

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

\*\*\*\*\*

Via Videoconference  
January 8, 2026  
Commencing at 2 p.m.

Tiffany Felts, CVR  
Certified Verbatim Reporter

APPEARANCES

**BOARD MEMBERS:**

Dr. Sheila Schuster, TAC Chair  
Steve Shannon  
TJ Litafik  
Valerie Mudd  
Tara Hyde (Melissa Allgeier)  
Misty Agne (not present)

1 DR. SCHUSTER: Misty's not going to  
2 be able to make it and we still have that  
3 opening for Mary, so the other two would be  
4 TJ and Tara.

5 MS. WASH: Yes.

6 DR. SCHUSTER: And I'm hoping that  
7 they are going to be joining us. I have not  
8 heard from them that they are not, so if you  
9 might look for them, that would be helpful.

10 MS. WASH: Yeah, so far, I don't see  
11 them on here, so.

12 DR. SCHUSTER: Okay. We actually  
13 just need one of them to join and we'll have  
14 our quorum, but hopefully both of them will  
15 be available.

16 MS. WASH: I don't see -- you said  
17 Misty will not be here at this meeting?

18 DR. SCHUSTER: Yes, she had a  
19 conflict, right. So it's TJ Litafik and  
20 Tara Hyde.

21 MS. WASH: Tara's not on and neither  
22 is TJ, so -- but they could sometimes call  
23 in by phone, too, so I'll keep my eyes open.

24 DR. SCHUSTER: Okay, thank you.

25 MS. WASH: Mm-hmm.

1 DR. SCHUSTER: Okay. Are we pretty  
2 clear in the waiting room, Barbara?

3 MS. WASH: Yes, but we still do not  
4 have TJ or Tara.

5 DR. SCHUSTER: Okay. Let me text  
6 them real quickly.

7 MS. ALLGEIER: I'm here for Tara.

8 MS. WASH: Oh, okay.

9 DR. SCHUSTER: Oh, Melissa, hi.

10 MS. ALLGEIER: Hi, Sheila.

11 MS. WASH: Okay.

12 DR. SCHUSTER: All right. And let me  
13 text TJ just to see --

14 MR. LITAFIK: I'm on here now.

15 DR. SCHUSTER: Oh, wonderful. Thank  
16 you, TJ.

17 MS. WASH: There we go.

18 DR. SCHUSTER: All right. So here we  
19 go. Good afternoon, and Happy New Year.  
20 And we'll call the first meeting of the 2026  
21 Behavioral Health Technical Advisory  
22 Committee to order, also affectionately  
23 known as BH TAC. And welcome to you all.

24 Let's see, let's have our voting  
25 members identify themselves, please.



1 Valerie, you're the first I see on my  
2 screen.

3 MS. MUDD: I'm Valerie Mudd with NAMI  
4 Lexington and Participation Station. I'm  
5 here to represent folks with mental illness,  
6 like myself.

7 DR. SCHUSTER: Great, thank you.  
8 And Steve?

9 MR. SHANNON: Steve Shannon with KARP  
10 Association with 12 of the 14 community  
11 health centers.

12 DR. SCHUSTER: All right.  
13 And Melissa?

14 MS. ALLGEIER: I'm Melissa Allgeier  
15 with People Advocating Recovery. I don't  
16 know who I'm representing, I was not given  
17 that information, but I would assume people  
18 in recovery.

19 DR. SCHUSTER: You're representing  
20 all the people that are looking for recovery  
21 from addictive disorders, how's that?

22 MS. ALLGEIER: Perfect.

23 DR. SCHUSTER: Okay.  
24 And TJ?

25 MR. LITAFIK: TJ Litafik, NAMI

1 Kentucky. Happy New Year to everybody.  
2 Unfortunately, I am going to have to jump  
3 off a little early today. I have something  
4 else that's come up, but happy to be with  
5 everybody.

6 DR. SCHUSTER: All right, thank you.  
7 And NAMI Kentucky is a statewide  
8 organization representing families and  
9 consumers of those affected by serious  
10 mental illness.

11 And I'm Sheila Schuster, a  
12 psychologist and longtime chair of this  
13 august group by virtue of being the  
14 executive director of the Kentucky Mental  
15 Health Coalition.

16 So can I get a motion from the voting  
17 members for the approval of the minutes of  
18 our November 13th meeting, please?

19 MR. SHANNON: So moved. Steve  
20 Shannon.

21 DR. SCHUSTER: Great, Steve. And a  
22 second?

23 MR. LITAFIK: Second.

24 MS. MUDD: Second. Val.

25 DR. SCHUSTER: All right. It was a

1 tie between Val and TJ, so we'll leave it at  
2 that, thank you. All in favor of approving  
3 the minutes, and this is a vote of the  
4 voting members, signify by saying "aye."

5 (Aye).

6 DR. SCHUSTER: And opposed, like  
7 sign.

8 (no response)

9 DR. SCHUSTER: And abstentions?

10 (no response)

11 DR. SCHUSTER: Thank you very much.

12 The schedule for the BH TAC was sent  
13 out at the last meeting, so we're continuing  
14 our second Thursday of the month starting in  
15 January, and we will continue to meet  
16 between 2 and 4 p.m.

17 I think I mentioned to you that the  
18 MAC meetings were being rescheduled, and  
19 that schedule is the first Thursday of every  
20 other month, but the months are alternating  
21 with what they had been. So they start in  
22 February and they go, you know, February,  
23 April, da-da-da, and we are meeting from 10  
24 to 12 in the morning. The members voted for  
25 a two-hour meeting. We'll see if we can

1 squeeze in all of the business that we  
2 typically do at the MAC meeting.

3 And I think the BAC meeting -- I was  
4 looking for verification, I think their  
5 meetings are on the second Monday of the  
6 month starting in January, and I think they  
7 run from 1 to 3 in the afternoon. The BAC,  
8 you will remember, is the Beneficiary's  
9 Advisory Council, and that's a brand-new  
10 council. They've had one meeting and this  
11 is their second meeting coming up.

12 We're going to shift the agenda a  
13 little bit because we have somebody who is  
14 working directly on the Rural Health  
15 Transformation Fund, and his name is Andrew  
16 Bledsoe, and we're very appreciative that  
17 you're with us, Andrew. He's going to give  
18 us a brief summary, and I was particularly  
19 interested in you all hearing this because  
20 there is a behavioral health component. The  
21 good news is that Kentucky's application was  
22 approved by CMS at full funding. In other  
23 words, the full funding that they requested,  
24 and I think I heard that we rank in the top  
25 ten states in terms of the amount of money

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1           that we received, which is great. It's  
2           212 million for this first year. So if I'm  
3           wrong about any of that, Andrew, you can  
4           correct it, but let's -- I'll turn it over  
5           to you, Andrew.

6           MR. BLEDSOE: Okay, thank you. And  
7           thank you all for having me. You know, this  
8           is actually the first group external to the  
9           cabinet that is getting to hear any of this  
10          information directly from us. So, you know,  
11          fortunately for you guys that you tuned in  
12          today, you get to hear this and be the first  
13          ones. I'm Andrew Bledsoe. I am now the  
14          deputy director for Rural Health  
15          Transformation here within the state, and so  
16          I may -- I see some familiar names on here,  
17          some of you may recognize me. I have  
18          previously been the executive director of  
19          the Kentucky Rural Health Association and so  
20          started just this Monday as we are getting  
21          our leadership team put together here with  
22          the state that's going to be working on  
23          Rural Health Transformation.

24          And so as Sheila had announced, the  
25          state was awarded 212.9, nearly to

1           \$213 million under Rural Health  
2           Transformation. One thing I'm noting to  
3           delineate is, you know, a lot of people are  
4           thinking that this is the entirety of H.R. 1  
5           or OBBA, but this is a provision of or a  
6           funding initiative of House Bill 1, and so  
7           it is just a portion of that. I'm trying to  
8           be intentional in calling that out because I  
9           know there's been a lot of confusion around  
10          that.

11                 We did, we were ranked No. 11th,  
12          actually, for our funding, and so we  
13          submitted for 200 million, and we received  
14          213 million. And so I think that is a big  
15          testament to the work that's going on here  
16          in the state that the federal government is  
17          seeing -- and seeing the work that's going  
18          into these initiatives, they believe in the  
19          work that we have proposed and the work that  
20          we're going to be doing, and sought to give  
21          us some additional and enhanced funding.

22                 The funding is restricted, and so  
23          that's kind of really important to denote  
24          here. There's a lot of questions out in the  
25          communities around what this is going to be

1 funding. It's actually pretty specific what  
2 can and cannot be funded, and reimbursement  
3 for duplicative services or reimbursement  
4 for services provided is not one of the  
5 items that was allowable to be funded at the  
6 federal level. There is, on our website, we  
7 have the notice of funding opportunity that  
8 would detail all of the things that were  
9 able to be funded and not able to be funded.  
10 And I know because there's a lot of  
11 organizations that have been reaching out to  
12 us and asking, "Can I get so-and-so service  
13 reimbursed under this? Can I get this  
14 reimbursed under this," this funding is not  
15 allowable for those -- for services being  
16 provided to patients in that way. And so on  
17 our website, if you would -- if you're  
18 interested in seeing our -- the notice of  
19 funding opportunity as well as our  
20 application, we do have our full application  
21 on our website. It is  
22 ruralhealthplan.ky.gov, and I will put that  
23 in the chat so that everyone has that in  
24 just a minute.

25 DR. SCHUSTER: Great.

1 MR. BLEDSOE: And so  
2 ruralhealthplan.ky.gov. And so, like I  
3 said, that will give you the Notice of  
4 Funding, that will also give you our  
5 application. It's a rudimentary site, so we  
6 are now -- you know, I'm four days in, and  
7 so we're now four days in and getting things  
8 running, so we wanted to get information out  
9 there as quickly as possible, so it's kind  
10 of rudimentary, but keep checking back on  
11 that site and you'll see information in that  
12 website continue to evolve as we get more  
13 individuals brought in, as we start to have  
14 more information, and as we are starting to  
15 offer more ways for the community to engage  
16 with us. And so that's going to be our  
17 focal point there.

18 Our application identified five  
19 priority areas for the transformation, and  
20 so at a high level, this is Rural Community  
21 Hubs for Chronic Care Innovation, and this  
22 is working on coordinating intervention  
23 across chronic diseases. We have Powering  
24 Rural Maternal and Infant Health, working on  
25 maternal and infant health. We have the



1           Rooted in Health Kentucky Rural Dental  
2           Access program. And then the two other  
3           verticals -- we're calling these five  
4           verticals. The last two are pertaining to  
5           or have parts pertaining to behavioral  
6           health, and one is the Rapid Response to  
7           Recovery, and this is our EmPATH Model and  
8           Mobile Crisis. And so this is where we are  
9           going to do EmPATH expansions for rapid  
10          stabilization and psychiatric treatments,  
11          along with community-based behavioral health  
12          crisis supports. We have a component of  
13          this, for tele behavioral health hub, and  
14          also, we're going to be supporting  
15          technology to enable connections across the  
16          entire crisis continuum. So you can read  
17          some more about that in our application.  
18          The other one is from Crisis to Care:  
19          Integrated EMS and Trauma Response. This is  
20          where we're going to be working on treatment  
21          in place and transport to alternative  
22          destinations, as well as leveraging things  
23          like a regional medical operations  
24          coordination center for ensuring that there  
25          is -- that EMS is provided the training and

1 the ability to appropriately manage and  
2 treat, and information in behavioral health  
3 episodes in an EMS situation.

4 So we are now -- as we mentioned,  
5 we're working on -- since we were given  
6 additional funds, we're working with CMS on  
7 what does that mean for our application.  
8 And so we're working collaboratively with  
9 CMS to identify where those funds will be  
10 allocated as part of our application.

11 And then lastly, as we move forward,  
12 we are going to be heavily focused on  
13 stakeholder engagement and collaboration.  
14 As I said, you know, we're just barely a  
15 week in. I'm now on my fourth day to this,  
16 so we're still getting our bearings, but you  
17 will start to see some information coming  
18 out around community meetings, listening  
19 sessions, town halls, a bunch of different  
20 ways for you to become engaged, and also  
21 share with us information about these  
22 potential projects, your feedback, as well  
23 as any issues and concerns.

24 But in the meantime, please go to our  
25 website. On our website, there is -- you

1 will have the ability to connect with us on  
2 there. It's got our web -- or an email  
3 address that you can send any questions or  
4 information to. There are several of us,  
5 myself included, that are monitoring that  
6 email address, so it's not something that's  
7 just going to go into the void. It is  
8 something that we are actively looking at,  
9 so I would just direct anyone and everyone  
10 to there for some education at this point.

11 DR. SCHUSTER: Great. That's a great  
12 overview. Let me see if there are any  
13 questions from anyone, not just voting  
14 members, but anybody else who's on the --  
15 tuned in on the meeting, are there any  
16 questions?

17 MR. BLEDSOE: And I will also throw  
18 in there again, you know, this is the -- you  
19 are the first group, this is the first time  
20 we are saying anything about this publicly  
21 other than the governor's press release. So  
22 I know, and I see some other familiar names  
23 on here, we are starting to push information  
24 out. So we are going to be reaching out to  
25 all of the partners, we're attending all of

1 the TAC committee meetings, and working  
2 through a long list of stakeholders to how  
3 we can coordinate and provide information to  
4 them. So if you've not heard from us yet,  
5 you will be.

6 DR. SCHUSTER: Well, thank you, and I  
7 want to offer the BH TAC as a place for you  
8 to disseminate information, Andrew, to the  
9 behavioral health community. We don't have,  
10 obviously, everybody on, but we have  
11 probably the biggest attendance of any of  
12 the TACs because we, you know, open it up  
13 for providers, consumers, family members,  
14 MCOs, obviously, DBHDID staff, and the DMS  
15 staff. So I would also offer the Kentucky  
16 Mental Health Coalition, I'll send you that  
17 information to your website as a place where  
18 you can disseminate information.

