of the 8-day turnaround. But just compilation of the information that we received from our members, to put in context the burden of some of these audit requests that are being placed on providers, we received feedback from nine

of our members, and 53 -- they had received 53 different requests on behalf of WellCare participants within the last ten months, and at least 35 of those requests were received within seven days during the month of August. Those 53 record requests asked for records from 1,744 clients. And we are talking that they are asking for at least a year's worth of records. In some instances, it was up to 18 or 20 months of records.

Of the 35 requests that were received in that one week in August, they asked for records of 1,302 WellCare clients. And again, most of the timeframe requests were for a year, but some went up to 18 to 20 months. So we have had difficulty finding out the purpose of all of these audit requests, and why so many records are needed. The only explanation given is that the purpose is to collect all current diagnosis codes in the patient's medical chart to best ascertain the health status of the patient. So we have all these providers scurrying to pull

records on over 1,700 clients, and that's just from nine of our members. It's my understanding that all kinds of providers have been hit with these requests.

So again, we had members that had difficulty when they reached out to Datavant to request an extension. Many did not want to grant an extension, and we do appreciate the 15 days, but we had some members that had over 190 client records requested, and you can't pull records for 190 clients for a year in 15 days. You just can't do it.

MR. SHANNON: No.

MS. ADAMS: We have not had any positive feedback. They sent all this information in and it's like, it goes in a black hole. You never get any response on what you can be doing better, any of that. So it's just, again, this is just one example of WellCare audits. In the meantime, our members have other audits coming in, and again, we are concerned with the frequency of these audit requests; the number of records being

requested; the short time that providers are being allowed to provide the records. It's like they don't have anything else to do. The extensive audit timeframes that they are requesting -- 20 months of records. Confusion and duplication in the records that Datavant specifically requested. We have some members that have one request for 145 records, like on August 16th, and then the next week they got another request for 145 records. They've had others where there were duplication between those that they requested, and it has been very difficult in getting responses from the Datavant representatives. And again, just the confusion around why are we having to do all of this?

So I think that kind of summarizes the concerns, but we have gathered all of this information. I have given -- compiled the information. I have provided it to our WellCare reps. I have provided it to Sheila as per the behavioral health chair, and I have also

provided it to Medicaid.

DR. SCHUSTER: Thank you, Kathy. I see we have Dr. Patel on who is the Chief Medical Officer of WellCare.

Welcome, Dr. Patel.

DR. PATEL: Yes. Thank you so much.

So let me first start by saying that we, WellCare, apologize putting undue extensive and so much burden on the provider. That's never the intent; right? But let's just talk about how we got here; right? There are no BHPAs; right? So we don't have a very good ability on our side to understand practice patterns, understanding if our members, who we are, you know, responsible for being good stewards of the state dollar. That is our role. We have no ability to see that; right? So this audit, while it appears extensive, and it is, and I apologize for the undue burden, it helps us to understand if the whole cohort, the whole panel of the eight providers in this ecosystem are practicing evidence-based

guidelines, doing what is in the very best interest of the members that we are could instead of.

And it helps us understand, should we be advocating for more services, or having discussions with DMS about, maybe, some services are being over utilized, or maybe they are being inappropriately utilized. Are we seeing the clinical outcomes? And so, while you guys are delivering the care at the point of delivery, we are also in the background making sure that the several hundred thousand members that we are all, you know, are here to serve are getting the right thing. And we are not the only ones doing this. The other MCOs are doing this as well. So while I appreciate you calling us out, it makes us feel pointed and special, we are not the only ones who are doing this.

MS. ADAMS: If I could respond. I am not hearing complaints from my members about any of the other MCOs requesting records to this extent, at all.

And that was, in fact one of our questions. If this is required of all the MCOs, then why aren't members getting -- providers getting requests from the other MCOs? I have a couple of examples. But my examples are, they are requesting one or two records.

DR. PATEL: In response to that, I would say WellCare, as a steward of the state's dollars, it is our job to have extensive rigor and due diligence around ensuring that the members that we serve get appropriate, timely, and correct services, and that is the essential reason for the audit.

Once again, and this will be the last statement I will make, we apologize for the undue burden that we caused providers, but that is the reasoning that we do what we do.

DR. SCHUSTER: Let me ask you, Dr. Patel, and thank you for being on. We appreciate the apology. I guess my question would be, when we hear from providers that they have asked for

extensions, for instance, and they are not being granted, do you have a response to that?

DR. PATEL: I do. Respectfully, we can take each example, one by one, with the provider. We can give you a number today.

Beth, can we make sure that we have a one-to-one contact -- and we can handle that.

Respectfully, I don't feel like it is appropriate to bring an individual complaint about individual cases in a forum like this. If there are individual cases, I think Stuart, myself, we have always made ourselves readily available to contacts, expeditiously, to help make sure we expedite the care of a member. We've never been a barrier to the care. So while you are saying that you have examples, we have not seen the examples.

MR. SHANNON: But you asked for the information, Dr. Patel, so you know how much the volume you've asked for. What percent of people accessing

behavioral health services, that are being audited, you know, 12, 18, 20 months -- you acknowledged yourself, it is an undue burden. You said it yourself. Is there a better approach? A better way to do this that you can -- because --

DR. PATEL: Yes. There is a better approach. There is. We have, in multiple venues, asked for partnerships to think about having certain parts of PA turned back on. We have talked about different mechanisms of oversight, because there is not any PA. So this is not --

MR. SHANNON: But have you thought about a sampling methodology that doesn't have this large volume and has sufficient time? Because I think if -- the data from Kathy -- I've heard similar data from CMHCs -- very comparable -- Pathways is on, they've had the same -- I think it was 400+ records --

MS. WILLIS: We had over 800 records.

MR. SHANNON: Excuse me?

MS. WILLIS: We've had over 800

records.

MR. SHANNON: Over 800 records from Pathways.

DR. PATEL: Respectfully --

MR. SHANNON: Go ahead, sir.

DR. PATEL: We are doing what is in the best interest of the member; okay? And I think we can take back a different methodology, and we've said that this is ending September 23rd; right? Because there is a time defined end point for this in the next round, because, obviously, at some point, one day in the future -- cannot determine when -- there will be another audit. We can ensure that the burden is not un-towards. However, what I will say, is there was a reason that this was done. There was a data element that we wanted to see to ensure that, again, putting the member first, and the responsibility of the MCO will be a good steward of the tax dollar of the Commonwealth, to ensure that our members are getting the right service, at the right time, and in the right amount, which

is what we are here to do as part of the audit. So it is my full belief that all of us need to be fully engaged in that exercise, and because there is no ability for there to be BH outpatient PA, we are not all fully engaged in that process.

So I apologize, once again, I think this is the fourth time -- we are definitely apologetic for the burden, however, this won't be the last time that there will be an audit.

MR. SHANNON: Right. I appreciate you being apologetic, but the reality is, we are fully engaged in the process by submitting you hundreds and hundreds -- if you look at two CMHCs, Pathways, 1400 cases, 1400 files. We are very involved in the process. We are just thinking this is, again, an administrative cost, it diverts licensed people, staff, away from their duties to perform these functions; okay?

I just think that this is a venue to discuss -- as opposed to just using prior auth, which is the answer that

you are putting forth, do you need 800 files?

DR. PATEL: No. I agree --

MR. SHANNON: You've determine the pattern. Do you need 600 files to determine the pattern; right? Can you send WellCare staff on-site?

MS. ADAMS: We can.

MR. SHANNON: I think, again, that is a mechanism to move forward so we can participate. In reality, and I've said this for years, this is becoming a huge function that we are copying records, we are sending files, sending information. There has to be a better way and there has to be an effective sampling method than this large volume.

MR. OWEN: Real quick. I want to say real quick about the on-site. We actually do. I'm looking at the letter. We offer to go on-site. Just as far as that. We actually do offer to go on-site and do that. We also offer remote where the provider gets access then Datavant will do the actual retrieval, so I'm just

putting that out there, those are a couple options that's in the letter.

DR. PATEL: And I will end with this. I appreciate, I acknowledge everything you are saying, but let's just remember how we got here. The BH outpatient utilization in Kentucky is one of the highest in the country, but yet we don't see the clinical outcomes to match. In our due diligence to find out why this is occurring -- well we have many hypotheses, you probably have many hypotheses, too -- but in the spirit of time, to get to a place where we have appropriate utilization for the appropriate service for a great outcome for the citizens that we are responsible for, we are searching for data. Again, we are several --

MR. SHANNON: You are getting data. You are getting data. There is no reason to search. I just think it's burdensome.

DR. PATEL: I will end my comment there.

MR. SHANNON: It takes away from the mission of the behavioral health organizations.

DR. PATEL: But you don't have any thoughts --

MR. SHANNON: Higher rates than other states, maybe we do, you know, that's because we focus more on their individual needs, and we try to move forward. We can debate this for a very long time, but I just think, again, an excessive number of records, in a short period of time with no feedback provided, what is it? It doesn't seem collaborative to me.

DR. PATEL: I will end with: Let the record reflect that WellCare has formally apologized for the asserted burden of the pulling of the data files.

DR. SCHUSTER: And we appreciate that, Dr. Patel. I guess we are a practical, lets work together for solutions, and while this may end, here, in about two weeks, it's going to come up again.

MR. SHANNON: Yeah.

DR. SCHUSTER: And we are just trying to figure out a way to avoid this excessive burden, as you have described it, and we appreciate that, while still all of us wanting the outcomes and so forth.

So Bart, I think you had your hand up, and then Nina, and then we will probably move on.

Bart?

MR. BALDWIN: Yeah. So just point of clarification. I think that's what we are looking for is a solution and a commitment that the excessive work burden won't be there in the future, and we can find a better way to gather the data that is in the due course of the delivery of services and billing, but it doesn't require such excessive time.

And I want to go back to a comment that you made, Stuart, a couple of times, just for clarification. Your comment around remote -- explain that to me what you mean by remote.

MR. OWEN: Yeah, yeah.

MR. BALDWIN: That they would access the medical record system within the provider? Is that what you are referencing?

MR. OWEN: Yeah, literally the vendor, because I'm looking at the letters. Like, you contact Datavant and set it up -- you actually set up Datavant, where the provider would give them access, Datavant, maybe you have concerns about that, but that is an option. Literally, it says contact Datavant about how to do that, and so the Datavant staff would pull the records, and it does mention, as well, on-site chart reviews, where they can come on-site and do it, as well. I don't know if anybody has tried the remote thing. But it is an option. I'm looking right at the letter. You would have to have staff that gives them access, there, and sit there, but the Datavant would do the retrieval of the medical records.

MR. BALDWIN: But you can't do that without opening up your entire

system.

MR. SHANNON: Correct.

MR. OWEN: Right. You would have to sit there and open it up and give them access and everything.

MR. SHANNON: Yeah.

MR. BALDWIN: Okay. All right.

MR. SHANNON: Sounds like a breach --

MR. BALDWIN: I hear what you are saying as an option, but I don't know how realistic that is in terms of somebody being willing to open up their entire digital medical record system, for everybody. Not just for -- because you are getting clients that are not WellCare clients there.

MR. OWEN: Oh, that? It says secure, I mean, it says secure, and honestly, I don't know the details. But it says secure. I'm sure it would be HIPAA compliant. I don't know the details, but it does say, "secure, remote, DMR retrieval," but honestly, I don't know the details.

MR. BALDWIN: Okay. It's worth looking into. It sounds like it's not being utilized.

MR. OWEN: I'm assuming it's not.

MS. WILLIS: I can tell you that our attorneys said absolutely not.

