DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter

A T T E N D A N C E

TAC Committee Members:

Sheila Schuster, PhD, Chair
T.J. Litafik
Valerie Mudd
Mike Barry

DR. SCHUSTER: Good afternoon to all. This is the point in your flight where the stewardess says, "If you are not going to Paris, then you are on the wrong flight." So I hope you are all on the Behavioral Health TAC flight. And we are welcoming all of you.

We have our voting members, T.J. Litafik representing NAMI Kentucky, Valerie Mudd representing Participation Station and the Consumer Voice, and Mike Barry with People Advocating Recovery, which is our substance disorder group.

And as I mentioned, Steve Shannon is out of the country and Diane had a work conflict. And hopefully Eddie Reynolds will join us.

So I will call the meeting to order. And I will ask for a motion from one of our voting members to approve the minutes of our July 14th Behavioral Health TAC meeting.

MR. BARRY: This is Mike. So moved.

DR. SCHUSTER: Thank you. And a second, please.

MR. LITAFIK: Second.

MS. BICKERS: T.J., can you turn your camera on, please.

DR. SCHUSTER: Oh. That's right. Yeah. Thank you. You are required to be in-person, kind of, for open meeting, open records. So...

All right. So we have a motion and a second. Any additions, corrections to the minutes?

(No response)

DR. SCHUSTER: All those in favor of approving the minutes signify by saying "Aye."

(Aye)

DR. SCHUSTER: And Aye. Thank you very much. The minutes are approved.

If you all will remember, we had quite an active discussion at our July meeting about the provider credentialing. And Claire Arant from Kentucky Hospital Association was very helpful in providing us with some information and then putting us in touch with the folks that are helping KHA and their partner, Verisys I guess is how you say

it, to do the provider credentialing.

So I'm going to welcome Shea Lykins and Laura Malloy. And Erin has enabled one or both of you to share your screen if you would like to do that to show your PowerPoint.

MS. LYKINS: Hello. Laura is going to be sharing her screen. So just a second, please.

DR. SCHUSTER: Sure. Thank you, Shea.

MS. MALLOY: Yes. Hi. Hold on. I am pulling it up right now. Let me know when you can see it.

DR. SCHUSTER: Yes, we can see it.

MS. MALLOY: Okay.

DR. SCHUSTER: And you are much quicker than I am. This is always the moment of truth for me, where I have a backup, somebody else can share their screen if I can't get mine up. And how do you say, is it, Verisys (pronouncing)?

MS. MALLOY: It is Verisys (pronouncing).

DR. SCHUSTER: Verisys

(pronouncing).

MS. MALLOY: You are very close, very close.

DR. SCHUSTER: Like as in "verify."

MS. MALLOY: Yes. Exactly.

DR. SCHUSTER: Okay. I will remember that.

Yeah. All right. Thank you so much for joining us. And I had sent you a number of questions that folks had. So we look forward to having your presentation. And then we will see if there are some questions when you are finished, if that's all right.

MS. MALLOY: That's perfect.

DR. SCHUSTER: All right. Thank you.

MS. MALLOY: Shea, I believe you are going to kickoff.

MS. LYKINS: Sure. I will be glad to. Thank you all for inviting us to do a presentation today. We hope that we can answer any questions that you have.

Of course, I am Shea Lykins with the Kentucky Hospital Association. I am the

credentialing manager. And with me is Laura Malloy. She is the Vice President of Strategic Accounts and Implementations. And then also Amber Henderson is also a great contact at Verisys. Here is our information, if you all would like to reach out to us afterwards with any additional questions.

DR. SCHUSTER: And we will share the PowerPoint afterwards to everyone, as we always do. And thank you for making that available.

MS. LYKINS: Sure. So KRS 205.532 allowed KHA to form the Kentucky Health Alliance to provide the credentialing services. For this venture, we contracted with Verisys, who was formerly Aperture Health and they were well-known to the industry, to help with credentialing. And this alliance currently consists of Aetna Better Health of Kentucky, Passport Health Plan by Molina Healthcare, and WellCare.

So some of the benefits of the Kentucky Health Alliance are to establish one standard application for the MCOs who are participating in our alliance, to reduce

completion time of applications by monitoring the credentialing and enrollment dates to ensure that the KRS deadline is being met, so now there are timelines on when these applications actually have to be processed, to improve the communication between the MCOs, Verisys, the providers and facilities, to follow-up on applications that are not submitted for re-credentialing or that are submitted incomplete, and then, also, to assist hospitals with employed provider credentialing to reduce a delay in the payment for the services that they have provided.

And then I am going to turn this over to Laura to go a little further into it.

MS. MALLOY: Sure. And I included just a couple of slides about Verisys, just to give you a little bit of history. We have been in the business for over 25 years, really known as Aperture, Aperture Health, Aperture Credentialing. I'm just going to kind of go through these slides pretty quickly. You can go back and view them, you know, if you choose.

We are NCQA accredited, URAC accredited, and we also have specific standards that we meet for committee functions. This just gives you a list of our different capabilities. And with this particular initiative, we are looking at our credentialing services that we offer.

And these credentialing services fall into these different categories. As Shea mentioned, we will be assisting with application management, you know, we will be assisting with the primary source verification that goes along with the credentialing as well as the committee services.

So then to really get into the specifics of this Kentucky Health Alliance, we wanted just to talk through how the process will work. And there's, basically, two different processes. One would be for the initial brand new providers who are coming into one of the plan's networks. And really nothing changes in step one. That provider is going to be reaching out to the respective health plan to begin that

contracting and credentialing process at some point in time. When the health plan is ready, the plan submits the work order to Verisys. So the plan is really in control of when that credentialing request is going to get kicked off with us. Then we will take that work order that the plan sends to us and we will start the primary source verification.

When we start that, a letter is always sent out to the provider or if the plan has a credentialing contact it would go to that credentialing contact to -- directions on what to do with the applications. In the case of a practitioner who uses CAQH, I will show you the letter, it is going to direct the provider/practitioner to CAQH. If it is a non-practitioner type, a facility or different types of entities, there will be a facility application attached to the letter.

No primary source verification is started until we get the application back. So we are going to be in what we call app gather. If we don't get an application, we

will be doing follow-ups out to the provider, reminding them that this is in process and we need the application. Those are in set intervals, based on what the plans have required. And then it is typically a 60-day app gather that's allowed for the application to be completed and submitted.

So then in step three, when we get the application, we will then evaluate it. Do we have everything that is needed to complete PSV? If something is missing, then our verification coordinators will reach out to the provider on the e-mail, that's usually on the application, and ask for that missing information. So, you know, it could be a variety of things, maybe something expired, we needed some updates on information. That outreach will go to the provider.

Once the primary source verification is complete, the information is then moved into the credentialing committee, who evaluates it. The plan then will notify the provider. So notification of the results of credentialing comes from the plan. It does not come from Verisys. But each

individual plan will send that notification and will handle any appeals.

And then, just through this whole process, once a provider is approved, then the provider will then move into a re-credentialing cycle with the health plan and will be added to what we call their monthly roster.

Does that make sense?

(No response)

MS. MALLOY: I think it is pretty straightforward. With re-credentialing it's, basically, the same thing in that the plans drive when Verisys will start that work order for re-cred. What's different is that with these three plans, we're taking in their network rosters and we're comparing, if a provider contracts with all three plans, we're comparing those compliance dates. So what is the earliest date that that provider might be due for re-credentialing? And we are going to take that earliest date. So, you know, if it is May for Aetna but it might not be until November or December for Passport Health, we are still going to

kickoff that re-credentialing work order at the earliest date. So that would be May. And it will be on behalf of any of the plans that that provider is contracted with. So if the provider is contracted with all three plans, when we start that re-credentialing event it is going to support all three of the participating plans. So the provider won't then have to complete something for Passport Health and then complete something for WellCare.

We will send a letter, just like we do with initial's. And on that letter it will, basically, reflect the participating plans and give directions on where to go to submit the application or to return the application. It follows the same type of reminder intervals. We do target re-credentialing based on compliance date. So the schedule is really based on when that event needs to be approved in committee and back to the provider to know that they are approved for all of the plans on an ongoing basis.

So the difference between initial

and re-cred is that the re-cred event is triggered off of the health plan's network rosters and compliance date. And, again, it is based on the earliest and supports all plans if the provider is contracted with all plans.

To give you just a glimpse of what the letters will look like, you will see the logos across the top of the page, so you will know these are the three plans that participate in the Kentucky Alliance. And then there is the verbiage. In this case this is a practitioner letter, so it is giving directions about where to go to complete the application on CAQH. It's also giving additional information about if there's any questions, if a paper application needs to be completed, so maybe the provider isn't active on CAQH and doesn't plan to be, we will accept a paper application in that case. And there is a method to be able to upload that directly to a site so you're not having to fax it or mail it.

This is exactly what the letter is going to look like. And over here in the

right-hand corner where it says "client requesting information," that's where you will see the plan names. So it could be one, it could be two, it could be all three. So that will indicate to the provider who all will be participating in this credentialing event. And, so, it will basically handle those two or three plans all at one time.

The facility letter is a little different. Because with facilities we have found sometimes there could be different services that need to be credentialed at the same location. They could have different NPIs. And, so, we get a little bit deeper into the detail of the letter with facilities and provide information as to the location that the plan has asked us to credential.

So in this case, what is the NPI? What is the tax ID for that facility? What kind of facility is it? Is it a skilled nursing facility? Is it a community mental health center? You know, so what type of facility is it? And then in this case, if there is a credentialing contact name, that would go there or the primary service

location name, whatever the plans have given to us.

So in the body of the e-mail you will find more detailed information about that specific facility. And we are doing that to try to eliminate questions, because a lot of times we will have some additional questions around specific locations.

The facility application that will be attached to that re-cred letter will, again, have the logos, so you know this is supporting the Kentucky Health Alliance. And it is a seven page application that includes this cover page and just really asking for the specific information around the primary source verification needs.