19 Any ques -- I do have -- I was trying  
20 to think what EmPATH stood for, and maybe  
21 Val knows. EmPATH is the emergency  
22 renovation that was done at Eastern State  
23 Hospital under UK's leadership, and it's  
24 been hugely successful. They've worked with  
25 New Vista, which is the community mental

1 health center there. And I've been racking  
2 my brain because I should've looked it up  
3 before you got on. Do you have any  
4 recollection, Andrew, of what that is?

5 (Mr. Bledsoe speaks on mute).

6 DR. SCHUSTER: I'm sorry, you're  
7 muted.

8 MR. BLEDSOE: It is -- I don't have  
9 that right in front of me, unfortunately,  
10 no.

11 DR. SCHUSTER: Yeah, that's all  
12 right. Here it is.

13 MR. SHANNON: It is Emergency  
14 Psychiatric Assessment, Treatment and  
15 Healing.

16 DR. SCHUSTER: Well, Emergency  
17 Psychiatric Assessment, Treatment and  
18 Healing, okay. Emergency Psychiatric  
19 Assessment, Treatment and Healing. Thank  
20 you very much, Hannah. That was Hannah from  
21 Mental Health America of Kentucky.

22 So let me ask you this, Andrew,  
23 obviously, this is a rural health  
24 initiative, so will all of the services be  
25 offered in those rural counties? And I know

1           most of the counties in Kentucky are  
2           considered rural, but how do you all -- you  
3           know, what's the -- what's the site, what  
4           are the locations of services?

5           MR. BLEDSOE: It will be, and as  
6           we've mapped this out, about a little around  
7           90 or a little over 90 percent of the state  
8           is considered rural if you get down to the  
9           ZIP codes.

10          DR. SCHUSTER: Yeah.

11          MR. BLEDSOE: And so we're looking  
12          beyond the county into the ZIP code so we  
13          can make sure that we capture as much as  
14          possible. Now, the focus of this is  
15          certainly on rural health, but there are  
16          ways as we roll this out that services may  
17          be able to be provided broadly to the  
18          entirety of the state. It's just that the  
19          focus of it may not be on an urban area, and  
20          so there may be some crossover.

21          DR. SCHUSTER: Okay. That makes  
22          sense. All right, anybody else have any  
23          other questions for Andrew? Val?

24          MS. MUDD: Now what about  
25          transportation? Did I -- did I miss what's

1 the transportation issues?

2 MR. BLEDSOE: There are provisions  
3 for transportation within each of the five  
4 verticals. But it was not a -- it was not  
5 its own vertical or service initiative that  
6 we are addressing as part of this.

7 DR. SCHUSTER: So you have those five  
8 pillars, let's call them, that you've  
9 outlined --

10 MR. BLEDSOE: Yeah.

11 DR. SCHUSTER: Transportation --

12 MR. BLEDSOE: That's correct.

13 DR. SCHUSTER: -- is a facet of each  
14 of those five. And obviously --

15 MR. BLEDSOE: That is correct.

16 DR. SCHUSTER: Obviously, in the  
17 Crisis to Care, we're talking about probably  
18 EMS and ambulance and so forth, right?

19 MR. BLEDSOE: Yep.

20 DR. SCHUSTER: Yeah.

21 MR. BLEDSOE: That's correct.

22 DR. SCHUSTER: Okay. Does that help,  
23 Valerie?

24 (Ms. Mudd nods head "yes.")

25 DR. SCHUSTER: Okay. We've got a lot

1 of static, I don't know where that's coming  
2 from.

3 MR. BLEDSOE: Oh, okay.

4 DR. SCHUSTER: Any other questions  
5 for Andrew because I know he's got another  
6 meeting to get to?

7 (no response)

8 DR. SCHUSTER: All right. Well,  
9 thank you, thank you, thank you so much for  
10 making the time for us. That was an  
11 excellent -- and we're honored to be the  
12 first outside group to receive this  
13 information. And thank you for putting the  
14 website in the chat, Andrew.

15 MR. BLEDSOE: Awesome.

16 DR. SCHUSTER: And I think the  
17 director -- you're the assistant director.  
18 The director I think is Tom Walton; is that  
19 correct?

20 MR. BLEDSOE: Tom Walton, that is  
21 correct.

22 DR. SCHUSTER: Yeah.

23 MR. BLEDSOE: He is the director.

24 DR. SCHUSTER: For those of you who  
25 may not know him, he's been at U of L for a



1 long, long time, and he's the one that  
2 worked with Steve and me around putting what  
3 we were then calling respite care is now  
4 called recuperative care into one of our  
5 waiver applications. People with SMI and so  
6 forth were getting treated in the hospital  
7 for either a physical or behavioral health  
8 condition and then were being discharged to  
9 the street, and obviously, that was not good  
10 opportunity for respite or recuperative  
11 care. So we were -- he was great at working  
12 with us on that, so I'm delighted to see  
13 him, and he obviously understands behavioral  
14 health issues as well, so we're very excited  
15 about that. And you obviously are bringing  
16 the rural health perspective, Andrew, so  
17 that's great. A great team.

18 MR. BLEDSOE: Wonderful. Thank you.  
19 Thank you, everybody.

20 DR. SCHUSTER: All right, thank you.  
21 Okay, we'll be in touch, thanks.

22 All right, returning to the agenda,  
23 an update on resumption of prior  
24 authorizations, what's the latest, folks?

25 MS. STALEY: Hi. This is Sherri from

1 Kentucky Medicaid.

2 DR. SCHUSTER: Hi, Sherri.

3 MS. STALEY: Hello. We, you know,  
4 are continuing to monitor the situation.  
5 Our research and analytics branch has  
6 developed a side-by-side report, so we are  
7 looking at that monthly for total denials  
8 for pre-authorizations from each of the  
9 MCOs, what those services were, what was the  
10 top reason, and looking for any outliers, of  
11 course, to be able to communicate with the  
12 MCOs about those things.

13 So far, things are looking pretty  
14 consistent across the board, and we haven't  
15 really heard a lot of issues. I do just  
16 want to stress to folks, you know, if you  
17 are having any issues with the  
18 pre-authorizations for the MCOs, please  
19 utilize the process of the MCO inquiry and  
20 your appeal rights to do that before  
21 bringing to DMS. We want to make sure that  
22 people are going through the proper chain  
23 for those situations, and then, of course,  
24 if you can't get that resolved, DMS is happy  
25 to take a look and see what we can do.

1                   But we are regularly communicating  
2                   with the MCOs, asking them monthly, "what  
3                   are you all seeing?" And we feel that while  
4                   there are, you know, minor issues here and  
5                   there, overall, things are going well.

6                   DR. SCHUSTER: Sherri, would you mind  
7                   putting in the chat the link to those  
8                   forms --

9                   MS. STALEY: Yes.

10                  DR. SCHUSTER: -- the MCO inquiry  
11                  form and the appeal right. I know you've  
12                  done it every meeting, but there may be new  
13                  people on and so forth. And it never hurts  
14                  to remind people, so thank you very much for  
15                  that. I think --

16                  MS. STALEY: Absolutely.

17                  DR. SCHUSTER: I think one of the  
18                  questions that came up in the November  
19                  meeting, and I think back in the September  
20                  meeting was access to the bypass list. Do  
21                  you know, Steve, if that's improved at all?  
22                  Is that still an issue?

23                  MR. SHANNON: Yes, it's still an  
24                  issue. We have not gotten that -- and  
25                  actually, I had a situation recently, today,

1           one of MCOs is denying services to -- for  
2           individuals who are associate level, so CSW,  
3           a licensed professional clinical counselor  
4           or associate and others. It's a U4  
5           modifier, you know, it's like a foreign  
6           language, but because they're not on the  
7           bypass list. And it's the same situation,  
8           we'll never get a denial from Medicare or a  
9           lot of -- some commercial plans for an  
10          individual because they don't cover that  
11          individual, they're not included, they won't  
12          be included, they don't include them. So  
13          you don't end up getting a denial, and  
14          therefore, there's not a way for it to be  
15          paid for that service. And this happened  
16          just in the past 24 hours, I got several  
17          emails about this situation, so.

18                 MS. STALEY: That's something we can  
19          put on our agenda when we meet with the MCO  
20          behavioral health directors and speak about  
21          that. You're right, no associate levels are  
22          going to be paid by Medicare, and I know the  
23          MCOs are aware of that. It's just, I think,  
24          a paperwork situation, but yes, the bypass  
25          list is still something we continue to talk

1 about, and what is the best situation for  
2 that. We'll add that to the agenda for our  
3 Behavioral Health Directors meeting.

4 MR. SHANNON: Great.

5 DR. SCHUSTER: Thank you, Sherri.  
6 And we'll -- I'll try to remember to  
7 highlight that on the agenda for our March  
8 meeting so that we can get some feedback  
9 because that's been a persistent issue, the  
10 bypass list. Nina has her hand up. Nina?

11 MS. EISNER: Yeah, just real briefly,  
12 the Hospital Association, all the hospital  
13 providers, DMS, and the MCOs all met in  
14 August to develop a side-by-side on critical  
15 issues that we were going to monitor, and  
16 we're going to reconvene that meeting again  
17 in February. But we are having operational  
18 issues, such as how do we access a prior  
19 auth. Is there access to live review, or is  
20 it just fax or Availity? We're monitoring  
21 the response time of the MCO to a request  
22 for a prior authorization. We monitor --  
23 let's see here. We monitor the IMD issue,  
24 which has been resolved. That's the IMD  
25 exclusion, and the whole issue around ASAM

1           4.0. But we've gotten great resolution on  
2           that with our DBHDID and DMS partners.  
3           We've also been monitoring peer-to-peer  
4           issues, whether or not we can access a  
5           peer-to-peer for an appeal, which is part of  
6           our appeal process going up to and including  
7           SB 20. And we are also monitoring the --  
8           just the collaborative nature.

9                     We look at readmissions within 7 to  
10          30 days, and we look at whether or not  
11          someone is able to get into ambulatory  
12          follow-up within 7 days. And that's -- we  
13          think those are indicators that we think we  
14          can collaboratively work with DMS and the  
15          MCOs because those are HEDIS measures for  
16          the MCO, and they're quality of care  
17          measures for our patients. So long story  
18          short, there have been problems.

19                    We have an opportunity every -- once  
20          a month, the Hospital Association and  
21          providers meet with DMS representatives and  
22          each individual MCO, and we're able to bring  
23          issues up there. put them on a log and track  
24          them to resolution. So the process is, I  
25          think, well in place with DMS partners to

1 try to monitor what our issues are, but I  
2 wish I could tell you that we haven't had  
3 problems, but we have. So more to come.

4 DR. SCHUSTER: So it sounds like  
5 there's been some progress and some  
6 methodology for tracking and keeping track  
7 --

8 MS. EISNER: Yes.

9 DR. SCHUSTER: -- of what's going on.

10 MS. EISNER: Yes. And some MCOs are  
11 perfectly collaborative and following the  
12 rules, if you will. We have some -- one  
13 particular provider, who I won't name -- or  
14 MCO, rather, who we have most of the issues  
15 with, and we've recently met with their CMO.  
16 And so, yeah, it's just a big change, and we  
17 are seeing problems in terms of shortened  
18 lengths of stay and readmissions going up.  
19 And so it sounds, though, from Sherri that  
20 many of the things that we're monitoring are  
21 similar to what DMS is monitoring. So it's  
22 just a process, and it's very difficult, but  
23 what we want to ensure is that the patient  
24 isn't caught in the middle of the  
25 bureaucracy.

1 DR. SCHUSTER: Right. Right.

2 MS. EISNER: And I will say, we don't  
3 have any problems with prior-auth in our  
4 outpatient services, which is good news.

5 DR. SCHUSTER: So all of these are  
6 inpatient issues.

7 MS. EISNER: Yes, correct.

8 DR. SCHUSTER: Okay. I'm not --

9 MS. EISNER: Thank you.

10 DR. SCHUSTER: I'm not sure all the  
11 outpatient providers -- the other outpatient  
12 providers can say that, but I'm glad to hear  
13 that.

14 MR. SHANNON: Right.

15 MS. EISNER: Yeah.

16 DR. SCHUSTER: Herb Ellis has his  
17 hand up.

18 MR. ELLIS: Yeah, and I just -- I  
19 wanted to just echo kind of what Steve said  
20 and Sherri just to bring it to your  
21 attention. Sorry, this is Herb with Humana.  
22 And that -- I did look at that Medicare  
23 bypass list this morning from -- as  
24 requested from one of the providers. That  
25 U4 modifier is on the list, it's just not on



1           there for the provider type that's in  
2           question. So provider type 30 and provider  
3           type 16, that U4 modifier is not there.

4           MS. STALEY: We will --

5           MR. SHANNON: But it's on the bypass  
6           list, Herb?

7           MR. ELLIS: Yeah, it's on the bypass  
8           list for other provider types, but 16, 30,  
9           it's not.

10          MR. SHANNON: And that's -- 30 is the  
11          CMHC, 16's the CCBHCs, so if there's --

12          MR. ELLIS: Correct. Yeah. I'll  
13          just make sure the department's aware of  
14          that.

15          DR. SCHUSTER: Okay.

16          MS. STALEY: Thank you. Right, it  
17          should function the same way in a CMHC and a  
18          CCBHC as all the other provider types, so we  
19          will take that back and see if we can make  
20          that correction.

21          DR. SCHUSTER: Yeah, that would be  
22          great. Thank you, Herb. Any other  
23          comments? Yeah, Steve.