MR. SHANNON: Not the attorney, the IT guy; right, Jennifer?

MS. WILLIS: Yes.

MR. OWEN: Because of HIPAA concerns?

MS. WILLIS: Yes. There is no way to let you just enter a certain chart. You're in the entire chart.

DR. SCHUSTER: While we are on this, I see this from Tracy, but I've also heard this from numerous other providers, that when they tried to contact Datavant about any questions -- Jennifer, I think you have this issue, too, they are not responsive.

MR. SHANNON: Rita Harpool. Her comment as well. She is trying to raise her hand:

"I wish I could figure out but... Datavant doesn't even want notes from mental health providers."

DR. HARPOOL: Hi. I am Dr. Harpool with Hope & Healing in Western Kentucky. Sorry. I couldn't figure out how to raise my hand.

I just recently learned this and after having all of these chart reviews. I've contacted Datavant several times during these chart reviews, but for whatever reason, this was the first time I had been given this information. The representative wanted me to have the notes or have the information turned in a certain period of time. I told her that that just wasn't possible, because I'm kind of a one-woman show here, and that wasn't enough time. And I explained to her how many notes that would be, and she said:

Well, what kind of doctor are you?

And I said, a psychologist.

And she says: Oh. You are

behavioral health. You don't need to turn in all those notes. We don't want all those notes. She said: What we want from behavioral health is we just want for each client, and for each patient that we listed, to send in a one-page summary that has -- and she gave me four items that needed to be in the summary -- a diagnosis, a functional treatment plan, if it existed, a prognosis, and there was one other thing, which I can't remember off the top of my head.

And I told her -- I said: That would be very helpful to know, because that would save me a lot of time. I have never been told this. I've been sending in all of these notes for all this time now, and nowhere in your four-page document that you faxed me requesting this information, does it say anything about behavioral health needing to provide it in a different kind of format. I said: Nowhere does it say that. What you are sending me appears to be material for a medical doctor.

She apologized for it not being in the paperwork. And she said: Yes, you are correct.

And then I requested that they send me something in writing saying that this is all they require of me. I haven't received that yet, but this conversation just happened last week. I went to the MCO, the Medicaid forum in Owensboro, just this week, I think it was on Tuesday, and I talked to WellCare, there, about that as well, and I spoke with Medicaid about that. But that's information that I certainly didn't know.

DR. SCHUSTER: Yeah.

MR. OWEN: Yeah, and I'm looking at the request for medical records to ensure that it properly reflects the clinical condition, so it clearly says the record, but, diagnosis, what you talk about is number one. I mean, it doesn't say anything about the summary, because it has to be documented in the medical record. I mean, the diagnosis.

MS. ADAMS: And doesn't WellCare

get the diagnosis on every claim that's submitted?

MR. OWEN: If it's reported. If it's reported. Not all diagnoses are reported. We absolutely see that where they don't report the diagnoses. And I think that's part of this. Looking at the medical record, is there indication of given, you know, diagnosis, but it is not captured, you know, in the claim? We absolutely see that. Our providers may report the primary diagnosis, but not secondary or third diagnosis, for example.

DR. SCHUSTER: Let me go to Nina, because she has been very patient and has had her hand up for awhile.

MS. EISNER: Thank you. You know, sitting here listening, we don't do as much outpatient work as we do inpatient, but it is the responsibility of the payers and providers to ensure that the medical care that is provided -- the behavioral health care that is provided, is appropriate to the patient, and verifiable through the criteria or SAMSHA

or other criteria.

I'm just wondering, based on the fact that there was a comment from someone at WellCare, I think it was Dr. Patel, that you aren't seeing outcome data. The hospitals working with CMS on the HRIP program, came up with a variety of outcome measures, which are required to be reported on a very regular basis, and are the basis for continued ability to secure the funding and participate in the program. And I'm wondering if, perhaps, the MCOs and some of the providers can come to terms and, you know, audits are going to happen. The last thing I want to see happen is go back to prior auth for behavioral health. That was a nightmare. But I think we have to come up with some way to verify and report that our care and treatment is appropriate and achieving the outcomes that are determined to be proper and required.

So, I guess, just as a way of tying it up in my mind, I'm wondering if that might be an important step.

DR. PATEL: Yeah. I can respond to that, if you don't mind. That is a fantastic point. There are two types of outcomes; right? There is the clinical outcome that we would measure, as a whole clinical outcome; right?

MS. EISNER: Right.

DR. PATEL: Did they have an admission or did they get better from their diabetes, like a chronic condition manager; right? And I think in BH, sometimes it's a little harder to measure, but there are definitely NCQA-based, patient-reported outcomes, there are a bunch of things that we can all agree upon. We have never gotten to that point, because I think we stay in the weeds instead of going macro sometimes as a group, and what we are seeing on our side is exponentially increasing utilization of what we would call lower-level clinical services, but very important services. Nobody is disputing that wraparound, lower-level, clinical services are not important. They are very important. But

what is equally important is that core-clinical service has to be gold standard. And what we are seeing is the core-clinical service is not always evidence-based, and then the wraparound services are increasing, you know, exponentially, like Space X, to the moon, and then what we are seeing in return is not a decrease in inpatient utilization, ER utilization, we are seeing often polypharmacy. We are seeing tons and tons of adverse utilization. We have tons of kids on psychotropics. Multiple psychotropics without one of the medications at a sufficient maximal dose. That is not good clinical care. For us to make sure that you know, nobody likes to hear this -- broad waste and abuse. To make sure that our pediatric members are not on polypharmacy. Our adult members are being navigated to the right long-term destination of care. Because these are long-term patients now, right? Are they getting the right long-term level of service? Not more and more service. So,

yeah, we would love to have an open discussion about these things, but for us to have a good barometer of what is actually happening in the marketplace with our members, we need to have some insight. And the audit, really, is the only way for us to have that insight without having some circumscribed level of PA on for outpatient BH services. You know, it's my purview that if we had some, not all, outpatient BH PAs on, then the level of audits would go down exponentially, as well, because then we would have dialogue around which services should have PA and which should not have PA. Can we auto-approve things that are really high level, and important to our members, because the things that we are not seeing good outcomes for. Maybe there needs to be PA for -- there needs to be back-and-forth dialogue. Right now, it feels we are at a total impasse in the thing that we are arguing about is the level of audit and the burden of audit. We realize it is burdensome and you

realize it is cumbersome. We want to get back to talking about the member. We don't want to be mired and talking about the audit. We want to be focused on the member. Right now, we are not being member focused.

MR. OWEN: And to add on to that, Nina, particularly, what we would like to see is very targeted prior auth, specifically peer support, psycho-education, we literally have a lot of providers, especially in the addiction sphere. We have hundreds of new providers who have come in and exploited the -- we even asked for authorization after a threshold. But very targeted, two or three services, but we have providers that is what they do, no matter what your diagnosis. You are -- you are addicted to heroin, cocaine, you had fentanyl overdose, you get a ton of peer support, you get psycho-education, and maybe a little something else. You are not getting clinical treatment and the outcomes are worse so it is very targeted

is what we are wanting, what we are looking for, not everything.

MS. EISNER: I think we can come to that. I think we can come to that. One of the metrics and the hospitals is nobody gets discharged on antipsychotics. There is another one that talks about ambulatory follow-up post-hospital care within certain days, or a certain number of days. So we can even marry some of the more higher-level outpatient services to be in correlation with some of the hospital parameters for ensuring evidence-based, clinically-appropriate care, and the outcomes that DMS also wants to see, as we try to move the metric on a healthier population overall, both medically and behaviorally. So I would love to participate in -- I am more of a neutral party, although I won't be neutral if you talk about reinstituting prior auth, but to get a cadre of people together to work with WellCare and DMS to really come up with what are the quality measures that we want to see for the

various levels of care, not just hospital care.

DR. PATEL: So you tell us where to be, when to be, we will be there, in person. Okay? But we have a guardrail as well.

MS. EISNER: Sure.

DR. PATEL: This premise that more is better, unlimited access is better, that has never been born out to be true anywhere in the United States, especially for population health for BH. So as long as we can agree to, you know, a certain set of facts, and not be in a chamber, we will be there open-minded.

MR. OWEN: And literally, it is a business model. It is paraprofessional care, it is low-wage, high-profit margin. They have invaded and are choking out -- we have very good behavioral health providers who give clinical care and the ones who have that business model are choking out, and actually they are very aggressive in marketing to members and that is like what we are trying to

address. We are trying to get our members to the good providers, to the clinical providers, and that's what we why we want targeted PA and not being able to do it has prevented us from being able to help our members to get the good quality providers to get clinical care, or at least mixed in.

MR. SHANNON: Are you concerned about those services, are you auditing all services? Are you auditing all providers? Are you citing those as your concerns, are those providers the first on the audit list?

MR. OWEN: For the data?

MR. SHANNON: I don't think the answer to that question is yes. I don't think the answer is yes. It is -- it is across the board. It is not a strategic approach to the audit process, to address a concern that you cited. It's not that. It's everybody. I would love to have a conversation about how to move forward. I think that's a great idea.

But let's just acknowledge, you

are looking at, across the span of behavioral health is what matters. You are not looking at the ones that you are concerned about besides educational services and peer support services? Are you doing those first? I don't know.

MR. OWEN: No, no. Yeah.

MR. SHANNON: There needs to be a good dialogue give-and-take, but let's just acknowledge it across the board. And I've taken too much time. I apologize.

DR. SCHUSTER: Okay. This has been a great discussion. We appreciate your being on, Dr. Patel, and engaging in dialogue.

MR. SHANNON: And Stuart, good work.

DR. SCHUSTER: And we will take this back and figure out how to go next. I don't know that this -- we talked about WellCare. Obviously, you are not the only ones doing audits, and if you're going to institute some metrics and talk about some metrics for knowing what the outcomes ought to be, it should be across the MCOs.

But I'm going to follow up with what Steve said to you, Stuart. And that is, if you know who the offenders are, I'm not real sure why people who are not doing SUD or not doing the bulk of SUD services are being audited to the extent that they are. And I will just leave it at that.

MR. OWEN: We have done some and we are actually prepaid review and I think that is on the agenda. We actually have lobbied for a lot of things and had very little success. We want targeted PA, or at least off after a threshold in limits and we keep getting rejected, and we think that would really be critical and stave off the audits, because everybody hates audits. Audits don't help, you know, I mean, ultimately that's what we have been told, that you can audit, but the members already had the service and if it's something that they didn't really need -- but anyway. We have been trying.

MS. EISNER: I would just end my conversation with suggesting that as the behavioral health providers on this phone

get together with the MCOs, or DMS or whomever else, that provider representation from the hospital psychiatric and addictions treatment forum also be included, because there are many of those organizations that provide the continuum of care. And, you know, I think that hospitals have become pretty good at -- not to say that you all aren't, that outpatient isn't, but ensuring that there is criteria before a patient moves into a certain level of care, and that there is monitoring for how much of that care is provided at that particular level. I'd offer myself up, but I am sure that their would be others and I would just leave it to say -- by the way, I used to serve on the WellCare Clinical Advisory Committee and it was a pretty robust group, and diverse in its membership, and perhaps something like that -- not just with WellCare, but perhaps for the MCOs globally, because WellCare is not the only group with the responsibility for fiduciary and clinical quality monitoring.

DR. SCHUSTER: Right. Let's go back to number 4, which is our discussion of phase II multistate study. And I shared with you all the recommendations that the BH TAC sent in.

Is Victoria on?

MS. SMITH: Yes, ma'am, I'm here. I am going to share my screen.

DR. SCHUSTER: Thank you, Victoria.