The providers can expect to receive outreach if there is something missing from the application. So, if you recall, once we get the application, that verification coordinator is going to look at it, see if it is complete. If something is missing, usually the outreach will come by e-mail and it will be in this format. So I thought it would be helpful, you know, if you are

sharing this with providers, that they can see, this is normal. This comes from Verisys. And it gives them the information that we're missing. Again, this is just kind of a test scenario. But it will say which plan it is representing. So if it is all three, you will see all three, or one. And then it also allows for the ability to upload information directly, so attach the document, upload it. Or, you know, you can always e-mail back or call if you have questions.

So that's kind of just a quick summary of the process in 15 minutes to try to just give you all an idea of how it's going to work. We are getting really close. We are hopeful that at the end of this month we will be able to kick it off. Shea and the MCOs were all looking at that and testing and reviewing now. So if it is not the end of this month, it will be in October, just to kind of give you an idea of the timing.

And, Shea, is there anything else you would want to add?

MS. LYKINS: No. The only thing, you know, if for some reason your

credentialing compact does not respond to any of the e-mails from Verisys, you will get a phone call and an e-mail from me. And I will reach out several times to your office, to your personal cell phone, whatever contact information we have to let you know what is going on and what is holding up your application, you know, what the delay is. And then once we get that information, of course we send it on to Verisys so it can be reviewed and sent on to the credentialing committee.

DR. SCHUSTER: Thank you so much. In terms of the go-live, how will you all notify folks that you are up and running? Or let me ask that a different way. If you would notify me when the system is up and running, I can certainly get it out to all of the organizations that typically are participants here at the BH TAC. And then through the Mental Health Coalition we can also get it out to our network of folks. Does that make sense for you all?

MS. LYKINS: I will be glad to let you know whenever our go-live is set for,

that way you can share that information as well. But we will have some communication going out, too.

DR. SCHUSTER: Great, great. Let me open it up at this point to folks that have joined us for this meeting, and I think many have joined because they wanted to hear this, and see if there are any questions out there.

I can't see you all, so just speak up.

MS. LYKINS: I do see in the chat that we had mentioned that it takes 60 days for the provider to complete the application. Once the provider's application is complete, how long will it take to be approved?

So once we get 100 percent of the information and it goes on to the credentialing meeting, and those are usually hosted once a week, and then once the decision is made, it goes on over to the MCO so that they can work on enrollment or appeals or whatever that need is.

DR. SCHUSTER: Yeah. And I see that -- thank you for that. And thanks for

the question, Dr. Theriot.

I see that Kathy Adams from the Children's Alliance has a question also.

Laura, how does the provider start the process? Will contacting one of those health plans, WellCare, Aetna, or Passport, start the process?

MS. LYKINS: If they are contracting, so if they are a brand new provider and they want to contract with one of those plans, it would be the same process as they would have done before Aperture or Verisys was involved. So typically I would think that is their first step. If any of the plans are on, they could also comment.

Again, the plans will be the ones that trigger the credentialing event with us. So once they have completed that contract for initial, that initial provider, then they will submit that work order to us.

If it is a re-cred and they are already contracted with plans, they will receive a letter that tells them that we are starting the re-credentialing process. And that will be their indication that, you know,

we are looking for that application and for them to go to CAQH and update their information or complete the application.

DR. SCHUSTER: Okay. If you are a brand new, brand new provider and you want to be credentialed with all three, what is the best process? Do you contact all three or do you contact one and once you go through the process it is easier than to be credentialed with the other two?

MS. MALLOY: I think that they would all need -- still need a contract with each respective MCO.

DR. SCHUSTER: Okay.

MS. MALLOY: So that initial provider would be reaching out to each respective MCO. Unless, Shea, there is another process that you all have created.

MS. LYKINS: Nope. That is the process for now.

DR. SCHUSTER: Okay. So in many ways the plan -- the process is the same except that we have got an entity, Verisys, that is kind of riding herd on this, to my way of thinking, making sure the timelines

are met, creating maybe a better communication back to the provider about what is missing, what happens next, and so forth.

MS. MALLOY: And hopefully to eliminate paperwork and time on the provider's part, where if the provider is contracted with three plans, when it comes to re-credentialing they should only have to complete it one time.

DR. SCHUSTER: Ah, okay.

MS. MALLOY: Instead of three.

DR. SCHUSTER: Yeah, yeah. That makes a lot of sense.

Any questions from anyone who is with us today?

(No response)

MS. LYKINS: Yeah, but we are in negotiation with the other MCOs. So there may be others that are added to this as time goes on.

DR. SCHUSTER: Yeah. That was another question that we had in July, I think. So thank you. I would hope that the other MCOs would see the wisdom of this and get on board. Anything that cuts down on

paperwork for all of us providers and payors has got to be helpful.

MS. LYKINS: Exactly. And if you all have any suggestions, anything that you want me to look further into, please let me know. And I will be glad to look into it and see, you know, if possibly there is a solution out there.

DR. SCHUSTER: Okay. Great.

MS. ADAMS: Sheila, I had another question.

DR. SCHUSTER: Yeah, Kathy. Sure.

MS. ADAMS: So during the presentation they spoke about the difference between a provider and a facility. And, obviously, a hospital is a facility. They mentioned a CMHC as a facility, which is something we normally -- in my half of the world, we don't consider CMHC's facilities. But I was wondering what a BHSO or a Behavioral Health MSG is. Are they a provider or are they considered a facility, since a CMHC is considered a facility?

MS. MALLOY: So this is Laura. I think that that depends on how the plans are

currently credentialing. So when I mention a facility, I'm thinking an entity, right? It could be like a home health agency. It could be different types of non-practitioner entities that are contracted for Medicaid services, something that wouldn't be a practitioner.

If some of these organizations, the plans are currently contracting just the practitioners, I tend to think that they are also contracting with the entity, having a license and such. We would want to credential that entity. So it just depends on how it is structured. And I would look specifically to the MCOs or Shea that might have a better idea around that. I am not an expert in that particular situation.

DR. SCHUSTER: Yeah. Because the BHSOs get licenses, the AOD, the alcohol and other drug, entities get licenses.

MS. MALLOY: Uh-huh. Yeah. We would typically want to see that application. And it is called a facility application. But when you see the facility types, it is a variety of entities, non-practitioner types.

And, Shea, we could probably share that application with them. That might be helpful. Which I only showed the first two pages. But we can definitely get that application over so you can see what it looks like.

DR. SCHUSTER: Okay. I think that would be helpful.

MS. MALLOY: Okay.

DR. SCHUSTER: Does that help, Kathy?

MS. ADAMS: Yes. So it sounds like a BHSO or behavioral health multi-specialty group would be considered an entity as they have various different practitioners practicing for them.

MS. MALLOY: That would be correct.

MS. ADAMS: Thank you. And, so, I guess one other clarification.

So while it streamlines the re-credentialing process so that if you need to be re-credentialed with one of those three MCOs, it will take care of all three and it is just one application. For the initial application, you still have to submit

individual applications to each of the three MCOs?

MS. MALLOY: What is good about the -- that's true. What is good about the application is, the application was designed to support all three MCOs. So you complete it one time and it will support all three. So you are not creating -- you are not completing different paperwork, if you will.

MS. ADAMS: Awesome. That's good to know. So it is one application but it works for all three MCOs?

MS. MALLOY: Yes. That's correct.

DR. SCHUSTER: Okay. That's very helpful. I think the other question that came up, and this gets back to the kind of entities, facilities. So if you have an entity, let's say a CMHC, and you add staff who need to be credentialed, how does that work? Do they still need to -- do you still need to submit the paperwork for each of those additional staff people?

MS. LYKINS: For the providers, yes, you would.

DR. SCHUSTER: Okay. But, again,

that process would be the same, whether that is a person who is in an entity or facility or a -- you know, has their solo practice, with the application and the re-credentialing.

All right. If there are no other questions, I am so grateful to Shea and Laura for presenting this. And, as I said, Erin will get this out to us. And I will make sure that you all get it. And let's spread it widely. And we will wait for an early go-live.

And thanks very much to Claire Arant, who is the BH TAC representative from the Kentucky Hospital Association, for making this possible. So we appreciate it very much. Thank you all.

MS. MALLOY: Thank you.

DR. SCHUSTER: And you certainly are welcome to stay for the rest of the meeting if you would like to.

MS. MALLOY: All right. Thank you.

DR. SCHUSTER: It is scintillating, let me tell you.

So our next item on the agenda is a

report on which providers are reporting patient no-show data. And that had been a Lee Guice question. She helped me formulate it better. And I sent it to Justin Dearinger at DMS. And I don't know if he is on or not.

MS. BICKERS: I don't see him, Sheila. I'm sorry. I can follow-up with him after the meeting.

DEPUTY COMMISSIONER HOFFMANN: Sheila, yeah, I am not seeing him either. I had spoke with Angie earlier. We will see. I will make sure that we reach back out to Justin as well.

DR. SCHUSTER: Okay. He had said that he would try his best to get it ready for us. But he, you know, is new in his position, I know, and I'm sure he has a lot of pieces to pick up --

DEPUTY COMMISSIONER HOFFMANN: Sure.

DR. SCHUSTER: -- and keep going.

DEPUTY COMMISSIONER HOFFMANN: Knowledge. Our history and our knowledge.

DR. SCHUSTER: Right, went with Lee. So if that is not available, we will

keep that item on for the next meeting.

DEPUTY COMMISSIONER HOFFMANN: Sure.

DR. SCHUSTER: And that will be great.

So we have now another presentation. And this is a follow-up on an earlier presentation that we had back in May on prescription digital therapeutics. And we are very pleased to have Dr. Katie Marks, who is the project director of K.O.R.E., K-O-R-E, the Kentucky Opioid Response -- what is the E? --

DR. MARKS: Effort.

DR. SCHUSTER: -- Effort. Yeah, Effort. I'm sorry, Katie. So, welcome. And we look forward to your presentation.

DR. MARKS: Hi.

MS. MUDD: Just real quickly, on my phone it said Queen Elizabeth has passed away.