24          MR. SHANNON: I have one, Sheila.  
25          This just came up again this week; I got a

1 call. It appears that with targeted case  
2 management initially, and maybe some peer  
3 support services, but TCM for sure, one, you  
4 know, going through the prior-auth process,  
5 they want to have the individual TRIS  
6 number, that's a deviation number that we're  
7 certified for -- provide TCM, and their  
8 supervisor. And this is not -- it's a  
9 recommendation, not a requirement, and what  
10 has happened to several community health  
11 centers -- this was a call that was on  
12 Tuesday I think -- those PAs are denied  
13 because that information is not included.  
14 And again, it's not required, it's  
15 recommended. Not everyone knew it was  
16 recommended, and therefore, once the PAs  
17 have denied, the only recourse is the appeal  
18 process, which essentially is a clerical  
19 error. It's not a decision made based upon  
20 medical necessity, it's really, we want to  
21 see this TRIS number, and we want to see,  
22 and, you know, who is the case manager. And  
23 several CMHCs -- you know, the prior auth is  
24 between the CMHC and the MCO on behalf of  
25 the individual. It's not between the

1 specific staff person, but we end up being  
2 that we have to go through the appeal  
3 process for essentially, what is a clerical  
4 error, and what is really a recommendation  
5 to include, not a requirement. Now, we all  
6 heard that, that message has been given, but  
7 it still seems there should be some other  
8 recourse for a prior-auth that is denied for  
9 what really is an administrative clerical  
10 issue, not a medical necessity issue. And  
11 why do you have to start that whole process  
12 and go through that exercise to address this  
13 issue? And the TRIS information is  
14 available, MCOs can check it, you know,  
15 we'll do a better job making sure it's on  
16 there, but there should be some other  
17 recourse than the appeal process because it  
18 really wasn't denied for medical necessity.

19 DR. SCHUSTER: Is that something you  
20 can put on the list, Sherri?

21 MS. STALEY: Absolutely. I was just  
22 going to say, I don't know if any of the  
23 MCOs that might be on want to speak to that,  
24 they're welcome to.

25 DR. SCHUSTER: Yes, by all means.

1 MS. JONES: Hi, Sheila and Sherri.

2 This is Cat with Aetna. We do have a  
3 process, and I believe our provider rep head  
4 may have already responded with this  
5 information. We call it a reconsideration.  
6 So if, for example, information like the --  
7 I'm just giving some examples -- like the  
8 information, the name of the targeted case  
9 manager, or the -- maybe the treatment plan,  
10 or etc., if those pieces were inadvertently  
11 left off, what they can do is submit that  
12 information via fax because there are some  
13 challenges, I believe, across the board, not  
14 just with Aetna Availity, but with Availity  
15 in general once a decision has been made  
16 about going back in and attaching via  
17 Availity. So they can fax in that missing  
18 information making sure to reference the  
19 authorization number, and then that will  
20 come into the system, they will attach that  
21 to the authorization record, and that  
22 information can be reviewed.

23 We are working on an updated provider  
24 education document. We have to get that, of  
25 course, approved by our DMS partners to

1 answer and to provide additional, more  
2 detailed what if this happens, what if that  
3 happens regarding, you know, challenges with  
4 the PA process. And so we hope to have that  
5 out very soon about, you know, really kind  
6 of diving into specific, well, what if this  
7 occurs? Or what do we do if this happens?  
8 And hope to get that out very soon, but they  
9 do have the opportunity to submit that  
10 information via what we're -- we call a  
11 reconsideration without having to go through  
12 an appeal, a peer-to-peer, etc. And we'll  
13 be more than happy to provide additional  
14 details outside of here if that would be  
15 helpful.

16 DR. SCHUSTER: Let me ask --

17 MS. JONES: And I see Liz's chat as  
18 well, and our time frame is the exact same  
19 as what --

20 MR. SHANNON: Yeah, I think that  
21 we've got that information, appreciate that,  
22 Cat. We received that --

23 MS. JONES: Okay, great.

24 MR. SHANNON: -- it appears that  
25 this -- and this has happened since -- you

1 know, I got another update on this recently,  
2 that the staff that is reviewing the PA,  
3 never offered up the reconsideration option,  
4 and that still isn't across all folks at  
5 Aetna, so they're being told you still have  
6 to appeal even though this reconsideration  
7 option makes sense. One CMHC said, "We did  
8 that. We were told we could resubmit it, we  
9 could fax it, we couldn't use Availity," but  
10 one got that information and the other did  
11 not. So maybe they're all getting it now,  
12 but the concern I have is does the staff at  
13 Humana, are they really aware or are they  
14 sharing the reconsideration option? Because  
15 this has just been appeal, appeal, appeal.  
16 It hadn't been offered up unless you talk to  
17 the right person. Like an internal issue,  
18 it's not necessarily just the whole process  
19 doesn't seem to be working well. Does that  
20 make sense?

21 MS. JONES: Yes, it does. And I  
22 think that is our goal with that, you know,  
23 more detailed, fine-tuned communication that  
24 we're working on. We're also having, you  
25 know, additional virtual office hours to try

1 to supplement that and also acknowledge  
2 challenges, especially, you know, not  
3 speaking for all the MCOs, but, you know, we  
4 have different processes, we're different  
5 teams within our organizations. Maybe  
6 handled the different parts of the process,  
7 you know, intake versus the actual BHUM, and  
8 so we will definitely work on getting that  
9 information to make sure that our intake,  
10 for example, department, who processes all  
11 incoming requests, are aware of that  
12 reconsideration option, and that, you know,  
13 it's not an issue of, you know, new intake  
14 staff, or new staff coming on and not being  
15 familiar with that. We'll make sure that  
16 they have that information.

17 MR. SHANNON: Great, thank you.

18 DR. SCHUSTER: So I have a question,  
19 I guess, Cat, to you, since you volunteered  
20 early on. If people are being dinged, and I  
21 mean given a denial because they don't have  
22 a piece of information that's not required,  
23 what you're really saying is that you all  
24 are going to require this even though it's  
25 not any place that it's required. I mean, I

1 don't understand the difference between  
2 saying, "it's recommended --

3 MS. JONES: Sure.

4 DR. SCHUSTER: -- and, oh, but if you  
5 don't have it, we're going to deny you."

6 MS. JONES: Sure. And that's a  
7 miscommunication I think maybe by the  
8 providers is we communicated that we have to  
9 know who the person is that's providing the  
10 service, because we are checking to see if  
11 the individual targeted case manager and  
12 their supervisor, you know, are compliant  
13 with the training and education requirements  
14 for -- in order to provide that service. So  
15 we have that very clearly mapped out in our  
16 provider virtual office hours, frequently  
17 asked questions, and actually, sent that out  
18 as a notice as well that we need to clearly  
19 have that. It is very helpful when we have  
20 -- because there could be several John  
21 Smiths in the TRIS system. It's very  
22 helpful if we have that ID, but it's not --  
23 you know, we're not simply denying because  
24 that TRIS ID is not there. If we -- if we  
25 are -- you know, our staff -- you know,



1 every name that's associated with the  
2 request, we are looking that up because it's  
3 not always clear who exactly is the targeted  
4 case manager and who is the supervising  
5 professional. So we don't just -- if it's  
6 that number's not there, we deny it, that is  
7 definitely not the case. We look at name,  
8 we look at if the ID is there, however --  
9 you know, we're reading through the  
10 documents trying to glean who is the  
11 targeted case manager so we can do that  
12 check to see if they are compliant. So I  
13 wanted to assure the group of that.

14 DR. SCHUSTER: Okay. That was not  
15 the impression I had from the provider. But  
16 Liz Stearman had her hand up first, I think.  
17 Liz?

18 MS. STEARMAN: Yeah, I was just going  
19 sort of, you know, pat Cat and Aetna on the  
20 back for doing this because this is  
21 absolutely a requirement to deliver the  
22 service. They're doing their due diligence  
23 for the providers on the front end and  
24 checking on that, but, you know, we hear a  
25 lot of concerns and complaints about all the

1           recoupments and post-payment audits around  
2           targeted case management. The vast majority  
3           of those are looking for this exact thing,  
4           so really what Aetna is doing is they're  
5           taking a much more proactive approach to  
6           make sure when they authorize it that they  
7           really, truly will be able to pay it.  
8           Whereas those of us that are not doing that  
9           level of investigation at the front end, are  
10          relying on our back-end processes, or the  
11          department alerting us that we need to look  
12          at it, and so it actually results in  
13          recoupment.

14                 So I don't want folks walking away  
15          thinking that this is just something extra  
16          that's being placed. This is a requirement  
17          of all of us as MCOs to make sure that we  
18          are paying only under those conditions.  
19          When that check happens is the difference  
20          that Cat is explaining, so.

21                 MR. SHANNON: But is that information  
22          required on the prior authorization form?

23                 MS. KOENIG: Hey, Cat, I'm happy to  
24          jump in, too, because I think we have some  
25          similar process. So, Steve, United does

1           require it, and so similar to what Aetna's  
2           process is, we do initially, on the front  
3           end of the authorization, do go into the  
4           TRIS database to try to validate. We also  
5           offer an option on our portal, say they have  
6           continuing education that hasn't been  
7           submitted, so it may not show on the TRIS  
8           database accurate information, so the  
9           provider can send in updated information so  
10          we're not immediately denying. We're giving  
11          the provider the opportunity to provide  
12          additional documentation or supporting  
13          documentation. But to Liz's point, this is  
14          required. They have to be a certified  
15          provider to deliver these services.

16                 MR. SHANNON: No, no, no. Wait a  
17          minute, I'm not saying they're not certified  
18          providers.

19                 MS. KOENIG: But --

20                 MR. SHANNON: They are certified  
21          providers. It's that in the process, as I  
22          understand it, the TRIS number is not a  
23          required field. They are all through the  
24          process, and their supervisors are eligible  
25          supervisors. That's the distinction. We're

1 not saying people who are not eligible to  
2 provide the services should provide the  
3 services. We're saying, in one situation,  
4 PAs are being denied, and the appeal was the  
5 option when it wasn't clearly stated on the  
6 form "provide this information." That's --  
7 that's the distinction.

8 MS. KOENIG: Well --

9 MR. SHANNON: That's the issue. We  
10 don't want people who are not eligible  
11 providers to provide services. We're not  
12 arguing that. We're saying people were  
13 being -- PAs are being denied and the appeal  
14 process was being required because the  
15 information, which we were told after the  
16 fact was recommended, not required to be  
17 submitted on the PA. That's the  
18 distinction. It's not that it -- we're --  
19 we don't want to use the appropriate level  
20 of staff, it's that it was not required on  
21 the PA.

22 MS. JONES: Steve, we're not denying  
23 if the TRIS ID is not there. We --

24 MR. SHANNON: Well --

25 MS. JONES: -- we have communicated,

1           and the -- I believe Holly attached the  
2           actual --

3           MR. SHANNON: Right.

4           MS. JONES: -- guidance when we  
5           resumed PA. We had, you know -- and we have  
6           the name of the TCM, the name of the TCM  
7           supervisor, and we have documentation that  
8           the TRIS ID is recommended. If we cannot --  
9           if we cannot verify with at least that  
10          minimal information, the name, that there is  
11          someone with that name that is compliant, we  
12          are not approving the service, that is  
13          absolutely correct. We are not denying  
14          because that singular number, or this --  
15          the -- is not present, but if we cannot  
16          confirm that the targeted case manager is  
17          compliant, we are not approving services.

18          MR. SHANNON: Okay. As of Tuesday,  
19          they were being denied, and this was  
20          reported by 1, 2, 3, 4 CMHCs out of the 14.  
21          And one was told specifically, "It is not  
22          required on the form, but it is  
23          recommended."

24          MS. JONES: The TRIS ID, but we must  
25          be able to verify that the targeted case

1 manager is compliant. Either that we have  
2 documentation that was sent out to the  
3 providers that says it must provide the name  
4 and the name of the supervisor for us to  
5 check. It is recommended that the TRIS ID  
6 be included because that is the quickest,  
7 fastest, easiest way to look them up. It is  
8 split second versus trying to find the name  
9 in the documents of who those individuals  
10 are, and oftentimes, not ever being able to  
11 determine who the provider is via the  
12 documents. The TRIS ID 100 percent is the  
13 easiest, fastest way, most accurate way to  
14 confirm. So I think that, you know, that's  
15 the issue. We need to be able to confirm if  
16 the provider is compliant.

17 MR. SHANNON: I mean, okay, I hear  
18 you, I'll pass it on. But again, we're kind  
19 of talking on opposite ends of the coin  
20 here. We are not saying we want to use  
21 people that are not TRIS certified. We're  
22 saying why is it denied -- now there's the  
23 reconsideration that wasn't discussed on the  
24 call Tuesday, wasn't mentioned.  
25 Reconsideration was an option Tuesday. I'm

1           glad it is, I will send that message out to  
2           the CMHCs. But again, if it's required,  
3           shouldn't there be a space to put that?

4           MS. JONES: The TRIS ID is not  
5           required, it's recommended. The name of the  
6           targeted case manager and the name of the  
7           targeted case manager is required.

8           MR. SHANNON: Okay.

9           MS. KOENIG: And Steve, just to  
10          clarify for United, it is required on our  
11          PA, so --

12          MR. SHANNON: Yeah.

13          MS. KOENIG: -- if they're requesting  
14          targeted case management, and then they're  
15          given the additional option on the portal.  
16          For whatever reason, you know -- and I think  
17          there's a scenario that, you know, with the  
18          CMHCs, they have up to, you know --

19          MR. SHANNON: Yeah.

20          MS. KOENIG: -- from the start of  
21          employment for the first six months they  
22          have to obtain that certification. That was  
23          also the intent, to be able to put  
24          supporting documentation as we know that  
25          they haven't completed the full training.

1           So it is required in our portal system.

2           MR. SHANNON:   So -- and again, this  
3           has not been an issue on a United call to  
4           date, but it was an issue Tuesday.

5           MS. KOENIG:   Okay.   Well, I just  
6           wanted to clarify United's process just as  
7           we're all talking and to jump in, so thanks,  
8           Steve.