MS. SMITH: And I'm going to share what you sent to me, Dr. Schuster, and I thought we could walk through and just add some notes to this. I think we can take it back and expand on this a little bit. The number one completion -- going back and adding that MD level shouldn't be a problem at all. We have all of those fee schedules and we captured those and going back and looking through them, great idea we can definitely do that. And then looking at the analysis again.

If the ABA or the Children's Alliance would like to send us any

published fee schedules that we can look at for consideration, we would be happy to look at those. Again, we are looking at fee-for-service, and looking at non-population specific analysis in that phase I piece. As you move into phase II, there had been some suggestions to add different populations and whatnot, and we can look at that, but to go back and complete phase I, we will be doing exactly what we did before, we will just be adding the MD level practitioner to that analysis and then we will rerun those tables. So anything you want to forward. If you could forward them either through Dr. Schuster or Erin, I think it's a cleaner way to communicate so everyone has it forwarded to us.

DR. SCHUSTER: Let me just say, Victoria, you can send it to me at kyadvocacy@gmail.com. I will gather it. That's what I have always done. It keeps the flow of information straightforward. Thank you.

MS. SMITH: Yes.

MS. ADAMS: Can I ask if you received the information from Michelle Sanborn with the Children's Alliance? She's not able to be on today.

MS. SMITH: We have received several grids from the Children's Alliance, and we've also received resources from the ABA. Some items that we have received didn't match because of those things that I explained the last time. We are looking at something very specific in this phase I. We are looking at fee-for-service and the very specific fee practitioner level. Some of the information that was sent over by the Children's Alliance and ABA was population specific, and as I explained in the last presentation, we didn't do that in phase I. We are not opposed to doing that in phase II, but that is not part of the phase I work. So anything that you would like to send to us, if it is not straightforward, fee-for-service fee schedules that is included in the survey, then that would be added in to the phase

II work. We are looking at specific populations. Does SSI pay more for a behavioral health diagnosis? Or does SUD pay more for a behavioral health diagnosis? Those types of things will be added into phase II, if that makes sense.

MS. ADAMS: Yes. And is it possible to have a conversation with you, or whoever helps you, about what we sent to find out about what works and what doesn't?

MS. SMITH: Again, what we are using is fee-for-service fee schedules off the Medicaid website of the states that we are looking at. So we are not looking at any kind of added bonus for a particular population. If you remember the phase I study, there were some rates that we found in other states that had a bump because of a Senate bill that went through that state, and they focused on a set of services and so we are going to pay more for those services. Well, we didn't include those in phase I because we don't do that in Kentucky so we are looking at

apples to apples as much as possible in phase I.

Phase II is going to move in to a different scenario. We are going to look at it a little bit differently, if that makes sense to you guys. We are going to go back to phase I, add in that MD level. That's not a problem. I already have all of those resources and that should be a fairly quick task. Once we do that, we are not opposed to adding to this list. You know, we suggested that in our phase I presentation. So this second set, this deeper dive into these services that show either higher or lower in another state, taking that deep dive, and so we do anticipate that these six services, these number of services may grow and so, yes, we will add to that. Adding Illinois and Missouri, absolutely, like I said, my bad coming here from out of state. In my mind, I thought I had all the touching states, and I didn't. So, yes, absolutely adding Illinois and Missouri.

DR. SCHUSTER: Well, they don't touch much of Kentucky, so it's understandable.

MS. SMITH: But Tennessee, we still have an issue with, and I wanted to talk to you about this and help you understand. If we add in Tennessee, we would have to go back and redo phase I, and look at MCO rates. Because you can't really compare an MCO rate to a fee-for-service rate. And then, as you know, we looked at MCO rates because of that negotiation thing that happened, we'd have to look at a lot of averages, I don't think that's going to give us a robust analysis and tell us really what we want to have. So I'm still opposed to adding Tennessee, unless you can give me a great argument, because you are not going to be looking at the same thing. You are going to be looking at two different types of rate. So saying one is higher than the other one doesn't really matter, because they are two types of rate.

Does that make sense,

Dr. Schuster?

DR. SCHUSTER: Yes.

MR. BALDWIN: Can I comment on that?

DR. SCHUSTER: Bart, you've raised this issue. Do you want to respond or ask a question?

MR. BALDWIN: Yes. I think the issue -- the lens -- I think Victoria gets to the lens, the questions at the end of why do the study. I mean, I understand that there is a difference between Medicaid fee-for-service rates and MCO rates, but the purpose, at least in my mind, the purpose of all this is to do an evaluation and analysis. Are the rates in Kentucky adequate to meet those four questions below? And seven border states is a big part of that issue. Competing for staff and competing around the border states, and Tennessee is the majority of our southern border. I realize there is fee-for-service and there is MCO, but the reality is, the MCOs are what pay for these services in Kentucky.

MS. SMITH: And I understand that and can I get through the whole thing and then we will come back to that, Bart? Because I get what you are saying. As we walk through phase II, so far what I am talking about is just adding to that comparative. Does this rate pay more -- like, does a half gallon of milk cost more in Kentucky than Tennessee? We might be able to get there in phase I, but phase II, you are really morphing into a different type of study. This is no longer a rate analysis or a rate comparison. This is an analysis about access, and rates are only one part of access. How far do I have to drive to get to my provider may be part of access, and how many providers in my area might be a part of access. So if we want to, in this next phase of this study, look at barriers to access, I think, then, we have to really to design a more comprehensive study that includes much more than just rates. If we really want to understand the barriers to access, we can do that,

and we can look at that very robustly and then we can say, is it rates? Maybe rates are a component of that, but how far I have to get to my provider is another component of that, and maybe the number of clinical practitioners at the level that I need is one of those things; right?

So I think to answer these four questions, this no longer becomes a comparison of does Tennessee pay more than Kentucky. To answer these four questions, I think we need to really develop something more robust.

I met with Dustin Wall this morning, and what we would like to do is take the next couple of weeks and design that study for you, develop a study that would answer these questions for you, as well as some other questions. Now that we understand that what we really want -- what the real question is, are people having a barrier to service for any reason? Is it how much we pay our providers, or how far we have to drive, or what is it? So if you agree, that is

where we will go next.

I would like to say that over the next couple of weeks, you funnel up to Dr. Schuster, any other outcome questions that we can add to this list in that type of analysis. And then, what we would like to do is take that back and design that study, and bring that study plan at the next TAC, to get your yay or nay on it, and then we will deep dive into that and get you the answers that you want in that respect.

Does that make sense, Bart? I didn't mean to cut you off in the MCO and the fee-for-service question, but to answer these four questions, I do believe it is much more than who pays more; right? There is a lot about access.

MR. BALDWIN: Right.

MS. MARLOWE: This is Mandy Marlowe, sitting here with Bart, just sitting offscreen. He gets the limelight. But want to say, thoroughly appreciate the thoughtfulness of what phase II might look like, and how we might comprehensively

tackle those four questions. But don't want to lose sight of the fact, that while we are looking at those other factors, whether or not you have a provider in driving distance; whether or not that provider can be staffed; we do think those are largely dependent upon rates, upon the resources that we have available.

MS. SMITH: Absolutely. We are not saying to take rates out of it, Mandy. That phase II work would be folded in -- that phase I work would be folded into phase II work. All I am saying is you can't answer the question: Is it a barrier to service? Is a rate a barrier to service? Because that may not be the only barrier to service; right? I'm just saying that we have to incorporate the rates as well as some other things. So the rates would be looked at in phase II.

DR. SCHUSTER: Let me suggest a different way of looking at this, because what you are suggesting, Victoria, is where we want to get, eventually. I guess I see it in between steps. I think what

happened after phase I, is that you identified, and then we identified some tweaking of that first model, that comparison model, and there were some services that were left out. You know, you mentioned the six here. You know, certainly, the IOP and partial and therapeutic and behavioral health services and others. Bart's group is certainly interested in some of the ABA services, and there is some question, I think, that we had raised about are we doing apples to apples in terms of who is providing those services, because I think there was some confusion, initially, about how we were defining the providers. So I guess I am wondering if --

MS. SMITH: And, again --

DR. SCHUSTER: If we might add these services on the list here, these six, and then also, IOP, partial and therapeutic behavioral health services, and maybe there are one or two others, and then kind of go back to that phase I model.

MS. SMITH: And to be clear, Dr. Schuster, phase I will be refreshed looking at all of those things on the top of this sheet. Absolutely. We are going to refresh phase I, and look at these again, with the suggestions that you have given us.

DR. SCHUSTER: Okay. All right.

MS. SMITH: I do want to point out, though, IOP partial hospitalization, therapeutic behavioral health services were included in phase I. There were just some states that we could not compare them to, because they provide them so differently than we provide them. So they are on those original tables, and wherever we can find where the service definition matched, then we compared. So you do have some comparison there.

We don't mind doing that analysis of why they specifically didn't match, we can definitely do a grid that says, why we didn't feel like they were defined correctly. And add those richer definitions in a subsequent. But I am --

and I didn't mean to get off and misstate this, but we are looking at phase I refresh to include all of these concerns that you have. Adding those additional states, re-looking at those numbers, those codes that you wanted us to look at. Looking at those things. Populations are still going to be tricky, because our fee schedule doesn't give an additional dollar amount for a specific population. So those are still going to be difficult to compare, but we can certainly add them to the grid, we are just going to organize them a different way.

So phase I will be refreshed. We will look at the MD level, we will add the extra state, we will add those additional CPT codes, do a deeper dive and give you a better analysis of why we didn't feel like IOP and partial hospitalization matched up. We are definitely going to do all of that work. The only thing I am trying to point out is, answering these questions based on rate alone, will not give you an

understanding of access or barriers to access. So I would just recommend that when we get to that part, we really look at it comprehensively, instead of just saying: Well, if we paid more, then more people would have access.

DR. SCHUSTER: Absolutely.

MS. SMITH: Does that make sense?

DR. SCHUSTER: Yes, it does. I just want to be sure that we are not losing these additional services.

MS. SMITH: No, no, no --

DR. SCHUSTER: So we are really going to have a phase I refresh, as you are calling it. I think that's a good way of looking at it. It's the same MO, if you will. The same study design, but with additional states, physicians, and the additional services.

MS. SMITH: Yes. And I will give you a better analysis of why we couldn't match these.

DR. SCHUSTER: Why they couldn't match up.

MS. SMITH: Instead of just saying they weren't able to be matched, I will give you a better analysis of that.

DR. SCHUSTER: Yeah.

MS. SMITH: So that would be part of our study plan, the phase I refresh.

DR. SCHUSTER: Okay.

MS. SMITH: And then, what I would like to suggest is if you could all take the next little bit thinking about what else you want in that phase II to answer these questions, or maybe we can add a couple more questions to that, that second analysis. If you can get those to Dr. Schuster by September 30th, Dustin Wall and I will sit down and design this for you. And, like I said, bring it back to the TAC and make sure that we are covering all the bases and making sure that we are looking at it the way you want us to. And I will bring back as much of that refresh as we can. We might do that refresh in stages, because I do believe that I can do some of that fairly quickly,

because I already have it. It's a matter of plugging it in and rerunning the data for us. So that, I might be able to get some of that phase I refresh by next TAC. I'm not going to promise, but I will work hard on it. And then we will come up with that plan, and we will show you how we are going to look at it to make sure that you are all on board, and we are not missing any steps, and once we get your blessing I will start that. I am going to tell you that a study like this is going to take months. This is not going to be a quick turnaround. We worked six to eight months on phase I, and we are probably at six to nine months on that phase II analysis, and really digging into some of those barriers to access, even in terms of rate, right? And we will take that Tennessee question back. How do we include Tennessee in that phase II? That, you know, access -- is rates in Tennessee causing access -- a barrier questions for our southern folks? We will bring it into phase II. I just don't think it can be included in phase I,

because of the way that we did the analysis. We would have to start completely over if we wanted to look at MCOs rather than fee-for-service.