(Oh)

DR. SCHUSTER: How sad. Well, thank you, Val. I think most of us feel like we grew up with her as our Queen Mum or

something. So, yeah, thank you.

So, Katie, I will happily turn it over to you and let you take it away.

DR. MARKS: Oh. I appreciate that, Dr. Schuster. And I will also acknowledge the moment and maybe just respectfully take a second to pause for the loss of the Queen. And I know her role permeated our experience in American culture as well.

DR. SCHUSTER: It certainly did.

(Moment of silence observed)

DR. MARKS: All right. So thank you for the introduction. I will make my portion of this brief. And that is to talk about what K.O.R.E.'s experience with reSET-O has been like and to share with our Pear partners in presenting some data. I think most of you that have ever seen me talk before know that I get most excited when I get to have data along with a conversation about clinical work. And, so, this is that perfect combination.

If you are not familiar with K.O.R.E., though, K.O.R.E., it is a SAMHSA funded grant initiative that is awarded to

the Department of Behavioral Health, Developmental and Intellectual Disabilities. It has a very focused mission, which is to increase equitable access to high quality, evidence-based prevention harm reduction treatment and recovery support services.

And, so, we know that there are a couple of key interventions within K.O.R.E. that are really important to fund to reduce overdose death. And, so, Naloxone distribution or Narcan is, of course, one of those medications for opioid use disorder. Community outreach and engagement, care coordination, and recovery support services all fall under what we do.

Contingency management, though, is an extremely well evidenced-based intervention that has been researched for decades that shows that we can reduce illicit substance use and improve treatment retention by using monetary rewards to reinforce targeted behaviors. And targeted behaviors could be attending appointments, attending sessions, providing urine drug screens that are negative for illicit substances.

So contingency management from a theory perspective is really kind of simple. You provide reinforcers and people tend to adhere when those reinforcers are monetary or in some monetary form. But in practice, it is challenging to implement. There is a lot to do in terms of designing the contingency management program to fit the needs of the interventions being delivered. It can be challenging to track all of the behaviors, record them, provide payments to participants, track the payments.

And, so, contingency management, even though it is really well evidence-based, has not seen the level of implementation that we need in the state. And, so, as we have thought about how K.O.R.E. can support this EBP, the opportunity to partner with Pear and their digital therapeutic that combines cognitive behavioral therapy techniques with contingency management just seemed particularly ideal.

And, so, we sought to do a pilot with Pear and with the reSET-O digital therapeutic for two key reasons. The first

was that SAMHSA has given us a challenge. And I say that in somewhat of a joking manner. They have set a cap of $75 as an annual cap on the amount of reward someone can receive. And we know from the literature that $75 is just not sufficient. It is too low of a cap. But we have to pass that requirement on to our grantees. And, so, we -- because the reSET-O was designed to be able to provide a larger cap, we needed to pilot the test with the larger -- with a smaller cap. And, so, that was the first reason, was to pilot the $75 cap placed on individuals. And the other was to just have Kentucky specific, K.O.R.E. specific data to look at, uptake, both the provider perspective and the patient perspective, on how this went.

And we decided to partner with federally-qualified health centers. They were great candidates for two reasons. First, several of them are participating in a project with the Kentucky Primary Care Association and K.O.R.E. to implement medications for opioid use disorder in their

clinics. And, so, they are already doing a lot of this good work towards supporting OUD treatments and stimulant use disorder treatments. And, so, this was a great addition.

And the other thing is that many of our FQHCs don't have as much behavioral health infrastructure as they had hoped. And, so, the ability to provide this adjunct therapy that could be delivered in off-hours, it would not increase significantly provider burden, it seemed like a great fit.

And, so, we came to Pear. We said, "Will you do a pilot?" We went to our FQHCs and said, "Would you participate in a pilot?" And that's exactly what we have done.

A hundred people were included in the first round. We are doing our second round of funding at this point. But what we have to present to you today are the results of the first pilot. And I will turn it over to our Pear partners to walk through the data. But I'm happy to answer questions at the end if that would also be helpful.

DR. SCHUSTER: Thank you so much,

Katie.

MR. SCHEPERS: All right. Thanks, Katie. I am going to go ahead and see if I can share my slide, if I have that capability. Here we go. All right. Does everyone see my slides here?

DR. SCHUSTER: Yes. Uh-huh. Thank you.

MR. SCHEPERS: Great. So I am going to just quickly walk back a bit and just provide an overview on what we are talking about.

I think we spoke about this a few months ago, but just to reiterate before we get into it, that reSET and reSET-O involved addiction specific cognitive behavioral therapy that, alongside that contingency management, a reward system provided 12 week patient prescription, that patient completed over a course of, as I mentioned, a 12-week prescription. In combination with that, there is a patient that -- or a provider-facing dashboard that we see in the second little screenshot here that providers, clinical care team members can access through

a secure username and password, in some cases through a 30-HR delivery system, which provides the providers and the patients in some instances with realtime data on the patients as they move through it.

The final little screenshot that we see on the far right represents the patient services center, which is adherence support that is provided to patients who use the reSET and reSET-O therapeutic in regards to some of those patient fall-offs, patient drop-offs in treatment, as well as some technical or product-related issues that they might have as well.

So Katie really well covered the collaboration with K.O.R.E. and the objectives of the study. So I am going to walk right into some of the details, starting with just some of the demographics information in the trial. So here we just see over the course of the five months how patients were on-boarded across these clinics into their practice, making a total of 100 patients in this first pilot. And then we see how they were distributed across

different treatment locations. So we see by in far the majority of patients were treated at Whitesburg at the Mountain Collaborative Health Corporation, 72 of the patients were treated there, 14 percent in Cumberland, 7 in Harlan, 3 in Cornettsville, and 4 in Owensboro.

We see the majority of patients were using the reSET-O therapeutic. So that is the therapeutic that has indications for patients who are opioid use disorder patients specifically and using Buprenorphine alongside their treatment as the on-label medication here. The reSET therapeutic on the right, which is a smaller percentage of patients, those are substance use disorder patients more broadly, alcohol, cannabis, cocaine, stimulants would be the primary indications there.

We will start by looking at just who these patients were and how they reported themselves in terms of their age and their sex. These are data that we often see across different patient populations. Just for a little bit of background, I believe the total

patient population that have been treated with reSET-0 in the State of Kentucky is over 1,000. But we see these same patterns in terms of the age and sex. So as we see here, most of the patients fell between these 30 and 49 age ranges, the vast majority of patients, but we had patients in 18 to 29 and some older patients, even over 60. We do tend to see a skew towards female patients, 61 to 37 percent of the population were female, which is actually pretty interesting given that we do tend to see the prevalence rates and treatment seeking rates higher among males in terms of opoid use disorder specifically. But we do see that skew across our data for reSET and reSET-0.

So moving on to some of the details around the study. The data we are going to be sharing are looking specifically at 79 of the patients who were considered engaged. So these are patients who started using the therapeutic and completed at least one lesson. So all of the data we are going to be walking through are looking at those 79 out of 100 patients. Across those patients

they completed 2,351 lessons or they engaged in 2,351 lessons and completed 1,638 modules. On average, patients who were engaged spent about 49 minutes per week inside these prescription digital therapeutics, receiving content, reporting cravings, reporting urges, as they would.

The final bullet point there just shows a little bit of that information that Katie also touched on, that patients do use this outside of hours where they might be able to see a provider. So we measure that as patients using the material, accessing sessions outside of what we might think of as a normal clinic hour. So we see 86 percent of the patients in this pilot used or started a session between 7 p.m. at night and 8 a.m. in the morning.

And now we will look into this data a little bit more specifically. This slide is just showing us patients' activity over the course of that 12 week prescription. So, of course, 100 percent of the patients who were active used the therapeutic during the first week. And consistent with other data

we see patients -- we see fewer percentage of patients that are active over the course of the prescription. That could be for a variety of reasons. That can be patients having intermittent or consistent use over cohorts, sometimes patients finish the content early.

But also, of course, patients drop out over time. But I think when we look at the fact that we have 60 percent of patients still engaged in weeks 9 through 12, in this patient population I think these are pretty robust when we use comparisons related to things like Buprenorphine adherence, which are in the 35 percent range nationally for patients at four weeks or when we look at other data that we have around patients using digital health and wellness applications, we see those retention rates are about one and a half percent after a month. So in that context, just I know that these retention and adherence data are kind of difficult to process, but in that context it can help us to understand kind of how robust they are.

When it comes to lessons, this

slide is looking at average lessons or average addiction specific cognitive behavioral therapy lessons patients are completing on average over the course of the 12 weeks. So in the therapeutic we consider perfect use to be four modules per week. We see the best outcomes when patients are completing four modules a week. But the K.O.R.E. patients really did pretty well here, I would say received a passing grade. If we are considering four modules per week perfect, we see that even by the end of treatment the patients that were completing modules were completing about three and a half, 3.3 modules over that week.

And when we look at that in a slightly different way, here we are looking at percentage of patients who did achieve that perfect use of the therapeutic, here at the end of treatment we are seeing 63 percent of patients in the pilot that we are completing was four or more modules in the course of that week. And we see some ebb and flow in that number over the course of the 12 week prescription as well.

The data we see on this slide are looking more at those hours of day, right? So this is what we talked about before, looking at the patients using the therapeutic during clinic hours and using the therapeutic outside of clinic hours. So that is the figure that we see on the left. And, so, this is percentage of lessons completed. And on the X axis we see the time of day, so between 12 a.m. and 11 p.m. And we see the majority of activity occurs during most typical clinic hours. But, again, we see a large percent of patients use these therapeutics outside of these clinic hours as well.

And on the right we just see days of week. So we see patients use the therapeutic, for some reason patients seem to use the therapeutic a little bit more on Thursday and on Wednesday and Friday than other days. But I don't know if there's a whole lot we can read into that, either.