9           MR. SHANNON:   Yeah.   Yep.

10          DR. SCHUSTER:   So it appears to me  
11          that the MCOs have the ability to require  
12          the TRIS information if some of you are  
13          doing it, so I guess I would say to Aetna  
14          and to others, why don't you put that on the  
15          PA form?   If that's what you absolutely need  
16          to make sure that they are certified  
17          providers, then it seems like the simple  
18          solution is for you to make it a requirement  
19          of the PA.

20          MS. JONES:   We can definitely provide  
21          that feedback, but providers do have the  
22          option of using the state-provided DMS  
23          universal PA form.   If they choose to use  
24          that, we don't have any input about -- about  
25          that form.   We can make recommendations, but



1 changes would be initiated that way.

2 DR. SCHUSTER: Would have to be done  
3 by DMS; is that right?

4 MS. JONES: Correct.

5 DR. SCHUSTER: So a provider can  
6 submit a PA form that's specific to the MCO  
7 that is covering the patient, or they can  
8 use the state form; is that right?

9 MS. JONES: That's correct. And  
10 the -- I'm not sure about the other MCOs,  
11 but our Aetna PA form is a national form.  
12 It is not specific to every -- every  
13 service, and so there would be some -- some  
14 hoops. That's why we initiated  
15 communication of -- on the onset of PA, some  
16 specific guidance that was sent out  
17 regarding this is what you need to submit  
18 for targeted case management, for all of the  
19 other services where we resumed PA and also  
20 discussed that in our virtual office hours.

21 DR. SCHUSTER: Okay. And I'm getting  
22 some stuff in the chat that some of you are  
23 now wanting to have specific PA forms only  
24 for targeted case management, so --

25 MR. SHANNON: Right.

1 MS. KOENIG: I think -- Dr. Schuster,  
2 I mean, I think each MCO probably operates  
3 differently, and I think to Cat's point --

4 DR. SCHUSTER: Yes, I see that.

5 MS. KOENIG: -- we have different UM  
6 teams that are handling different service  
7 codes, so I think from an operational  
8 standpoint, we've made different decisions  
9 based on national forms that are utilized  
10 versus state-specific forms, etc., within  
11 our organizations, so.

12 DR. SCHUSTER: So I guess the best  
13 response is for you all to recognize the  
14 reconsideration process, and for Steve and  
15 other providers on here to disseminate that  
16 information if this issue comes up.

17 MR. SHANNON: Yeah.

18 DR. SCHUSTER: That certainly is  
19 better than going through the entire appeals  
20 process.

21 MR. SHANNON: Right.

22 DR. SCHUSTER: And I would urge the  
23 MCOs who do not require the TRIS number to  
24 please inform your staff to offer and make  
25 sure that the provider knows that

1 reconsideration is a possibility. That  
2 seems like the best we can come up with.  
3 And Sherri put the email address in for  
4 resolving issues. Thank you, Sherri.

5 Now we go to an equally easy  
6 discussion topic: MCO audits of providers.  
7 And, you know, we continue to get all kinds  
8 of feedback about issues that come up,  
9 and -- with these MCO audits. And I'm  
10 wondering, instead of talking about  
11 specifics, if there isn't some way that we  
12 can improve the communication process or  
13 some kind of feedback loop. I've heard  
14 about MCOs that are not following the regs,  
15 either in terms of the time frames or in  
16 terms of what is being required. There  
17 certainly has been a lot of frustration on  
18 both sides, and I worry, of course, because  
19 we're hearing stories about providers  
20 leaving the Medicaid provision. We're  
21 talking about private providers and group  
22 practices or solo practices who are just  
23 saying, "It's not worth the hassle to  
24 provide services to Medicaid members." And  
25 I am really, really concerned about that,

1           folks. So I think we need to somehow  
2           improve the communication or the  
3           understanding about these audits.

4                       We've been very clear here on the BH  
5           TAC, we were not happy about PAs coming back  
6           at all. And I think we made that very  
7           clear, but with PAs back, we certainly were  
8           hoping and we certainly have articulated  
9           that, and maybe we were incredibly naïve to  
10          think that with the resumption of prior  
11          authorizations that there would be some  
12          lessening of audits and recoupments and the  
13          size and scope of the audits, and that seems  
14          to be going in the other direction. So I'm  
15          not sure what to make of that. What we  
16          heard from many of the MCOs early on when we  
17          didn't have PAs was that they were having to  
18          up the ante, if you will, with the audits  
19          because we were not doing prior  
20          authorizations.

21                      So I don't know, I invite any of the  
22          providers that have any ideas about  
23          improving communication or what some of your  
24          frustration has been to speak up. And let  
25          me answer the door. Come on in, Kenny,

1           thanks. Anybody want to weigh in on this?

2           MS. STALEY: Since no takers, I'll  
3           just say, you know, we certainly can talk  
4           with Program Integrity about something that  
5           we could present to this group about volume  
6           of audits, those that were appealed, things  
7           like that. It just gets tricky for several,  
8           several reasons, but I think that we could  
9           certainly work with the MCOs and Program  
10          Integrity to figure out a way to be more  
11          transparent with this group.

12          DR. SCHUSTER: I appreciate that very  
13          much, Sherri, and I certainly think that  
14          getting some data would be very, very  
15          helpful. Because it does feel like it's  
16          a -- it's a widening abyss, and I really am  
17          worried about the level of frustration, and  
18          maybe the frustration is just as great on  
19          the MCO end, but I hear it from the  
20          providers, and occasionally, even from the  
21          families or consumers when these things come  
22          up. And I know I'm hearing about providers  
23          that are dropping out as Medicaid providers,  
24          which again, is of great concern to me  
25          because I think we have a shortage, always,

1 of behavioral health providers.

2 So yes, if you could do that, and  
3 we'll put that certainly on the agenda for  
4 the next meeting to look at some data. I  
5 would appreciate that.

6 MR. SHANNON: And, Sheila, closing  
7 the loop process is something I hear about.  
8 It's like you respond to, submit  
9 information, and you never hear back. You  
10 never know, you know, what happens, and  
11 there are more requests. It just seems to  
12 be the provider doesn't know the outcome, or  
13 when the process ends, or what it looks  
14 like, and, you know, large volumes of  
15 information being sent.

16 DR. SCHUSTER: Yeah, I think that's  
17 true, too. Mostly, I've heard it from  
18 providers in terms of asking for an  
19 extension and then not being clear that they  
20 ever were given an extension, which seems  
21 like a pretty rudimentary kind of provision  
22 that ought to be there.

23 I think we also are hearing from  
24 providers that they're being audited on  
25 things that were initially approved, and I

1 don't know whether that's -- you know, one  
2 of the MCOs in their earlier discussion said  
3 -- I think it was Liz Stearman -- said, you  
4 know, depends on when you do the process at  
5 the front end or the back end. And I don't  
6 know how many of those claw backs, if you  
7 will, are due to finding out that the  
8 provider was not appropriately certified at  
9 the time of the session or whatever. But I  
10 have heard from providers that they will  
11 meet with the same MCO over the same issues  
12 and get told two entirely different things  
13 about the same situation, and that's  
14 incredibly frustrating.

15 MS. BICKERS: Dr. Schuster?

16 DR. SCHUSTER: Yeah.

17 MS. BICKERS: Hi, this is Erin. How  
18 are you doing today?

19 DR. SCHUSTER: Fine. How are you,  
20 Erin?

21 MS. BICKERS: I'm wonderful, thank  
22 you. I just wanted to reiterate, too, if  
23 providers are having issues with the MCOs  
24 not adhering to the guidelines, please have  
25 them send that to the MCO compliance email

1 with examples, names of who they've talked  
2 to. That's the best way for DMS to track  
3 and monitor, is this an across-the-board  
4 issue? Is this an isolated issue with one  
5 MCO? Chelsea and Jeremy's group do a  
6 wonderful job of monitoring that and  
7 reaching out, trying to figure out what's  
8 going on, but that's the best way outside of  
9 these TAC meetings for DMS to monitor those  
10 complaints, and then they can kind of reach  
11 out and try to figure out what's going on.  
12 But the more information that they can  
13 provide to the compliance email, the better  
14 the DMS staff can kind of try to help step  
15 in and figure out what's going on there. So  
16 we really just want to encourage all  
17 providers to use -- utilize that process if  
18 needed.

19 MS. EISNER: Hey, Erin, it's Nina.

20 MS. BICKERS: Yes, ma'am.

21 MS. EISNER: Is there a separate  
22 clients' hotline for each MCO, or is there  
23 just one?

24 MS. BICKERS: I have an email  
25 address -- if Chelsea is on. I just know



1 the email address that I usually provide for  
2 you guys, and I can drop it in the chat --

3 MS. EISNER: Thank you.

4 MS. BICKERS: -- is the best way I  
5 know --

6 MS. EISNER: Okay.

7 MS. BICKERS: -- because I know it's  
8 heavily monitored by multiple staff members.

9 DR. SCHUSTER: Okay.

10 MS. EISNER: Okay, great. Thank you  
11 so much.

12 DR. SCHUSTER: So --

13 MS. AGEE: Hey, Erin.

14 MS. BICKERS: Oh.

15 DR. HOFFMANN: Chelsea's on.

16 MS. AGEE: Chelsea here.

17 MS. BICKERS: Oh, thank you.

18 MS. AGEE: I'll -- I believe Sherri  
19 had put the email contact information in the  
20 chat already of -- looks like it was the --

21 DR. SCHUSTER: Is it the  
22 ProviderMCOInquiry@ky.gov?

23 MS. AGEE: Yes.

24 DR. SCHUSTER: Okay.

25 MS. AGEE: Yes. And so, you know,

1           what -- just to -- in case anyone is  
2           unfamiliar with what Contract Monitoring  
3           Branch's role is, we provide contract  
4           oversight for the MCO partners. So when we  
5           review disputes that come to our branch,  
6           we're reviewing that to determine if there's  
7           been a deficiency that we've -- you know,  
8           once we do the review of your dispute,  
9           whether there's been a deficiency for a  
10          contract, you know, whether there's been a  
11          violation of state/federal law. So, you  
12          know, that's kind of our process when we get  
13          those disputes, and then we follow up with  
14          the MCO if we determine that there has been  
15          any type of breach, we can open a compliance  
16          review with that MCO.

17                 But I just want to reiterate, we  
18                 don't -- we do not get involved with  
19                 re-adjudicating claims or anything like  
20                 that. That is not our purview. We  
21                 specifically just review disputes to  
22                 determine if there's contract compliance  
23                 concerns and if the MCOs have -- you know,  
24                 are deficient in any of those areas. So I  
25                 just wanted to provide a little bit of

1 insight into what our role is, specifically  
2 in my branch, as it relates to MCOs.

3 DR. SCHUSTER: I appreciate that,  
4 Chelsea. Does that include violations of  
5 the regs?

6 MS. AGEE: Yes. Any type of  
7 state/federal contract regulation that we  
8 review and determine is -- the MCO is  
9 deficient in, you know, we have mechanisms  
10 in the contract to correct that with the  
11 MCO, but we just don't -- we would not be  
12 involved in, you know, helping a provider  
13 get a payment, or get a claim paid --

14 DR. SCHUSTER: Sure, yeah.

15 MS. AGEE: -- particularly. We're  
16 just looking to make sure the MCO is  
17 following the process correctly, following  
18 all the state regulations, federal  
19 regulations, that type of thing.

20 DR. SCHUSTER: Okay, that's very  
21 helpful because one of the providers had  
22 emailed me with several things that appeared  
23 to be violations of the regs either in terms  
24 of the time frame or in terms of the  
25 process, and we were trying to run it up the

1 flagstaff. And so having this email address  
2 is very helpful. I appreciate that, thank  
3 you.

4 MS. AGEE: Yeah, absolutely. And as  
5 Erin was saying, you know, if you do want to  
6 send -- if you, you know, have a concern  
7 that you feel is a deficiency that a federal  
8 or state or contract regulation's been  
9 violated, you know, include as much evidence  
10 that you can in your submission to us. That  
11 will help us in our review to determine --  
12 you know, we have to have as much evidence  
13 as possible to open compliance reviews --

14 DR. SCHUSTER: Sure.

15 MS. AGEE: -- because, you know, that  
16 involves sanctions, penalties, things like  
17 that. So we have to be able to, you know,  
18 have enough information to open that review.

19 DR. SCHUSTER: Okay. That certainly  
20 makes sense. So it's not a global thing or  
21 hearsay, or -- you know, it's "on this date,  
22 I received this email saying so and so,"  
23 whatever, whatever.

24 MS. AGEE: Yeah.

25 DR. SCHUSTER: Yeah. Yeah, that

1 absolutely makes sense. And again, I think  
2 getting that information out to the  
3 providers will be important.

4 MS. AGEE: Yep, absolutely. And  
5 we're happy to help, so again, Sherri put  
6 that email in her message in the chat, so  
7 feel free to reach out to us if you all have  
8 any of those types of concerns.

9 DR. SCHUSTER: Yeah, thank you. And  
10 thank you, Erin --

11 MS. AGEE: Yep.

12 DR. SCHUSTER: -- for coming on and  
13 reminding us of that avenue, we appreciate  
14 that. Any other provider or MCO want to say  
15 anything on this topic?

16 (no response)

17 DR. SCHUSTER: All right. Going  
18 once, going twice. So, Sherri, we'll look  
19 for some feedback from you from the  
20 integrity group, and we will get that  
21 information out to providers in terms of the  
22 provider MCO inquiry as a means of looking  
23 into this as well. I just -- I don't want  
24 us to all get so polarized is my concern,  
25 and Nina said it well earlier, you know,

1           when the payers and the providers get  
2           incredibly alienated, the people who are  
3           supposed to receive the services are going  
4           to lose. And I -- we don't want that to  
5           happen, so thank you all.

