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

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Via Videoconference
January 8, 2025
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)

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

MS. WASH: Yes.

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

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

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

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

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

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

DR. SCHUSTER: Okay, thank you.

MS. WASH: Mm-hmm.

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

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

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

MS. ALLGEIER: I'm here for Tara.

MS. WASH: Oh, okay.

DR. SCHUSTER: Oh, Melissa, hi.

MS. ALLGEIER: Hi, Sheila.

MS. WASH: Okay.

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

MR. LITAFIK: I'm on here now.

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

MS. WASH: There we go.

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

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

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

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

DR. SCHUSTER: Great, thank you.

And Steve?

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

DR. SCHUSTER: All right.

And Melissa?

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

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

MS. ALLGEIER: Perfect.

DR. SCHUSTER: Okay.

And TJ?

MR. LITAFIK: TJ Litafik, NAMI

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

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

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

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

MR. SHANNON: So moved. Steve Shannon.

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

MR. LITAFIK: Second.

MS. MUDD: Second. Val.

DR. SCHUSTER: All right. It was a

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

(Aye).

DR. SCHUSTER: And opposed, like sign.

(no response)

DR. SCHUSTER: And abstentions?

(no response)

DR. SCHUSTER: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

DR. SCHUSTER: Great.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Mr. Bledsoe speaks on mute).

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

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

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

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

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

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

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

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

DR. SCHUSTER: Yeah.

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

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

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

the transportation issues?

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

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

MR. BLEDSOE: Yeah.

DR. SCHUSTER: Transportation --

MR. BLEDSOE: That's correct.

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

MR. BLEDSOE: That is correct.

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

MR. BLEDSOE: Yep.

DR. SCHUSTER: Yeah.

MR. BLEDSOE: That's correct.

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

(Ms. Mudd nods head "yes.")

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

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

MR. BLEDSOE: Oh, okay.

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

(no response)

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

MR. BLEDSOE: Awesome.

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

MR. BLEDSOE: Tom Walton, that is correct.

DR. SCHUSTER: Yeah.

MR. BLEDSOE: He is the director.

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

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

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

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

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

MS. STALEY: Hi. This is Sherri from

Kentucky Medicaid.

DR. SCHUSTER: Hi, Sherri.

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

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

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

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

MS. STALEY: Yes.

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

MS. STALEY: Absolutely.

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

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

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

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

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

MR. SHANNON: Great.

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

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

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

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

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

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

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

MS. EISNER: Yes.

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

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

DR. SCHUSTER: Right. Right.

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

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

MS. EISNER: Yes, correct.

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

MS. EISNER: Thank you.

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

MR. SHANNON: Right.

MS. EISNER: Yeah.

DR. SCHUSTER: Herb Ellis has his hand up.

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

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

MS. STALEY: We will --

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

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

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

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

DR. SCHUSTER: Okay.

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

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

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

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

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

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

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

DR. SCHUSTER: Yes, by all means.

MS. JONES: Hi, Sheila and Sherri. This is Cat with Aetna. We do have a process, and I believe our provider rep head may have already responded with this information. We call it a reconsideration. So if, for example, information like the -- I'm just giving some examples -- like the information, the name of the targeted case manager, or the -- maybe the treatment plan, or etc., if those pieces were inadvertently left off, what they can do is submit that information via fax because there are some challenges, I believe, across the board, not just with Aetna Availity, but with Availity in general once a decision has been made about going back in and attaching via Availity. So they can fax in that missing information making sure to reference the authorization number, and then that will come into the system, they will attach that to the authorization record, and that information can be reviewed.

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

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

DR. SCHUSTER: Let me ask --

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

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

MS. JONES: Okay, great.

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

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

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

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

MR. SHANNON: Great, thank you.

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

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

MS. JONES: Sure.

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

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

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

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

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

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

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

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

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

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

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

MS. KOENIG: But --

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

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

MS. KOENIG: Well --

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

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

MR. SHANNON: Well --

MS. JONES: -- we have communicated,

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

MR. SHANNON: Right.