And this is, finally, the slide that we are showing here, is looking at patients reporting cravings and triggers. So

we didn't go into that very deeply. But patients have the ability to really in realtime report on some of the urges, some of the cravings that they might be experiencing for a substance. And alongside that they can report some of those physiological or psychological triggers that they might be experiencing as well, really provide some better understanding of some patient specific issues where some specific content might be applicable.

So this is just showing the numbers of check-in's. And we see how they did it over the course of day. And, again, we see that same pattern, where patients do a lot of it during the day but we see patients reporting cravings and triggers even during the middle of the night and in the evening hours as well. And then on the right we see the days per week of check-in's.

So that is really what I have, is a high level on the clinical data. I do think it is worth reiterating here that. As Katie mentioned, our therapeutics are typically provided with a -- when we are not subject to

SAMHSA requirements around funding to a $599 price limit or contingency management limit. With the K.O.R.E. grant these were at a $75 contingency management limit, as Katie mentioned, in many cases it is not sufficient to see the outcomes that we hopefully would from other trials using the larger amounts.

I am happy to take any questions.

DR. SCHUSTER: Thank you very much. Let me see if anyone has any questions about the data, about the study.

(No response)

DR. SCHUSTER: I noticed in the chat, Dr. James, that -- oh. That's just to me. Can I share that? Tom, are you --

DR. JAMES: Yes, I can. Yes, you can share that.

DR. SCHUSTER: Okay. So Tom James, the Medical Director at Passport by Molina. Passport has a policy of covering FDA approved digital prescription therapeutics. Most are in the behavioral health or diabetes area.

Yeah. I think that would be interesting to see. And I guess my follow-up

question with -- both with Dr. Marks and Dr. Schepers is:

Where are we with approval for these digital prescription therapeutics on the substance use disorder side?

MR. SCHEPERS: Yeah, I'm happy to touch on that. These are both -- both of these therapeutics, reSET and reSET-O, are FDA authorized as Class II medical devices through the software's medical device kind of pathway through the FDA. But they are authorized much in the same way through the same pathway as we see in, like, a Dexcom or a glucose monitor has been approved under or has been authorized under. So that is a good question. Thank you.

DR. SCHUSTER: So there was legislation in this last session. And I know Chad is on, can probably answer this because my memory is a little fuzzy. It was a resolution, I think, Chad --

MR. GRANT: Yeah.

DR. SCHUSTER: -- to urge Medicaid to look at this issue.

MR. GRANT: Yeah. Dr. Schuster, it

was House Resolution 28. And what it did is it requested that the Kentucky Department of Medicaid Services get a response back from CMS whether they would cover it. And, so, right now where we are kind of in that process is that by now the Kentucky Department of Medicaid Services should have sent that notice over to CMS. We have not heard back if CMS has responded yet or where we are in that process. But there is a report due by early December. It is going to run to the Legislature, of course the Administration, but also runs to the federal legislators also.

So we will have a clear, concise idea of what CMS plans to do with this, you know, typical situation. Hopefully CMS doesn't take too long getting back to the Commonwealth. But that is kind of where we sit right now. So maybe an update from Medicaid would be great to hear if they have heard anything back. But we have not heard anything yet. So...

DR. SCHUSTER: Leslie, do you know if Kentucky DMS has heard anything back from

CMS?

DEPUTY COMMISSIONER HOFFMANN: Not that I am aware of. If you don't mind, I will follow-up for you; is that okay?

DR. SCHUSTER: Yeah, that would be fine. Yeah. I think we want to keep an eye on this.

And, Chad, you are very good about staying in touch with me, so I'm sure I will hear from you about what the status is. But if there is a report issued, you know, I think there are a number of us that would be interested in seeing that when it is out.

MR. GRANT: Yeah.

DR. SCHUSTER: And let me ask Katie. And I should know the answer to this but I don't.

How much longer is the SAMHSA funding available for K.O.R.E. and all of the wonderful activities that you all are doing?

DR. MARKS: So the current SAMHSA grant ends in a year from now. And we are on our no-cost extension beginning in 21 days. But the SOR 3, which is the fourth award from SAMHSA, will begin September 30th. That will

continue for two years, through September of 2024.

DR. SCHUSTER: Okay. So it looks good.

Yeah, a good question here in the chat. Are there any changes in the study design for the second cohort? I assume you mean for the digital therapeutics.

DR. MARKS: Not in the intervention itself. I know that there are additional FQHCs that are participating in this round. But the intervention, the cap, those are all the same.

DR. SCHUSTER: Okay. And then, Marcie, Mental Health America of Kentucky, is asking what data you have on employment status and work hours and whether there is usage during -- when people are not working.

MR. SCHEPERS: I would say that we at Pear do not collect information related to patients' employment. Whether Katie's group collects that information, I am not sure.

DR. MARKS: We collect employment, but the data is not linkable in that way. And, so, we wouldn't be able to answer that

question.

DR. SCHUSTER: Oh, okay. You know, it is an interesting question because I think there has been so much -- and sometimes the legislators get real fixated on whether people are working or not regardless of what their situation is, but I do think that we -- you know, when we think in terms of recovery, we want people to be able to return fully to their community and to society and certainly work or school or those kinds of things are part of that. So interesting to look at that. Excellent presentation. We appreciate that.

Any other questions from anyone on the meeting?

(No response)

DR. SCHUSTER: All right. Well, thank you so much. And keep up the good work, Katie, with K.O.R.E. I'm sorry I couldn't remember the "Effort" part. I should have remembered that first.

It is great that we are having such a focused intervention around the opoid use for sure. And we will look for some

follow-up information from Chad as things move forward. So thank you. Appreciate it.

MR. GRANT: Thanks, everyone.

DR. SCHUSTER: Our next is a return to an issue that I keep hoping is going to get resolved and then it doesn't get resolved, and that's the claims payments for services to dual eligibles.

So we heard in July that there still were some issues. Bart Baldwin could not be on the call today, but he did send a letter, which I will read to you.

"For the MCOs that have bypass lists, providers are able to use them but it is not without issues. The administrative burden is high for already over-taxed providers. MCOs have separate and distinct processes, which adds to the administrative and time burden. MCOs still process claims in error and deny EOBs. It is a very time-consuming process and ultimately it takes an inordinately long time for the provider to get paid, if at all."

And then he goes on to say that two of the MCOs, WellCare and United, do not have

bypass lists. And, so, providers have not been paid for services provided and either accept that they will not be paid or have decided to stop accepting dual eligible clients altogether. And he asks for some assistance from Medicaid.

Kathy, do you want to give a brief report of -- I know you are in the data gathering stage with the Children's Alliance folks, but you are having trouble again getting the bypass list to work I think.

MR. OWEN: Dr. Schuster, may I intervene for a second?

DR. SCHUSTER: Yes.

MR. OWEN: This is Stuart Owen from WellCare.

DR. SCHUSTER: Yes.

MR. OWEN: We do have a bypass list. We have been working on it extensively and with providers, so we do actually have one. I think the complaint is that we don't publish it on-line, but we do have one. I believe we launched it in June.

And, you know, the big concern is, we're required by law, Medicaid is, to be the

payor of last resort. And I know, you know, it is kind of a delicate balance because some providers simply don't want to do anything to demonstrate that they have billed commercial first. So that's what the challenge is. But we have got a group that has been working on this very extensively and we do indeed have a list and I think it went live July one -- June 1. I know it was in June. But we do have a list, so I just wanted to share that.

DR. SCHUSTER: Okay. So if a provider has someone who is a WellCare -- or WellCare is their MCO, Stuart, how would they -- would they contact you to get the list?

MR. OWEN: They -- you know, you might as well for now. That would be fine. That would be fine.

DR. SCHUSTER: Okay.

MR. OWEN: And I can get it -- yeah. And I can get it to the right people. That would be fine. I will put my e-mail in the chat.

DR. SCHUSTER: Okay. That would be great.

MR. OWEN: Sure.

MS. ADAMS: And the list will -- if we e-mail you, Stuart, we will get the list? Because I had some members tell me, just learned I guess it was last week, that WellCare was in the process of developing a list and then heard that it was developed but that it wouldn't be -- they weren't releasing it and that literally you had to go code by code and ask your provider rep if this code is covered or not.

MR. OWEN: Yeah. I mean, I --

MS. ADAMS: (Inaudible).

MR. OWEN: Well, sorry. I was going to say, yeah. I mean, because the concern with publishing it is that there can be -- I mean, there would be scenarios where the commercial insurer does cover it but just the fact that it is published, providers will skip it. Do you know what I mean? They won't bill the commercial insurance first. They'll just say, "Here's the list. I am not even going to bother with it." So that, you know, that is a concern.

And, again, we can get audited by the Department of Medicaid Services. "Why

are you paying for this? You know, you are paying as primary and Medicaid was not primary in this scenario."

So, like I say, it -- you know, it's -- it's -- there's a balance there. You know, the provider still has the obligation to bill. So...

But I know just from internal talks we don't pub -- intend to publish it for that reason, because we don't want providers just to skip to, okay, I'm just going to bill WellCare for this, when in reality they're getting -- you know, commercial insurance varies, the plans. There are different plans, different types of plans, not just different insurers. So it could be covered.

And, again, by law, you know, we are required to be the payor of last resort. So...

MS. ADAMS: I thought the purpose of the bypass code list was so that they didn't have to bill the commercial insurance because we already -- what the MCO was saying with their bypass list is, we know commercial insurances won't cover these codes.

Therefore, you can bypass sending your EOB -- or sending your claim to them and trying to get an EOB, which you rarely ever can get an EOB.

MR. OWEN: Yeah. I mean, I know that the group has worked at -- they have identified given codes, you know I guess higher volume codes, that don't seem to be covered by commercial and just kind of, you know, slowly building out, I guess is the best way to say it.

MS. McFALL: Stuart, this is Paula. And we have had -- senior leadership is in the process of discussing a partial list of those (inaudible) codes that are almost never paid by commercial. But, again, I think the request from WellCare is that you file for primary in addition to filing with WellCare.