6                     An update on the credentialing of  
7           peer support specialists, and I didn't  
8           invite specifically people from DBH or  
9           Medicaid, but I certainly would welcome your  
10          input. Also, I'm hoping that, Steve, you  
11          would share what you know about possible  
12          legislation, but let's see if there's  
13          anybody on from DBH or DMS who would like to  
14          speak to the -- where we are with the peer  
15          support certification.

16                    MS. STALEY: I can give --

17                    MS. MUDD: I'd be interested to know  
18          -- I'm sorry. I'd be interested to know,  
19          too, that I know January 1 was when the  
20          change is supposed to be in effect, and I'd  
21          kind of be interested to know if anybody  
22          knows how many jobs were terminated or lost.

23                    DR. SCHUSTER: Yeah, it's a good  
24          question, Valerie, and I don't know that we  
25          have anybody on that can tell us that. But

1           --

2                   MS. WASH:  So, yeah, Dr. Schuster, I  
3           can bring that back to Medicaid if you'd  
4           like me to for our next meeting.

5                   DR. SCHUSTER:  Yeah, I don't know --  
6           I don't know --

7                   MS. STALEY:  I can give just a small  
8           update.

9                   DR. SCHUSTER:  Yeah.

10                   MS. STALEY:  We don't have any  
11           information about people who have lost jobs  
12           or transitioned to other roles.  We do know  
13           that as of today, there are 72 of the  
14           registered peer support specialists with the  
15           Drug and Alcohol Board, and so those people  
16           are eligible through the bill to provide  
17           services and be reimbursed by Medicaid.  
18           And, of course, you know, this doesn't  
19           impact anyone outside of SUD peer supports,  
20           so peer support specialists for mental  
21           health, SMI, other types of things, those  
22           have not been impacted in any way.  So those  
23           will continue as normal.

24                   DR. SCHUSTER:  So of the peer support  
25           for family, youth, mental health, and so

1           forth, I think --

2                   MR. SHANNON:   They're okay.

3                   DR. SCHUSTER:   Well, I think the  
4           concern, though, was if they're in a CMHC  
5           and they're seeing somebody with a  
6           co-occurring disorder, right, Steve?

7                   MR. SHANNON:   Right. Co-occurring,  
8           so substance abuse and one of the other  
9           categories of peer support specialist. The  
10          substance abuse peer support needs to go  
11          through the board, so that's going to  
12          decrease access for that co-occurring. And  
13          it also creates confusion for the individual  
14          being served and supported, you know, which  
15          peer support specialist do I go to with what  
16          issue, or what happens, or if I mention to  
17          my mental health person, a substance use  
18          problem, they have to stop talking to me. I  
19          mean, that's not going to happen. But it's  
20          a concern, so I think that's taking place as  
21          well.

22                   And there's still -- and to date,  
23          that I haven't heard of specific jobs lost  
24          yet. I think people are hoping that there's  
25          a legislative fix pretty quickly that would



1 allow, you know, to move forward. I just  
2 don't know how quickly that can take place  
3 during the session, but, you know, from the  
4 CMHCs, they're going to try to keep people  
5 employed as long as possible in other  
6 capacities, maybe doing some other work.

7 The other concern is some peers left.  
8 They opted not to go through the process,  
9 and they want to do something else, so.

10 MS. MUDD: Well, probably because  
11 they were scared they were going to lose  
12 their job.

13 MR. SHANNON: Yes. Yeah.

14 DR. SCHUSTER: Well, what can you  
15 tell us about what might be happening  
16 legislatively, Steve?

17 MR. SHANNON: There's been a group  
18 that's been meeting with Representative  
19 Moser to come up with some -- a plan, some  
20 guidelines for this and what could happen.  
21 There's also been discussions taking the  
22 existing system, not current, but the  
23 December 31 DBH process, and extending that.  
24 As opposed to ending it January 1, carrying  
25 it through maybe through July 1 of '27 or

1 July 1 of '28. Initially, there was  
2 discussion of January 1 of '27, but we don't  
3 want to be in the same problem next year.  
4 We don't want to have to keep doing this.  
5 So we'll see.

6 And if that does come to pass, and I  
7 don't know the most recent status, but  
8 hopefully, ideally, it has an emergency  
9 clause, which legislatively means when it  
10 passes both chambers and signed by the  
11 governor, it becomes law. And the folks  
12 involved appreciate the urgency of this. My  
13 position -- excuse me -- was much more  
14 concerned about the January 1 cliff,  
15 essentially, and what can we do to address  
16 that. And there's other pieces are good,  
17 you know, could there be a separate board  
18 for peers, CB peers, some other mechanism?

19 I just want to get this issue  
20 resolved as quickly as possible and move a  
21 bill as quickly as possible. It's just, you  
22 know, so pressing, and I think if there's --  
23 can get done quickly, the impact on both  
24 employed peers and individuals in recovery  
25 accessing services can be minimized the

1 faster we can all act and get this resolved.

2 DR. SCHUSTER: Yeah. And there are,  
3 we know, from Karen Haskell's participation  
4 in November, that there are number of people  
5 in process through the Alcohol and Drug  
6 Counselor Board. Unfortunately, House Bill  
7 505 made them temporarily --

8 MR. SHANNON: Temporary.

9 DR. SCHUSTER: -- certified or  
10 temporarily registered, and we know that  
11 Medicaid does not pay for temporary licenses  
12 or registrations or so forth, so that's not  
13 really a fix. So our best hope at this  
14 point is movement through the legislature as  
15 quickly as possible, and I know there were a  
16 number of people working on that.

17 There was a question here for peer  
18 support specialists, "Does that affect  
19 crisis services like mobile crisis?"

20 MS. STALEY: It affects people that  
21 are SUD peer supports working in BHSOs or  
22 other AODE locations. So if that person is  
23 specifically an SUD peer support, yes, that  
24 impacts them.

25 DR. SCHUSTER: But it's SUD peer

1 supports working in AODEs or BHSOs.

2 MR. SHANNON: BHSOs, right.

3 MS. STALEY: Correct.

4 DR. SCHUSTER: Okay. Another recent  
5 article I read said there were 16,883 peer  
6 supports certified. Do we -- I don't know  
7 that I've ever seen a number, Steve or  
8 Sherri.

9 MR. SHANNON: I heard similar  
10 numbers, and that's through -- you know, the  
11 certified is through the Department of  
12 Behavioral Health, so I don't know if that's  
13 the most recent number, but that's a number  
14 I've heard or close to a big number. And  
15 that's all peer support specialists through  
16 the Department of Behavioral Health, which  
17 again, December 31 included SUD. There's  
18 still SUD, but they're not all eligible to  
19 provide services. Includes the traditional,  
20 the mental health peer, the family/youth  
21 peer, so that's that number as I understand  
22 it.

23 COMM. MARKS: That's correct, Steve.

24 MR. SHANNON: So those peers, the  
25 RSUD, are a separate category.

1 DR. SCHUSTER: Yeah.

2 COMM. MARKS: This is Katie Marks,  
3 that's correct. That's the number that's in  
4 TRIS, which is the system for all peers.  
5 That doesn't necessarily mean that all of  
6 those peers are actively working in the  
7 field either.

8 MR. SHANNON: Correct.

9 COMM. MARKS: It means they have a  
10 certification, so that's been one of the  
11 challenges is, to date, not knowing what  
12 proportion of those individuals are active  
13 working in the field and delivering SUD peer  
14 support. Thanks.

15 MR. SHANNON: Yeah.

16 DR. SCHUSTER: Right. Yeah, thank  
17 you.

18 MR. SHANNON: I know several folks  
19 who were peers who are now doing something  
20 else. I don't know --

21 DR. SCHUSTER: Yeah.

22 MR. SHANNON: -- and I suspect they  
23 didn't go back and take their name off the  
24 list.

25 MS. DOBBINS: And correct me if I'm

1 wrong, Sherri or Dr. Marks, but aren't most  
2 of the -- or Steve -- aren't most of the  
3 peers that we're talking about in that  
4 16,000, aren't they, the majority are  
5 substance -- providing services in  
6 substance -- the substance use field, SUDs?  
7 The majority.

8 COMM. MARKS: That is the -- yes,  
9 that's the assumption that it's the majority  
10 are in the SUD field.

11 MS. DOBBINS: Just wanted to clarify  
12 that, thank you.

13 DR. SCHUSTER: It would be  
14 interesting to track the timeline, Kathy,  
15 because they started out as mental health  
16 only --

17 MR. SHANNON: Yeah.

18 DR. SCHUSTER: -- or mental health --

19 MS. DOBBINS: Yeah.

20 DR. SCHUSTER: -- and substance use,  
21 not differentiated, right?

22 MS. DOBBINS: Right.

23 DR. SCHUSTER: I mean --

24 MS. DOBBINS: And it didn't -- it  
25 changed with the Affordable Care Act and

1 expansion of Medicaid, where they -- well, I  
2 guess that's when it became available,  
3 that's right, but they still weren't  
4 differentiating, that's correct, yeah.

5 DR. SCHUSTER: Yeah.

6 MS. DOBBINS: I had to think that  
7 through a second.

8 DR. SCHUSTER: Yeah. Yeah. So --

9 MS. MUDD: I mean, I've been an APSS  
10 since 2000, blah, blah, blah, and, I mean, I  
11 didn't get the SUDPs, and I know a lot of  
12 people -- of course, we don't bill Medicaid  
13 at my place, so I'm a total different  
14 animal. But I know a lot of folks that work  
15 at my Participation Station don't have the  
16 SUDP, so -- but again, we're a different  
17 animal, we don't bill Medicaid. So -- but I  
18 know probably the majority of the folks that  
19 I work with at Participation Station would  
20 have to get their SUDP in, so.

21 MS. DOBBINS: Well, I mean, our peers  
22 are mental health not SUD, Wellspring. And  
23 I assume that's true for Bridgehaven, and  
24 so, you know, some of the others of us who  
25 are BHSOs because our focus is on the

1           mental health side, primarily, even though  
2           we're working to, you know, increase the  
3           integrated care, and we see a lot of people  
4           who are dually diagnosed. But, you know,  
5           we've been billing peer support, as Valerie  
6           says, long before it was available for folks  
7           with substance use disorders --

8           DR. SCHUSTER: Right.

9           MS. DOBBINS: -- which came about, I  
10          think, with the expansion of Medicaid --

11          MR. SHANNON: Right.

12          MS. DOBBINS: -- which is a good  
13          thing, but -- and that has exploded.

14                 But for us, you know, many of our  
15          peers, it's just a different ball game.  
16          They don't -- many of them work part-time,  
17          not full-time. Managing full-time is  
18          challenging for some individuals who are  
19          also working on their mental health  
20          recovery. Yeah, it's just a different ball  
21          game, so I understand why some of these  
22          changes are being made. They make sense to  
23          me.

24          DR. SCHUSTER: Well, the timeline is  
25          the biggest problem, and quite frankly, the



1           very laborious process that people have to  
2           go through under the Alcohol and Drug  
3           Counselor Board. I mean, they're using a  
4           very, I think, clinical, you know,  
5           certification process, very heavily  
6           clinical. They're being supervised by  
7           clinicians and their hours--

8           MS. MUDD: At NAMI, we've got folks  
9           that, you know, run DTR groups, you know,  
10          and they've been doing that forever and a  
11          day, you know, and are mental health court,  
12          you know, the folks who work in metal health  
13          court as peers, you know? I mean, they have  
14          to get the SUDPs because, you know, the  
15          majority of our people in mental health  
16          court have probably -- don't hold me to this  
17          but I'd say probably 80 percent of our folks  
18          in mental health court also have a SUDPs,  
19          you know?

20          MS. DOBBINS: Well, our peers also  
21          have to have -- to be supervised by a  
22          licensed clinician, Sheila. I think that's  
23          an across-the-board thing.

24          DR. SCHUSTER: Well, my -- okay. I  
25          was thinking about people that were going to

1           be seeing dual diagnosis, and I'm not sure  
2           that supervision only on the AOD -- on the  
3           SUD side makes a lot of sense.

4                   MS. DOBBINS: Well, we're all seeing  
5           dually diagnosed.

6                   DR. SCHUSTER: Exactly.

7                   MR. SHANNON: It's not what you're  
8           seeing, it's what your billing.

9                   MS. DOBBINS: Right. Exactly.

10                  DR. SCHUSTER: Yeah.

11                  MR. SHANNON: I mean, not until the  
12       board meets.

13                  DR. SCHUSTER: Well, hopefully when  
14       we meet in March, we will have some  
15       resolution, not just a bill that's making  
16       its way through, but actually something that  
17       maybe has gotten passed with an emergency  
18       clause. So if we get wind of that being  
19       filed and so forth, we will certainly let  
20       you all know so you can advocate for it,  
21       because that's the only light at the end of  
22       this tunnel, I think, right now.

23                       Can we get an update on the 1915 SMI  
24       SPA, please?

25                   DR. HOFFMANN: Tanya should be on

1 from DBH.

2 DR. SCHUSTER: Thank you.

3 MS. DICKINSON: I am. We can -- and  
4 we can get an update. Hello to everybody,  
5 and Sheila.

6 DR. SCHUSTER: Mm-hmm.

7 MS. DICKINSON: Good afternoon,  
8 folks. My name is Tanya Dickinson. I'm  
9 with the 1915(i) RISE implementation team,  
10 and I know the time is short, so I'll just  
11 try to give a quick update for folks, and  
12 then I'll put some resources in the chat  
13 afterwards.

14 I think most here are aware of what  
15 1915(i) RISE is, but just in case, it's a  
16 new program for adults diagnosed with  
17 serious mental illness that offers  
18 Medicaid-funded community-based support  
19 services ranging from case management to  
20 residential supports to supported education  
21 and employment. And it's being jointly  
22 implemented by BDID and Department for  
23 Medicaid Services.