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

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

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

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

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

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

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

MR. SHANNON: Okay.

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

MR. SHANNON: Yeah.

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

MR. SHANNON: Yeah.

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

So it is required in our portal system.

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

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

MR. SHANNON: Yeah. Yep.

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

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

changes would be initiated that way.

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

MS. JONES: Correct.

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

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

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

MR. SHANNON: Right.

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

DR. SCHUSTER: Yes, I see that.

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

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

MR. SHANNON: Yeah.

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

MR. SHANNON: Right.

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

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

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

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

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

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

thanks. Anybody want to weigh in on this?

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

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

of behavioral health providers.

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

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

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

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

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

MS. BICKERS: Dr. Schuster?

DR. SCHUSTER: Yeah.

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

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

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

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

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

MS. BICKERS: Yes, ma'am.

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

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

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

MS. EISNER: Thank you.

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

MS. EISNER: Okay.

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

DR. SCHUSTER: Okay.

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

DR. SCHUSTER: So --

MS. AGEE: Hey, Erin.

MS. BICKERS: Oh.

DR. HOFFMANN: Chelsea's on.

MS. AGEE: Chelsea here.

MS. BICKERS: Oh, thank you.

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

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

MS. AGEE: Yes.

DR. SCHUSTER: Okay.

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

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

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

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

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

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

DR. SCHUSTER: Sure, yeah.

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

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

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

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

DR. SCHUSTER: Sure.

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

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

MS. AGEE: Yeah.

DR. SCHUSTER: Yeah. Yeah, that

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

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

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

MS. AGEE: Yep.

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

(no response)

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

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

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

MS. STALEY: I can give --

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

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

--

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

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

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

DR. SCHUSTER: Yeah.

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

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

forth, I think --

MR. SHANNON: They're okay.

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

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

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

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

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

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

MR. SHANNON: Yes. Yeah.

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

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

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

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

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

faster we can all act and get this resolved.

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

MR. SHANNON: Temporary.

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

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

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

DR. SCHUSTER: But it's SUD peer

supports working in AODEs or BHSOs.

MR. SHANNON: BHSOs, right.

MS. STALEY: Correct.

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

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

COMM. MARKS: That's correct, Steve.

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

DR. SCHUSTER: Yeah.

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

MR. SHANNON: Correct.

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

MR. SHANNON: Yeah.

DR. SCHUSTER: Right. Yeah, thank you.

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

DR. SCHUSTER: Yeah.

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

MS. DOBBINS: And correct me if I'm

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

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

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

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

MR. SHANNON: Yeah.

DR. SCHUSTER: -- or mental health --

MS. DOBBINS: Yeah.

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

MS. DOBBINS: Right.

DR. SCHUSTER: I mean --

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

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

DR. SCHUSTER: Yeah.

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

DR. SCHUSTER: Yeah. Yeah. So --

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

MS. DOBBINS: Well, I mean, our peers are mental health not SUD, Wellspring. And I assume that's true for Bridgehaven, and so, you know, some of the others of us who are BHSO1s because our focus is on the

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

DR. SCHUSTER: Right.

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

MR. SHANNON: Right.

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

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

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

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

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

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

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

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

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

DR. SCHUSTER: Exactly.

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

MS. DOBBINS: Right. Exactly.

DR. SCHUSTER: Yeah.

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

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

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

DR. HOFFMANN: Tanya should be on

from DBH.

DR. SCHUSTER: Thank you.

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

DR. SCHUSTER: Mm-hmm.

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

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

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

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

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

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

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

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

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

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

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

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

We're using an internationally recognized assessment tool called inteRAI,

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

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

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

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

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

week --

MS. DICKINSON: Absolutely.

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

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

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

MS. DICKINSON: Yep.

DR. SCHUSTER: -- for both provider

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

MS. DICKINSON: Oh, good. Good.

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

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

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

MS. DICKINSON: I think Valerie has a question.