DR. SCHUSTER: Thank you for that. I would like to hear from the other MCOs that are on in terms of it. I understand what you are saying, Stuart, about Medicaid being the payor of last resort. But the issue has been that you can't get an EOB because they are not going to say that they don't cover that

service, you know, and that's always been the hang up.

So I guess I'm a little bit unsure why people have to go through that process if we already know that a commercial plan x is never going to cover codes, you know, a, b, c.

DR. HANNA: Sheila, this is Dave with Passport.

DR. SCHUSTER: Yeah, yeah.

DR. HANNA: And we have a list and we make it available.

But I do want to say that I worked a couple of years ago very closely with the Community of Mental Health Centers trying to get a list together. And there is a major problem in that different commercial insurance companies cover different services and they cover different codes. And you can identify a very small group of codes that never get covered.

But to Stuart's point, when we are responsible for making sure that people try to bill the insurance, unless we see something or look at -- you know, get some

evidence that this particular insurance doesn't cover it, it is tricky to manage. I mean, I think, you know, we are trying to do it. We have a list and people can see that and I know people are going to, you know.

And, but, you can't -- you know when we get this, you know, this provider bills for, you know, Bill Jones and they bill for Mary Smith, and they are still responsible if their commercial covers it to bill that first, and it is truly hard to manage.

MR. OWEN: And, Dr. Schuster, I was going to say, there is an option for providers that we have to send an attestation, essentially, that we tried, we tried to bill. We are not going to get the EOB but we tried, we made an attempt, just to document. You know, again, just to document. Because we can get audited. Again, why are you paying as primary?

So, but, we do give them that option, just send us a statement that you attempted or that it is not -- that

particular code is not covered by the particular plan. Again, there are multiple plans. But then, you know, it is not like one size fits all commercial insurance.

DR. SCHUSTER: Right, right.

MR. OWEN: Yeah.

MS. ADAMS: So is that the TPL form? Because DMS allows a TPL form, third-party liability. And it is basically a form saying that you can submit -- I think it is after 90 days of you submitting the EOB to the commercial insurance and you don't hear back, then you can submit that third-party liability letter and get paid.

MR. OWEN: Yeah, I don't know exactly. That makes sense. That sounds logical to me. But I don't honestly know. I can check on that. Basically, will the TPL form suffice as the attestation?

MS. ADAMS: Yes. That's the question.

MR. OWEN: Okay. Yeah, I will check on that.

DR. SCHUSTER: So in that case a provider who regularly deals with commercial

insurance x and knows that they never pay for code, you know, a, b, c, could sign an attestation form or this third-party liability form and say, "They simply don't pay for this, so that's why I am billing you, MCO."

MR. OWEN: Yes. Exactly. Because there's got to be some kind of documentation. You know, if we get audited in the state auditor's office, CMS audits, what proof do you have that you were -- that, you know, there was no primary? You know, there has to be evidence. So at least attestation puts it on the provider, you know, that they are attesting to that. And they say, "Here we go. We have got this statement from the provider," you know, something to document.

DR. SCHUSTER: Okay. Leslie or somebody, Angie, I don't know, can you send me that TPL form so we have it, please.

MS. PARKER: Sure. Yes. Our Program Integrity Division.

DR. SCHUSTER: Okay.

MS. ADAMS: And Sheila, I'm sorry, I'm frustrated.

DR. SCHUSTER: Okay.

MS. ADAMS: I feel like we are chasing our tails. Because years ago, years ago, two, three years ago some of the MCOs were accepting the TPL forms and life was a little bit better. And then the MCOs stopped accepting the TPL forms. And, so, now it seems like we are circling back around again and saying, "Oh, we will accept the TPL forms."

I -- you know, until they program their billing systems to accept that TPL form, it -- again, it's going to kick the claim back. And we are back to where we started and back to Bart's letter of it is just so, so time-consuming to jump through all of these hoops to try to get paid for something like targeted case management, comprehensive community services; you know, those are services. You know, show me a commercial insurance that provides and will cover those services.

It was my understanding that the purpose of the bypass list was to -- you know, is that the MCO had acknowledged

that commercial insurances don't accept these codes, therefore, the provider can bypass sending these codes, claims for these codes to the commercial insurance and bill them directly to the MCO. I thought that's what a bypass code list was. But apparently they're still expected to send bills to the commercial insurance, even when there is a bypass list. I mean, this is the first I've heard that.

And then the other thing is, you know, providers can't do all of this. You know, I understand. You know, and I -- and we have been told that the very reason DMS doesn't have a commercial bypass list is because there's so many commercial insurances out there and you have to insure that Medicaid is the payor of last resort.

So, again, do we have bypass lists and can we use them? Or is the expectation still that we send it to the primary insurance?

And then the other question that Bart raised was that now the bypass code lists aren't working anymore; for some of the

MCOs the bypass lists aren't working. And I've reached out to our members to try to assimilate some examples of that.

But we had a meeting with our billing staff last week, and that was -- Bart had raised that issue with me. I hadn't heard it. And then when we met with our billing staff last week, definitely it came up. And, you know, unfortunately, the bottom line is, as you have said numerous times, Sheila, here is somebody that has commercial insurance --

DR. SCHUSTER: And Medicaid.

MS. ADAMS: -- and Medicaid and they should be getting better services. And what happens is they don't get any because the Medicaid providers can't continue to provide services and jump through all of these hoops to still never get paid.

MR. OWEN: Kathy, a quick point. If -- I misspoke if I said -- if it is on the bypass list, then you don't have to submit proof. If I said that you do, then I misspoke.

MS. ADAMS: Thank you.

MR. OWEN: Sure.

MS. ADAMS: That's what I understood, that's what I heard, so I may have heard wrong.

DR. SCHUSTER: Okay. Yep. That helps, Stuart, because I had understood you to say something different than that.

MR. OWEN: Sorry about that.

DR. SCHUSTER: Yeah. You know, when I think back, and Steve is not here, but Steve and I have wrestled with this for 20 years, I know. And it just makes no logical sense to me that people that have two coverages are more likely to not get served.

And my real concern -- and we know it's -- a lot of times it's kids that have the commercial plan plus Medicaid. And I really worry that our providers are going to quit serving them, I mean, if you think you are not going to get paid or the cost of getting paid is more than what you are going to get paid.

MS. ADAMS: And that's exactly what is happening.

DR. SCHUSTER: Yeah. I mean,

you know, one of the good things about behavioral health providers is that they continue to provide needed services whether they think they are going to get paid or not. The bad news is, that they keep providing services whether they think they are going to get paid or not, then we're coming to a point I think where the margins are so thin and there is so much work to be done and fewer staff to do it and more people in need that, quite frankly, I could see an agency or a provider saying, hey, if I have a choice of serving Johnny, who has commercial plan x and Medicaid, or Suzie, who has just Medicaid, you know, it would certainly push you in the direction of serving Suzie, quite frankly. And that really is of concern.

Let me throw in something else. Because I had not read my own notes from the meeting and, so, belatedly I reached out to Angie Parker. And she had mentioned Jeremy Armstrong, who is the branch manager. I guess it is Jeremy Armstrong-Derossitt. And I got a very nice e-mail from him on Friday, actually, saying I am very willing to work

with you all and with the MCOs. And, so, I have reached out. Bart knows that, Kathy knows that, Steve Shannon and the CMHCs know that. If others of you are having these dual eligible issues, if you want to send the information to me I will make sure that Jeremy gets it. Or, Angie, maybe you could put his e-mail address in the chat. That might be a more direct route.

MS. PARKER: Yes, ma'am. I will do that.

DR. SCHUSTER: Yeah. Thank you. Let's do it that way, because I don't want to be responsible and I am not sure I need to know all the details.

But he said, make it as detailed as possible so he knows what the situation is. So name the MCO for sure, name the commercial insurer that is involved, and, you know, what your road to not getting paid has been.

And, so, he has offered to be in that position. And we will keep this on the agenda. This is one of those I think, Kathy, that we may never get rid of. Hopefully, it will get better.

But let's get some clarification as well, maybe Angie, I don't know if it should come from you or from Jeremy about the use of the TPL and how that would help or not help.

MS. PARKER: I was just talking with Jennifer Dudinskie, who is our Division Director in Program Integrity.

DR. SCHUSTER: Yes. Thank you, Jennifer. I see that you are on and helping Medicare.

MS. PARKER: Yeah. And the TPL aspect, we can certainly -- I know that this TPL form has been shared with the MCOs before.

DR. SCHUSTER: Okay.

MS. PARKER: And we can certainly look to see who is using it or who is not. But I guess if you are not getting that information back from the MCOs, they may not be using it now. So we will look into that.

DR. SCHUSTER: Yeah. I think if, you know, if you all at DMS, Angie, could put your heads together, just give us some guidance about whether the TPL is something that ought to be submitted with the claim to

the MCO, if that is helpful. I am still a little confused about what all needs to happen in this.

And if you need to talk with a couple of people, let me know and we can set up maybe a Zoom with some of the folks that are involved.

MS. ADAMS: DMS has the TPL form and the instructions as part of the BHSO and BH -- Behavioral Health MSG billing Manuals. So that information is in both of those manuals.

DR. SCHUSTER: Okay. I have not heard about it on the CMHC side, but that's usually Steve's bailiwick, so I will have to see. I know we've got some CMHC folks on here, but whether they are the billing people or not. I did reach out to the CMHCs, and I know Bart did as well. But let's see if we can get some clarification on that.

The bottom line, and I think we all have the same goal here, providers want to be able to serve everyone who has Medicaid, whether they have another coverage or not, number one. Number two, the people need the

services. And number three, the providers need to get paid for providing the service.

And there's Jeremy's e-mail address. I also just sent it to him at Jeremy.Armstrong@ky.gov and he got it, Angie.

MS. PARKER: Okay.

DR. SCHUSTER: Yeah. That's very helpful. Thank you very much.

MS. PARKER: Uh-huh.