24 And right now, today, I'm mostly  
25 excited to share with everybody that we will

1 go live with participant referrals on  
2 January 15th in Community Mental Health  
3 Center Regions 2 and 12, which is Pennyroyal  
4 and Kentucky River Community Care, so that's  
5 one in the east and one in the west. And  
6 we'll be bringing on additional regions of  
7 the state as we reach the full complement of  
8 services within each of those regions.  
9 There are 10 total services, and they need  
10 to be -- an individual participant would  
11 need to be able to access them all within  
12 their service region.

13 We're always looking to recruit more  
14 providers to join the program, and there  
15 will be some information for providers that  
16 I'll put in the resource box. We have  
17 office hours every week to help folks  
18 through their certification application  
19 process, and in short, we're happy to help  
20 anybody get through that process with as  
21 much support as we can.

22 Since we're going live with  
23 participants referrals on the 15th, we are  
24 now reaching out to folks who've contacted  
25 us over the past couple of months to -- who

1 are in those areas and seeing if they are  
2 still interested in participating and  
3 starting them up on the assessment process.  
4 And following the assessment process, we'll  
5 refer them to a case manager, and then that  
6 case manager will then help them access the  
7 remaining services that might be on their  
8 personal services plan.

9 Let's see, right now, we have a total  
10 of 80 participants on that follow-up contact  
11 list, and so, like I said, we're starting to  
12 reach out to them on or before the 15th to  
13 get them into that queue. To date, we have  
14 81 providers somewhere in the process from  
15 downloading the certification application  
16 packet after our new -- after attending a  
17 new provider orientation, and all the way  
18 between downloading the application and  
19 actually having received their certification  
20 from us. We have eight certified providers  
21 so far, and if you're interested, you can  
22 review who those are. Once they've attained  
23 their Medicaid enrollment, which is kind of  
24 their final step in becoming -- they're not  
25 just certified by us, but then enrolled in

1 Medicaid under that provider type. Once  
2 they achieve that Medicaid enrollment, you  
3 can go to the provider directory that's on  
4 BDID's webpage and see who they are.  
5 That'll also be one of the links I'll put in  
6 the chat when we're done.

7 Basically, I think the message is  
8 keep an eye out for further details, both in  
9 the near term, we'll be putting out that  
10 information with the 15th in a much more  
11 focused fashion so that folks know that we  
12 are open for business and can take  
13 participant referrals. The webpage that we  
14 have has both for providers and for  
15 participants subpages that explain how to  
16 make a referral to the program, and  
17 basically, we are happy to work with anybody  
18 through any way that they contact us. We  
19 have to get lots of paper, you know? It's  
20 government, so we need paper, but the  
21 startup, the contacting and reaching out to  
22 us can be done through the individual, their  
23 family, a current provider, and there's a  
24 form that is filled out, of course, and that  
25 can be emailed or faxed into us, or we can

1 take an initial referral over the telephone.  
2 Again, all that's published on the webpage,  
3 and so I'd send folks there for that  
4 information.

5 But then once the individual goes  
6 through a quick eligibility screening, are  
7 they medical eligible? Do they have a  
8 serious mental illness diagnosis that would  
9 qualify? Then they go to that -- then they  
10 proceed to the assessment process. And the  
11 one question or variations of the question  
12 that we continue to get is how long from the  
13 time we call you until the person starts  
14 receiving services? And I wish I could tell  
15 you. There's no -- there's not ever going  
16 to be one set answer to that question. It's  
17 going to be a question of how long does it  
18 take us to gather the necessary  
19 documentation for the individual, and then  
20 how long -- you know, what pace are they  
21 able to work with the participant? What  
22 pace are they able to work with through the  
23 assessment process?

24 We're using an internationally  
25 recognized assessment tool called interRAI,

1 I-N-T-E-R-A-I, for those who want that  
2 information, but that will -- more  
3 information will keep coming out as we go  
4 along and as we are able to bring on each  
5 region, we will put up a new announcement  
6 and then reach out to that regions'  
7 individuals who are on our participant  
8 follow-up list.

9 I think that's really all that I have  
10 for folks. If there's any questions, I'm  
11 happy to answer them. But, you know, this  
12 is a new process, so we're learning as we  
13 go. We've done at least one or two test  
14 cases for participants entering them into  
15 our system, and so at this point, systems  
16 are go, so we should be ready to rock 'n'  
17 roll on the 15th. So that's all I've got.

18 DR. SCHUSTER: I feel like we should  
19 have had the champagne ready, Tanya. Some  
20 of us have been working on this for many,  
21 many, many, many moons.

22 MS. DICKINSON: Many moons. This is  
23 years coming to fruition.

24 DR. SCHUSTER: So this is exciting,  
25 really exciting to think that in another



1 week --

2 MS. DICKINSON: Absolutely.

3 DR. SCHUSTER: -- we're going to be  
4 enrolling some people. I mean, that's  
5 phenomenal, and I'm glad that we've got 2  
6 regions of the state; obviously, we want to  
7 get all 14 regions of the state covered, but  
8 we will continue to put the word out. But  
9 thank you for that good news.

10 MS. DICKINSON: I think we'll bring  
11 them on fairly quickly, I'm hoping. Like I  
12 said, we're continually recruiting  
13 providers, and we're also trying to work  
14 with ways of streamlining the process as  
15 much as possible. You know, again, there --  
16 it's got some requirements of what we have  
17 to do, but we want to make this as efficient  
18 and supported a process as we can for both  
19 the providers and the participants.

20 DR. SCHUSTER: Absolutely. And I  
21 know you've done this at every Zoom you've  
22 been on with me, but will you again put  
23 those email addresses in --

24 MS. DICKINSON: Yep.

25 DR. SCHUSTER: -- for both provider

1 and for the families are -- in fact, I just  
2 sent that to a family I heard from --

3 MS. DICKINSON: Oh, good. Good.

4 DR. SCHUSTER: -- with a question. I  
5 said, "Here it is," you know? I said, "send  
6 to your" --

7 MS. DICKINSON: I've got a bunch of  
8 resources I can put in the chat box.

9 DR. SCHUSTER: Yes, that would be  
10 great, thank you so much. Any other  
11 questions for Tanya?

12 MS. DICKINSON: I think Valerie has a  
13 question.

14 DR. SCHUSTER: Oh, I'm sorry,  
15 Valerie.

16 MS. MUDD: Yeah, so you're starting  
17 out with Pennyroyal and Communicare, and you  
18 say you've got 81 providers --

19 DR. SCHUSTER: No, it's Kentucky  
20 River, I think.

21 MS. MUDD: Oh, I'm sorry. I'm sorry.

22 MS. DICKINSON: KRCC.

23 MS. MUDD: So you said 81 providers  
24 and 8 are certified, so how many of those  
25 are in Pennyroyal and Kentucky River?

1 MS. DUDINSKIE: I don't have the  
2 numbers right at my hand, but what we -- as  
3 we bring on each region, the threshold for  
4 bringing on a region is that the  
5 participants would have access to all 10  
6 services covered under the program within  
7 that region. Some of them can be statewide  
8 providers --

9 DR. SCHUSTER: Right.

10 MS. DICKINSON: -- some of them can  
11 be just local folks. So rather than looking  
12 at it as a number of providers at a given  
13 address or a given ZIP Code, it's more that  
14 there are 10 -- all 10 services are now  
15 available to the individuals within that  
16 region.

17 MS. MUDD: Okay.

18 DR. SCHUSTER: Right. That make  
19 sense, Val?

20 (Ms. Mudd nods head).

21 DR. SCHUSTER: Yeah.

22 MS. DICKINSON: And it's 81 that we  
23 have tracked in our orientation in our  
24 online training system that have at least  
25 downloaded the application. So some of them

1           probably will download it and not want to  
2           proceed. Some of them will, you know, want  
3           to provide services in multiple areas or  
4           statewide, so.

5           DR. SCHUSTER: Right. Well, great.  
6           So we'll do an imaginary popping of the cork  
7           here, but thank you for that very exciting  
8           information --

9           MS. DICKINSON: Thank you.

10          DR. SCHUSTER: -- that we're -- we've  
11          gotten over the hump here I think, folks.  
12          That's great.

13          MS. DICKINSON: We're very excited.  
14          It's been a huge team effort, and between --

15          DR. SCHUSTER: Yes, I know it has.

16          MS. DICKINSON: -- between all the  
17          folks in the community, in the field, and  
18          across the state, and a couple of very large  
19          agencies figuring out how to get all this  
20          done and put together --

21          DR. SCHUSTER: Yeah.

22          MS. DICKINSON: -- and out -- back  
23          out to the community, it's been a great team  
24          effort. So it's been a lot of --

25          DR. SCHUSTER: Yeah.

1 MS. DICKINSON: -- fun to deal with.

2 DR. SCHUSTER: Well, my thanks to you  
3 all.

4 DR. HOFFMANN: Dr. Schuster?

5 DR. SCHUSTER: Yeah?

6 DR. HOFFMANN: This is Leslie.

7 Before you move onto the next one, as I said  
8 earlier, and I've got Angela on if you've  
9 got specific questions, but the companion to  
10 the 1915(i) RISE, the 1115 SMI, will also  
11 roll out on January 15th. So that's --  
12 recuperative care was another companion,  
13 that one's going to be a little bit later.  
14 As you know, CMS changed that to a  
15 health-related social needs arm, and we'll  
16 be rolling that one out, I believe, in  
17 April. So I just wanted to -- that's two  
18 that we'll have rolling out on the 15th, so  
19 we're really excited.

20 DR. SCHUSTER: Yeah, and remind me  
21 what the 1115 SMI --

22 DR. HOFFMANN: That's for --

23 DR. SCHUSTER: -- that's the IMD.

24 DR. HOFFMANN: That's the IMD so that  
25 we can provide medically necessary

1 short-term stays up to 60 days, but we  
2 cannot exceed the 30-day average --

3 DR. SCHUSTER: Yeah.

4 DR. HOFFMANN: -- and Angela's on if  
5 I misspeak or if you need to know more  
6 information.

7 DR. SCHUSTER: Yeah. Yeah, so that's  
8 the piece that's rolling out on  
9 January 15th.

10 DR. HOFFMANN: With the RISE, that's  
11 correct.

12 DR. SCHUSTER: With the RISE, okay.  
13 Yeah, thank you. That's exciting as well.

14 And then we're ready to go to the  
15 Reentry Waiver and the Child Waiver, please.

16 DR. HOFFMANN: Angela?

17 MS. SPARROW: Yes, thank you. Angela  
18 Sparrow again, technical project specialist  
19 --

20 DR. SCHUSTER: Hi, Angela.

21 MS. SPARROW: Hey. Glad to see  
22 everybody in the new year to provide an  
23 update on the Reentry 1115 project. Again,  
24 it's underway, has been underway, so we're  
25 hopefully in the final stages here as we

1           trek towards our full implementation  
2           April 1st.

3                       So regrouping a little bit into the  
4           new year, lots of, again, initiatives across  
5           all of our partners. We do still have our  
6           implementation plan pending with CMS. I  
7           think that was submitted even in 2024, and  
8           that's okay. In this instance, we still can  
9           move forward with implementation without  
10          that approval. I think we're pretty close.  
11          CMS has had very minimal responses or  
12          feedback for us, so we followed up in the  
13          new year hoping to get approval for that.

14                      Our partners, Mercer, who's our  
15          independent evaluator, the state is required  
16          to have an independent evaluator of the  
17          project. They also have to obtain approval  
18          from CMS on their evaluation design.  
19          They've received some feedback from CMS, and  
20          so we can continue to communicate with them  
21          around that approval. Again, in this  
22          instance, we can move forward with our  
23          implementation without that approval and  
24          work towards that. So those things we just  
25          continue to track and monitor.

1           Our partners, DOC and DJJ, we've  
2           talked again, in the past, just to give a  
3           quick overview for those that might not be  
4           as familiar with the demonstration. DOC and  
5           DJJ, again, will be providing MAT services,  
6           so Medication-Assisted Treatment services  
7           under the demonstration for those  
8           individuals with substance use disorder.  
9           They, again, have become enrolled as a  
10          Medicaid provider. We've developed a new  
11          provider type for them. They're individual  
12          prescribers and practitioners that would be  
13          providing components of that service. For  
14          those that haven't enrolled with Medicaid,  
15          are required to enroll with Medicaid. So  
16          those individual practitioners are  
17          completing that process that's kicked off  
18          and has been underway, so we hope to wrap  
19          that up in the next few weeks in working  
20          with our provider enrollment team to get  
21          those applications processed. So that is a  
22          new process for some of those providers that  
23          work with DOC and DJJ.

24                Again, the MCOs will be -- and so the  
25                individuals, just for those that aren't as



1 familiar, for services that are eligible in  
2 that 60-day pre-release period, they will be  
3 enrolled in a managed care organization.  
4 And so the MCOs will be providing and  
5 supporting pre-release case management, so  
6 developing, identifying, you know, what  
7 those needs are in the community upon  
8 release, working with the individual and  
9 with our DOC and DJJ partners to develop  
10 that plan that will be implemented in the  
11 community. So again, the MC -- excuse me,  
12 DOC and DJJ will be contracting with the  
13 managed care organizations, and so we've  
14 been working to develop kind of a standard  
15 provider agreement to support that  
16 contracting for DOC and DJJ with the MCOs.  
17 So that's been underway, again, hoping that  
18 we can start that process, DOC and DJJ can  
19 work with the MCOs around that.

20 Also, again, some of those  
21 credentialing, which is not as familiar for  
22 DOC and DJJ to credential those individual  
23 providers credentialing with the MCOs, so  
24 supporting, again, what that work is -- and  
25 process is going to look like for those

1 practitioners, so that work continues.