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

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

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

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

MS. DICKINSON: KRCC.

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

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

DR. SCHUSTER: Right.

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

MS. MUDD: Okay.

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

(Ms. Mudd nods head).

DR. SCHUSTER: Yeah.

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

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

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

MS. DICKINSON: Thank you.

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

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

DR. SCHUSTER: Yes, I know it has.

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

DR. SCHUSTER: Yeah.

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

DR. SCHUSTER: Yeah.

MS. DICKINSON: -- fun to deal with.

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

DR. HOFFMANN: Dr. Schuster?

DR. SCHUSTER: Yeah?

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

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

DR. HOFFMANN: That's for --

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

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

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

DR. SCHUSTER: Yeah.

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

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

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

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

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

DR. HOFFMANN: Angela?

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

DR. SCHUSTER: Hi, Angela.

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

trek towards our full implementation April 1st.

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

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

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

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

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

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

practitioners, so that work continues.

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

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

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

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

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

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

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

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

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

MR. SHANNON: Drug Control Policy.

DR. HOFFMANN: Drug Control Policy.

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

MR. SHANNON: That's not a thing

anymore.

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

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

DR. SCHUSTER: Yeah, I think so.

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

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

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

DR. SCHUSTER: All right.

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

DR. SCHUSTER: Yes.

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

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

DR. SCHUSTER: Okay.

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

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

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

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

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

DR. SCHUSTER: Yeah.

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

DR. SCHUSTER: Great.

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

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

(no response)

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

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

DR. HOFFMANN: That's correct.

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

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

DR. SCHUSTER: Oh, okay.

DR. HOFFMANN: -- I think at the same

time there.

DR. SCHUSTER: Yeah.

DR. HOFFMANN: Go ahead, Carmen.

MS. HANCOCK: I can, thank you. Thank you, Dr. Schuster --

DR. SCHUSTER: Sure.

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

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

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

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

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

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

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

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

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

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

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

FAQs --

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

MS. HANCOCK: Yes.

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

MS. HANCOCK: Fantastic.

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

MS. HANCOCK: Yes, ma'am.

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

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

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

MS. HANCOCK: Yes.

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

DR. SCHUSTER: Okay.

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

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

(no response)

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

list numbers, Carmen --

MS. HANCOCK: Yes, ma'am.

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

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

DR. SCHUSTER: Okay.

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

DR. SCHUSTER: Okay.

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

DR. SCHUSTER: Right.

MS. HANCOCK: But the unduplicated

number there is 16,642.

DR. SCHUSTER: Fifteen or sixteen thousand?

MS. HANCOCK: Sixteen, one-six.

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

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

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

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

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

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

DR. SCHUSTER: Yes, because you all

will work on regs after the session ends --

MS. HANCOCK: Yes, ma'am.

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

MS. HANCOCK: You're welcome.

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

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

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

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

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

Let me go back to my notes. And this

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

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

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

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

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

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

MR. SHANNON: Yes.

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

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

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

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

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

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

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

(no response)

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

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

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

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

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

MR. SHANNON: -- right now,

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

DR. SCHUSTER: Yeah.

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

DR. SCHUSTER: Hmm.

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

DR. SCHUSTER: Oh, wow.

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

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

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

MR. SHANNON: Sorry, it is 176.

DR. SCHUSTER: Okay, great.

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

DR. SCHUSTER: And what's --

MR. SHANNON: That's 178.

DR. SCHUSTER: Okay.

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

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

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

MR. SHANNON: Correct.

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

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

(no response)

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

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

(no response)

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

(no response)

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

MR. SHANNON: It's been less.

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

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

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

MS. WASH: I will mark it down.

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

DR. HOFFMANN: Thank you, Dr. Schuster.

MR. SHANNON: Thank you, Sheila.

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

MS. WASH: Thank you, Dr. Schuster.

(Meeting adjourns at 4 p.m.)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, herby 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 18th day of January, 2026.

Tiffany Felts, CVR

Tiffany Felts, CVR