Is that good for you, Bart? Is that a good compromise?

MR. BALDWIN: That's good on phase II. I just wanted to point out that if we can find a way because of the border state issue to include Tennessee in that analysis. That would be helpful. Before -- I know a lot of people with hands up, so I don't to dominate, but I do want to answer your one other green question that you have on here, Victoria, around primary ABA codes. That was not meant to be a specific population.

MS. SMITH: Is it just for any kids?

MR. BALDWIN: It is. Any age. In Kentucky, I think this is one of the things in Kentucky, licensed behavioral analysts are in the state plan are primary Medicaid providers, so they can provide ABA services within their skilled practice

for any age population or diagnosis. Not just children -- even though, obviously, ABA is closely tied with young children with autism, but in Kentucky, it is any age -- there are no age limits or diagnosis limits in Kentucky in terms of providing ABA.

MS. SMITH: Okay.

MR. BALDWIN: So other states, they define ABA with autism diagnosis 21 or under, but it's still the same code.

MS. SMITH: Well, it is the same code, but remember we didn't compare codes, Bart, we compared services.

MR. BALDWIN: So it is the same service.

MS. SMITH: And what we found, though, is some of those codes, the 97153 and the 97155, they got bumped. They had a state Senate bill in the state, so they got special attention. You can't compare that to what is in Kentucky, then. Make a note that that state chose to identify that as a concern and gave it special attention, but you can't really compare

it; right? Because --

MR. BALDWIN: Yeah.

MS. SMITH: -- because they pay higher, but they pay higher, but -- again that's in the analysis, that's not in the comparison. Do you know what I'm trying to say?

MR. BALDWIN: Maybe not phase I you can't compare, that but in phase II, you can.

MS. SMITH: Absolutely. And I think what I need to help you guys understand is, we compared those codes. They were left off of the table because they were not an accurate match, so I think what I need to do is add why they were not a match in the analysis for you instead of just eliminating them from the table, which is what I did.

Again, phase I, we were asked to compare rates apples to apples does this pay more than that? Understanding what you are really looking for has helped, because I think in this phase I refresh, we are able to give you much more

information about why something didn't end up on the grid. So you may have found it on a fee schedule in a state that we looked at, and we left it off the grid, and you all are going: Why did you leave it off the grid? We left it off of the grid, because the definition was different, or there was some kind of special circumstance that Kentucky didn't have. So that is the part of the analysis that I want to bring into that phase I refresh, to help you guys understand why we didn't do the comparison. So it's part of the conversation, it's just not part of the comparison. Does that make sense? And I apologize because looking back, I wish I'd have added all of that to the phase I, but again, I was just saying does Kroger pay more for milk or does Savemart? Who pays more? But now that I understand some of the nuances, I will definitely bring that into the narrative and in to the phase I refresh to help you understand what we looked at. Because you are right, maybe that is something that we look at in

Kentucky. This particular population needs special attention. You know, I don't know. I'm not the expert on that. All I can do is bring the information, but I will do a better job of explaining it in the phase I refresh.

DR. SCHUSTER: Let me go on. Nina, then Dr. Patel, and Kathy, and then there was a question in the chat about having somebody from each discipline be a part of this.

And let me just say, as you all can tell by having 134 people on here, I run a very open TAC. Anybody can join and we entertain input from even not voting members. So anybody who wants to weigh in on this and send me information or whatever, I'm open to receiving that.

So let me go on and ask Nina about her question or suggestion.

MS. EISNER: Just a quick question on rates I want to know. Did DMS publish an updated BHSOADE rate schedule in 2024?

MS. SMITH: That I would have to

find out from you. Is anybody on from BH that can answer that question?

MS. EISNER: Or does anybody else know? I haven't seen it, so.

MS. FITZPATRICK: Hi, Victoria. It's Leanne. I'm on the BH team.

MS. EISNER: Hi.

MS. FITZPATRICK: There was a schedule effective July 1, 2024, that is out there.

MS. EISNER: Okay. I haven't seen it. Is it on your website?

MS. FITZPATRICK: Yes, ma'am. I will put a link to it in the chat.

MS. EISNER: Thank you so much.

MS. FITZPATRICK: Absolutely.

DR. SCHUSTER: Dr. Patel?

DR. PATEL: Hey. Thanks so much.

So quick question about the study itself. Is there any way we can have this study if we want to, like, make recommendations regarding study design, what might be considered scope. There are people on the MCOs side, surprisingly,

that are pretty smart with, you know, study design. So given that this is a partnership, we have things that we would like to see as outcomes to help us better serve the members of Kentucky, because we are member-centric, member-focused. So would love to see if that is an opportunity for us to be collaborative in this process.

DR. SCHUSTER: Dr. Patel, I'm going to get a little miffed here. We are collaborative. Every bit of information that Victoria has provided to us is available on the website and to your MCOs. And we welcome their input. I have never sent out a request for information that said I only want to hear from one group of people. So have at it.

DR. PATEL: Perfect.

DR. SCHUSTER: Kathy?

MS. ADAMS: I have a couple of questions. I think the biggest one is what is going to be done with this information? What is it going to be used for?

MS. SMITH: Dr. Schuster?

DR. SCHUSTER: Well, I assume it is information for us to use, for whatever purpose.

MS. ADAMS: I just want to stress that the Children's Alliance would hope that phase I could be done just as soon as possible. You know, this is our top 30 most utilized codes, and we are hopeful that this information as it is clear that Kentucky's rates, at least for these 30 codes, appear to be lower than the surrounding states that were used, and we would like to see phase I completed and move to another implementation of how do we get Kentucky's rates up in comparable to other states. And I think that -- the Children's Alliance thinks that if we can just go ahead and do that for phase I, the top 30 codes, then that would make a pretty significant difference for a lot of providers, because these are your most used codes. So I want to say that.

And then, one other question I had. Well, I'm losing it. Just go on.

That was -- I guess that's -- if I think of it I'll raise my hand again. I apologize.

DR. SCHUSTER: Okay. So anyone else have their hand raised? I can't see everybody. I don't see anybody else.

MR. OWEN: Dr. Schuster? I'm sorry I don't have my hand raised. I thought, and I brought this up on a prior call, you know, as the study shows, as the other ten states don't cover psycho-education as a reimbursable service, it's a part, it's inherent, and DMS raised the rate in 2023 over 300 percent and I thought if you lowered that rate, that you could use that money, because we have absolutely seen providers exploit the heck out of psycho-education. If you lower that rate, those funds can be routed to other services, actual clinical services to incentivize the better clinical quality services. You know, use that money to raise the other rates. So I just want to throw that out there.

MR. BALDWIN: That is great,

Stuart. I just want to say, Victoria, that the rate comparison is not for the -- it is all about access to services. And what you hear from us about the rates is directly tied to access to services and network adequacy. So I think there is no question there are other issues in terms of access, but at this point, we feel like it's the primary issue, certainly 70 percent of the problem, pick your number -- and I think as you increase that, you can -- because it's a recruiting and retention issue. The staff. We are losing staff to other states. We are losing staff out of this field all together. Just giving you a background and context all together for your thinking moving forward. It is all about being able to recruit and retain the staff, because I've heard from many of our clients saying they have lost licensed clinicians with 15 years of experience to work at the Kroger Deli or work at Amazon. We are losing people. The rate is a direct connection to the ability to pay

staff at an adequate and competitive rate or wage. So that's why -- it's not that we are unaware or ignoring the fact that there are other issues in terms of access, but that one, right now, is just the most crucial.

MR. OWEN: And the super high psycho-education is incentivizing a ton of psycho-education, rather than other services, and there's a lot of money spent on that. So, I think, they can lower that and incentivize the other services in the study, that would be a great idea.

DR. SCHUSTER: I guess my question is, and I don't know, Victoria, if you are the one to answer, and I don't know on what basis DMS decides to raise or lower rates. I mean, what prompted them to raise the psycho-education rate 300 percent?

MS. SMITH: Leslie? BH team? You are the experts. Help me out here.

MS. HOFFMAN: Sorry. I don't think you want me to answer that in that I didn't make the final decision, however

there was a justification that was brought forth and we reviewed, and it was a cabinet decision to do that.

So I think one of the things we were trying to do with what Victoria is doing so is to see if we were truly comparable to other states, and when she got into it, it's not apples to apples, which no Medicaid programs are, right? So there's definitely a lot of variations when she was trying to go through that.

Victoria, just going back to what you said earlier, I think it would be very beneficial for you to show you why you didn't include some of those. It's not like we just chose not to or the rate was, you know, there were other reasons why.

So if legislation or General Assembly decides to fund something, like, I think is what happening in one of the states, Victoria, that was something that was pushed forward for additional funds to increase those rates. So I'm just throwing that out there, too.

DR. SCHUSTER: So the follow up question for you then, Leslie, is, would the cabinet -- does the cabinet go back annually and look at the rates and reevaluate them? In other words, you've gotten some feedback now, at least from the MCOs that psycho-ed has rocketed in billing frequency.

MS. HOFFMAN: I don't want to misspeak to what Victoria is working on for the Commissioner but I believe, Victoria, it is something that we are going to try to look at annually; isn't it now? Is that something you're trying to do annually?

MS. SMITH: Yes, we are keeping track of that now, now that we are looking that data, we will be keeping an eye on that. I would like to point out, too, that not all of the top 30 codes were lower than the majority of the other states. I do want to say that. I do want to give us a little bit of kudos on that.

DR. SCHUSTER: There were some nuances.

MS. SMITH: And we did give you -- we did give you a reason why we didn't compare them. I think you just need more information on that. So for those of you who had an opportunity to look at the PowerPoint and then the accompanying workbook, we did add all of those reasons, but I think we just need to help you understand, instead of saying why they didn't match -- why didn't they match? And then maybe you can help us understand that it really does match.

Like you were saying, Bart, it really does match. You're just looking at it wrong. And I am not the expert. I'm just trying to look at the data, redo the manuals, read through the fee schedules, read through the regulations from other states and match it up as best as I can. So we are not saying that we are the experts on this, and we are not saying that -- but I do want to make sure that we understand that all 30 of those codes were not lower -- we weren't lower across the board on all the other states, on all 30

codes.

DR. SCHUSTER: Yeah. I don't think any of us are saying that. People need to go back and look at the PowerPoint, and I guess that leads me to the question because Dr. Patel, apparently, has never seen this, and I don't know whether Stuart has, but he had presented at the last meeting, but where does that PowerPoint reside that you used last time?

MS. SMITH: Erin?

MS. BICKERS: Dr. Schuster, all presentations shared are uploaded on the TAC. So this one would be on the Behavioral Health TAC website. I'm happy to share that with Stuart and Dr. Patel after the meeting.

DR. SCHUSTER: Yeah. So people can always go to the DMS website, to the BH TAC, and look for those presentations that are readily available. Thank you, Erin for the reminder.

MR. OWEN: And I --

MS. SMITH: And I will say, too,

that as far as looking at the rates every year, that DMS did raise 20 of those top 30 services in 2024. We saw a rate increase on 20 of those top 30. So, you know, we are aware, and we do try to look at those regularly, so I'm not trying to downplay the higher or lower comparative issue on phase I, and I do understand that the direct correlation between how much we pay with how many people will do it and all that, I do get that and I'm not trying to discount that at all. That part of the study, though, is going to be easier done in the phase II part of it, if that makes sense.