2 The MCOs, again, have begun hiring  
3 and making plans to hire case managers to  
4 support those pre-release and post-release  
5 case management services under the  
6 demonstration. Significant system changes  
7 that we've talked about to support  
8 identification of individuals who are  
9 eligible in that 60-day pre-release time  
10 period where we've talked about there's, you  
11 know, a couple of initiatives between the  
12 reentry demonstration, the CAA, 5121  
13 services for our youth. And so again,  
14 trying to identify what services are  
15 eligible under which authority, DOC and DJJ,  
16 really working with them on some of those  
17 system changes to support that. So partner  
18 testing, testing those system changes has  
19 kicked off and will continue through  
20 February. It's also part of that's going to  
21 support our partners being able to submit  
22 Medicaid applications, so even today, they  
23 still utilize paper applications, so that is  
24 going to be, I think, a big and great change  
25 for our partners. So there's lots of

1 training around provider enrollment,  
2 billing, completing those Medicaid  
3 applications to occur.

4 Finalizing standard operating  
5 procedures across all of our partners to  
6 support implementation. We'll be conducting  
7 readiness assessments that's required, you  
8 know, into March and even before go-live  
9 that will also be submitted to CMS as well.  
10 So lots of work as we kind of gear up for  
11 this quarter heading into 4/1  
12 implementation.

13 We've also, again, kind of talked  
14 about earlier in the Reentry TAC, some of  
15 the things to keep on the radar in 2026 and  
16 post-implementation, again, is really also  
17 aligning with some of the other projects  
18 that we talked about implementing within DMS  
19 and across the state that will impact our  
20 incarcerated populations. So, for instance,  
21 for individuals that might be eligible for  
22 the 1915(i) RISE, conducting those  
23 assessments, connecting them to those  
24 programs and those services, what does that  
25 look like? So that -- again, that work,

1 we're keeping that on the radar for how we  
2 can integrate that.

3 Some of the other initiatives under  
4 the 1115 demonstrations, the Recovery  
5 Resident Support Service that our  
6 incarcerated -- our individuals in our DOC  
7 prisons with SUD at release would be  
8 eligible for. So how do we identify  
9 eligibility for those services again, and  
10 connect them with that in that release  
11 period or upon release? And so, again,  
12 working, again, to make those connections  
13 and support, and again, connect them to  
14 those additional services outside of the  
15 demonstration is important, too, throughout  
16 the year.

17 So I'll pause there to see if there's  
18 any questions. We did receive notice today  
19 actually, so this is something that we've  
20 talked quite a bit with our partners in over  
21 the last year, Kentucky was awarded grant  
22 funding to support the CAA for the youth  
23 services implementation and compliance for  
24 the federal requirements. Last year, we had  
25 not received that funding but did receive

1 notice just as today that those funds should  
2 be released, which is great because that is  
3 going to support DOC and DJJ, as well as we  
4 bring on jails later in the year to come in  
5 compliance with CAA. So that was great news  
6 to start off the year, and we'll work with  
7 our partners to get that funding to them as  
8 well.

9 DR. SCHUSTER: Great. That is good  
10 news, and you all have been working,  
11 working, working I know. For those of you  
12 who don't know, Steve Shannon chairs the  
13 Reentry TAC, and it meets at 9 o'clock  
14 Eastern Time, 8 Central in the morning on  
15 the same days that the BH TAC meets. So  
16 it's a great opportunity to hear from the  
17 CMHCs, from the MCOs, from the office of --  
18 the Governor's Office of Drug -- whatever  
19 that --

20 MR. SHANNON: Drug Control Policy.

21 DR. HOFFMANN: Drug Control Policy.

22 DR. SCHUSTER: Drug Control Policy.  
23 I was going to say "drug enforcement," and I  
24 knew that wasn't it.

25 MR. SHANNON: That's not a thing

1           anymore.

2                   DR. SCHUSTER: Right. Yeah, that's  
3           Van Ingram. Anyway, it's a great  
4           opportunity, and I believe one of your TAC  
5           members, Steve, has been named to the -- to  
6           serve on the MAC.

7                   MR. SHANNON: Is that true? Is that  
8           Nathan?

9                   DR. SCHUSTER: Yeah, I think so.

10                  MR. SHANNON: I don't know who it is.

11                  DR. SCHUSTER: I've gotta go back and  
12           look. Yeah, but anyway, yes, so great  
13           progress. And we're still looking April 1,  
14           right, Angela?

15                  MS. SPARROW: That's what we're  
16           tracking towards, yes.

17                  DR. SCHUSTER: All right.

18                  MS. SPARROW: It's been a long time  
19           coming, right? Yep.

20                  DR. SCHUSTER: Yes.

21                  DR. HOFFMANN: Dr. Schuster, I put in  
22           the chat, we call -- when the opportunity  
23           came out, of course, it was part of the  
24           Consolidated Appropriations Act, but now  
25           that we're getting into it and really going

1 to start doing some work once we have the  
2 agreements between DOC and DJJ for this  
3 grant, you'll hear Kentucky CARES, so that's  
4 Continuity of Access -- I put it in the chat  
5 -- to Resources --

6 DR. SCHUSTER: Okay.

7 DR. HOFFMANN: -- and Essential  
8 Services. So we're very excited.  
9 Everything's coming together this first  
10 quarter.

11 DR. SCHUSTER: I don't know how you  
12 all remember -- come up with and then  
13 remember all of your acronyms. You've got  
14 to have a whole glossary someplace where  
15 when somebody says, "oh," you know? In  
16 fact, when I see anything with a bunch of  
17 just letters, I think, "Oh, I'm sure there's  
18 an acronym for it someplace."

19 DR. HOFFMANN: Well, if I can't think  
20 of one, I go to Dr. Robbins at DBH. She's  
21 always good at coming up with acronyms.

22 DR. SCHUSTER: Oh, Tena? Yeah, I'm  
23 sure.

24 DR. HOFFMANN: She's really good with  
25 that.

1 DR. SCHUSTER: Yeah.

2 DR. HOFFMANN: This grant, I believe,  
3 Angela, it's 4 years, and it's -- the total  
4 grant is just a little less than 5 million,  
5 I think it's 4.9.

6 DR. SCHUSTER: Great.

7 DR. HOFFMANN: Yeah, we're very  
8 excited. We can have boots on the ground  
9 going, working with the jails and things  
10 like that.

11 DR. SCHUSTER: Great. All right.  
12 Any questions for Angela? Or any questions  
13 about the Reentry Waiver?

14 (no response)

15 DR. SCHUSTER: So countdown  
16 continues. Thank you, Angela.

17 And I think you said Carmen is going  
18 to update us about the Child Waiver.

19 DR. HOFFMANN: That's correct.

20 DR. SCHUSTER: It's rolled out  
21 already, right?

22 DR. HOFFMANN: Yeah, she can do eight  
23 and nine --

24 DR. SCHUSTER: Oh, okay.

25 DR. HOFFMANN: -- I think at the same



1 time there.

2 DR. SCHUSTER: Yeah.

3 DR. HOFFMANN: Go ahead, Carmen.

4 MS. HANCOCK: I can, thank you.

5 Thank you, Dr. Schuster --

6 DR. SCHUSTER: Sure.

7 MS. HANCOCK: -- and other members of  
8 the TAC. I'm Carmen Hancock, the division  
9 director for Long-Term Services and Supports  
10 with Medicaid. And like you said, I'm here  
11 to talk about the Child Waiver, the 1915(c)  
12 CHILD, Community Health for Improved Lives  
13 and Development.

14 We have kept -- we've maintained an  
15 aggressive schedule getting this 1915(c)  
16 Waiver up and running, and like you said, we  
17 are -- we've implemented. We're ready, it's  
18 live.

19 So the Child Waiver is a new 1915(c)  
20 Waiver that is designed specifically to help  
21 children and youth with the most complex and  
22 significant behavioral health or  
23 developmental challenges. So these would be  
24 youth that are under the age of 21, and who  
25 would meet the level of care, like a

1 psychiatric inpatient hospital, or an ICF  
2 IIT. But they can still be safely supported  
3 in the community with the right sets of  
4 services and supports.

5 The services that we're offering in  
6 the Child Waiver are case management,  
7 respite, community living supports,  
8 environmental and minor home modifications,  
9 clinical and therapeutic services, and  
10 supervised residential care. So like I  
11 said, we've -- we've been, over the last few  
12 months, finalizing all of the fee schedules,  
13 the developing all of our technical  
14 platforms, performing testing, doing  
15 integration, and that sort of thing. All  
16 systems are go. We have actually received  
17 both participant applications already as  
18 well as provider certification applications.  
19 We have eight providers in the process right  
20 now. Those providers do represent some --  
21 they have stepped forward and represent each  
22 service, so we do have a provider that's  
23 stepped up for at least one of each service,  
24 and a couple of those providers do offer  
25 services statewide. So we are very pleased

1 with that so far. We are moving those along  
2 very, very quickly because we already have  
3 applicants for participants. I actually,  
4 right before this call, was working with  
5 our -- one of our nursing teams to do those  
6 initial capacity reviews and make sure that  
7 we're doing those right from the start. So  
8 we're here, we're doing it.

9 I will say as a side note, there was  
10 a new provider type that was created for the  
11 Child Waiver, so even if you -- if there is  
12 a provider who is an existing 1915(c) Waiver  
13 provider, they would have to go through the  
14 certification process to be certified as a  
15 Child Waiver provider. We are really  
16 working to streamline that knowing that if  
17 we have an established provider, they likely  
18 already have many of the policies and  
19 procedures and processes in place that would  
20 need to be in place for the Child Waiver, as  
21 well as executive director qualifications  
22 and some of those other things. So we're  
23 really, you know, just taking a look at what  
24 they already have in place ensuring that it  
25 can -- that they can incorporate the Child

1 Waiver into what they have already, and  
2 moving those along pretty quickly. But  
3 again, they must go through that  
4 certification process.

5 Same thing for participants. If they  
6 happen to be on a waiting list currently for  
7 another waiver, they would not automatically  
8 be considered for the Child Waiver. There  
9 would have to be a new application submitted  
10 for the Child Waiver for us to consider them  
11 in that regard.

12 Let's see, I think that might be  
13 about it. We've -- like I said, this has  
14 just been sort of a whirlwind. The teams  
15 have done tremendous work to get this up and  
16 running, and we're excited to -- I am -- I  
17 want to have some providers enrolled within  
18 the next couple weeks, I'm going to say by  
19 the end of January for sure and have that  
20 first participant served also by the end of  
21 January. So again, very aggressive  
22 schedule, but it's very much needed.

23 We will -- I can drop into the chat  
24 both -- we have a participant-facing and a  
25 provider-facing website with tools there,

1           FAQs --

2                   DR. SCHUSTER:  Yeah, that would be  
3           great, Carmen --

4                   MS. HANCOCK:  Yes.

5                   DR. SCHUSTER:  -- if you would post  
6           those in the chat, and I'll send those out,  
7           too.

8                   MS. HANCOCK:  Fantastic.

9                   DR. SCHUSTER:  I'm thinking I need to  
10          do a regular kind of waiver update for my  
11          long waiting list, which reminds me, if any  
12          of you are on here and don't get emails from  
13          me reminding you of the BH TAC meeting, if  
14          you put your -- if you'd email me at  
15          kyadvocacy@gmail.com, I'm happy to add you  
16          to my list.  I have a big list for the  
17          Mental Health Coalition, and then I have a  
18          big list for the BH TAC.  But that would be  
19          great, Carmen, thank you.

20                   MS. HANCOCK:  Yes, ma'am.

21                   DR. SCHUSTER:  Any questions for  
22          Carmen on the Child Waiver?  Because this  
23          has really been a rapid turnaround.

24                   DR. HOFFMANN:  Dr. Schuster, just an  
25          FYI, if any providers reach out, or if you

1 all that are on the call hear about  
2 providers that are interested, I know it's a  
3 small waiver right now, but many of our  
4 waivers started out very small. I think we  
5 had 25 slots in ABI when we started, the ABI  
6 Rehab Waiver, so -- rehabilitation. So if  
7 you hear of anybody, we'll work quickly.  
8 We're going to work quickly.

9 MS. HANCOCK: Yes.

10 DR. HOFFMANN: We're all dedicated to  
11 getting out there and getting places of  
12 business, you know, getting our boots on the  
13 ground to see the facilities and ensure they  
14 meet the standards and those kinds of  
15 things. We'll work this very quickly, so if  
16 you get any calls --

17 DR. SCHUSTER: Okay.

18 DR. HOFFMANN: -- or if you know of  
19 anybody to send them our way.

20 DR. SCHUSTER: Yeah, will do, thank  
21 you. Any other questions for Carmen on the  
22 Child Waiver?

23 (no response)

24 DR. SCHUSTER: All right. And then I  
25 think you're going to give us some waiting

1 list numbers, Carmen --

2 MS. HANCOCK: Yes, ma'am.

3 DR. SCHUSTER: -- on the 1915(c).

4 MS. HANCOCK: Yes, I can go right  
5 into those.

6 DR. SCHUSTER: Okay.

7 MS. HANCOCK: For the waiting lists,  
8 as in past months, our ABI Acute and our ABI  
9 Long-Term Care Waivers, as well as the Model  
10 II Waiver, do not have anyone on the waiting  
11 list at this time. Child Waiver does not  
12 have anyone on the waiting list at this  
13 time.

14 DR. SCHUSTER: Okay.

15 MS. HANCOCK: The Home and  
16 Community-Based Waiver, we're sitting at  
17 5,712 people on that waiting list. Michelle  
18 P. is 9,868. And SCL, Supports for  
19 Community Living is 3,810. So that's a  
20 total of 19,390. That's total. Again, that  
21 is -- that's duplicated. That might be  
22 people who are already on another waiver or  
23 who are on multiple waiting lists.

24 DR. SCHUSTER: Right.

25 MS. HANCOCK: But the unduplicated

1           number there is 16,642.

2                   DR. SCHUSTER:   Fifteen or sixteen  
3           thousand?

4                   MS. HANCOCK:   Sixteen, one-six.

5                   DR. SCHUSTER:   Sixteen.   Okay, I  
6           thought --

7                   MS. HANCOCK:   Sixteen, six-four-two,  
8           yes, ma'am.

9                   DR. SCHUSTER:   I was hopefully  
10          thinking that it was going down and you were  
11          saying, "15," but I doubted that that was  
12          the case.   So 16,642 unduplicated.