DR. SCHUSTER: We also -- and, again, this is something. The MCO audits we thought were kind of solved, but we are hearing again that they are up in number and up in duration. And I can't remember. Kathy, did you have anything specific on the MCO audits?

MS. ADAMS: Just that it seemed like I wasn't hearing as much, you know, as many complaints, and they have started up again. We had an example given by one of our members, and it is a huge member, that in '20 to '21 they had 250 to 300 audits, of pre-billing audits, prepayment audits, and in this last year they have had 2,800.

DR. SCHUSTER: Wow. Woo. That

kind of takes your breath away. Angie, I think that you have told us in the past that people -- you know, that there's some limitations certainly and they are supposed to give 30 days at least for a reply and people could ask for more time and so forth.

But if that number is an accurate number, just the sheer number of things to be dealt with seems extremely difficult.

Are you all at DMS putting any pressure or requirements on the MCOs with regard to audits?

DEPUTY COMMISSIONER HOFFMANN: Sheila, this is Leslie. The only thing I can think of right off the bat is because there are still no prior authorizations for the most part. So there is a back-end check. There is nothing that we have asked for more audits or anything like that. I'm just saying, there is no prior authorization. So of course the MCOs are still held accountable for quality assurance and best practice and things like that in billing.

DR. SCHUSTER: Yeah.

DEPUTY COMMISSIONER HOFFMANN: It

was my understanding, though, previously that they can ask for more time. Unless an MCO disagrees with me today, I think it was offered for additional time for submission.

DR. SCHUSTER: Yeah. So you are going to put the time in and see they are going to be, in justifying it on the prior authorization end or you are going to get it on the audit end is essentially the situation.

MS. PARKER: And in some circumstances that could be the reason, yes. But as we have mentioned before, if the provider is having challenges with meeting that time frame, that the MCOs can certainly ask for additional time and the MCOs should be able to grant that.

DR. SCHUSTER: Yeah. So the only relief, actually, is -- there is no relief on the numbers, the sheer numbers of audits. It is really on the time frame for replying.

MS. PARKER: And Jennifer Dudinskie, who is also in Program Integrity, I don't know if you can discuss any of the audits in place, if this would be

appropriate.

But as far as a sheer number per provider, that is based on the claims that they are receiving. And as Deputy Commissioner Hoffman stated, they do have the ability and should be auditing certain claims to determine medical necessity.

DR. SCHUSTER: Okay. So, basically, what they are saying is that since we don't have the ability to determine if the service meets medical necessity, we are going to come back after the service has been provided to ask for that justification.

MS. PARKER: They can do that, yes.

DR. SCHUSTER: Okay.

MS. BICKERS: And Jennifer is going to respond via text. She is having a little bit of issues with her voice today.

DR. SCHUSTER: Yeah, I see that. Thank you, Jennifer. And we will come back to that.

MS. ADAMS: Angie, is there something -- it's just -- I'm sorry. It's left my train of thought. That didn't take long, did it? You can circle back to me.

Sorry.

MS. BICKERS: Jennifer responded and said, "I think the audits that you are mostly referring to are likely to be TCM audits. And those are required of us. Therefore, we can only be lenient in regard to the time frames."

DR. SCHUSTER: So those are targeted case management audits. And those are --

DEPUTY COMMISSIONER HOFFMANN: Sheila, I can speak just a tad to that.

DR. SCHUSTER: Okay.

DEPUTY COMMISSIONER HOFFMANN: We have had two state audits and two federal audits and another one that has come around again. So we are held very tightly to the gun to provide that information.

And that was an audit that came to Program Integrity as well as the behavioral health group side. So I wasn't thinking about that, but that definitely could be a driver.

DR. SCHUSTER: So is that from the feds?

DEPUTY COMMISSIONER HOFFMANN: It started out as a state audit, then it went to a fed -- that drove to a federal audit. And this is when I first returned back. And then since then we have had another state audit that was driven to another federal audit. And I think we have just had one more state one recently. So it is probably starting to very much compile on each other after this many audits.

And we usually provide those responses jointly, between me and Angela in her previous role and then Jennifer Dudinskie's group as well.

DR. SCHUSTER: Okay. So you all -- I know that you have said in the past, Leslie, and I understand, I am not -- you know, I'm trying not to point fingers. We are just trying to get services done and keep providers in business and make sure our Medicaid folks get what they need.

So I know that you all have a responsibility and you have to report to CMS that you are auditing what is being done in Kentucky on all Medicaid services, right?

DEPUTY COMMISSIONER HOFFMANN: Yes. And we have a state auditor as well. So we have a state auditor, just like anybody else, we have a state audit that checks us, and then we have a federal audit if the state auditor has additional questions that we were not able to answer at the time.

DR. SCHUSTER: So, and, those state audits have been specifically around targeted case management?

DEPUTY COMMISSIONER HOFFMANN: Yes, ma'am.

DR. SCHUSTER: Okay.

DEPUTY COMMISSIONER HOFFMANN: And that started right before I returned a couple of years ago. So, like I said, we have been through several rounds now with those audits, both state and federal.

DR. SCHUSTER: Okay. So at least -- I guess the answer, Kathy, then for -- it would be interesting to go back to your person who had the 2,800 audits to see how many of them were about targeted case management, just out of curiosity.

MS. ADAMS: I can do that. They

didn't clarify at the time.

DR. SCHUSTER: Yeah.

DEPUTY COMMISSIONER HOFFMANN: I hadn't thought about that, and I apologize for not thinking about that.

DR. SCHUSTER: No, that's all right.

DEPUTY COMMISSIONER HOFFMANN: That could definitely be a driver for you, Sheila.

DR. SCHUSTER: Yeah. Well, it also reminds me that we still have, you know, some data and some follow-up steps with Commissioner Lee on that targeted case management data. So I'm hoping that we can use that in some ways to respond to some of these issues.

DEPUTY COMMISSIONER HOFFMANN: Sure. Is there anything you need me to do on that follow-up? Are you waiting for her? I know we finished the data.

DR. SCHUSTER: You know, I was waiting for her. She was going to get in touch with the UK.

DEPUTY COMMISSIONER HOFFMANN: Oh. That's right. University Partnerships for --

DR. SCHUSTER: Partnership with all of the data collection over there. I forgot what it was called.

DEPUTY COMMISSIONER HOFFMANN: I remember her saying that. Okay.

DR. SCHUSTER: And I had never heard from them. And she thought maybe they would be in touch with me. No, not KIPRC. No, not case management. It's the data analytics, isn't it?

DEPUTY COMMISSIONER HOFFMANN: OHDA?

DR. SCHUSTER: No. It is the UK.

DEPUTY COMMISSIONER HOFFMANN: IPOP? I can't remember.

MS. PARKER: University Partnerships?

DR. SCHUSTER: Ask the Commissioner.

DEPUTY COMMISSIONER HOFFMANN: Okay. So I will check on that one for you.

DR. SCHUSTER: I know the guy's name and I --

DEPUTY COMMISSIONER HOFFMANN: Oh. Jeff Talbert's group?

DR. SCHUSTER: Jeff Talbert, yes.

DEPUTY COMMISSIONER HOFFMANN: Yeah. He used to be with IPOP. Now he has moved.

DR. SCHUSTER: All right. Whoever he is with, he is the guy.

DEPUTY COMMISSIONER HOFFMANN: Yeah.

DR. SCHUSTER: And they -- he is -- the last that I talked with the Commissioner about our data, she said, "I want to pursue this more. And let's get UK involved. And I am going to talk with them and they will be in touch with you." And I have not.

DEPUTY COMMISSIONER HOFFMANN: Yeah. Okay. I will follow-up.

DR. SCHUSTER: Yeah. I think it is Talbert, not Talbot.

DEPUTY COMMISSIONER HOFFMANN: Yeah. Sorry.

DR. SCHUSTER: Yeah.

MS. BICKERS: Kathy, Jennifer said if there are others outside of the targeted case management, she is happy to look into that and figure out what is going on.

DEPUTY COMMISSIONER HOFFMANN: Uh-huh.

DR. SCHUSTER: Oh, okay. That would be helpful. So one of the things that, I will get back with Bart and talk with Steve as well, is we are gathering information to get to Jeremy, let's look at what these -- no. That is dual eligibles. Pardon me. Forget that.

Yeah, let's look at what these are about. That would be helpful. Thank you.

MS. ADAMS: And I did remember my question. I'm sorry.

DR. SCHUSTER: Yes.

MS. ADAMS: And that is that some members indicated that they are being audited back to 2019. And I know that there's either KRS or KAR that says that audits can go back 24 months, I think, from the time that they were remitted.

And then some seem to think that DMS put something in writing that allowed the MCOs to audit back to the time when PAs were waived. So is there anyone that can provide clarification on that?

DEPUTY COMMISSIONER HOFFMANN: Angie, do you remember?

DR. SCHUSTER: It says in the text that some audits can go back five years.

MS. ADAMS: And do we know which ones those are?

DR. SCHUSTER: Yeah. Maybe Jennifer or Angie, somebody over in the Program Integrity, can do a little research for us on that.

MS. ADAMS: Thank you.

DR. SCHUSTER: She says the TCM audits are likely going back to 2019. So that's when -- but in 2019, prior auth was in place. Okay. She is going to get us information on the audit time frames, Kathy.

MS. ADAMS: Great. Thank you.

DR. SCHUSTER: Thank you very much, Jennifer. So we will keep this again on our November agenda.

Leslie, any update on our waiver for incarcerated people?

DEPUTY COMMISSIONER HOFFMANN: Yeah. I think if it is okay, Sheila, I'm going to go back. I put some information

there in the chat. Let's start out by just talking about the -- there's lots of moving parts right now, you know that.

DR. SCHUSTER: Yeah.

DEPUTY COMMISSIONER HOFFMANN: Our big Kentucky 1115 authority that allows us, for all of those wonderful flexibilities, and allows us to do things outside the -- you know, thinking outside the box kind of things. It is time for renewal. So we have it out for public comment right now. And I just put in the chat the link. The public comment is still open, if anybody on this call is interested in sending in the public comment. I think it is until the 13th.