DR. SCHUSTER: All right. Well, Victoria, thank you for your expertise and your patience with us. I think this has been a good discussion, and certainly, I have a much better feel now that we are looking at a refresh on phase I with many of those aspects, and then our phase II is going to be really focused on the barriers to answering those questions. And again, if somebody wants to put it in the chat,

my email is kyadvocacy@gmail.com and you are welcome to share with me your thoughts about that.

MS. SMITH: Dr. Schuster, you need those by the 30th of September?

DR. SCHUSTER: 30th of September.

MS. SMITH: If we can get those by the 30th of September, then we can get you a project plan for the next TAC meeting and then we will also do as much of that refresh from phase I for the next TAC meeting.

DR. SCHUSTER: That would be fantastic. Thank you very much.

MR. OWEN: And real quick, Dr. Schuster and Erin. I do have the fee -- Dr. Patel isn't on these calls every time and I have it. I apologize. I did not send it to him before, so I do have it for WellCare. Erin, you don't need to send it to me -- the presentation.

MS. BICKERS: Thank you, Stuart.

MS. ADAMS: I do have one more question for Victoria. I hope she's not

gone. And I apologize, I couldn't remember it earlier. Thanks, Victoria and again, thanks to DMS for all of your patience and hard work. We really do appreciate it, and you have done an outstanding job. And I may not be understanding, but I believe I heard you say that there were some -- a special circumstance where a state got extra money or they passed a bill and raised some of their rates. Did I hear that?

MS. SMITH: So those are noted on the tables. It will be noted. It will say that this came off of this fee schedule and SB something. And I would have to look at the table. I'm sorry, I don't have those states in my mind, because there were a couple of them. And there were a couple of states as well that moved some of their behavioral health services to an ASO model. So those we couldn't compare because it was a different delivery model. Those notes are on the original workbook that we sent you. And if you have any other questions,

Kathy, just send them through Dr. Schuster, and I will be happy to clarify.

MS. HOFFMAN: So Kathy is where the state probably had a bill, and then a line item put money in the budget for that specific line item so it couldn't be moved anywhere else, it had to be for that one line item.

MS. ADAMS: But those rates were included in the table; right? They were still compared even though they got a rate increase?

MS. SMITH: Yes. But there was a note saying what we took it off of, yeah.

MS. ADAMS: Perfect. Thank you very, very much.

DR. SCHUSTER: All right. Let's turn our attention to my favorite topic which is the 1915(i) SMI SPA, and I see that our friend Ann Holland is on. Some of you know, Ann Holland has leapt over from Medicaid to DBH, and is heading up that. So where are we with the 1915(i)?

MS. HOLLEN: I have to say, it was kind of difficult to not jump in and talk about the stuff, you know, freshly out of Medicaid and about the fee schedule and stuff since that is what I used to do; right? The fee schedule. But Leslie and them handled it just fine.

Good afternoon, everyone. As Dr. Schuster said, I'm Ann Hollen, I am an executive advisor in the Department for Behavioral Health, Developmental and Intellectual Disabilities. And I am the lead on our side -- it's kind of weird to say, "our side" -- for the 1915(i) state plan Home and Community-Based services.

I just want to level set a little that this state plan is for individuals 18 and older with primary SMI or SUD diagnosis who need intensive support and treatment, but who are living either independently or with support in the community. They do not necessarily have to meet nursing facility level of care, but it is an eligibility process where we will assess them utilizing a

locus assessment tool for SMI ASM assessment tool for SUD, and then a functional assessment tool called the Daily Living Activities 20, where it looks at their functional needs around activities and daily living.

They also have to meet a duration episodic criteria, which is hospitalization for a behavior health condition more than once in the past two years, and either clinically significant symptoms of behavior health that have persisted in the individual for a continuous period of at least two years, or a history of one or more episodes with marked disability and clinically significant symptoms are expected to continue for at least a two-year period. I know that was a mouthful. But the services that will also be included in our state plan amendment are case management, and that means that person is going to manage all care, not just our services. There could be traditional state plan services this person might need or already

have. They will also have that listed on their plan of cares and make sure that they get all that they need. They will also have potential for supported employment, supported education. There are some dollars for transportation, assisted technology, planned respite for caregivers, medication management, in-home independent living supports, tenancy supports, and supervised residential care. With those last three, they also have to meet a risk for homelessness. And we are actually still in the negotiation process for CMS, so we don't have final approval of the SPA, however, we did submit on August 30th, our responses to CMS to their requests for additional information, so we are waiting now for a response from them. So part of the responses that we did amend or actually use to improve our implementation, we aligned the capacity limits for supervised residential care to three individuals for maximum capacity in a home. It said up to four, and that has tended to get some states in trouble,

because it classifies it as a group home, so we amended that.

We clarified the target group by adding the state's definition of SMI, and listing all SUD diagnoses designated in the latest addition of DSM, with the exception of tobacco.

We also changed the requirements for case manager to align with the requirements that are listed in the C-waiver case manager requirements, so it's a little more broad. And then, as I said before, the duration and episodic criteria, that also we ensured that read exactly the way I read it to you. So we are not just sitting and waiting. The next steps in the next weeks and months, we are beginning to work on our system updates with DMS, so we are looking at system changes with the waiver portal, the Medicaid waiver application -- did I say that wrong?

Leslie, you might have to help me here. MWMA is what it is known as.

MR. SHANNON: MWMA, correct.

MS. HOLLEN: Okay. Then, as well as provider-type development, payment, you know, the payment system, regulation development, and then certification criteria for our providers. We are co-developing educational tools, communication strategies, and then community partner collaboration to design and implement of the services.

So that's kind of where we are sitting right now. Any questions? I know I went fast.

DR. SCHUSTER: And, Kathy Dobbins had a question about, is this independent case management?

MS. HOLLEN: Yes. It is independent. It's the same as it is for the C-waivers.

DR. SCHUSTER: Okay. So the case manager needs to be independent of the --

MS. HOLLEN: Independent of the providers, correct.

MS. DOBBINS: A conflict of interest.

MS. HOLLEN: Yes.

MS. DOBBINS: I figured that, but curious.

MS. HOLLEN: Yeah, and as I said, I'll be honest, the focus was getting a response back to CMS. We are looking at a July 1st, 2025, implementation date so we have to get that going. So now we are starting to work on the other pieces.

DR. SCHUSTER: So you are in, kind of, a holding pattern with CMS to see if they have any further questions or anything?

MS. HOLLEN: Correct. But that's not going to stop us --

DR. SCHUSTER: From going on and working on the other pieces.

MS. HOLLEN: Yes. Yes.

DR. SCHUSTER: All right. Does anybody have any questions?

MS. HOLLEN: My email address was the same as it was when I was in DMS. So it's ann.hollen@ky.gov. I asked for that to stay the same, since I was

established with that already. If you do, please do not hesitate to email me. I'm pretty good about responding to my emails.

DR. SCHUSTER: Yes. We appreciate that, Ann. Thank you.

MS. HOLLEN: Thank you.

DR. SCHUSTER: How about a status update on the reentry waiver? Is that you, Leslie?

MS. HOFFMAN: Yes, I'm going to go over that. And I will just mention, too, on the 1950 state plan amendment. It is very simple. You are all used to working with our programs and we have the oversight for the CMS authority and we may contract out with the Department of Behavioral Health and the Department of Aging and Independent Living. So we are partnering with this, so our role in the state plan amendment will be that we are still the CMS authority or oversight in compliance piece for CMS, and we have all been working really well together. It is exciting. Remember, this is going to be a companion to our 1115 SMI for more of a

holistic approach for Kentucky. Very exciting times.

So as far as the reentry, there is some moving parts. I made an entry to go over with. As you may or may not know, we got up approved July the 2nd of this year, for what they call the reentry opportunity, which is much different than what was submitted many years ago as an incarceration amendment for SUD only.

So this one encompasses a larger population, and then has a little bit of a narrower package of services, however, I do want to mention that we are really trying to work with CMS, and that's how we got approved on July the 2nd was to stay in alignment with the state Medicaid director letter that came out in April of 2023, to get that approval quickly so that we have an approval to build upon. So we are very excited that we are moving forward. I do want to also mention, since there is a large amount of folks on here, I get a lot of questions about: Okay, you are approved so when do you go ahead and

implement? Well, there are a lot of things that go into an 1115, unfortunately. There are a lot of things that we have to keep up with, that we have to implement, and that we have to have CMS approval before they let us go forward on the first day. So we have an implementation plan due as we did for the SUD back in '18 or '19, if any of you all remember that. The implementation plan will be due on October the 30th, and we are currently working with our advisory committee now. I think some of you sit on the advisory committee, which is our Kentucky Advisory & Community Collaboration for reentry services work group. We had a meeting last week that really started providing some preliminary gap analysis findings that we're bringing forth.

We have a core team that some of you may already sit on. We have biweekly meetings that discuss any key decision and decision points to make decisions on.

We have a weekly workgroup with

our Department of Corrections and our Department of Juvenile Justice. Just as a reminder, it is a Kentucky implementation, not just Medicaid, so we are working closely with our sister agencies that are outside of our cabinets, the Department of Corrections and Juvenile Justice and assisting them with project management, because this is very, very new to them. So we are working through those things.

We just completed stakeholder engagement, or started earlier this month, to support the mapping of our current state and identifying needs and gaps. Those focus groups included providers, MAT providers, primary care providers, the Department of Public Health, Department of Aging and Independent Living, the Department of Community-Based Services, our MCOs, Department of Aging and Independent Living -- I don't know if I said that one -- and our Administrative Office of the Courts are also included.

We are currently going around right now and meeting with a lot of the

court systems. We have already done training with the mental health courts, circuit clerks, and then we will be doing the Judges' College -- I think on Monday, we will be doing the Judges' College. So I wanted to mention that, and try to share with them the vision of the state and what these opportunities are and what they are going to look like currently going forward.

A couple other reminders that I have been getting questions about. We asked for 60 days because we were trying to stay in line with the state Medicaid director letter to get that early approval with three other states, so we were allowed, with three other states in a cohort, to get approved out of that long group that were waiting, but we can also ask later for additional expansions, but we want to get something quickly to build upon, so we did ask for 60 days prior to release, and that is what is available to us right now.

We are still, currently, looking

at that gap analysis that I told you about and doing a needs assessment.

The implementation plan that I talked to you about that will go in first to CMS, will be high-level, because it will be due at a time that we are really still working on a lot of things we have going here in Kentucky and partnering with our sister agencies.

After the implementation plan, we have to develop monitoring protocols. Those are due in November, and then we also have to develop an evaluation design that shows CMS how we will evaluate ourselves. We have an independent assessor that will handle that -- part of that -- and then we have to report to CMS constantly. There is one other piece to this reentry that we've never had before, and it's called a reinvestment plan, and that is due in December. So if you can hear all the things that I am telling you that are due in the next 180 days, it is very daunting to think about what we've got to get done, but believe it or not, we

are on target, so just keep your fingers crossed and continue to work with us.

The reinvestment plan will be only those services that currently are being covered. We can reinvest those dollars back into the system, so they can't be used for anything else. They have to go back into the reentry system. So as those kind of services maybe later get expanded, those would be more reinvestment dollars that we could have. Right now, we only anticipate the 30-day supply of medication at the time of release to be a piece of what we might be able to reinvest and DOC is covering that right now.

Again, very exciting times. Lots of work to do. And the partnership has been wonderful. I don't know if you all were aware, but we were part of the (indiscernible) collaboration. And I was so very proud, if you saw on our social media, with the Office of Direct Control Policy, the commissioner, Van Ingram, the Commissioner for the Department of

Behavioral Health. Angela and I attended for Medicaid, and we had the Commissioner for the Department of Juvenile Justice all together standing hand-in-hand in Washington DC together, working with other states and collaborating with them and trying to help with best practices as well, to help these states that are coming in after the four of us, if that makes sense. So all very exciting times.

DR. SCHUSTER: Thank you, Leslie.

MS. HOFFMAN: Yes, ma'am.

DR. SCHUSTER: I would ask what services does an individual with an SMI get? What are they eligible for in this reentry waiver?

MS. HOFFMAN: So currently, right now, and I wanted to go over that with you today. They are only eligible for the services that CMS says they can have, that's 60 days prior to release. So that is intensive case management, Medicaid-assisted treatment, if there is an SUD diagnosis, and 30-day supply of

medication, and that includes physical health and behavioral health medications. Once they leave -- let me back up -- during that 60 days, they will be connected with the MCO of their choice, and once they leave, there are things like education, food, housing, all those things that we would expect in the social determinants of health to identify before they leave, and to be aligned for them upon entering back into the community.

So we want them to be successful, we want to help them to have all of the tools that they need in the setting either incarceration or confinement for DJJ youth, and have a one-year follow-up with the MCOs after incarceration. So we will follow up with that intensive-care management for one year after they leave incarceration.

DR. SCHUSTER: So are we assuming that they are getting some mental health services in the prison or in DJJ?

MS. HOFFMAN: Yes.

DR. SCHUSTER: So this would be

adjunct to that?

MS. HOFFMAN: Yes, ma'am. And we are not allowed -- CMS has made this very clear that we are not allowed to supplant any dollars that DOC or DJJ, justice cabinet are currently covering. All individuals have the right or access to mental health services, physical health and behavioral health services. I don't know if you remember, Dr. Schuster, but we met back in 2020 with the services that are out there, and they were growing at the time with Sarah Johnson, which, I believe, just moved over to the Department of Behavior Health. We are so glad to have her in our cabinet, because we worked with her a lot back in the day.

So they have SAP and SOAR. You remember we talked about that with the substance abuse recovery system -- substance use system, and they also have a recovery system, SOAR program. It's been awhile since I looked at that. We don't have that in all facilities, but that is growing, and they should have access to

the holistic need of the individual.

Anyway, still a lot to come, still a lot to learn. And can we expand later? Sure, we can, as long as CMS will approve it.

DR. SCHUSTER: Okay. Any questions or anything you want to add, Steve?

MR. SHANNON: Yes, there is a reentry pack. It's really a good place to get much more -- great information by Leslie. That was about 45 to 50 minutes of the Reentry TAC meeting this morning. And I think it's important to remember that it is individuals leaving state prisons, not state prisoners. A lot of state prisoners in jails, we are not there yet; right, Leslie?

And it's kids in development centers in DJJ. That is the target right now. And it's really anyone leaving. We learned today that there's about 8,000 people a year discharged from a DOC facility. So that is 8,000 people. And they are going to get 14 months of case

management; right, Leslie?

MS. HOFFMAN: Yes.

MR. SHANNON: Two months prior, and 12 months afterwards. MAT if it is an SUD diagnosis; right? And those other services: Connections, housing, vocational stuff; those aren't waiver services, but the connection is the waiver service; right, Leslie?

MS. HOFFMAN: Yes, and we are already -- we have already started our collaboration with the jail associations already. We do want to look at those in the future, but an 1115 is one of those things, when you tell CMS that you are ready to implement, it can't be that these ten jails are ready and these 12 aren't and these --

MR. SHANNON: It has to be eligible to everyone; right?

MS. HOFFMAN: It has to be eligible to everybody across the state, so that's where we are, Dr. Schuster.

DR. SCHUSTER: And they each one very independently.

MS. HOFFMAN: They do. Very individualized, you know, they are elected officials in each county. Yeah. And DOJ -- DOC will also tell you that there are a lot of differences in each county. So we are working on that and figuring out how we can align that later, but there was no way that we could meet the deadlines with, I think, there's 50 or 52 jails across the country.

MR. SHANNON: There's a lot.

DR. SCHUSTER: Nina, do you have a question?

MS. EISNER: Yes. Real quickly. I had an opportunity to participate in one of those focus groups, and it was really wonderful. It was great.

The only concern I have, and we don't have to talk about it, I just want to put it on the table, is that my understanding is that to participate in the waiver services, you have to be linked to KHIE, and if you don't have an EMR, you may not be linked to KHIE, so I don't know if that was accurate, what I took away

from it, but if you don't want to respond now -- but if we can at least keep that on the list of things to clarify.

MS. HOFFMAN: I would just mention two things, Nina, thank you for bringing it up, because I didn't mention it.

This opportunity, also, because many states, the Medicaid Department is not connected with the Department of Justice or the Department of Correction or DJJ, they have allotted us some additional IT funds for technology, because we don't have the linkages, especially even outside of our cabinet, even if they were in our cabinet, we might have limited access. So that is one thing we are looking at. If you heard KHIE brought up, I don't think that was a final decision, we are trying to find a platform that we have to leverage and/or to figure out if we need to build one, and how we need to incorporate -- DOC and DJJ have some sort of similar technology-based systems, and we are trying to figure out how we can

leverage what we have to develop it.

And not that you want to hear all of this, we also have the ability to apply for, if we decide to, additional funds for technology at what they call a 90-10 advanced planning document.

MS. EISNER: Thank you.

MS. HOFFMAN: So none of that has anything to do with --

MS. EISNER: Thank you very much.

MR. SHANNON: The reentry things specifically said, "help data exchange," it did not say KHIE.

MS. HOFFMAN: Okay, we have said it --

MR. SHANNON: Right. But the language used was help data exchange. We sought to have that mechanism, but it wasn't specifically identified yet.

DR. SCHUSTER: Does that answer your question, Nina?

MS. EISNER: It does. But I'll tell you, in my group, KHIE was mentioned. But the clarification that Leslie has

provided is really -- I am very optimistic about that. Thank you very much.

DR. SCHUSTER: Thank you.

Our next item is, can providers respond to an ultimatum from an MCO? How can they respond? And the ultimatum is take this 10 percent cut in rates or we will end the contract.

So I guess I'm looking for some guidance from DMS about -- how we have asked before -- about audits. What recourse does a provider have in that situation?

MS. CECIL: Hi, Dr. Schuster. It's Veronica Cecil.

DR. SCHUSTER: Hi, Veronica.

MS. CECIL: Hello. I think what our response to that would be, is that it is a negotiated contract. It takes both parties to be in mutual agreement, and the provider does not have to accept it. That's just, unfortunately, the reality of the situation. So I will tell you, because this is starting to come up a lot. We are -- we are holding the managed-care

organizations in compliance with our contract that ensures access to services, so that they have to have an adequate network when they do have a provider that might terminate from their network, that they have to follow and provide us certain information to make sure that there is a smooth transition of care. So as these are starting to pop up, I can assure you that we are requiring the MCOs to meet our expectations on access, network, and transition.

DR. SCHUSTER: So how do you know that the letter has been sent? Let me ask a really basic question. In other words, I guess I'm asking, does the provider need to contact DMS to tell them they have received such a letter?

MS. CECIL: The managed-care organizations are required to notify us when they are making a rate change, especially, if it is going to cause abrasion. But if it will result in termination of a network provider. We have heard it from both sides, though. We

have providers that have reached out to us, obviously concerned about receiving reductions from multiple MCOs, so, providers are welcome to reach out to us when they are in these situations, but as I said, we have to, kind of, step back, because we are not aparty to that contract, and we have to monitor it from our side, which is really about access and transition of care for the member.

DR. SCHUSTER: Okay. If a provider felt a need to contact you all, what part of DMS should they contact, Veronica?

MS. CECIL: That would be the managed-care monitoring compliance branch and we can put that email address in the chat.

DR. SCHUSTER: Yeah, that would be helpful.

Any other questions from anybody on the Zoom want to follow up on that at all?

MS. CECIL: One other fine point to that, Dr. Schuster. MCOs need

providers. They need to have adequate networks. And I think the other thing that we are encouraging MCOs to do is to make sure that they are having a conversation with providers. They have to follow a process. So they send out something notifying the provider that they want to reduce the rate, and they have to give them a certain amount of time to respond, and then if they decide, and they can't come to a mutual agreement, the contract speaks to how they can end the contract, so all of those things have to be followed, but the other thing we are just trying to recommend for providers is to try to have that conversation. What is, maybe, differently that you can do to work out, maybe, quality metrics. That is what we're hearing a lot from managed-care organizations, ensuring that it's not just about have delivery of services, but quality of services, and are we looking at outcomes? We always encourage providers to try and have those conversations with managed-care organizations about what you

can bring to the table, and why you should get paid more. I know several providers who have done that and have gotten at least 100 percent of the fee schedule, or maybe even more, if they can deliver better outcomes as a result of the delivery of services.

So I just really encourage, you know, we are encouraging the MCOs to come to the table with providers to make sure that they are in those conversations and, again, ensuring that access.

DR. SCHUSTER: Yes, I think we are very concerned about access, because I think, in some ways, the headcount for providers treats the different behavioral health professions as if they all do the same thing and have the same training and see the same people and provide exactly the same services, which is absolutely not true, for one thing. So one does not equal one does not equal one.

And it's scary when some of the larger MCOs that have so many covered lives kind of go down this gauntlet, which

is what it feels like to the provider, and I think we have had that discussion on previous BH TAC meetings went this has come up.

I think we also need to remember, and I had this conversation with the legislator very recently, in a lot of cases, the behavioral health provider is really a cottage industry. Once you get outside the CMHCs or the BHSOs, there's a ton of --

MR. SHANNON: Small, little folks.

DR. SCHUSTER: -- of single practices, or maybe two people in a practice, and they have a very part-time staff person, or that kind of thing, to answer the phone, occasionally. So these cuts in rates, you know, are pretty darn scary.

But if we keep focusing on access to services, we obviously need to keep our behavioral health providers out there. Thank you.

MS. CECIL: You're welcome.

DR. SCHUSTER: Who has, maybe, the current 1915(c) waiting list numbers?

MS. HOFFMAN: Sorry. Took a second to get off.

DR. SCHUSTER: That's all right.

MS. HOFFMAN: Just a second. I think I have everything you've asked for. I think this was as of yesterday. I've told you all. I can check on these every 20 minutes, and they change. So if you are in a meeting in the morning and the afternoon -- they are fluid. They just are. ABI is 0; ABI LTC is 0; Home and Community-Based is 2,207; Model Waiver II is 0; Michelle P. waiver is 9,169; and SCL is 3,536. That is the waiting list counts.

DR. SCHUSTER: Well, that sounds really high for Michelle P. I can't remember the last time we got the numbers. I would not have remembered that it was in the nine thousands.

MS. HOFFMAN: Sheila, this was the last time -- I think I talked at the Thrive meeting, and I had 9,297.

DR. SCHUSTER: I would have to go back to our July BH TAC. Anyway.

MS. HOFFMAN: Like I said, they are fluid.

And your other question was regarding how long does it take from the time you have a slot allocated to receiving services. We did this in a couple ways for you. I've got the average days per waiver, and then I've got an average for all of the waivers, and then I did a three-year period trying to catch comparable time periods. So I don't know what exactly you want, I will go ahead and give them to you, average days by waiver.

DR. SCHUSTER: Okay.

MS. HOFFMAN: So ABI is 73.8; HCB is 59.14 days; Michelle P. waiver is 94.41 days.

DR. SCHUSTER: 94 point --

MS. HOFFMAN: 94.41. I could have rounded these up. And SCL was 63.8.

DR. SCHUSTER: So that's from the time they get notified that they are off the waiting list and into a waiver,

and what are you counting as the beginning of services?

MS. HOFFMAN: I think we did from capacity, they went into capacity to get a slot to the time they're PA to start services. I believe that's how they have it pulled for me.

DR. SCHUSTER: So approved to get services?

MS. HOFFMAN: Yeah. So if you averaged all those waivers together, I wanted to show you this because it actually made me feel a little bit better, so I wanted to share it with you.

DR. SCHUSTER: Okay.

MS. HOFFMAN: So using the reserved capacity, the day that they are told they can go forth; right? To the day they get the PA, all waivers together from September the 1st of '21 to August the 1st of 2022, it was 106 days, point 41. So 106.41. And then, I did the next from '22 to '23, and that was 120.28. So that went up. And then September of '23 to August the 31st of this year, we went down

to 66.57.

DR. SCHUSTER: Wow.

MS. HOFFMAN: So that makes me feel a little bit better.

DR. SCHUSTER: That's almost cutting it in half.

MS. HASS: Can Leslie put that in the chat so everyone will have access to those numbers?

DR. SCHUSTER: Yes. And I tried to capture those, too, Mary. But that would be great.

MS. HOFFMAN: I have a large -- can I send it to Erin and she can send it out?

DR. SCHUSTER: That would be fine.

MS. HOFFMAN: It's fairly big and I've got a grid.

DR. SCHUSTER: So I just talked to a mom today who has been waiting on PDS services and Michelle P., and it has been like two years.

MS. HOFFMAN: I don't know about two years, but I know that there are folks

who have been waiting for services and we are addressing it, and we've got some questions from CMS. I think you asked at one point, maybe on another call, we don't have an official cap or anything like that, but we are working with CMS and a contractor to help us make some decisions on how to improve that process here in Kentucky, for our members, and I think we have a meeting with CMS -- I want to say the 30th of this month.

DR. SCHUSTER: Okay. And the July meeting was 9,200. It just shows my memory is faulty. Thank you.

MS. EISNER: It was 9,214 and the SCL was 4,553. When we heard those numbers today, I thought woohoo, those numbers went down some.

DR. SCHUSTER: Yeah. So you are going to be talking to CMS, Leslie, about the PDS?

MS. HOFFMAN: Yes. We have an additional meeting with CMS just to discuss PDS. We can let you all -- I don't have an official cap or anything

like that, but they had several informal conversations with us about, you know, how to streamline the process, how to figure out other ways, they want us to come up with recommendations, too, about how to streamline and make this process quicker, because we don't want anybody on any waiting lists at all; right? So I wanted to tell you all, too, that you all are aware that we released the 2025 slots, so also when we were in that process for the first couple of weeks, I noticed that there was quite a bit of an increase of applications coming in. Even though there were waiting lists, we had an increase of applications. So it was like the waiting list was growing while we were like trying to get -- and then we don't want those slots that we released to bottleneck, so we are releasing those slowly. We have a three-month plan to get all of those out there. And I know this is hard for folks to understand, but we are never at 100 percent full capacity, because there is always this overflowing amount of slots

that folks don't utilize, or allocations. Once we get those allocations out there, that they either don't meet eligibility; or they are on another waiver and receiving services; they moved out of state; they passed away; and there is always this regular rotation they do every month. I will get asked, like, why did you release 50 slots last month, and that's because of the rotation. It's not an additional 50 that we received, it's 50 that we already had, if that make sense.

DR. SCHUSTER: Let me ask you one follow-up question on the PDS. Have you all authorized more agencies to provide case management for PDS?

MS. HOFFMAN: Those are things that we are looking at, Dr. Schuster. I don't to speak to that today. We are looking at several options that we will take back to CMS and talk to them about it. I don't want to say anything today that might end up not being -- that's not too far away, though, because, like I said, we've got conversations with them,

we have not received a formal cap, but we know that they do have concerns on the PDS process.

MR. SHANNON: And there's two pieces to PDS; right, Leslie? There is the financial management piece and the case management piece.

MS. HOFFMAN: That's correct.

DR. SCHUSTER: Yeah. I just am hearing from a lot of folks about PDS and about being in a waiver and not getting those services, because they want PDS services. So I will follow up with you, Leslie. I appreciate it.

MS. HOFFMAN: All right. No problem.

DR. SCHUSTER: And then the question -- update on the ABI waiver, access to therapy services. I understand we are still in a holding pattern.

MS. HOFFMAN: That is correct.

MS. HASS: Okay. Update on ABI. Everybody is still in the holding pattern. Is Leslie still on here? Maybe she can tell us something. The one scary thing

is, as I was at a provider meeting, and they are saying that after the therapies come out, they are going to take behavioral services and canceling services, also. I don't know if that is a rumor, or if Leslie can address that, but that is the thing right now. We are just not in a good position with providing services to our ABI waiver constituents. Right now, Neuro just bought -- NeuroRestorative just bought out an ABI long-term waiver care provider in Louisville, which is very concerning. So pretty much, unless you choose Neuro, or one or two small mom and pops, you really don't have much choice. And I will just speak to the Louisville area, because that's what I know about. This just came about supposedly effective October 12, NeuroRestorative will acquire the one larger ABI provider here in Louisville.

Then, you have the other issue which we just talked to Leslie about, PDS services, because of the low availability of choice of ABI providers, many families

would like to do PDS. Their loved ones are already in the waiver, but you are looking at a long -- we are talking possibly six months for somebody to be able to access the PDS services that would be able to get them a provider to help them as far as providing companion care and, you know, other needed services that they are currently getting in the waiver. So it is a big issue, as many families feel that if they can go the PDS route, then their loved ones would be better served. But right now, I am very depressed. ABI looks nothing like what it did even two years ago with the long-term, and then acute, what I am hearing, again, these are from families saying that they are having a tough time, that evidently they are being told that they have to automatically go into long-term care, which right now there is not a waiting list, but again, some of these folks could benefit from acute services, and I don't know if Leslie could address why some folks are being turned away.

MS. HOFFMAN: I'll go back just a little bit. So no updates or we have not moved forward with the ABI therapies. We do have a consultant who is assisting us and I think we have been trying to do a little bit of research in Kentucky about our therapies as well, so nothing has moved forward. Promise we will do tons of communication.

Mary, you know I would not just say that it is tomorrow. I would not do that. I worked in brain injury for 20 years. I know we had to have a lot of communications and a lot of working with the members, and I want to make sure that we have options if we move forward. I am talking about options like step-by-step processes, what that looks like, I want to have FAQs and all of those things that we worked on years ago when the state was working on this.

One of the things, probably Mary, is the thing of the unknown when talking about behavioral health services and things like that, the ABIQ waiver

because I was there from year one, we were the first waiver in the state of Kentucky that offered a lot of the psychiatric services that were not in the state plan at the time. We had family, group counseling, counseling services and things like that, and we could allow substance-abuse counseling, where none of the other waivers had that. We were allowed to do that, because the population that we were working with was mental-health in nature, and we were able to get CMS to agree to that, number one because it wasn't in the state plan. I'm sure those conversations are starting to come about because of the fear of the unknown, because they are in the state plan and have been since 2014.

MS. HASS: The problem that I see as it is now, is that no one really realizes the difference between ABI and even though mental health or your intellectual disabilities, I was told the other day when I said something, they said the SCL folks aren't complaining. That is

why we have two different waivers. You have the SCL waiver and the ABI waiver. I think, right now, everybody is trying to group everybody together, and that is just not providing a good service to our folks.

And like I say, right now, we have two or three people Sheila is aware of one of the folks that we are talking about. I can understand that if you have an ABI waiver slot, automatically why you cannot just go over to PDS. I understand part of it is the case management, and it's kind of like what Steve said, and you have the fiscal management, and a lot of the current ABI case managers will do the, what you call, traditional case management in the waiver, but they don't want to do that fiscal management piece and so those are some of these things that we just really need to have a good conversation around this, because ultimately, the folks that I care about and folks like you said, back to the days -- we are just not providing what they need, and part of it is when you have one provider having,

again, I don't know, you would have to tell me the numbers, but if they are part of the other section in Louisville, they will probably have 20 percent of the ABI population. That is just scary to me, that you have one provider with that much control, and if I get taped, I get taped, but that is just very scary to me.

MS. HOFFMAN: I appreciate you sharing that with us, Mary. And at least you've got me working where I've been in brain injury for many, many years. Again, we haven't moved forward on anything related to the therapies and won't until we can communicate with the public wholehearted.

MS. HASS: I appreciate that. Thank you. And other than that Sheila, I do have to jump off, because I have another appointment at 4:30.

DR. SCHUSTER: Thank you.

Misty, do you --

MS. AGNE: Yes. I have a couple of quick questions as it relates to provision of therapy services under the

state plan. One of my concerns, and just general areas of interest, is the authorization process for therapy services is often very cumbersome and lengthy for providers. And what I have seen in my own experience, is often they are requesting that outcome measures be used, which I am not opposed to, provided that those outcome measures are reflective of the neuro population and they are sensitive to change, especially for individuals who are in a chronic state where they are not going to show significant improvement and some of these measures that are utilized. So I'm just curious if you could speak more to that and if there's any consideration to the types of measures that are being requested, when we are requesting authorization, and then moreover, I'm also interested if, whether or not, the state has considered there being a number of visits being approved for patients with brain injury.

MS. HOFFMAN: If you are using services and state plan services have

already been designated and units and numbers, and I don't have all of that in front of me, and it's been awhile since I have looked at it, but I wanted to say, too, that part of the communication I was talking about earlier, is how you go about utilizing and accessing those state plan services for folks who aren't used to it. So I would get with our director, Justin Dearinger's, area who handles therapies, and we would get together and develop -- and we did this when CMS was asking us to remove these in 2014 -- I can't even remember the year now -- but we handled a lot of FAQs and processes and one-pagers to help folks, whether you be a case manager or a provider in general, or if you are a member or guardian or representative and that kind of thing. So we did have a bunch of one-pagers back then, too. But those are the things that we've got to address and we are working with a contractor to get all that in place for you, so again we are not moving forward at this time. This is not a new

conversation. I don't know if Mary Haas is on.

DR. SCHUSTER: Mary had to get off.

MS. HOFFMAN: We went through all of this, sometime in 2012 or 2014, I don't remember the timeline, so I just want you to know that it is the same conversation from CMS saying why haven't you done this? Why can't you do this? My involvement back in 2014 was pretty stern with federal government, and they didn't want to hear that OT or PT was different with brain injury than any other population, and at the time I was very involved with brain injury and went to bat for it. I had several of the doctors in our arena -- in our brain injury arena -- to write letters to CMS, to help us to argue our point, so they weren't willing to listen so that's where we are. There are about three options in the CMS technical guidance that is about 300 pages long. There are three options and we've got one of the three options. You either

have a state plan, or you don't have a state plan, and, remember, the last time that we looked into 2014, 30 some thousand people were utilizing it, so we wouldn't want to remove it from state plan services. You can have both, but there are extreme limits when you do that, and oversight and watch. Or you can utilize the state plan and then the waiver as well, and then you have to ensure that we use the state plan services first. We have been through this over the years, many times, so I wanted to let you all know that at least we are versed in it. If you are a person who has been around in brain injury a long time, it's the same conversation that we had many years ago, it is just coming back with CMS.

DR. SCHUSTER: Did you have any other questions, Misty?

MS. AGNE: No. I just hope there are some is some consideration to the types of items that are going to be utilized for those authorizations and that, perhaps, there is engagement from

the providers to identity appropriate items for that. That is my only comment.