13                   MS. HANCOCK:   Yes, ma'am.   Mm-hmm.

14                   DR. SCHUSTER:   Okay.   That's super  
15          helpful, thank you very much.

16                   MS. HANCOCK:   Yes, ma'am.   And then  
17          ABI Waiver, Access to Therapy Services, this  
18          is -- there has been no change with this.   I  
19          wouldn't expect that there would be a change  
20          until after session when we do have, you  
21          know, the opportunity to make changes to  
22          regulations and get motion in that area.   So  
23          I don't anticipate an update for that, you  
24          know, within the next quarter, at least.

25                   DR. SCHUSTER:   Yes, because you all



1 will work on regs after the session ends --

2 MS. HANCOCK: Yes, ma'am.

3 DR. SCHUSTER: -- and start that  
4 process up again. Okay. Thank you very  
5 much.

6 MS. HANCOCK: You're welcome.

7 DR. SCHUSTER: Medicaid Oversight and  
8 Advisory Board, and Steve, feel free to jump  
9 in. We had a very long meeting, actually,  
10 on December the 10th. It started at 10 and  
11 concluded at 4:30, and they had a break.  
12 They actually had too long a break at lunch.  
13 I think they were thinking that more things  
14 were -- anyway, so we had lots of -- the  
15 first part of the meeting was very  
16 interesting because we had sponsors of bills  
17 that were going to be filed in the 2026  
18 session that had to do with Medicaid  
19 presented their bills, and there was really  
20 no opportunity to question or ask for  
21 further information. But the bills were  
22 presented in a discussion, a very brief  
23 discussion by the sponsors, and the reason  
24 they're doing that is that if you look at  
25 House Bill 695 out of the 2025 session that

1 established the MOAB, the MOAB technically  
2 has jurisdiction over any changes that are  
3 going to be made to the Medicaid program.

4 So the bills ranged in scope from  
5 some people wanting to put new services in.  
6 Senator Julie Raque Adams had one for  
7 Medicaid coverage for palliative care that  
8 has not been covered by Medicaid, or changes  
9 in benefits. Representative Watkins had a  
10 bill to extend postpartum care for 2 years,  
11 was extended to 12 months by legislative  
12 action 2 sessions ago. So that kind of  
13 thing. All of those came before the MOAB.

14 And also -- Steve, can you carry on  
15 for a minute? I've got to go answer my  
16 door.

17 MR. SHANNON: Yeah. One of them was  
18 a proposal by Senator Meredith, Community of  
19 Health, Accountable Communities for Health,  
20 where maybe three ad districts would be  
21 carved out for a managed care, and the funds  
22 would be used to manage the Medicaid  
23 population within those regions. He  
24 presented that.

25 Let me go back to my notes. And this

1           was all day long we had these conversations.  
2           We heard from Governor Fletcher about the  
3           substance abuse continuum of care that he  
4           was proposing as a possibility in that  
5           presentation. We heard about palliative  
6           care, as Sheila mentioned, some  
7           non-addictive pain management. Essentially,  
8           Senator O'Neill brought this bill  
9           previously. It's non-opioid pain  
10          management, to make that available. There  
11          was one on access to care. Not legislation,  
12          it's the pharmacists' reimbursement by DMS.  
13          That's been filed already by Senator  
14          Richardson. There was one, Representative  
15          Willner, doula services presented.  
16          Representative Watkins, as Sheila mentioned,  
17          cost-sharing, this really relates to the  
18          federal action and House Resolution 1,  
19          that's BR 834. I don't think that's been  
20          filed yet, how that's going to work. Some  
21          discussion of a dashboard, related  
22          indicators, MCO performance. So that was  
23          most of the legislation we heard.

24                 Then we actually had a presentation  
25          from the Attorney General's office about

1 Medicaid fraud and the work they're doing,  
2 and then we actually went over the  
3 recommendations and the findings. I think  
4 we meet Monday, right, Sheila, to finalize  
5 the recommendations.

6 DR. SCHUSTER: Yes. Yeah. There  
7 were -- thank you, Steve. There were 12  
8 recommendations and findings that actually  
9 we had not seen. None of the members, or at  
10 least the non-legislator members of the  
11 MOAB, had not seen those until we actually  
12 got into the meeting, or maybe the day  
13 before they went out. There were 12 of  
14 them, and they made a Statement of Findings  
15 and then they had some recommendations under  
16 each. Senator Rocky Raque chaired that part  
17 and took feedback, not really on the  
18 findings. There were some of those findings  
19 that I thought were kind of interesting and  
20 probably needed to be restated, but we gave  
21 our feedback on the recommendations just for  
22 clarity and so forth.

23 So our meeting -- we're meeting again  
24 on Monday the 12th at noon, and I guess the  
25 stop time is whatever time they go into

1 session that day on a Monday. But it's to  
2 adopt, actually, a final version of these  
3 findings and recommendations. There was a  
4 -- we think a very significant finding and  
5 recommendation was the 12th one out of 12,  
6 and it had to do with the lack of integrated  
7 services for people with behavioral health  
8 issues; integration obviously meaning  
9 integration of physical health services.  
10 And out of that came the recommendation that  
11 the funding for the four current CCBHCs, the  
12 Certified Community Behavioral Health  
13 Clinics --

14 MR. SHANNON: Yes.

15 DR. SCHUSTER: -- and the expanded  
16 ones, and I think there are six, Steve? Six  
17 new ones coming on board.

18 MR. SHANNON: Six new ones for a  
19 total of ten.

20 DR. SCHUSTER: Yeah, for a total of  
21 10. That funding under this original  
22 innovation grant from SAMHSA, actually runs  
23 out on December 31st of 2027, so it doesn't  
24 take us all the way through the second  
25 fiscal year. And so we had made the case

1 with a presentation by the four CCBH centers  
2 that that funding needed to be in place to  
3 make sure that the CCBHCs were carried  
4 through the full biennium budget, and that  
5 was the recommendation that came from the  
6 MAC. So we were very excited about that,  
7 and we hopefully will see that put into the  
8 budget bill or however they decide to do  
9 that.

10 There also were a couple of  
11 recommendations, we've had some  
12 presentations here on reimbursement rates,  
13 but more so the one that Bart Baldwin gave  
14 us last session about -- or last meeting  
15 about lack of network adequacy. And so  
16 there were some findings and some  
17 recommendations around trying to improve  
18 network adequacy, holding the MCOs  
19 accountable, and actually, the only two  
20 provider groups that were talked about in  
21 terms of some of those issues were the  
22 behavioral health group providers and the  
23 dental providers. So the dental and mental  
24 seem to be at the bottom of the totem pole  
25 in terms of reimbursement rates and so

1       forth, but we were pleased that the  
2       presentations that had been made on some of  
3       those issues, and there was a previous  
4       presentation made about dental services,  
5       were being responded to by the legislators.

6               So we encourage you -- the meeting on  
7       the 12th is in person, Room 154 of the  
8       Annex, or you can watch it live. I think  
9       KET's been carrying them, or else the LRC  
10      YouTube if you're interested. And then we  
11      don't really know whether we will be meeting  
12      during the session or not. It's going to be  
13      really tough to schedule a meeting, I think,  
14      because it involves so many legislators.  
15      Any questions from anyone?

16                       (no response)

17               DR. SCHUSTER: Hearing none, I have  
18      not looked at all the new bills that have  
19      been introduced in the current four days of  
20      the session. There's -- well, three days up  
21      to this point. There's been a slew of them.  
22      Some of those bills that we mentioned that  
23      were presented at MOAB, I'm sure have been  
24      introduced. I will tell you that the bill  
25      to -- I just lost it. House Bill 279 is the

1 Behavioral Health Parity Bill, and so if you  
2 want to look at that House Bill 279, you  
3 know we keep trying to get the full parity  
4 that we deserve on the basis of both  
5 Kentucky and federal law, and as Steve has  
6 said so wisely many years ago, we never  
7 establish the parity police. So we tried it  
8 with the Department of Insurance, and  
9 nothing really happened, so we're trying --  
10 this bill would make the Attorney General  
11 the parity police. And it is being  
12 sponsored by a relatively new Republican  
13 legislator, Vanessa Grossl, and her primary  
14 cosponsor is Representative Lisa Willner,  
15 who's been in the legislature as a licensed  
16 psychologist since 2018, so I would draw  
17 your attention to that bill.

18 Any others you want to point out,  
19 Steve? You probably have looked at them  
20 more than I have.

21 MR. SHANNON: I don't know about any

22 --

23 DR. SCHUSTER: The budget bill was  
24 not introduced --

25 MR. SHANNON: -- right now,



1 specifically, but there is a fair number  
2 that had already been filed. I have not  
3 seen today's.

4 DR. SCHUSTER: Yeah.

5 MR. SHANNON: There's one regulating  
6 recovery residence --

7 DR. SCHUSTER: Hmm.

8 MR. SHANNON: -- that's been filed  
9 previously. That will be interesting to the  
10 group. And administrative regulations for  
11 medications for substance use disorder,  
12 again, that's Representative Willner's bill,  
13 and that's House Bill 153. For recovery  
14 residences is House Bill 128. House Bill,  
15 165 an act proposing creation of a new  
16 section of the Constitution of Kentucky  
17 relating to Medicaid expansion, so put  
18 Medicaid expansion into the Kentucky  
19 Constitution.

20 DR. SCHUSTER: Oh, wow.

21 MR. SHANNON: Yeah. And  
22 Representative Moser has a bill on prior  
23 authorization, and truthfully, I haven't had  
24 a chance to look at it yet. She's --

25 DR. SCHUSTER: I think it's one -- it

1           was 423 last year, what's the one -- what's  
2           the number?

3           MR. SHANNON:   Sorry, it is 176.

4           DR. SCHUSTER:   Okay, great.

5           MR. SHANNON:   She also has her  
6           Psychiatric Collaborative Care Model, which  
7           she's talked a lot about.

8           DR. SCHUSTER:   And what's --

9           MR. SHANNON:   That's 178.

10          DR. SCHUSTER:   Okay.

11          MR. SHANNON:   And on the Senate side,  
12          the Senate Bill 90 from several sessions  
13          ago, the Behavioral Health Conditional  
14          Dismissal Program, this bill would continue  
15          that through 2031. And that's --  
16          individuals can enter this program versus  
17          going through the court system, and they get  
18          access to treatment and services really  
19          quickly. And Senate Concurrent Resolution 9  
20          is Senator Meredith's proposal for the  
21          Accountable Communities for Health Medicaid  
22          Delivery Model Pilot Project, and that  
23          really is a feasibility study. So it  
24          wouldn't necessarily happen this session,  
25          but it directs the General Assembly, the

1 Legislative Research Commission to do a  
2 feasibility study of that model.

3 DR. SCHUSTER: Right. Okay, so that  
4 gives you some idea of what's out there, and  
5 this is but the tip of the iceberg because  
6 --

7 MR. SHANNON: Correct.

8 DR. SCHUSTER: -- they can actually  
9 drop bills in until March 2nd for the Senate  
10 or March 4th for the House, so we're going  
11 to see many, many more days of many, many  
12 more bills to try to keep track of.

13 New recommendations to the MAC, do  
14 any of the voting members have any  
15 recommendations for the MAC meeting in  
16 February?

17 (no response)

18 DR. SCHUSTER: Okay. We made note of  
19 a number of follow-up items for the agenda  
20 from our discussions around the prior-auth  
21 and the audits, and we'll put those on the  
22 agenda.

23 Any new business? Anything that  
24 we've not covered so far that's a burning  
25 issue for you all?

1 (no response)

2 DR. SCHUSTER: Hearing none, any --  
3 it seems like our agenda is a lot of old  
4 business because we never solve anything, we  
5 just keep monitoring things. How about any  
6 formulary issues?

7 (no response)

8 DR. SCHUSTER: You know, I have to  
9 say, since the new PBM model went in, we  
10 have really had --

11 MR. SHANNON: It's been less.

12 DR. SCHUSTER: -- zero, zero  
13 formulary issues. It's really been nice  
14 because we used to spend a lot, a lot of  
15 time -- Valerie will remember this -- on all  
16 kinds of formulary issues that were coming  
17 up.

18 Just a reminder that the MAC meeting  
19 is February 5th, again, the first Thursday  
20 every other month starting in February, and  
21 it's 10 till noon. And then our next BH TAC  
22 meeting would be March 12th, so we'll stay  
23 on the second Thursday of the month on the  
24 same months where we have been meeting from  
25 2 to 4.

1                   And my gosh, it's right at the clock  
2                   striking 4, we're really on time. This is  
3                   -- Barbara, send up a flare that we finished  
4                   on time.

5                   MS. WASH: I will mark it down.

6                   DR. SCHUSTER: With exclamation  
7                   points. I thank you all for your  
8                   participation. I hope this is helpful to  
9                   you. We try to keep things positive and  
10                  moving along, but we do try to solve  
11                  problems, so we sometimes have to talk about  
12                  things that are unpleasant. But we will  
13                  persevere, and I wish you all a Happy New  
14                  Year, and we will see you again, hopefully  
15                  in February at the MAC meeting, and then  
16                  next March at the BH TAC. So the meeting is  
17                  adjourned and thank you very much.

18                  DR. HOFFMANN: Thank you,  
19                  Dr. Schuster.

20                  MR. SHANNON: Thank you, Sheila.

21                  DR. SCHUSTER: Uh-huh, bye-bye.

22                  MS. WASH: Thank you, Dr. Schuster.

23                  (Meeting adjourns at 4 p.m.)  
24  
25

\* \* \* \* \*

C E R T I F I C A T E

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

Dated this 30th day of June, 2026.

  
Tiffany Felts, CVR

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