We have already completed and I think some of you attended our two forums that we had. And it was publicized in at least three of the largest papers. You can send public comments to the Commissioner's office. And all of that is in that link that I just sent you. Just make sure that we have contact information and contact agency, if applicable, and contact information, including your address as well.

And then we will get responses posted back out within a week or two, and they will be posted on the DMS website under the comments section prior to submission of the application. So we have to do all of that prior to sending it to CMS.

So within that 1115 authority we are asking not for a lot of changes but I did want to let you know that we have asked to rename it "Team Kentucky 1115" and get the old name completely out of there. It brings up a lot of issues for folks, so we want to get that name out.

Also, within the 1115 demonstration it includes the incarceration. And they know that we are going to continue work on that. As well as, if you remember, the SUD officially is only in year three of five years, but they have asked us to renew that as well so that we can get our timelines together.

So we have submitted that to -- I'm sorry. We have got that out for public comment until the 13th, and then we will proceed there. Because this is a 1115 for

all of Kentucky, and it does have pieces that have nothing to do with behavioral health in it, other pieces that CMS handles, employee-assisted insurance and -- or sponsored insurance and former foster care and things like that. So we have other pieces within that big period, our big 1115 extension.

The extension is actually due one year prior to the end. So that means it is due to CMS around 9/30. It will require an approval and letter by the Governor. So I wanted to let you know that. So that is kind of where we are. There is a hope that they can go ahead and approve the amendment, since it was submitted prior to the submission of the 1115. We are still working with CMS on an ongoing basis to work on the incarceration amendment. I feel like a broken record every time I am on here. There is nothing negative related to the incarceration amendment, they are literally just trying to get their own policies and procedures in place before releasing us, being the first state that has tried something like this. I think they are

up to over 20 now. It was 19. I think they are around 22 requests from other states now. So they want to get it right with us when they roll it out.

So we are very excited about it still and hoping to have you some information fairly soon. Again, I can't tell you any time frames because it will be left up to CMS on their approvals of the big authority to also include other authorities that are within that.

Our SMI/SED waiver, Sheila, that we are drafting as well as other components that we are working on for SMI, those things will come along after the approval. So they can be there pending, but they won't approve it until we have the big authority on the 1115 side approved.

So I have told you a whole lot. I'm sorry.

DR. SCHUSTER: Yeah, yeah. So that is the approval of the extension.

DEPUTY COMMISSIONER HOFFMANN: Yes. It is the great big -- it is our big authority for all of Kentucky. So all of our

behavioral health stuff just falls under that in bits and pieces as well as some other Medicaid functions. But the rest of it was repealed, of course.

DR. SCHUSTER: Yeah. Okay. Thank you very much.

DEPUTY COMMISSIONER HOFFMANN: Yes, ma'am.

DR. SCHUSTER: For those of you who are not speaking directly, if you could mute your line. I think there are some background conversations going on. Thank you very much.

I wanted to ask all of those in attendance if there are any issues right now with the Medicaid formulary or with access to medications.

(No response)

DR. SCHUSTER: I have not heard anything recently. And, again, we keep this on here because medications are so very important to our folks. But I have not heard anything. I wanted to give you all a chance to ask any questions about that or pose any problems.

(No response)

DR. SCHUSTER: So hearing none, that's great. Number 10, this is a huge victory for us. If you remember, in July we made a recommendation to the MAC that DMS do a Frequently Asked Questions about their new guidance. And they did us one better. They not only said yes, we will do that, they actually produced it and then they also produced a very attractive flyer.

So, Erin, if you could share your screen and just show the FAQs. I think I sent them out to everyone I had on my e-mail list.

Which reminds me, if you want to receive notifications of the BH TAC and any materials, please e-mail me directly and I will put you on that list. It is an easy e-mail to remember. It is Kyadvocacy@gmail.com. Marcie, maybe you could put it in the chat for people. I would appreciate it. Because I have a pretty large list of people that I send to, but we are happy to send that out. Thank you, Marcie.

And, Erin, can you post the Frequently Asked Questions document.

MS. BICKERS: Is it not showing?

DR. SCHUSTER: No. The agenda is still up.

MS. BICKERS: I was hoping if I just switched.

DR. SCHUSTER: Oh. Nothing is easy. You know how that goes.

MS. BICKERS: I should know better.

(Laughter)

DR. SCHUSTER: So this is quite a lengthy document. It goes, actually, three pages or two and a half pages. It is very detailed. It is just exactly what we wanted.

And it talks about the previous Bills. It talks about what the regulation does and does not do. It goes into asynchronous versus synchronous telehealth. It also points out, and this is important for all of our licensed providers on here, that your licensure board may have its own regulations about how telehealth can be used and who under their purview can use it. I know some of the licensure boards do not let some levels of licensure do telehealth, which has never made any sense to me. But that's

up to each licensure board.

It talks about Medicaid and the billing codes. And they are not looking to create any billing codes. CMS, the federal law, requires that you be in the United States. If you remember, House Bill 188 passed this last session. You may want to look at that, because it directs the licensure boards to allow providers who are out of the state to provide telehealth back to their instate clients and vice versa, that you can be in the state and provide to a client who is out of the state.

Unfortunately, when House Bill 140 passed in 2021, over in the Senate they made a change and the MCOs can pay a differential amount, usually a lesser amount, for telehealth and for in-person. That was never the intent, I don't think, of the original telehealth legislation. And I think that's unfortunate because people are getting, basically, the same service.

But it also talks about the asynchronous versus synchronous. One of the concerns about asynchronous is that people

are not getting direct contact with a licensed provider. They are handling something through a staff person and then it is being reviewed later, which I think is very different than having the interactive session with the provider.

So I'm extremely pleased that CMS responded so well. And we had a great session. And then they did this really nice one-pager with graphics and kind of, you know, it very succinctly talks about telehealth. So this is well worth, I think, distributing to your members. I'm thinking about the CMHCs, Kathy, your Children's Alliance groups and so forth, to just be real clear about what the regs do and do not do.

So our thanks, thanks thanks thanks, to DMS for taking our recommendation and doing such a beautiful job and doing it so quickly. So, Leslie, Angie, those of you on from DMS, please thank the responsible folks. Because that is I think a huge benefit --

DEPUTY COMMISSIONER HOFFMANN: Sure.

DR. SCHUSTER: -- for everyone. Actually not just in behavioral health. Remember, this is not just behavioral health telehealth. It is also physical health.

DEPUTY COMMISSIONER HOFFMANN: Sure.

DR. SCHUSTER: Any questions about that?

(No response)

DR. SCHUSTER: Okay. Thank you very much.

I don't believe that there has been any recent update on prior authorization guidance. Am I correct about that, Leslie?

DEPUTY COMMISSIONER HOFFMANN: That's correct. I double-checked with Jonathan today. And he may be on.

So I believe they would have had to notify us by November. Again, I'm saying I believe, right, because I don't have anything specific. But they would have had to let us know, like, in November for the 60 days. They have promised that they will give us a 60 day notification. Jonathan and I are still hearing, though, that it is going to

continue on at least until the end of the year. Now, that is not a promise. I'm just saying what we are hearing.

DR. SCHUSTER: Yeah. You are talking about the public -- the federal public emergency period, right?

DEPUTY COMMISSIONER HOFFMANN: Yes. That's correct.

DR. SCHUSTER: Yeah.

DEPUTY COMMISSIONER HOFFMANN: And currently all we have is just the two prior authorizations for behavioral health that we have turned on that you are aware of for inpatient.

DR. SCHUSTER: Yeah, yeah. The last rumor I heard on the federal public emergency was that it would go through the end of the year.

DEPUTY COMMISSIONER HOFFMANN: That's what we are hearing, too.

DR. SCHUSTER: Yeah, yeah. That would be great.

All right. The interim session meetings continue to go along. There is not anything that is specific to behavioral

health. There's been a number of presentations on workforce shortages. And while there hasn't been anything directly on behavioral health, I think we all are very aware that we have got to really put our heads together and recruit more people to come into the behavioral health field. I don't know of anybody who is doing any outreach at the high school level, but it really needs to start there. I'm hoping with the influx of behavioral health providers in the schools that maybe more of the students will, you know, kind of light a bell with them that this is a good profession to be in, whether it's social work or psychology or psychiatry, psychiatric nursing, counseling, and those kinds of things.

We also need to be recruiting more behavioral health providers from our communities of color. You know, there has always been tremendous stigma, unfortunately, in the black and brown communities around seeking help. And I think with COVID we are seeing more people reaching out. And I think therapy and interventions have got to be more

effective, if you are sitting in a room and looking across at a therapist or a counselor who looks like you and may have some of the same background and shared experiences. So just something to be thinking about.

In November most of the task forces are there. And one of them is on the emergency or EMS responses, so we will be watching that specifically to see if there are any recommendations that come up around either 202A transportation, I know it continues to be a problem in the eastern part of the state and now, of course, with the floods I'm sure it is, you know, magnified there as well. But usually the task forces come with their recommendations in November, so we will be looking for those.

Do any of the voting members of the TAC have any recommendations that you think we ought to put forward to the MAC at their September meeting?

(No response)

DR. SCHUSTER: I did not have any and I didn't get any from anyone beforehand. So seeing none, we will probably just make

our report of the meeting.

We have lots of agenda items for our next meeting because we have a lot of carryover items. The no-show portal, the dual eligibles, the -- I just lost my train of thought because someone is knocking at my door.

Marcie, do you want to go on to new business --

MS. TIMMERMAN: Sure.

DR. SCHUSTER: -- and bring up your issue? And I will be right back.

MS. TIMMERMAN: Okay. My question for Medicaid is: Do you cover psychiatric hospitalizations of children with autism or other severe behavioral health issues?

DEPUTY COMMISSIONER HOFFMANN: Do we cover hospitalization?

MS. TIMMERMAN: Yeah. Psychiatric hospitalization, uh-huh, of those under age 12.