DR. SCHUSTER: Thank you. I think we may need to have some additional questions about the ABI waiver and the services that has come up probably for the last year or more on the BH TAC, and we probably need to -- and with you on the BH TAC now, Misty, lets you and Mary and I talk a little bit about what we might do going forward.

I think that I am going to skip to Veronica. You have an unwinding on here, as always. I don't know if you were prepared with something or not. And you are muted.

MS. CECIL: Yes. I can do a quick, one-slide to update numbers if you --

DR. SCHUSTER: Yeah. Let's do that.

MS. CECIL: Okay. And of course we will share this with the group and post it afterwards, as well. Let me share my screen. Sorry. I should have had it

ready. Ready. Okay.

I am going to limit it to the past three months, and this is when we last spoke. We give you updated numbers. So most recently is August with 36,136 individuals who went through renewal, and we had a really nice, large, approval number for August. It is a smaller number overall, but we are still always happy to see a high approval rate. So we had 31,823 that were approved; 979 terminated; and we have 2 pending from August; and we did extend 3,332. Just a reminder, extension means that we are still under the flexibility were we can extend somebody. All members, one month and long-term care, 1915(c) waiver members, up to three months, if they have not responded to a renewal notice and have to take an active renewal. We've conduct additional outreach at that period of time, so we did extend 3,300. We already have 50 that have been reinstated in August, for the August renewal, and we are tracking that 90 days, and as a reminder

if anybody can come back within the 90 days following that renewal month, after being terminated and provide us information, and we can determine them eligible, we can automatically reinstate them instead of having to ask as if there is no gap in their coverage.

So still tracking June and July, 90-day periods. The numbers are a little lower, but the overall renewal numbers are low as well, so that's why, I think that is why we are seeing smaller numbers. That was really all I thought I would share for today since we are running out of time.

DR. SCHUSTER: We have run out of time, I think.

That is a really low termination right now. Love seeing that.

MS. CECIL: And the other question that we see a lot is what's up with the child renewals. We are hearing from CMS that we are going to reach out to us. That request is still pending and until we hear otherwise, we have been

extending children, automatically, so we will let folks know if we get any kind of response back from CMS.

DR. SCHUSTER: Okay. I think I put the children, specifically, on the MAC agenda, so that will be in three weeks and we will get that update. Thank you. You all are very dedicated to keeping kids on there.

Any new recommendations to the MAC at the September meeting?

MS. EISNER: Yes. This is Nina. Two things, and I will be quick.

IOP and PHP were recently acknowledged by Commissioner Lee to be able to be provided by Telehealth. And that was after she really worked hard with CMS and others to get that feedback. So the previous communication from the cabinet from DMS that precluded that was overridden by her direction. We just have one problem, and that is that providers at all levels, the hospitals and outpatient providers, need some kind of provider guidance from DMS, and also, specifically,

some communication about billing. The Telehealth billing, previously, was under the public health emergency, and we don't know if that might be different. So PHPIOP. And I think that is coming through the Hospital TAC as well.

And then the second thing is EPSDT services, specialty select services that are provided by a variety of hospitals in the state. Commissioner Lee and Secretary Friedlander worked with many of us and did approve an increase to $700 per day, and these are very intensive, hospital-based services, select services, like for sexually aggressive boys and girls, and so on.

Anyway, that was all great, but the MCOs are refusing to implement those rates. WellCare did implement it in one hospital, and that was because they had a contract that was specifically written around that for their EPSDT services. Of most concern, is Aetna has refused to implement it at any of the provider -- any of the hospitals, and of course, Aetna has

the SKY contract, and in any EPSDT inpatient program, the vast majority of patients are SKY kids, so that is the other one. Thank you.

DR. SCHUSTER: Are you raising those as questions for discussion here, or are you suggesting that we make a recommendation?

MS. EISNER: I don't know if we have time for a discussion. I don't know if DMS has a simple answer to those, but they are really just two things. IOPPHP, we appreciate the cabinet's approval for Telehealth to be reimplemented, and we need provider guidance on anything that we need to do, specifically, to re-implement that, because I will tell you, nobody is doing it yet, because we don't know exactly how to do it, or how to bill for it. And then, the EPSDT --

DR. SCHUSTER: Hold on that. I guess I'm going to ask: Are there any voting members of the TAC that want to make the motion to make that recommendation at the MAC meeting that DMS

give guidance to providers for delivering and billing for IOP and PHP services via Telehealth?

MR. LITAFIK: Motion.

DR. SCHUSTER: TJ, all right. And a second?

MS. MUDD: Second.

DR. SCHUSTER: I'm sorry. Valerie?

MS. MUDD: Yeah.

DR. SCHUSTER: All right. All those in favor of making that recommendation, again, this is just voting members. Signify by saying, aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: I need one more vote. Is Steve on? We lost a couple of our voting members is our problem.

MS. EISNER: Yeah.

MS. BICKERS: It looks like Tara is still on. I am not seeing Steve. I'm not sure you have a quorum, currently, Dr. Schuster.

MS. EISNER: Okay. Nevermind. We don't have a quorum on EPSDT, although

I did just get an email within the last hour that I do have a follow-up meeting scheduled with the commissioner on my EPSDT concerns, so in light of those issues, we will hold on that.

MS. BICKERS: And Nina, we can take this back after this meeting and start working on those.

MS. EISNER: Thank you, Erin.

DR. SCHUSTER: I was going to say, let's put this in the minutes, and we can also put it on the November agenda, Nina, if they are not resolved by then.

MS. EISNER: Thank you very much.

DR. SCHUSTER: We will make that recommendation.

MS. EISNER: Thank you.

DR. SCHUSTER: And I think if Barry Martin is still on, I think he had an issue that he wanted to bring up under new business. I don't know if he was able to stay on.

MS. BICKERS: Dr. Schuster, for the record, Steve has joined us again, so

you do now have a quorum.

DR. SCHUSTER: Okay.

MS. BICKERS: Just for the record. So we can take that back, or if you want to -- we are happy to take that back and work on it prior to the next meeting, and do a recommendation then, or you can redo your recommendation.

DR. SCHUSTER: Let's do that. We put it on your radar with DMS.

Let's see how much progress we can make, Nina, between now and November. Because all the -- making the recommendation to the MAC is just simply going to put it on DMS's radar. Okay?

Thank you, Erin.

Is Barry Martin still on?

MR. MARTIN: I am, Sheila.

DR. SCHUSTER: Oh, okay. Go, Barry.

MR. MARTIN: Okay. Just something for new business just to consider. We've had some issues with IOP, that's outpatient therapy, in that if a patient does not get that third visit in

the same week, then the whole service is disallowed. And we just wanted to see if there is any room for any kind of movement to change that methodology, you know, it seems like it is not fair that if we provide two thirds of the service, and if somebody has a doctor's appointment or gets a court -- is ordered back to court, or if something happens that third visit in that week, there is no way to get any kind of remuneration for it.

MS. EISNER: Sheila -- I'm sorry.

MR. MARTIN: Oh, that's all right.

MS. EISNER: I was just going to make sure that you know that it is three visits in a rolling seven-day week, not in a calendar week. We did -- this has been a huge issue for hospital providers, and that is one clarification that we received. The other thing we are trying to figure out, and I think we are still trying to work with DMS on this, that whether or not for those visits provided

in that timeframe, and I think that is a CMS interpretation -- DMS, correct me if I'm wrong, but that is not able to be changed, but whether or not this would be possible to have a bill with any services provided in the IOP, if that third visit in the rolling seven days isn't met. But I will agree with you, with all the providers I worked with, it is a huge issue.

MR. MARTIN: It is. So I was asking on behalf of some of the SUD and behavioral health providers to bring that up, and us, as beacons of hope. Just start a conversation of how we can remedy it, maybe. We understand the intent.

DR. SCHUSTER: Yeah. So IOP is a very important service, for sure.

MR. MARTIN: Yes.

DR. SCHUSTER: To provide intensive services, short of somebody having to be in the hospital, still allows them to be in the community and have a job and those kinds of things. So you are saying, Nina, that the seven days is not a

Sunday through Saturday.

MS. EISNER: Correct. It's a rolling seven days.

DR. SCHUSTER: A rolling seven days.

MS. EISNER: It's a rolling seven days, and that interpretation has been provided and clarified by DMS. I am not optimistic that anybody is going to be of the change the three visit rule within the rolling seven days, we have been working on this for about a year. So I think that the only thing that all of us know, is that sometimes people don't show up for visits or they, you know -- that doesn't indicate that they are not in continued need.

The only other outstanding question that I have come up with, and others, is whether or not for those services which we cannot bill, and/or that are being recouped, because that is another issue that is happening for providers is the recoupment, can we bill for component -- can we take that apart

and identify billing codes that are DMS-authorized, provided within that IOP encounter, that we can bill for separately. And that is one thing that at least the Hospital TAC and the hospital community is continuing to try to clarify. And I think the answer is the same whether it's the Children's Alliance provider or the hospital provider that is doing the IOP. So I do think that is important to keep out there.

MR. MARTIN: From an outpatient standpoint, in a clinic setting, having outpatient available seven days out of the week is kind of hard to keep providing on a Saturday and Sunday.

MS. EISNER: Yeah. Hospital providers don't do it either. It's a Monday through Friday service, but at least the rolling seven days, if somebody starts on a Wednesday, they can't possibly get in three visits if it ended on Friday, because it's usually provided three times per week. But the rolling seven days did help. And I'm sitting here talking like I

work for DMS. If I said anything wrong from some of the DMS interpretations, please correct me, but those are my understandings.

DR. SCHUSTER: And this might be one of those things where it might be helpful to have you on this, Nina, because you are also with the Hospital TAC, and we are two TACs working on the same issue, and there is some synergy there that can be very helpful.

MS. EISNER: Right.

DR. SCHUSTER: Barry, I will put this, along with Nina's issues, on the agenda for November, and in the meantime we will see if we can get some response from DMS on those issues. Okay?

MR. MARTIN: I appreciate it. Thank you, Nina.

MS. BICKERS: Barry, Nina, this is Erin. Would one of you mind to put that in writing for me? I tried to catch as much as I could taking notes, but I want to make sure I capture all of the issues, and the billing, and I can get

that over to policy to start looking at.

MS. EISNER: Sure. And what I will send you is, I will send you the communications from Commissioner Lee, and from DMS, that has advised as to how IOP is to be administered and what the limits and rules are.

MS. BICKERS: Thank you.

MS. EISNER: Thanks.

DR. SCHUSTER: Barry, why don't you send in your specific question, and then, Nina, you will do your IOP PHP, Telehealth, and then the EPSDT.

MR. MARTIN: Okay. I was going to say, Nina sounds a lot more elegant than I do. More educated.

DR. SCHUSTER: The two of you can work that out.

MS. EISNER: Yeah, thanks.

DR. SCHUSTER: One final question because we always ask that. Are there any formulary issues? Any access to medication issues out there that anybody knows of? We always ask that because we are always happy to have Dr. Ali join us,

if there are any -- you know how important medications are to our folks.

Hearing none, I appreciate so many of you staying on until we actually adjourned the meeting here -- 35 minutes -- but we had some very robust discussion, so the MAC meeting is September 26, and that's 9:30 to 12:30, and then our next BH TAC meeting is November the 14th.

Thank you, Erin, for keeping us on track and so forth.

And with that, we will adjourn the meeting and wish you all a happy rest of your day.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 26th day of September 2024

_/s/ Stefanie L. Sweet_____

Stefanie L. Sweet, CVR, RCP-M