DEPUTY COMMISSIONER HOFFMANN: Let me get additional information from you. I don't want to just speak off the cuff. If any of the MCOs want to chime in to what you

cover. But I don't want to say anything specific to autism until I research that, if you don't mind.

MR. OWEN: This is Stuart Owen with WellCare. I would just note that it depends on the criteria, you know, InterQual or Milliman, whichever is used. It is not -- it is, do they meet the criteria. It is not like this diagnosis or not; you know, it is just do they meet the criteria for admission. And I am not aware of any kind of limit regarding that.

MS. TIMMERMAN: Thank you.

DR. HANNA: And just for Passport, I mean, there is an issue they have to meet hospitalization criteria. But we have -- I know that we have kids under 12 with an autism diagnosis who are in the hospital or have recently been in the hospital. And we are paying for their care, just to be clear about that.

MS. TIMMERMAN: Thanks.

DEPUTY COMMISSIONER HOFFMANN: Thanks, David and Stu. I didn't want to speak off the cuff. I know as far as autism

goes, I know we -- I didn't want to speak to any specific diagnosis. I know we did have children that are out there right now.

MS. TIMMERMAN: Yeah. We are having a real lack of providers accepting patients who have both of those issues. I've had several families reach out to me having trouble when a patient really does meet criteria but finding a bed for them or finding a willing provider as well.

DEPUTY COMMISSIONER HOFFMANN: Right.

MS. TIMMERMAN: So I just wanted to kind of put that back on. I know it is an ongoing problem. But...

DEPUTY COMMISSIONER HOFFMANN: Yes. And we know that we have got -- we have got several committees that have started meeting around hard -- especially hard to place children and things like that. And we are trying to take a look at some of those issues on the SED side of our SMI/SED waiver and what can we change in state plan, what can we do as a pilot, what can we do quickly, rather than making an amendment to the 1115 that

will take a longer period of time.

So, yes, we are aware. And, Marcie, if you want to reach out to me, I can help on the side as well, too, with specific cases.

Dr. Lore [ph], I don't know if you are familiar with him, he works in public health. But he also works -- helps us in Medicaid, too, also. So we can see if we can work on some specific cases.

DR. SCHUSTER: Yeah. I could put you in touch with Dr. Lore also, Marcie. I think there is a group that meets out of Louisville at 7 in the morning that is a pediatric mental health group. And one of the populations of kids that we have talked about are kids who are both developmentally and intellectually disabled and have significant behavioral health issues. And, of course, that is a population of adults that we also have trouble with.

So and I see where Michael Gosser has also reached out to you from Peace. I think that there was a statewide meeting last year with legislators and Dr. Brenzel and

Commissioner Morris were on. And the question came up about transporting a child who needed hospitalization. And, you know, the comments were kind of it's -- you know, we really don't -- we don't have a state facility like we do at Eastern State, Western State, Central State, and so forth, you know, to provide that.

So Dr. Brenzel's on. Do you want to comment, Allen?

DR. BRENZEL: I'm sorry. I'm trying to get back on here.

You know, not specifically in terms of an answer. I am certainly acutely aware. I put in the chat that I met today with the Norton's group from the autism center as well as the specialty clinic as well as there at Norton adult outpatient. And, you know, the issue there was access to services and the limited numbers of sort of coordinated care settings.

But we have recognized that. And we have a number of folks right now in our state psych hospitals as adults that are there based on SCL providers having

experienced a lot of duress at this point, in terms of staffing inadequacies, inability to stay fully operational due to staffing shortages, so then with the lack of inpatient beds for both kids and adults for the co-morbid population.

We are actively exploring the possibility very, very early of, you know, some sort of dedicated unit at the adult level for folks with intellectual disabilities. And then there are some conversations with the Hospital Association about that population as well.

So it is recognized, but I don't see an easy solution on the horizon. But...

DR. SCHUSTER: Yeah.

DR. BRENZEL: I mean, whether it is capacity issues, I think some of the capacity is starting to come back on-line, but adolescent beds are at a premium still.

DR. SCHUSTER: Yes. Absolutely. And that is helpful.

You know, it occurs to me, Marcie, from time to time we have talked about this TAC meeting jointly with the Children's

Health TAC, particularly around over-use of psychiatric medications. And that is something that Dr. Lore is an expert in and tracks that in a program out of U of L. But this hospitalization or inpatient services issue is one that, you know, actually the Children's Health TAC and the BH TAC maybe could work on jointly. I don't know who is Chairing that TAC right now. Do you happen to know, Leslie or Angie?

DEPUTY COMMISSIONER HOFFMANN: Which TAC did you say? I'm sorry.

DR. SCHUSTER: Children's Health.

DEPUTY COMMISSIONER HOFFMANN: No. But I can find out.

MS. BICKERS: It is Mahak.

DR. SCHUSTER: Oh. Is it? Okay. Mahak Kalra from KYA.

DR. BRENZEL: There is also a lot of work on the SIAC. There is a systems array subcommittee. I Co-Chair that with the Chair of SIAC right now. And, so, there is a group. And we are looking at some options for utilizing an out-of-state consultant around developing a children's plan of care.

And, so, there's multiple -- what we have learned is there are about five or six groups working on the difficult to place, challenging children. And this, the SIAC, is trying to coordinate all of those activities, Sheila.

DR. SCHUSTER: Oh, okay.

DR. BRENZEL: And wanting to -- you know, what we are finding is there is a lot of duplication going on right now.

DR. SCHUSTER: Yeah.

DR. BRENZEL: And we are trying to pull together through SIAC.

DR. SCHUSTER: Okay. Well, maybe I should hook up with SIAC, maybe that through you, Allen, with --

DR. BRENZEL: Yeah.

DR. SCHUSTER: -- that group out of Louisville. That is Gail Williams --

DR. BRENZEL: Yes.

DR. SCHUSTER: -- with the Pediatric Mental Health, Behavioral Health Alliance. And they have been working --

DR. BRENZEL: Very strong advocates.

DR. SCHUSTER: Yeah. Yeah, very strong advocates. So that is helpful. Thank you.

The other piece of new business, and Diane is not on and I guess Eddie Reynolds was not able to join us today, but there is an upcoming public comment period for the ABI Long Term Care Waiver. And that notice has gone out. So I will send that link out. I know some of us, you know, we have strong representation on this TAC from the ABI folks. And, so, we really want to take a look at that long-term care waiver and make sure that it is offering all of the services that can possibly be offered to those folks; many of them have also significant behavioral health issues, either before the brain injury or as a result of the brain injury. So we have always had a close working alliance with them. And I think we may want to pay attention to that 1915(c) public comment period.

Any other new business from anyone who is attending the meeting?

(No response)

DR. SCHUSTER: All right. Just a reminder, that the MAC meeting, and remember that is open to all, I will be sure that you get the link to it, but it is a great way to hear all of the latest, you hear directly from Commissioner Lee and from other staff at DMS, and then you also, you know, have a chance to hear from all of the TACs.

And, Mike, I just see this in the chat, so thank you. The PAR Rally, Annual Rally for Recovery, is September 17th from 11 to 3 at the U of L Student Activities Center. They are partnering with U of L. So we will get that out to you all.

And, again, e-mail me directly if you are not getting these notices and so forth so that we can include you.

And then our last BH TAC meeting of the year, remember this is earlier, this is the first week in November because the MAC meets a week earlier because of Thanksgiving, so it is November 3rd from 1 to 3, again via Zoom. And we will be setting our 2023 meeting calendar.

So, Erin, I will check with you.

We may need to change the date, just to see what other dates may work out for DMS staff.

MS. BICKERS: I am currently working on the 2023 calendar for all of the TACs and I hope to have that out within a week or so.

DR. SCHUSTER: Oh, okay. Yeah. Because I think that we may need to move off of Thursday. I've had a number of people ask me to look for a different day, because there are a lot of physicians and providers who are very, very interested and have not -- can't make these meetings. So I will touch base with you directly, Erin.

MS. BICKERS: Thank you. And I will start looking to see, based off some of the other TACs, when we can work that.

DR. SCHUSTER: Yeah. Because I know we shopped around when we set this date because we were originally on a day that was just impossible for DMS staff.

And, Marcie, thank you for reminding me. The Kentucky Mental Health Coalition is celebrating its 40th birthday. Some of my gray hair is from holding together

these coalitions over a long, long period of time.

So we are having an actual in-person gathering. We are going to recognize -- I think we have a couple of retiring legislators, like Tom Burch and Mary Lou Marzian and Joni Jenkins, who have done tremendous work in mental health and substance use disorders who are leaving us and we want to recognize them. We are also going to try to gather current and former Commissioners and important people from the Department for Behavioral Health, formerly the Department for Mental Health, from the Cabinet and celebrate our birthday.

So we are having lunch at the Capital Plaza Hotel on September 28th. And Marcie has put the RSVP in the chat. It is actually a free event. But we need to have your RSVP so we know how many lunches to order. So we are hoping to have a celebratory crowd. We have not had anything in-person and, like most groups, for two plus years at this point. So we are eager to get together. And a little plug, that you can

renew your KMHC membership when you are on the website.

So I'm dismissing the meeting or ending the meeting by acclamation. You get five minutes more out of your day.

DEPUTY COMMISSIONER HOFFMANN: Sheila, one thing, I did send you the missing information, missing member and canceled appointments from Justin. I e-mailed that to you. It is quite lengthy, so you might want to take a look at it and then you can have it for the next meeting.

DR. SCHUSTER: Oh. Yeah. Thank you so much. And we will have him on maybe to discuss it, but we will also take a look at it and I will share it with the voting members of the TAC to look it over. So thank you so much.

And thanks to all of our DMS staff and helpers and to the MCOs who are on. But thank you to our presenters. It is really helpful to have KHA folks and the K.O.R.E. folks. And thank you, Erin, as always for your great support for us.

So have a good day. And we will

talk to you all, if not before, on November 3rd. Thank you.

(Proceedings concluded at 2:55 p.m.)

C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Behavioral Health 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 15th day of September, 2022.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR