DEPARTMENT FOR MEDICAID
BEHAVIORAL HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
March 12, 2026
2:00 p.m. - 4:05 p.m.

Theresa Prokop
Certified Voicewriter

A P P E A R A N C E S

BOARD MEMBERS:

Dr. Sheila Schuster, TAC Chair
Steve Shannon
TJ Litafik
Valerie Mudd
Tara Hyde
Misty Agne

MS. WASH: Danni Davis will be running this meeting today. I'm here to assist her though. And hello, everyone.

DR. SCHUSTER: Great. Thank you.

MS. WASH: Mm-hmm.

DR. SCHUSTER: And welcome, Danni, to this position.

MS. DAVIS: Thank you and good afternoon, Dr. Schuster. We're still working on clearing out the waiting room, but so far, we have committee members Steve Shannon and Valerie Mudd on.

DR. SCHUSTER: Okay. I've not heard from anyone that they cannot make it, so.

MR. MOORE: Hey, Dr. Schuster.

DR. SCHUSTER: Hey, Tim, how are you?

MR. MOORE: Good. Good. I wanted to give you a quick little heads up. When you get your nudge from me this time around, to edit 'em, I use Copilot now, because it's a lot quicker.

DR. SCHUSTER: Okay. I'll have to look and see if that makes --

MR. MOORE: You're going to still

get the digital notes, but there going to not be 15 or 16 pages. It condenses it down. And I still grammar check it manually, and then you still get your plain language notes. If I don't get them to you today, they'll be given to you Monday.

DR. SCHUSTER: All right. That's great, Tim. Thank you very much. Tim is my secretary in arms, and such a big help. I appreciate that, Tim.

And how are you today, Miss Valerie?

MS. MUDD: I'm getting there. I love that I'm on here for two hours, because I'm having some respite.

DR. SCHUSTER: You're having some respite from your caretaking, right? Well, that's good. We're happy to provide a respite for you.

MS. MUDD: I never thought that I would say this meeting was a respite.

DR. SCHUSTER: Well, lots of people say lots of things about this meeting. I'm not sure respite would be one of them, but, yeah.

And I see that some of my CMHC folks

are on. That's great, since we have an item of great interest.

Steve Shannon, how are you? You've already had one TAC meeting today.

MR. SHANNON: We're good. Good.

DR. SCHUSTER: Good.

So, we'll give people another minute or two.

Do you see, Danni, any other voting members on yet?

MS. DAVIS: Not at the moment. They're still slowly getting in.

DR. SCHUSTER: Okay. Thank you.

I see a good number of DMS folks joining us. That's great. Always happy to have.

MS. DAVIS: Absolutely. And if we can actually disable the Read AI to whomever joined and turned that on.

DR. SCHUSTER: I don't remember that ever coming up before, Danni. Is that not --

MS. DAVIS: Right. I think that's a new feature, I believe. I have never seen it, but I've been informed that we are not supposed to have that on.

DR. SCHUSTER: It may be turned on by one of the participants.

MS. DAVIS: Right.

MS. WASH: Dr. Schuster, this is Barbara. That had happened twice during our BAC meeting. Someone joined and it was a participant. So if you wouldn't mind, all looking to see if there's anybody who enabled it, we would appreciate it.

DR. SCHUSTER: So you want them to disengage it.

MS. WASH: Turn it off. Disengage it. Yes, please.

MS. GRAHAM: Do you know where you find it to see if it is engaged or not engaged?

MR. ELLIS: Top corner where it says recording with the red button.

MS. GRAHAM: Okay. Thank --

MS. MUDD: So, it says, AI-generated meeting summaries by Read AI. So I'm good to go? When you pull down that little thing next to the recording button it says, apps that access meeting content.

MS. BASHAM: It indicates it's the

host that's recording. I don't know if that's helpful, but whoever the host is might want to check settings.

DR. SCHUSTER: Well, I think Misty Agne is on, Danni. I just saw her.

MS. DAVIS: Yes.

DR. SCHUSTER: Yeah. Great. So, you all record though don't you, Danni? Or is that done by a court reporter?

MS. DAVIS: That is done by us. We do record. The AI Read as a separate feature that is offered to participants who join the meeting.

MS. SANBORN: If you hover over the Read AI icon, there's three little dots. You can click on that and it might allow you to remove it if you're the host.

MS. DAVIS: Yeah. I don't see it here.

MS. WASH: Danni, I don't see that you are enabled by AI. I don't see that.

MS. DAVIS: It came up in the chat box. It says here, Michelle added Read AI to the meeting notes. So that I think that's a participant. And it's saying to -- others are

suggesting to select the opt-out option for the participant who added that.

DR. SCHUSTER: Well, we've got a quorum.

MS. DAVIS: Yes, we do.

DR. SCHUSTER: So, let's go on and get started, because we have a lot of items on the agenda, and hopefully our other two voting members will be joining.

So, welcome to you all. Behavioral Health TAC known as the BH TAC, and I'm Sheila Schuster with the Kentucky Mental Health Coalition, your erstwhile chair. And Val, you want to introduce yourself, please?

MS. MUDD: I'm Valerie Mudd. I'm with NAMI Lexington and Participation Station. I am the consumer voice here on the BH TAC.

DR. SCHUSTER: Great. Thank you.

And Misty?

MS. AGNE: Hello, I'm Misty Agne. I am a rehab program manager for Frazier Rehabilitation Institute, and a board member for the Brain Injury Alliance of Kentucky.

DR. SCHUSTER: Right. And glad to have you, Misty.

And Steve Shannon.

MR. SHANNON: Steve Shannon with KARP, an association of 12 of the 14 community mental health centers.

DR. SCHUSTER: All righty. And TJ Litafik? Not on yet, I guess. And Tara Hyde from PAR.

MS. ALLGEIER: That would be me. I'm Melissa Allgeier in her spot.

DR. SCHUSTER: Okay.

MS. ALLGEIER: From People Advocating Recovery.

DR. SCHUSTER: All right. Thank you.

So, and Danni, do you want to introduce yourself, because people will get so they hear your name.

MS. DAVIS: Absolutely. My name is Danni Davis. I'm gradually stepping into the MAC, BAC, and TAC DMS liaison. If you guys have any questions or just need to reach out, feel free to send me an e-mail and use me as a resource.

DR. SCHUSTER: Right. And would you put your e-mail in the chat, please, Danni?

MS. DAVIS: Absolutely. I can do.

DR. SCHUSTER: Danni is going to be very busy, because we have the MAC is going again. The BAC is brand-new. You all remember the Beneficiaries Advisory Council. And then the TACs, and there are, I guess 16 or 17 TACs. So Danni's working more than full time, I would guess.

I was delinquent in sending out the minutes and sent it just to the voting members, but we can post those for you all. These are the minutes of our last meeting, which was January 8th. And I would entertain a motion from our voting members for their approval.

MR. SHANNON: So moved. Steve Shannon.

DR. SCHUSTER: Thank you. And do I have a second?

MS. MUDD: Second. Val.

DR. SCHUSTER: Great. Any additions, corrections, omissions? All in favor of approving the minutes, signify by saying aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: And any opposed like signed, and any abstentions?

(no response)

DR. SCHUSTER: Okay. So, this first item is one that came to me from Michelle Spurlock. I'm sorry --

MR. SHANNON: Sanborn.

DR. SCHUSTER: Michelle Sanborn. I've had Michelle Spurlock, who's somebody else I know, on my mind all day.

And it has to do with PAs for extended therapy services, which is the H0004. So, Michelle, would you kind of summarize for us, because I think there's some other folks also that have some questions and issues with this.

MS. SANBORN: Sure. Folks, some of our providers were getting denials for services that were billed through WellCare for the H0004 only to learn that I guess they had posted something about it and providers weren't aware. So they kind of extended that because they let folks know that, in fact, there was a notice that was posted out there.

The concern that we had was twofold.

One was the note that was posted really indicated that it was for substance abuse treatment, but then we learned that it was actually for all diagnoses. So all mental health and substance abuse treatment. It's been approved by DMS for all diagnoses, so I don't know why they only posted it and showed for substance abuse treatment, but it is for all.

I think the concern that we have is many of those H0004, because it's a prolonged service code, then the service has to be completed first before you do the prior auth.

WellCare has said that they will do a prior auth after the service is provided, but you have one business day to ask them for the prior auth for a service that's already completed.

And I've been asking to see if we can at least have seven business days, because I'm not sure what the rush is. If the service is already provided for a child, why we would have to, within 24 hours, request a prior auth for something that's already been completed.

I'm very concerned that they're

requiring a prior auth for service that's already been completed, because I'm concerned that therapists may, at the hour mark, decide maybe I can't justify another 15 minutes. And maybe it is needed, but then there's some back and forth in their head. Then they cut the therapy session short. And then only for something negative to happen to the child.

And I think I'm a little concerned because I don't know of any medical services that are provided by physicians where they have to provide the service and then justify it after the service is already provided. And so I have just kind of been questioning the mental health parity and the H0004 prior auth. But that's where we are right now.

As of right now it's for all uses, all diagnoses, and you've got one business day to get approval if you use it without the prior auth.

DR. SCHUSTER: Okay.

MR. SHANNON: And it's still an approval process, right, Michelle? I mean, the service could be prior auth after the fact, which obviously is hard for us to

process. It should still be denied at that point.

MS. SANBORN: That's correct.

MR. SHANNON: So I can still play out is just that in this situation where a clinician's making a decision that I have to go beyond what I've already been approved, and now I've got to get just the notion of prior auth the next day. But it still ends up being what happens if -- you know, one it's denied. Two, is that impact clinician practices knowing this is out there and what is going to take place.

We had a similar situation with a code that had to be prior auth that was changed, and it was changed effective, I think February 1, it was on the MCO's website. You know, and if you go back and check it every day, you will know. But we had monthly calls and it never came up on a monthly call we're going to prior auth this. So we had a lot of people.

So even things that didn't require a prior auth like the situation Michelle is raising, now does. And the communication is

really a passive approach. You have to go out and find it.

MS. SANBORN: Well, they're supposed to -- the MCO's are supposed to give folks 30 days' notice and so I think they had indicated they didn't send it out to providers because the providers have been complaining that they're receiving too much information. And so they just decided just to post it on their website, according to what I was told. So anyway.

MR. SHANNON: I was told the same. It's still a very passive approach.

MS. SANBORN: Yeah. No. I think they're required -- I think they're required by law or by their contract to give folks 30 days' notice before implementation. So I think that they, again, they did kind of give some grace period in the middle of the month when we reached out. So folks were able to kind of catch up, I think, by the end of February.

So one, yes, it was implemented incorrectly. But two, I'm just very concerned about the implementation for the H0004,

because it definitely will impact, especially new therapists as they're coming in, they're going to have to really be like literally within 30 seconds to a minute decide, is this medically necessary or not. And I think my fear is, out of an abundance of caution, because they're already losing money on an hour of therapy, they're going to cut that therapy session short and something negative can happen.

But again, I'm just -- I'm just not aware of any medical codes. I've asked for examples of medical codes where the physician is required to provide the service, within 24 hours justify that service. I haven't heard back. But I've just recently asked for those examples, so hoping that we can get some of those examples and then talk to our friends at the Medical Association about how to best implement this and what that looks like. How that impacts services, et cetera.

DR. SCHUSTER: Yeah. Let me call on Shannon O'Connor, because she also got in touch with me and had some information to share. Shannon?

MS. O'CONNOR: Yeah. I just want to echo what Michelle said. But this isn't just impacting child clients. This is impacting adult clients, and we have the same concern of clinicians needing to make an on-the-spot decision to end a session early and impacting if a client is in crisis, which is unpredictable. Feeling like they need to end that session early and jeopardizing client safety and therapeutic trust and process.

We've heard the same about allowing for 24 hours, but, again, the service has already happened. And what if it is, to Steve's point, denied after you've already provided the additional service. So just echo all the same concerns that Michelle raised.

MR. BALDWIN: Sheila, I just wanted to -- this is Bart. I just want to add in one additional piece. Concur with everything that Michelle, Shannon, and Steve have said. But also just the policy decision on this with MCOs and DMS approving it of doing a prior auth on therapy. Individual therapy.

I mean, it doesn't seem like we want people to have access to that therapy. We

want them to get that as early and as effectively as possible. So I mean, I understand prior auths on some services, but this seems like the front line where we shouldn't be putting any barriers between someone accessing the service. And certainly the complicating factors mentioned already.

MR. SHANNON: Yeah.

DR. SCHUSTER: So, was there a prior auth on an individual therapy before the COVID stuff and so forth when prior auths were suspended? I thought they were not being imposed? Can anybody remember back?

MR. BALDWIN: As a provider that was directly on that, I don't recall.

MS. RITTENHOUSE: No. There was not. There was not for therapy.

DR. SCHUSTER: Yeah, that's what I thought.

MS. RITTENHOUSE: WellCare's also added. Yeah. They've also added group and family therapy as well, which were not in place prior to the pandemic.

DR. SCHUSTER: I was thinking back to that period of time when we were working

with then CHFS Secretary Eric Friedlander, when remember the Cabinet was going to reinstitute prior auths, and there was no prior auths on outpatient therapy. Individual at least, and I don't remember, Susan, whether it was family and group, but there were no prior auths then.

MS. RITTENHOUSE: Correct.

DR. SCHUSTER: Right? So --

MS. RITTENHOUSE: Not for any therapy. Correct.

DR. SCHUSTER: Yeah. So is anybody on from WellCare?

MS. SANTINE: Yes. This is Beth. I am on.

DR. SCHUSTER: All right. Can you enlighten us?

MS. SANTINE: Sure. I've had conversations with Steve and Michelle, and they talked about some of those conversations we've had. We did add this on, on September -- or sorry, February 1st. And we had made a change in how we notified providers of items based on feedback we had had.

Based on this experience, we are

going to go back to multiple ways of doing notifications in addition to having them posted on our website, so that folks, you know, aren't dependent on just the one method of notification.

We do have monthly meetings, that will be a standing agenda item for any updates on prior authorization changes and any scheduled meetings that we have as well as other avenues for notification.

I'm not prepared to speak to which codes were on the prior auth list prior to prior auths being turned off due to COVID. I don't have that handy. It is something I can look into.

DR. SCHUSTER: Well, I think you will find that there were not prior auths, at least on individual therapy, and I think not on group and family. I mean, my understanding was that the insurers, the MCOs, the whoevers, the payers, were realizing that, at least for behavioral health, it didn't make a lot of sense to have prior auths on those individual, group, and family therapy sessions.

So I guess I'm -- are you the only

MCO that's putting prior auth on those therapies?

MS. SANTINE: I don't know. I couldn't speak (muffled speaking) have those or not.

DR. SCHUSTER: So, how about for the providers?

UNIDENTIFIED SPEAKER: Yes, they are.

MS. HUDDLESTON: Yes, they are.

UNIDENTIFIED SPEAKER: Yes, that's correct.

MR. BURKE: Yes, only WellCare.

DR. SCHUSTER: Only WellCare. I mean, I guess I'd have to say, it does not make a lot of sense to me. I mean, you all have to make a business decision, but the rubric in behavior health has always been, get people to therapy that they need, the support that they need, as soon as possible. We know that prior auth delays the provision of services.

MS. SANTINE: Yeah. And we're definitely trying to balance, you know, the access to care and responsible utilization

oversight. We do have -- we did, you know, allow for -- it is one business day, I've heard a couple different folks talk about how long it is you have to ask about that. I heard 24 hours.

It is one business day after the session to request that authorization, because we recognize it's not something you can plan in advance. If it meets medical necessity, it would be approved. And we recognize that, you know, that is occurring in realtime and not ahead of time, so that is why that was there.

We did -- because of the issues with the communication, we did allow for retro through the end of February, so any sessions that were done earlier in the month could have been requested throughout the end of February.

And we do look at parity when we add a prior authorization code, so that is part of the analysis we look at.

DR. SCHUSTER: Can you show us examples? I'm sorry. Can you show us examples over on the medical side?

MS. SANTINE: I would have to go back and see if we can provide those examples.

I don't have those handy.

DR. SCHUSTER: Yeah, I would be really, really interested in seeing that. And I guess the other thing is, because we have what you had posted on February 1st, which clearly says it's SUD only, and we can put that up on the screen if we need to.

MS. SANTINE: No.

DR. SCHUSTER: So, was this approved by DMS?

MS. SANTINE: Yes.

DR. SCHUSTER: Very beginning for both SUD and Mental Health?

MS. SANTINE: Yes.

DR. SCHUSTER: So, why did your notice say SUD only?

MS. SANTINE: It's the code that requires it. It's not just the diagnosis.

DR. SCHUSTER: Barbara, can you put that up for me, please? It's on the second page of what I sent you. Or Danni.

MS. WOOTON: So there's a preauthori -- is there a preauthorization required for the individual sessions too? I knew about the family and the group, but is this also for

individual sessions?

MS. SANTINE: It is, it's just that --

DR. SCHUSTER: (muffled speaking) Individual.

MS. WOOTON: I'm sorry. Yes?

MS. SANTINE: It is just for these codes listed here the 90847, 90853, H0004, and H2027.

MS. RITTENHOUSE: H0004 is an add-on code for an individual therapy session that's longer.

MS. SANTINE: Correct.

MS. RITTENHOUSE: And so if you've got an individual therapy session that's longer, it gets added on as part of the claim. And so, yes, now WellCare is requesting authorization for those longer individual therapy sessions, longer than I think it's 68 minutes.

DR. SCHUSTER: So, Susan, would the basic request on the mental health side be for a psychotherapy code and then you would add H0004?

MS. RITTENHOUSE: It would have to

be both, because a claim can't go out without the 90837 on it first, indicating that you got the hour-long individual therapy, and then the H0004 is on top of that, indicating that it's a longer session.

DR. SCHUSTER: So, as I'm looking at this notice, Miss Sardine from WellCare, it's really misleading, because if you attended for H0004, which is both an SUD and a behavioral health add-on code, you'd have to put it with the psychotherapy codes.

I don't understand the notice for one thing. I can see where every provider would look at this and say, oh, that's only if I'm doing SUD treatment. Can you explain?

MR. SHANNON: Poorly formatted, right, Sheila? Poorly formatted.

DR. SCHUSTER: Yeah.

MS. SANTINE: And we've been doing education when there's been inquiries.

DR. SCHUSTER: Well, how about publishing your policies in a way that you don't have to go back and do education on them?

MS. SANTINE: And we've taken that

feedback as well. Absolutely.

MS. SANBORN: I'm still -- I'm still -- I would still like to talk about the one business day to request these after the service has been provided. When the MCOs have five days to approve a PA, why would providers not have at least five days to provide it, if not longer, when the service has already been provided? What's the emergency that we have to do one business day to request these?

MS. SANTINE: I mean, I can take that back for consideration. I would have to, you know, see. I think this follows the rule for, you know, all services that require a prior auth is the one business day, so that would be an exception for this one.

MS. SANBORN: I would venture to say, most prior auths are prior to the service being delivered.

MR. SHANNON: Yeah.

MS. SANBORN: So, when -- when there is a service that is provided and you have to do a prior auth after that, I guess I need to see another example, because this is the only one that I am aware of. But why, again, I'm

still trying to understand why the one business day. Like it just seems -- it just seems to just be a barrier and an administrative burden to providers when they've already given you potentially free services. Why put an extra barrier, burden and challenge on those providers? I just don't understand.

MS. SANTINE: That's not the intention of this. And if we look at that, we'd probably have to look at it for all codes, because I think there are instances where, you know, for a hospital admission, for instance, I'm not sure that that person's not on the unit before an authorization is called in.

MR. DEARINGER: Hi, this is Justin Dearinger with Department for Medicaid Services. I wanted to just give a quick update on prior authorizations that are done after the service is performed on the medical side. We do have quite a few. We can try to get that list together.

Off the top of my head, I don't know the exact time frames. I think each one has

their own specific time frame, but as you brought up, inpatient care, hospital care, there's a lot of other, there's some dental codes. We may even have some other codes I'm trying to remember, but we do have multiple codes that do after the fact prior authorization. Again, I don't know what the time frame is on all of those. We can try and put that together to see how long they have to get those in.

Basically, it's the same thing as a regular prior authorization process. You're checking for medical necessity. And as you all know, Medicaid's forbidden by federal law to pay for anything that's not medically necessary. So it's only a medical necessity check, and it's something that should be done before the service, but in a situation like this and in other situations that we cover on the medical side, we have to do that after.

DR. SCHUSTER: Yeah. I think that would be very helpful, Justin. And I would love to have that information for the May meeting so we can continue this discussion. We are concerned about parity, and if there

are examples of this being utilized over on the medical side, medical/dental, that would be very helpful. I think certainly the time frame.

I think everyone understands that therapists are not going into the traditional session with a client, if they thought it was going to be a particularly difficult session, they would probably include the extended session in their original PA, but as we know as therapists, and knowing behavioral health issues as we do, things come up that are completely unexpected, and a patient may get into very confused or emotional state, particularly with a child, where I think it takes sometimes more time to be able to communicate, for the child to communicate what they're thinking, feeling, and so forth. But certainly with adults as well. And those cannot be anticipated. So I really would like to understand, you know, what the exceptions are. How this is handled and the time frame.

I guess I would really like to hear from somebody at DMS why the approval was made to institute PAs on individual, group, and

family therapy when they really have not been part of the Medicaid program.

MS. STALEY: Sheila, this is Leslie. I would have to call on Sherri if she's available. I know Jody Appelbaum's been researching this for quite some time. I've seen e-mails going back and forth. So Sherri, are you able to enlighten us at all about the situation on our side?

MS. STALEY: Yes. We, you know, once prior authorizations were reinstated, we have been pretty lenient with the MCOs in letting them determine, based on their own markets and their own utilization management, what is necessary for their members.

This was approved, the 90837 is the hour psychotherapy code. The H0004 is the add-on that replaced deleted codes a couple of years ago, and so there is no prior authorization for the individual therapy, just the add-on, if necessary. I'm not sure if there was some fraud, waste, and abuse in that space, but that could be the case.

And then for the family and group --

DR. SCHUSTER: Hold on. Sherri, I'm

sorry. Just hold on a second. Are you saying that there's not prior authorization for the basic psychotherapy?

MS. STALEY: That's correct.

DR. SCHUSTER: It's only with the add-on?

MS. STALEY: That's correct.

MS. RITTENHOUSE: So, Sheila, there is for family and group. There is not for individual. And this add-on is only for the individual. So, a provider could not request a prior auth because there is no auth for individual therapy. So it's always going to be after the fact once you go over the time limit.

At one point, I was told by WellCare that the H0004 is required in the WellCare market nationwide, but it's not used as an add-on code. That Kentucky uses it differently than the definition, and I'm wondering if that's where some of the confusion has come from is the way that DMS has utilized that code on our fee schedule compared to how maybe it's used in other markets nationwide.

But providers would typically not know that they're going to go over the amount of time, as Michelle and others have indicated. And there is no opportunity for prior auth because the base code is not on the prior auth list, so it is a very unique situation that is confusing.

MS. O'CONNOR: Sheila, if I can just add on to that, our providers are -- a lot of the providers that I work with have -- are not submitting prior auths. And so were very caught off guard by this, and that is not part of their system, they do not have processes for prior auths.

And I just want to follow up that our providers are not getting clear communication from WellCare on how they should be handling this moving forward.

DR. SCHUSTER: All right. So I misunderstood. I thought there was, when we talked about prior auth, I assumed that the prior auth was for individual, group, and family across the board. And what I'm hearing now is there is no prior auths for --

MR. SHANNON: Individual.

DR. SCHUSTER: -- individual psychotherapy codes, which makes this communication from WellCare even more difficult to read and understand, because it clearly says PA required. Psychotherapy. Solely those codes.

MR. BALDWIN: Well, it's still a prior auth on psychotherapy. It's just when it goes over the hour. It's the extended version.

DR. SCHUSTER: All right. But all I'm saying, Bart, is that there is no way that you could read what they send out.

MR. BALDWIN: Right. Yeah, I'm affirming what you're saying. Yeah. I agree. I'm affirming what you're saying. Yeah.

DR. SCHUSTER: So, it's 90847, 90853 plus the H0004.

MR. SHANNON: Yes.

DR. SCHUSTER: All right. I'm sorry, Sherri. When you said that, I was like, wait a minute, I'm not understanding. So, I see what you're saying, Shannon. You've got people that are doing basically individual therapy, not group, not family, and so they're

not used to doing PAs.

MS. O'CONNOR: No. And even if this had been communicated appropriately, and given notice, I, to your point, would have read this and assumed that my services, if I only provided individual therapy, where excluded. And so all of our folks only found out of this implementation once they had claims denied.

DR. SCHUSTER: Okay. All right. This is really confusing.

MR. SHANNON: And Sheila, there's some comments --

DR. SCHUSTER: I'm sorry.

MR. SHANNON: There's some comments people have added. One person says, "most likely, therapist will do the extended session but just record it as a regular one," which I think is probably true. Right? You're going to go ahead and do it and not bother with it. You know.

And another comment about why only one day. And again, only WellCare.

MS. SANTINE: And I am going to take those items away and look at them, and I know that we are already looking at most of these.

DR. SCHUSTER: All right. Let me go back to Sherri. And I do apologize, Sherri, for really interrupting you, but I was just -- I could not figure out what was going on.

MS. STALEY: That's okay. I do think, Susan had a good call out though. She's right. You know, states are able to define the HCPCS codes, and we use them a little differently. I believe West Virginia also uses this H0004 in the manner that we do. So that may be true.

So Beth, maybe that's something to think about as well, and make sure that, you know, it's specific for the Kentucky Medicaid market.

MS. SANTINE: We can take that back.

MR. SHANNON: Yeah. Because if you Google the code, it's behavior health counseling therapy for 15 minutes.

MS. SANTINE: Yeah. That is what we (muffled speaking) you know, to do on this, but I will take that back and double check on it.

MS. SANBORN: So I think the other thing that we need to talk about around the

H0004 code is when they are providing that service, are they then sending a prior auth for just the 15 minutes or do they have to then kind of justify the first hour for that service, or are they just justifying the 15 minutes?

Because it would seem to me that if I provide an hour-and-a-half or an hour and 15 minutes of therapy, and you're only looking at the second half, it might be a little more difficult for you to understand whether it's medically necessary when --

MR. SHANNON: Without having the rest.

MS. SANBORN: -- maybe you're questioning what happened in the first hour.

MS. SANTINE: It's only for this code. The add-on code.

DR. SCHUSTER: I'm not sure what you're saying, Beth.

MS. SANTINE: We are not doing prior authorization on the first hour. It is for the H0004.

DR. SCHUSTER: But Michelle's question is, is the provider just sending in a

PA for H0004?

MS. SANTINE: That is all they're requesting is that. So justification of the, you know, extension, the session extension.

MS. HUDDLESTON: I have a question. What is the documentation that will be required for this prior authorization?

MS. SANTINE: It would be using our regular forms that we have out on our website.

MS. HUDDLESTON: No. I mean, what documentation as far as from the provider, would we have to upload for this prior authorization? Treatment plan, for instance. Assessment. Like, what's going to be -- what's the criteria of what's required as far as uploading documentation to approve this?

MS. SANTINE: Sorry. I keep going on to mute somehow. The treatment plan isn't required for this one, you know, session that you might have had for your routine therapy session, the add-on code. It would be justifying just the add-on and what happened in that session that led to that medical necessity for that code to be used.

MS. HUDDLESTON: So there's no

specific documentation that's required? Because typically, we have certain documentation that we're required to upload per CPT code.

For instance, if it's a T2023, we know we have to upload assessments, treatment plans, care plans, all these things. What are we required to upload for an H0004? We don't know.

MS. SANTINE: Let me go back and look at our website that outlines that, and I will put it in the chat.

MS. QUICK: Excuse me. I am a little late to this meeting. It's the first time I've been to this meeting. So all you may have discussed this in previous ones, but my biggest question is about the 90847.

So, as a child therapy provider, I would be concerned with anyone providing child therapy that isn't also concurrently doing family therapy.

And so I'm wondering, with the 90847 now being a preauthorized service, is that going to continue for kids also? I mean, I fear providers are going to stop doing family

therapy with kids, which is not best practice in any way, shape, or form. So, just curious about if others are having that discussion. If that's out there. If where we are with the preauthorization for 90847 for child therapy.

MR. CORNETT: And --

DR. SCHUSTER: We're actually not, as I understand it, you're not required to submit a PA for 90847.

MS. QUICK: No. WellCare has now required a PA for 90847.

MS. HUDDLESTON: And we have also, just in the last two weeks, saw some agencies out in our area that is stopping family counseling.

MS. STALEY: Due to this issue?

MS. QUICK: Yes.

MR. CORNETT: I just want to jump in here. This is Zach Cornett. A 90847 is family therapy with client. That is a prior authorized service now by WellCare. What is not, is 90846, which is family therapy without the client. So this is an extraordinarily confusing set of circumstances in which we are able to provide family therapy without the

client present without a prior authorization, but we are not able to include the client in their own care without prior authorizing that service. And that is really antithetical to evidence-based practice, especially for child therapy.

DR. SCHUSTER: Who are you with, Zach? I'm not familiar with you.

MR. CORNETT: Key Assets Kentucky.

DR. SCHUSTER: Thank you.

MS. QUICK: And I think looking at it from, you know, looking for an insurance point of view also, you're going to have providers that then start doing family therapy within the individual session, right? Which actually bills higher than the family session would bill. So I'm not sure that the insurance company would be saving money at that point either. So just my initial thoughts on that.

MR. CORNETT: Yes. What that looks like on the ground in reality is I have providers calling me saying, do I need to ask my client to step out of the room? And I'm like, we'll do the PA. Do what you think is

best for your client.

DR. SCHUSTER: Beth, I would suggest you take back to WellCare that this whole thing is -- really needs to be looked at. And I would ask DMS to go back and look at this again. We only have one MCO that is requiring PAs in this way, and we're not just talking about extended. I'm talking about PAs for therapy sessions. Group and family. And now you hear, you know, and it's true. If you're dealing with kids, you've got to be dealing with that family in one way or another. And to play those games in order to either get it covered or to get it -- it just -- it's not in the best interest of the client. That's all I'm going to say.

And I really ask, Sherri, that you all re-look at this. Is that possible?

MS. SANTINE: Yes. We are.

MS. STALEY: We are as well.

DR. SCHUSTER: All right.

MR. SHANNON: Can that come in the form of a recommendation at the end, Sheila?

DR. SCHUSTER: Yes. We could do -- Yes, that's a good idea, Steve. Will you be

prepared to bring that to us?

MR. SHANNON: Sure.

DR. SCHUSTER: Okay. I appreciate everyone bringing this forward. And we're going to put it on the agenda for May, because I really think that -- I'm really concerned. I'm a child psychologist at heart, and that's what's my practice for 30 years, and I just -- and I know it's for adults too, but it really is going to come up a lot a lot with kids. And this is not, I don't think, in kids' best interest.

So thank you very much. I appreciate everyone bringing this to our attention. That's why we have the TAC, is to make sure that services are what people on Medicaid need and not ripping off the system and not padding anybody's pockets, but, you know, we have to do what we think clinically is the best for people on Medicaid in the behavioral health space. So thank you very much.

Barbara, you could take that down, if you would.

So now we'll go to an equally easy

thing to solve, I'm sure, and that is, we have newly-certified CCB agencies, certified community behavioral health centers. We have four that have been in operation since 2022, and I heard at a recent meeting of many of the CMHCs and CCBHCs that they are not getting paid by the MCOs. And it's a real -- it's a real stumper for me, since all of the MCOs have been paying the other CCBHCs, so all the codes, all of that ought to be a slam dunk. And so I know that there are several on here.

Steve, do you want to lead us off, or to have somebody that's going to speak.

MR. SHANNON: Yeah. No. I mean, whoever can chime in. The reality is, again, you said there are six. They went live January 1. I had a call this week. One MCO is now taking, accepting claims. Most have said it won't be delayed for one.

At the basic level, this is a real cash flow challenge, because you can't bill as a CMHC, right? Because, you know, it's a CCBHC, so you're not doing that. So folks who provide the services to members and they're not getting paid. And at some point, and it's

initially, some were paying paper claims. Now one reports they're taking electronic claims.

But the reality is, as you said, Sheila, we had four CCBHCs that were in operation since January 1 of '22. Added six more that effect January 1 of '26. And you end up being that it's become a very complicated process. There's contracts. Some contracts are long. Some were a couple pages addendum. And then it's getting all of the process done at each MCO.

But the concern is, folks aren't being paid. That's the real fear that's taking place right now. And, you know, we alerted folks, I think they were getting some pressure from Medicaid as well.

But it's still a concern going forward, and that meeting was last Friday. And one MCO reported -- one CCBHC reported that they just found out claim went through, or a handful of claims went through. So again, that was March 6th, so still over two months into the process.

DR. HOFFMANN: Steve, this is Leslie. And Dr. Schuster, I just would mention

I have asked Chelsea Agee, who is on, to give you an update. First of all --

MS. COLYER: (muffled speaking)

DR. HOFFMANN: First of all, congratulations. Very exciting. I mean, this is a wonderful opportunity.

MS. COLYER: Is he?

UNIDENTIFIED SPEAKER: Pardon?

DR. HOFFMANN: Sandra, are you -- can you mute if you're -- sorry. I just wanted to mention that we did have a really tight turnaround. I don't know if you're aware of this, but CMS did delay their approval of the certification, and we actually received approval the morning and the same day that we sent out the letters to the providers in order to make this time frame. So this was a very intense turnaround. But we are making progress, so I hear you, Steve, about the flow, the cash flow need, and we are going to be able to retroactive backdate.

But I will let Chelsea give the update. Chelsea, do you want to help out there? Thank you.

MS. AGEE: Yeah. Absolutely. Good

afternoon, everyone. My name is Chelsea Agee. I'm with the Contract Monitoring Branch and Health Plan Oversight. We're working closely with our CCBHC pilot coordinator and Dr. Hoffmann's team.

We have asked the MCOs to provide us with weekly updates on the status of the loading of the new providers. So we have so far received three weekly updates from the MCOs. It appears that all of them, you know, have indicated the new rates for the new CCBHCs will be effective 1/1/26, so that back date, you know, should be coordinated for all of the CCBHCs.

And there -- you know, we do acknowledge that there were different scenarios, you know, for each MCO. Maybe some different documentation that was needed depending on the MCO, but we're hoping with our weekly updates from the MCOs, and just that close coordination, that we will, you know, that these loads and credentialing will be completed very soon, if not have already been completed. It sounds like some are already getting claims paid, so that's great.

But if you do continue to have any concerns, issues, I'm going to put my branch's program inbox in the chat, and please feel free to reach out to us. We're happy to work with you, work with the MCO to see what kind of information we can get for you and a status update on that.

MR. SHANNON: Thank you, Chelsea. And, you know, back to January 1 is profound, but I think people, you know, they're fearful that their, you know, they need money now, you know, they may get a big check in a month and that, you know, it might not only be too late but it would be problematic, you know. And I think that's the real frustration.

The contract process took longer than they anticipated and credentialing took longer. It was, you now, and then it was until April 1 they'll be able to accept claims. And I understand it's hard, but it's three months in. But, you know, they're still serving people and still paying people, right?

DR. SCHUSTER: And I guess my question, Chelsea, would be, if everybody's going to have it all worked out by April 1st,

does that include all of the claims that have already been submitted? So the CCBHCs, the new CCBHCs can expect payment going back to January 1st?

MS. AGEE: So, I will clarify about as far as, you know, if the claims are expected to be paid by April 1st. I'm not sure on that piece exactly. I do know that we have expressed to the MCOs that, you know, we expect the 1/1/26 effective date. So the claims should pay back, you know, as appropriate to that effective date once the credentialing and loading is complete.

But I will -- I can follow up with the MCOs to determine the claims processing times and get a more definitive date for you all.

DR. SCHUSTER: Yeah. I think that's a huge problem. You know, you can imagine the cash flow problem that everybody has. I guess -- I guess a surprise to me is if these were the first time we ever had CCBHCs I completely understand this, but all of these MCOs have been paying for four years, three years, four years. Four others. So they know --

MR. SHANNON: And the process is, you're paying the same amount of money that initiates the wrap. That's my confusion. It doesn't seem to be a very complicated. I know providers times 16, so that's a change. Maybe there were some other changes, but, in reality, it's you -- they submit the claim and that triggers the payment by the MCO, and then it initiates the wrap payment from Medicaid. So the real change is a Medicaid function, primarily. I guess not. I don't understand it. But again, that's what I'm hearing from people. It's a level of frustration.

I had a call yesterday with an MCO, they said they are ready to take, you know, an electronic claim. I'm glad to hear that, and go ahead and, you know, process those. It's still very concerning that it's taking this long. And even back to January 1, and I think people want that. I guess that was an expectation. But they'd really like claims to be paid today, you know, but they've been told April 1. And I've heard it from -- on calls. I've heard it from four of the six that some MCOs are saying April 1, they should be ready

to go. That was quick turn around, but --

DR. SCHUSTER: So, Chelsea, will you check and see what April 1 ready to go actually means?

MS. AGEE: Yes.

DR. SCHUSTER: Does that mean that payments will be sent out on April 1? That's what we're asking for.

MR. SHANNON: Yeah.

MS. AGEE: Absolutely.

DR. SCHUSTER: If they have to wait until April 1 then we really need payments to be issued on April 1.

MR. SHANNON: Yeah.

MS. AGEE: Okay. Yes. I hear that. I'll definitely take that back and clarify. And, you know, I see Stephanie Koenig from UHC has her hand up, but I don't know if any other MCOs, you know, want to just speak to their process. I know each of them have a little bit of a different process and how they were handling this situation. You know, that could explain a little bit why some, as you had mentioned, Steve, some contracts were longer, some were shorter. So they each, you know,

have their own process for this. So I'm happy to let them speak to that process in general, but I will certainly take that back to get some more clarification around the date.

DR. SCHUSTER: And would you let me know what you find out, Chelsea?

MS. AGEE: Yeah. Absolutely.

DR. SCHUSTER: All right. Thank you.

MS. KOENIG: Can I just chime in really quick? Because, and I want this to be a collaborative approach. While there have been existing CCBHCs, I think some of the CCBHCs obviously are newer to this space and there is different billing guidance. So we did start accepting claims the end of February. And so prior to us accepting claims, we did do an audit of the claims that were previously submitted back to January 1, and we are finding significant billing issues.

So the claims, the way the claim submissions have occurred, they're never going to pay. And so I did address this with DMS on and IT agenda call, and my provider advocates

teams will meet with those six additional just to walk through, but I just want to make sure, from a collaborative standpoint, that they're getting the education, and the information is becoming these new provider types, because just from our early kind of auditing of our claims, the submissions of their claims have been inaccurate. So to prevent ongoing claims issues and ensuring appropriate resolution of payment, I just wanted to make sure that they're getting supported as well.

And I know that there is a point of contact with DMS to kinds of guide them through, and I just confirmed last week that they had gone through the training, because it seemed from our perspective there was only 15 claims out of about 300 that could have been paid. So there were significant errors.

So we'll take our steps with our advocates to ensure just a walk-through, but I just kind of also wanted everybody to be on the same page to make sure that we're supporting these providers, you know, as we entered into, you know, this --

DR. SCHUSTER: Stephanie, when you

did your audit, did you give feedback back to those CCBHCs?

MS. KOENIG: Yes. So our provider advocates are going back and walking through to give some of that education through the auditing experience and letting them know kind of what was not correct on the claims. And it is very specific to CCBHC billing that is required to be on the claim line. So it will definitely fail encounters and it'll past our edits. So I wanted to ensure, and that was my question last week when I was on with DMS, did these providers receive the same training afforded early on with the PowerPoints. And so they are going to recirculate that back just to make sure that there's no concerns with the understanding of how to bill for these services.

DR. SCHUSTER: Yeah. Well, that's obviously a problem, and that's why I asked, you know, in addition to letting DMS know and the trainers know, it seems like the information needs to get back to the CCBHCs ASAP right?

MS. KOENIG: Yep. We will. I just

wanted to provide that. Just wanting to know we are all definitely trying to work together to get this up and running.

DR. SCHUSTER: Okay. Jeff --

MR. SHANNON: They are running. They're running. Just to clear. They are running. CCBHC is operating, it's just this claims piece.

DR. SCHUSTER: Jeff Chapman from Molina, please.

MR. CHAPMAN: Thank you. I was going to say, so on the claim front we're all set. We have no issues there. We are processing those claims today. We did get a number of the six new CCBHCs requesting contract amendments from us. Those have all been executed and done.

Credentialing isn't actually new to them though, because we already had these providers in the network, so we're just adding that additional taxonomy, and some of them had some additional demographic updates. But everything is either currently in process or already completed with no other issue on the front end with processing claims there.

DR. SCHUSTER: Great. So, did you find that some of the early claims were incorrectly done, Jeff?

MR. CHAPMAN: We did. Yep. So we have seen the same trend where there are a number of different coding issues, and trying to educate those groups on how to submit those claims appropriately with the T10 [Inaudible].

DR. SCHUSTER: Okay. So you got back to those providers and provided that information to them?

MR. CHAPMAN: Yes. Yep.

DR. SCHUSTER: Yeah. All right. Thank you very much.

And our old friend, Herb Ellis from Humana.

MR. ELLIS: How are you all doing?

DR. SCHUSTER: Always glad to see you, Herb.

MR. ELLIS: Thanks. Yeah. I actually just pulled a report during this meeting, and I do see eight different 10's that are for CCBHC claims that are coming in to Humana's system and being processed.

And as you know, we like to bill

stuff at the very front door. So the providers are getting that education when they first key in the claim of what they did wrong. So we also will do provider outreach if it's a consistent issue with certain providers, but they are getting that very detailed message at the front door. If they billed the wrong taxonomy code, billed the wrong MPI.

And I think we are working with one of the providers where they billed it as a CMHC, and we're trying to resolve that on the other side so we can get it fixed as a CCBHC.

DR. SCHUSTER: Yeah. Because they still continue to function.

MR. ELLIS: Yeah. That's right. And I've been very upfront with Steve and the rest of the team about all of the issues we've had with CCBHCs, and yeah, I'm happy to report that we've resolved that. So this stuff's coming on our door.

DR. SCHUSTER: Okay. Thank you very much. And Dana, you just put something in the chat. Do you want to tell us what it is?

MS. MCKENNA: Sure. You know, I've been listening to the conversation, and I just

want to assure those attending that DMS trained the potential CCBHCs on appropriate billing processes early on in their certification process. And the PowerPoint training has been available on the CCBHC web page for any to access, and the link I put in the chat is for the CCBHC webpage.

DR. SCHUSTER: Okay. So have you been in on these conversations with the MCOs about what they're seeing in these early claims, Dana?

MS. MCKENNA: Not all the conversations, but some. Yes. I have been aware, but really just mainly from UHC's comments, of United's, and I was assured that they were reaching out to the providers, you know, to provide education.

DR. SCHUSTER: Mm-hmm.

MS. MCKENNA: That is all I really have. I saw that WellCare was actually ready to, you know, accept all claims, but I hadn't heard any issues with the claim submissions themselves, so some of this is news to me with the other MCOs having the same issues, but it's to be expected, I guess if UHC has been

having that issue with the providers.

DR. SCHUSTER: Then others would be likely also having them.

MS. MCKENNA: Sure.

MR. ELLIS: It's definitely a learning curve. I mean, you know, the billing guidelines for CCBHC, it's not, you know, it's not fourth grade level. So, you know, we can see why there's a learning curve here for both parties.

MS. MCKENNA: Right and it seems like the majority, and you can correct me if I'm wrong, what I was hearing was that a lot of the claims were lacking the T1040 identifier that's required for CCBHC claims.

MS. KOENIG: That's correct, Dana. For the Q2 modifier.

MS. MCKENNA: Yeah, and you know, that should be a separate line item on the claim to identify it as a CCBHC claim, as well as the Q2 modifier included on each claim line to indicate that that is a CCBHC service.

And again, you know, we held this training with the clinics early on, but, you know, it has to be expected, you know, there

are -- there is a learning curve.

DR. SCHUSTER: Okay.

MR. SHANNON: Yeah, and folks thought the contract, the credentialing process was too. I mean, all of the claims issues. And I think people have figured that out. I think part of the confusion was in January, do I submit it to CCBHC or CMHC. People had that question, and I think that was part of it.

But the T1040, the Q2, I think we've heard that message clearly. And thanks for that again. But even the process is taking, you know, a long time. Some contracts were very large, some were two-page addendums, some were so -- so the claims is the big issue. That's the (indistinct) issue. But even the whole process, some people thought it took too long, just not claims piece. I just want to make sure everyone understands that as well.

The credentialing, I think that is close to being wrapped up, but again, as Jeff Chapman said, Passport, mostly the same people, so the credentialing shouldn't take so long. Hopefully, people start getting paid.

And I understand some claims are being paid, and that's a good thing.

DR. SCHUSTER: So do we have any CCBHCs on that want to ask any questions or make a statement?

(no response)

DR. SCHUSTER: Are you satisfied that you might start getting paid in April? I hope.

(no response)

DR. SCHUSTER: Well, it sounds like --

MR. ELLIS: Just to clarify, Humana, we're paying them now. We're not having to pay -- okay.

DR. SCHUSTER: Okay.

DR. SCHUSTER: And it sounded like Molina was. Are you paying now?

MR. CHAPMAN: Yes. Yes, absolutely.

DR. SCHUSTER: All right.

MS. KOENIG: Dr. Schuster, UHC is too. Obviously, we're working with the providers for the corrected submission of the claims to ensure payment back to January 1st.

DR. SCHUSTER: Yeah. Do we have any

idea about WellCare? And I ask only because they have more covered lives than anybody.

(no response)

DR. SCHUSTER: Anybody on from WellCare that can answer that question about where you are with paying CCBHCs?

MS. SANTINE: Ellen, can you take that one?

DR. SCHUSTER: I'm sorry, Beth, what?

MS. SANTINE: I was thinking Ellen might be able to answer that one.

DR. SCHUSTER: Oh.

MS. EVERETT: At this time, I have to check with that team. I don't believe we are paying claims yet, but the projected time was April 1st, but I don't want to say that and be wrong, so let me go back to the team and make sure.

DR. SCHUSTER: Yeah. Thank you. I would appreciate that. And Cat from Aetna?

MS. JONES: Sure. We too are anticipating and project the day to 4/. And just to mirror what the other MCOs have put, it was -- we definitely had been paying the

four original CCBHCs from that implementation, but you know, it was -- it was a little bit more complicated, on our end at least, than just, you know, switching over a payment because, you know, all those things had to be built in the system. Not only did we have to have a signed contract in hand, some providers required, you know, the establishment of rates because the rates on the either the CMHC side or the BHSO side didn't exist for certain services that are covered under the CCBHC.

So we had to go through that process and get those rates established and agreed upon and sign a provider contract, and then we had to build those very unique contracts in our system, where we did have to require those Q2 modifiers and that T1040 to make sure when they did submit claims, they would get paid.

So, appreciate everyone's patience, and we too hope -- are anticipating being able to starting ingesting those as a 4/1.

DR. SCHUSTER: Okay, thank you for that feedback.

Anything else before we move on to the next agenda item?

So, Ellen, you'll get back with us in the meeting if you have some information. If not, if you would e-mail me please?

MS. EVERETT: I sure will. Thank you.

DR. SCHUSTER: It's kyadvocacy@gmail.com. Thank you very much.

All right, now another of our favorite topics. Any updates on the resumption of prior authorizations for Medicaid behavior health services?

This is different from the previous. This is a standing item in this BH TAC.

I did get an interesting bit of input from an agency that got a $37,000 recoupment from one of the MCOs, and the question was, are recoupments allowed for administrative concerns?

In other words, you know, the MCO came back and said the primary language spoken was not a requirement -- you know, it's required and it's not required for TCM services.

You know, we've had these things come up in other cases that we've brought

before the BH TAC where -- and we had that discussion last time, Steve, about the TRIS number.

MR. SHANNON: Yeah. Right.

DR. SCHUSTER: About the targeted case management and whether it was required or not. I still am so confused about -- it feels to me, and I'm not a provider in the system at this point, but it feels to me that the MCOs have a ton of leeway about what they can require or suggest, but then they can't take action based on that. I'm really confused about that, because it seems to me that if we are going to have any consistency across the MCOs, which would make the provider's life a whole lot better, that it ought to be, you know, in a statute, obviously, but certainly in regulation and at the least in guidelines from DMS.

And we've had these situations come up before, because I have brought them to the attention of DMS leadership where, you know, one person in the MCO tells the provider something and they do it that way, and then somebody else comes along from that same MCO

and says, "No, you know, that was not correct. We're going to ding you for it."

And in some cases it appears to be something that is not consistent with the regulations, so, you know, I just -- and I am not trying to hamper the MCOs from doing what they need to do, but it seems to me that inconsistency is not anybody's friend here, and I wish that somebody could give me some guidance on what's going on, because when I see these kinds of things, and they seem to be more around administrative details than -- it's not waste, fraud, and abuse kinds of stuff, I mean, I'm really confused.

MR. ELLIS: Dr. Schuster?

DR. SCHUSTER: Yeah.

MR. ELLIS: Can you like explain -- I'm sorry, can you give more detail about what you're seeing or what -- what's being seen?

DR. SCHUSTER: Well, I don't have a whole lot on that one. I have shared before much more detail, and it was a case where actually I just found out from them that they won their appeal against an MCO, and they had documented and documented and documented what

they were being told by the MCO, and there were instances where what they were being told by the MCO was not consistent with what was in the regulation, Herb.

And I actually brought that one to the attention of leadership at DMS, because I'm like, it seems like we ought to have some ground rules here about how everybody is to behave.

And if we have miscommunication like I think the WellCare, you know, thing that we just had up on the screen, is, I think, poor communication at any rate. It just -- I worry that we're going to lose providers, and we need all the providers we can get.

So let me go to Summer Cramer.

MS. CRAMER: Hi, my name is Summer and I am working with Dr. Rayapati in Lexington. And I specifically am a case manager, and something we deal with a lot is actually just different MCOs saying different things as far as guidelines go for case management. We have talked to some representatives who will say, you know, things are one way, and then whenever we get an audit

or we get some sort of feedback from a different representative from the same MCO then it's a completely different thing. So, I think that overall it is a little confusing, especially, as someone mentioned earlier, whenever different MCOs are requiring different things to the submitted. So I understand that all MCOs do things a little bit differently, but just across the board there is a lot of confusion, I think.

DR. SCHUSTER: Thank you for sharing that, Summer. That's very much -- it's inconsistent across the MCOs and then it's inconsistent within MCOs. That's what I'm hearing and that's why I am concerned about it.

Let me a call on Chelsea. You had your hand up.

MS. AGEE: Yes. Thank you. So I just wanted to say, you know, because there were some questions about the parameters MCOs have, and with, you know, SAVE having examples of what is occurring with some of the providers here, you know, I can just say anecdotally that MCOs are required to recover

any type of overpayments. They are required by their contract by law to recover those overpayments when they are identified.

Now, that being said, there was also questions around, you know, inconsistencies among -- or across MCOs, and again, you know, contractually, MCOs are allowed to implement their own policies that are unique from one another, and DMS does review those policies prior, and approves those before they're implemented.

So, I would say, if you're seeing issues that you're concerned about, such as you don't believe it's matching with a regulatory requirement for that particular overpayment, or if you have examples of that, you know, we are, in my branch, again, I can put, you know, our shared mailbox in the chat here, but we're happy to take a look at that and just see if we can identify any type of contractual compliance concerns that we can address with the MCO directly.

But again, you know, without having specific examples, it's really difficult and challenging for us to determine if the MCO is

potentially out of compliance in some way or deficient in some way if we don't have those examples.

DR. SCHUSTER: So, if every MCO can have their own policy about -- and this is the e-mail that the provider MCO inquiry. If every MCO can have their own -- can you define what a policy is? Can you give me an example? That's probably easier. I mean, I'm still trying to understand the -- you know, so there's not going to be consistency, is what you're saying, necessarily.

MS. AGEE: Well, I guess an example I could use is one that we've been talking about today, which is the WellCare's new PA implementation, right?

So, you know, we're saying that other MCOs don't have that same requirement, but WellCare does. That's kind of an example of where they might have different policies unique from each other.

DR. SCHUSTER: And those kinds of policies, which I consider a big policy, would have to be approved by DMS, right?

MS. AGEE: Yes, ma'am.

DR. SCHUSTER: So that's not just, you know, an MCO just up and deciding someday that --

MS. AGEE: Right.

DR. SCHUSTER: So, let's take that as an example, because I meant to ask this question when we were talking about that. So, there was obviously a communication between WellCare and DMS about why they wanted to start instituting prior authorizations on these therapy -- therapies. You know, and we can talk about whether it's individual with the modifier or, you know group or -- so at some point, they sent that in to you all, and at some point DMS approved that. What's the notification requirement? Because that's a significant change in policy.

What's the notification requirement for the MCO to let providers know? Because my understanding is that that was posted. And again, because people have said they got too much mail or whatever, unless you were on their website on January -- February 1st, you didn't know it. You didn't see it.

But are they posting that on

February 1st for a policy that's going into effect on February 1st?

MS. AGEE: No. They're required to give a 30-day advance notice for any of those network changes. And so I know there was a concern with when these are posted on the MCO websites. And I believe we've worked with the particular MCO to identify an improvement in that -- in that space, where there should be a specific timestamp on the website that shows when the policy was posted. And that way, providers know, you know, this was posted this day. It's effective this day. And we can clearly monitor that 30-day notification.

DR. SCHUSTER: So that policy was posted on February 1st, but my understanding is that it went into effect on February 1st. Is that even possible?

MS. AGEE: I would have to look in my -- look back. We -- I was going to say, Beth, do you know when that was posted, because I believe you all send that to us.

MS. SANTINE: I'm looking for the date, but it was in advance of February first. So, it was in advance of the date. It was

more than 30 days. I don't want to misquote, but I'm thinking it was like 12/20-something I'm looking for it. We don't have to stop the meeting while I look for it, though.

DR. SCHUSTER: Okay. So, the posting notice, and again, the question is, is that sufficient notice to providers to simply put it on the website, and I think we're all saying no. You know, otherwise providers have a responsibility to check the website of every MCO every day. You know, people can complain about having too many e-mails or whatever, but there's gotta be a better system than that.

David Crowley, you have had your hand up for a long time.

MR. CROWLEY: Dr. Schuster, I hate to be anti-climactic here, but I just wanted to note, for any Passport by Molina issues, feel free to shoot me an e-mail and we'll get -- we'll take a look at that and do some research and get it resolved. I put the contact info in the chat.

DR. SCHUSTER: Okay. Thank you very much.

Susan Turner.

MS. TURNER: I just want -- a couple things. I may be actually talking about two different line items on your agenda, so I'm sorry if I'm getting two things, but maybe we've been talking about two different things here a little bit.

DR. SCHUSTER: I think they've all kind of blended together here.

MS. TURNER: Yeah. So here you have it. I do want to just emphasize really what Summer said is exactly what is happening with us as well, as far as every one, every MCO has different things that they want for prior authorizations.

You know, case management is the one that we've been dealing with the longest at this point. And even within the same MCO we have a lot of confusion with you'll talk to one person and they want this, and you'll talk to another and they want that.

And we actually just had one yesterday that -- well, I guess it was Tuesday maybe, that was denied. And when we got the denial for case management, it said that the provider was not qualified to provide this

service.

So the case manager called and was like, I've got 15 others that are approved, PAs that are approved by your agency. Why am I not qualified to do these? I am qualified to do these. I'm not qualified to this to do this one. And she was told by the representative, "Give it 24 or 48 hours and send it in again. That could change." She was like, it's really hard for me to send in an appeal for something that I don't even know, you know, kind of what I'm appealing. But, you know, now we've got them saying, you know, "Send it in again in a few days and let's see if somebody else looks at it." You know, that's ridiculous.

And then to follow up on the H0004, which is that extender code, just to give you an example of something that happened to us on Monday, maybe this was Tuesday too, it's been a week. One of my clinicians walked out into the lobby to get one of -- her next appointment, and one of her other kids was sitting there in the lobby, and she's like, what are you doing here?

This very young teenager was suicidal and his grandmother had just dropped him off at the front door. There was no adult with him. There was nothing. So the therapist wound up spending somewhere around three hours with that child. We got him admitted to the hospital. It was, you know, it was a whole big thing. It was a whole morning of time that was spent sending that.

So now, this clinician, who's never had to submit a PA before, because we've not been told that therapy was something that required a prior authorization, this therapist has to go that day and figure out how to submit this prior authorization. And certainly, we all tried to help, but it was not until this conversation that I realized that the H0004 is a 15-minute code. And I think we just sent in an application -- or a request that said please approve this and not how many units. But today, as of, you know, 3:20 on Thursday, we still don't know if that has been approved or not.

So, again, just super confusing as far as the prior authorizations go.

And then to go back to, you know, what you were saying earlier about the individual who had the recoupment about the primary language spoken, I think what some of us as providers are curious about is, how -- so we got these audits. We have these audits and they come back and they say, this service is not eligible for payment, and the reasons are things like the member's primary spoken language is not listed on the case manager needs assessment. Well, that's not required, first of all.

Maybe something like, well, the member's rights and responsibility form isn't included. Well, that was included in their intake information, but that's not what you asked for. You asked me for June and July of 2025's progress notes. And that's what we sent you.

So, it's these administrative issues that result in a 100% recoupment. So they're not saying this was waste, fraud, abuse. They're not saying the service didn't happen. They're not thing the service wasn't medically necessary. They're saying, we wanted to know

what language they spoke. You don't have it on this form, so your service is not eligible for payment. And that's not accurate. The service was provided in good faith that the provider would be paid.

So, anyway, that's a lot on several items on your agenda. But I have feelings about this.

DR. SCHUSTER: All right. Thank you, Susan. That helps on the language not spoken. So the fact is that that was included in previous communications with the MCO because it's part of the intake form, right? And you don't send that information every time you have a PA.

MS. TURNER: Well, this isn't about PAs. This was audits.

DR. SCHUSTER: Oh, this is audits. Sorry, yeah.

MS. TURNER: This was audits and so a lot of times on audits they will just ask for specific dates of service. And if that was something that was collected at intake, then you aren't necessarily sending all the documentation that was part of that intake

packet, because that's not what was requested.

DR. SCHUSTER: Yeah, gotcha. Yeah. And you're already duplicating tons of pile of paper as it is. Thank you. That's very helpful.

Michelle?

MS. SANBORN: So, you mentioned that the targeted case management and the MCOs are looking at the TRIS system to see if they are certified or not.

DR. SCHUSTER: Right.

MS. SANBORN: And what we've learned is the TCMs have six months to complete a training that I know that the MCOs are looking for, but they have six months to complete that. And so what we've kind of been told is to beside the TCM's name where the TRIS ID would be, to write that the TCM's hire date is within that six months on the prior auth. So hopefully that they won't deny it because of those services. So I just wanted to kind of give folks a tip, because the MCOs are looking at TRIS, and there's really no way for them to note that they're not certified, because they wouldn't know their hire date. So, anyway,

just wanted to follow-up on that.

DR. SCHUSTER: So it doesn't show up that they've completed the training. Is that the issue?

MS. SANBORN: That's correct, because they have six months from the date of hire to complete it.

DR. SCHUSTER: Six months to do it, okay.

MS. SANBORN: So maybe the first few months they wouldn't have had that training. So if you just make a note of that on the PA form, that's a kind of an end around.

And then as far as notice to providers, I would really recommend that the Behavioral Health TAC make a recommendation that the MCOs, when they make prior auth changes and significant material changes that they do send out a notice via e-mail as well as posting on their website, because asking folks to look at a website when they are already underfunded and overwhelmed with all this is really not the best use of our therapist's time. And so a simple e-mail to those agencies would be very helpful.

DR. SCHUSTER: Yeah. All right. Thank you. Taylor -- Taylor Tolle?

MS. TOLLE: Hi, Dr. Schuster.

DR. SCHUSTER: Hi.

MS. TOLLE: Taylor Tolle with Isaiah House. A couple things that we have seen an increase on just with the resumption of the prior auths, they're more kind of specific to backdated eligibility, but we are definitely seeing an increase for United Healthcare specifically is where we are seeing the most issues, but clients who are receiving backdated eligibility.

So we're seeing that they get, you know, sometimes even the three months back for their backdated eligibility from admission when we submit those Medicaid applications. We get notification of those. We're submitting those retro auth requests in those situation; however, we are seeing that they're often only approved for a couple of days and the remaining dates for the services are denied for medical necessity.

However, in several cases, the client may or may not be in our facility any

longer by the time that backdated eligibility is approved. And by the time we've receive that authorization determination. So because at that timing, you know, we don't always have the opportunity to obtain the signed, authorized representative form from the client in order for us to proceed with an appeal.

So, given that circumstances, really trying to figure out what options are available for providers to address or appeal those denied dates when obtaining that form is no longer possible.

The second thing is that we are seeing an increase in recoupment requests from MCOs. Passport and United Healthcare specifically is where we're seeing the largest increase of where there has been some type of eligibility change within a two-year span is where we see the most on that patient's eligibility.

And so they are coming back and recouping from two years prior stating that that client did not have Passport at the time of service. However, we do have screenshots from KYMMIS that are dated showing that at the

time of that date of service, they did have Passport according to KYMMIS. But KYMMIS doesn't show that history as of the date of the recoupment, so it's very confusing for providers.

And I know that this is something that we have dealt with several times before, but we definitely are starting to see a larger increase of that issue now that the prior auths have resumed as well.

DR. SCHUSTER: And that issue has come up before. I've heard that as of, you know, consistent feedback from providers because you're stuck then and there's no place to go and get payment for the services.

MS. TOLLE: Yes, ma'am.

DR. SCHUSTER: And the provider was told at the time that they were a patient of that MCO. So, I don't know what the solution to that is, but thank you for that, Taylor.

Kathy Dobbins.

MS. DOBBINS: Okay, I'll try to do this quick, because I have to jump off here in a second, but our staff is having problems with the TRIS system. It is inconsistent, but

when you're billing for case management, I think it started in January, the licensed clinical supervisor has to be in the system. And even -- and there are too many occasions where the MCO says they can't find the licensed clinical supervisor. A lot of times they do. Sometimes they don't.

But if they don't, then we end up in an appeal process and then that requires, you know, having to fill out a bunch of forms, and it also requires getting the -- as I understand it, getting the client to sign off on the appeal for the organization to, you know, represent their interest in the appeal in order for us to get paid for the service.

MR. SHANNON: Yeah. And Sheila, that's an example of an administrative issue.

DR. SCHUSTER: Right.

MR. SHANNON: Not a clinical decision that merits an appeal. Right, Kathy?

MS. DOBBINS: I mean I would think so, Steve. But apparently it is being required, and there's a lot of hoops to jump through. And if you're not, you know, our clients are not that mobile, right? You know,

and some are homeless. And trying to get those, you know, you have to get the client to sign off that you can actually file an appeal for a service that's already been provided. I mean, yeah. And the inconsistency of it is, you know, very frustrating for our staff, for everybody, really.

DR. SCHUSTER: So, is the requirement to have the client sign off on permission for the provider to file an appeal, is that -- where does that come from? Is that a federal, a state law? Is that a regulation? Can anybody tell me that? I mean, that seems unnecessary for one thing.

MS. DOBBINS: I'm just getting this from our clinical director. And she's not on here to provide her direct feedback from the MCOs. I can certainly ask her precisely what she was told.

DR. SCHUSTER: Let me just ask the MCOs that are on, do you all require that? Do you require the client to sign off on some kind of permission is what it sounds like.

MR. CORNETT: So I can give --

DR. SCHUSTER: Humana does not, I'm

hearing from Liz Stearman.

MR. CORNETT: Sorry, Dr. Schuster. I can kind of, from a clinical perspective, speak to what we have experienced at Key Assets. That is that for Aetna clients, we do have to have a physical signature on a form in order to "represent them" by giving them additional appeal materials.

That form has to be physically signed by them and returned to the address within 10 days. So what that has looked like on the ground is staff scrambling to get -- to be able to meet that timeline. And we've had to end up overnighting multiple letters back to Aetna in order to have the appeal submitted.

DR. SCHUSTER: So Aetna does require that?

MR. CORNETT: And it is -- basically it's 10 days from the date that the letter is dated. So, obviously it takes a couple days to get to us. We scramble for a couple days, and then they have to receive the letter back within that 10-day time frame.

MR. SHANNON: And Zach, that's Aetna

SKY, right?

MR. CORNETT: I'm not 100% for sure. The client that I'm thinking specifically about was Aetna SKY, but I don't know if it is exclusively Aetna SKY.

MS. DOBBINS: I think the problem is happening with more than Aetna.

MR. SHANNON: Right. Right. Yeah.

MS. DOBBINS: At least the TRIS system issue is.

MS. TOLLE: Yeah. I know that Passport and United Healthcare require this as well, at least from our experience at Isaiah House.

MR. CROWLEY: This is David with Passport. We do require client consent to submit those appeals on behalf of the client. Sorry, Cat. Interrupted you.

MS. JONES: And then that was just what I was going to say, David, is that when there is a denial of q service authorization, so a preservice denial, that's considered a member appeal. And so in order for the provider to file an appeal on behalf of the member, we have to have that signed consent.

So just wanted to acknowledge that that was the reason behind that.

MS. DOBBINS: But Cat, if the LCSW is in the system and it's working for a lot of the clients, you know, a lot of the time, but not all of the clients all of the time, it's really not -- I don't even see how that's really an appeal, because the problem would seem to be on the MCO side.

MS. JONES: And that's what I'm not understanding, to be honest, is we're talking about the requirement that the -- that the TCM supervisor also be -- have all the same certifications and requirements as -- as the TCM, the actual case manager. So if that's the issue, that's -- that's regulatory. That's in regulation, and it is a requirement. So maybe I'm not --

MS. DOBBINS: It's not about the requirement, it's about finding it.

MR. RHODES: Yeah, the issue's not that they don't have the certification. The issue is that the certification was not found in the review and then the service was denied.

MS. CURTIS: I can speak from

experience. This has actually happened to us as well. So the names were all clearly stated. I sent the same information for a second time but I simply highlighted just to make it clearer. So the certification of the supervisor was there. The targeted case manager's name was there. It was really an oversight by the reviewer through the prior authorization process. And would it be acceptable, actually, to resubmit this prior authorization rather than filing an appeal because it was like an administrative oversight?

MS. JONES: Cynthia, definitely. We can avoid that appeal. We have a process that's a reconsideration process. So if you -- I'm going to put my e-mail in the chat, and if you would send me that specific example, it would be, you know, received securely, and I will forward that to our PA department and we can get that resolved for you.

MS. DOBBINS: Yeah. And thank you Cynthia, because that's exactly what I was trying to explain, and I think you probably did a better job of explaining it then I did.

But we've had it happen, you know, numerous times.

MS. TOLLE: I just want to piggyback off of that while we're still discussing this. So, Cat had mentioned that it was a preservice necessity for that form to be completed so that it was a member appeal. But in our circumstances regarding the backdated eligibility, it's technically post-service because it happened well after the fact. So is the member form and signature required still by the MCOs in these circumstances or how do we --

MS. JONES: In cases of retro eligibility, that would be a retro authorization request, so that would not be an appeal. That would just be, you know, you're requesting authorization because at the time you weren't aware that the member had whichever MCO coverage, and so you're submitting for that prior authorization service after the service has already -- yes, so that would be considered a retro auth request.

MS. TOLLE: Okay. So do we just

need to provide further education to our provider rep and the UM staff when we're advised that the form is required or?

MS. JONES: Yeah. I'm -- I'm struggling to understand that -- that it would be an appeal if there's nothing that's been denied.

MS. TOLLE: Well, the retro authorization was denied.

MS. JONES: So the retro authorization. Okay. So then that would be an appeal. If you've received a denial, it would be an appeal.

MS. TOLLE: Okay, thanks.

DR. SCHUSTER: Stephanie Koenig from UHC.

MS. KOENIG: Sorry. I couldn't get it off mute, Dr. Schuster. I just also put in, I know that we are one of the MCOs that does, on the front end of the preservice authorization require the TRIS certification number, and I think I addressed this, but if anybody has any questions, I did provide my e-mail contact.

In addition, if we're not able to

validate, and I recognize that DBHDID did send out that policy information to us and to the providers, and that is not our sole verification, so our portal does allow for supporting documentation and scenarios such as the six-month grace period for employment.

So if there's any questions that you have related to that, I'm happy to answer some of those. And we are similar, so if there is a denial, the member can appeal or the provider can appeal on the member's behalf.

MS. DOBBINS: I just want to go back to Steve's point, you know, that it's an administrative issue. It's not that -- I mean, we want to comply with all of the rules and regulations, and we think we are, but if the rep can't find it or after the fact we find out oh, they couldn't find it and it gets rejected when we know it's in there and our clinician has provided the number as well, then is it an appeal or is it a revalidation?

MR. SHANNON: A reconsideration.

MS. DOBBINS: A reconsideration. Thank you.

MS. KOENIG: From a UHC perspective,

I mean, you can request a peer-to-peer and there can be further conversation. I mean -- I mean there's various avenues. So it's not just looking at the TRIS database and the ID and the certification being provided, you can upload supporting documentation. You can request a peer-to-peer. Our goal is not to deny these services. What we are trying to do is validate that we have certified targeted case managers that are delivering and providing --

MS. DOBBINS: But if it's (indistinct) six out of 10 times, but you know, but not -- not 100% of the time, you still have to go through that whole process to prove something that has already been demonstrated to be in there by other MCOs or other conversa -- you know, other authorization. So it's -- it's a little frustrating.

MS. TURNER: Can I jump in too and say on the case that we had to call about with Aetna, there's not even a place on the form to put the TRIS number. So it has to be put down in the notes, and we have heard before, oh,

well, we didn't look at the notes. So if we need the TRIS number in there, then all the forms need to clearly say, here's what we need in there as well. And that would just make it easier for some of those things that you need, to make sure that they get on every single request that's out there, because all of our people are certified and trained, and like this specific case manager had several other authorizations that had been approved. This one was not, and they couldn't even really tell her why when she called. So it's just really confusing and it just adds another layer of work to everything that we're already doing.

MS. JONES: Hi, Susan, this is Cat. We definitely took that, heard that suggestion from other providers, so we do have a form update that is -- has been submitted to DMS for approval that we hope will, you know, providers can choose to use it. They're not required to use it, but it is something that would be something that's fillable that the information would be right at -- right at -- at the beginning, and would help, you know,

clearly point out all of that information, so hopefully we'll get that. And again, it is voluntary to use for providers, but once we get that approved, we hope that that will be helpful.

MR. CORNETT: Cat, will that be available on Availity as well?

MS. JONES: As far as you're able to -- to use it and -- and submit it with -- with your Availity as a -- as a document, what's currently, it's not something that will be built into Availity, but it's -- you can attach that -- that form with your Availity submission. Yes.

MR. CORNETT: Do the MCOs have a requirement to make prior authorization materials electronic?

MS. JONES: As far as you can submit via Availity.

MR. CORNETT: Right, but not all --

MS. JONES: But that form is an -- is as an attachment through Availity. So it's an additional form. It's not required. It's not, you know, much like the State universal PA form. It's a form that's specific to

targeted case management that would -- would assist to point out all that information, you know, in one place and very clearly, to Susan's point and suggestion.

MR. CORNETT: I guess my suggestion would be to make that as part of the Availity form, because now that is an additional step that actually is a required step and it is being omitted from the Availity form, which I think is a requirement for MCOs to have those materials available electronically.

MS. JONES: You know, there's -- there's more as far as Availity and what's built into that system is -- is kind of beyond what we can just add to the Availity system. But -- but I'll definitely take that as a take away. But that would mean that, you know, each MCO would have -- have to request Availity to have custom forms for whatever nationally each MCO used. I can see that being a little problematic, but I will definitely take that suggestion back.

MR. CORNETT: Thanks, Cat, appreciate it.

DR. SCHUSTER: Summer, you've had

your hands up for some time.

MS. CRAMER: Yeah, I was mostly just going to speak to what Susan and Kathy were saying where I think a lot of the times, you know, with all of the issues that we're having with representatives from the MCOs saying that certain people don't have TRIS IDs when they do, or saying that, you know, certain problems exist in one PA but not in other PAs. Like it's all just feels very much like a guessing game.

I've even been on the phone with like representatives who will say, you know, I don't really understand this aspect of what you're doing. Or like, can you explain -- I can't think of a specific example right now, but especially with like having people get resources that they need for case management, having people get assistance with their -- with their medication and remembering to take it. That kind of thing. Representatives sometimes just don't get the case management aspects of things, and it feels like they're not being like properly educated sometimes on what they're even looking for, which I think

can also lead to a lot of confusion with different -- different representatives from the same MCO saying different things.

So I believe it was Kathy who mentioned it, but everything just is very much dependent on whatever representative you get in contact with.

MR. SHANNON: (indistinct)

DR. SCHUSTER: Again, it's that, you know, whether there's consistency within the MCO or not. Let me go to Beth who's got some more feedback, and then we're going to move on to another agenda item. Beth, you have something in the chat. Do you want to --

MS. SANTINE: There was a follow-up item from earlier about the authorization process and what documents are required for the outpatient therapy request codes. So this does apply to the H0004 and the family therapy code also.

And then the other follow-up item was about what date we posted the notice. And that was on December 21st for the -- excuse me. December 26th for the prior authorization that took effect on February 1st.

DR. SCHUSTER: Okay. But there was no notice sent to providers. It was only --

MS. SANTINE: It was only for the (indistinct).

DR. SCHUSTER: Okay.

MR. SHANNON: On December 26th.

MS. SANTINE: On December 26, 2025, with the effective date of February 1, 2026.

DR. SCHUSTER: Okay. Thank you for checking that out.

MR. SHANNON: So, for the H0004 add-on, you need to receive the treatment plan and updated clinical information the last month they are needed.

MS. SANTINE: Yes. And if the member is brand-new, then just the initial assessment will do.

MR. SHANNON: Seems like a lot of work for 15, 20, 30 minutes. You know, with a crisis.

DR. SCHUSTER: Well, I think we still need to look at the whole prior auth on therapy. I'm sorry. I just -- I'm going -- I'm going to stay on that theme. Thank you for that.

MR. CORNETT: I would just second Steve in saying that you will spend more time completing that prior authorization than you spent time with the client if it's an additional 15 minutes.

DR. SCHUSTER: Yeah. So, which is why the providers are likely to just eat it.

MR. SHANNON: Yeah.

DR. SCHUSTER: Which is not good.

MR. SHANNON: Yep. Just a bit of a reminder, Sheila, it is 3:50.

DR. SCHUSTER: Yeah, I know. Let's skip for just a second. Steve, you were going to make a recommendation to the MAC. Let's be sure we get that in while we still have a voting quorum.

MR. SHANNON: Yeah. The recommendation is that the PA process for independent therapy, family therapy, and group therapy be reviewed for necessity or be discontinued. I don't know where the group was.

DR. SCHUSTER: So, this is a recommendation to DMS.

MR. SHANNON: Right. That's what I

mean. Right, yeah.

MS. DAVIS: This is Danni Davis with DMS. I'm going to go ahead and chime in. We have that new TAC recommendation process and an e-mail was sent with some updates on how to go about that new process, so you will make the recommendation during the meeting, and then also submit a form that will go to the MAC chair, myself. And then also there needs to be a member present at the next MAC meeting to provide background information as well as rationale to the entire MAC.

DR. SCHUSTER: Right.

MS. DAVIS: So it is a little bit different, but somewhat the same.

DR. SCHUSTER: Yeah. Thank you, Danni. So basically, we're saying, Steve, that the PA process for therapy for individual, family, and group, and each of those should be reviewed by DMS for necessity.

MR. SHANNON: PA requirement.

DR. SCHUSTER: Yeah, PA requirement. So be reviewed by DMS for necessity and --

MR. BALDWIN: Reconsideration of their approval.

MR. SHANNON: Yeah.

DR. SCHUSTER: And be reconsidered.

MR. BALDWIN: I'm not on the TAC; I'm just helping to wordsmith.

DR. SCHUSTER: If not found to be necessary.

MR. SHANNON: Yeah.

DR. SCHUSTER: I wonder if we ought to put in light of the concern about delay.

MR. SHANNON: Yeah. That instead of one business day. I mean --

DR. SCHUSTER: Well, no, I'm talking about having the PA and all on therapy.

MR. SHANNON: Yeah. Yeah, I agree. And we still have to talk about H0004, right?

DR. SCHUSTER: About delaying. Yeah. This is about the PA generally.

MR. SHANNON: Mm-hmm.

DR. SCHUSTER: Yeah. About delaying onset or access to therapy.

MR. SHANNON: Access to care. Yeah.

DR. SCHUSTER: Yeah. Okay. All right. So you're making that motion that we submit --

MR. SHANNON: I am making that

motion. Yes.

DR. SCHUSTER: All right. Do we have a second from one of the voting members of the TAC?

MS. MUDD: Second. Val.

DR. SCHUSTER: Thank you, Val. Any discussion? We've -- we've had a lot of discussion. So all in favor signified by saying aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: All right. Great.

Let's make a second recommendation that if -- well, do we want to just do this one and we'll come back to the issue of the one day submission? In case they -- in case they don't approve the PA?

MR. SHANNON: Right. Let's do this one first and see what happens.

DR. SCHUSTER: Okay. All right. Right. Thank you very much.

Steve, a two-second update on the credentialing of Peer Support Specialists.

MR. SHANNON: House Bill 470 had two readings in the Senate. It's passed the House, it's in the Senate, so it's close to

passing overall then they've got to go back.

What's going to happen is the DBHDID credentialing process shall be in effect through 1/1/27. It ended 1/1/26, so by the time this gets done we'll pick up nine more months. Those folks, those peers can go back to work or billable status. They're probably still working, many of them, but at billable status. And then 1/1/28 they'll be registered through the Alcohol and Drug Counseling Board (muffled speaking). So that -- those are the big pieces right there.

MS. RITTENHOUSE: Sheila, if I could ask one question. I asked this of Steve yesterday and so just inquiring if an individual, if a peer is doing substance abuse peer services, they have their registered credential, the RAD, and they've let their DBH certified peer lapse, are they billable now through Medicaid and the MCOs?

MR. SHANNON: Yes, because the RAD is billable. The RAD has been billable.

MS. RITTENHOUSE: I just wanted to make sure the MCOs were going to recognize that. So, okay.

MS. STALEY: Yes.

DR. SCHUSTER: Yes. Okay. Thank you. Thank you, Steve.

And let's get a brief update, because there's good news about the 1915 SMI SPA.

MS. DICKINSON: Sheila, if you'd like to go on to -- to the next item, I can put an update in the chat if that would work for 1915 RISE.

MR. SHANNON: Yeah, that would be good.

DR. SCHUSTER: That would be great. And on the reentry, I'm assuming that we're still looking at April 1st is a go-live date?

MR. SHANNON: Correct. As of this morning at the Reentry TAC, that was reported April 1.

DR. SCHUSTER: Great. Thank you.

MR. SHANNON: Good work, Medicaid. It's exciting.

DR. SCHUSTER: And the CHILD waiver, has the CHILD Waiver enrolled any participants?

MS. HANCOCK: We do. We've got --

we have two enrolled providers, and at this point we have four enrolled active participants.

DR. SCHUSTER: Great.

MS. HANCOCK: Yeah.

DR. SCHUSTER: And it will keep on going, right?

MS. HANCOCK: Yes, ma'am.

DR. HOFFMANN: Sheila, would you like -- Dr. Schuster, would you like Carmen just to drop -- for number 9, just to drop that information into the chat? And then there are no changes to the ABI waiver as far as therapy services at this time.

DR. SCHUSTER: Yeah. That would be great. Thank you very much.

DR. HOFFMANN: That'll speed you up just a tad.

DR. SCHUSTER: Yeah. Carmen, and give me the duplicated and unduplicated totals, please, when you do that.

MS. HANCOCK: In the --

MR. SHANNON: In the chat.

DR. SCHUSTER: In the chat.

MS. HANCOCK: Yes.

DR. SCHUSTER: Yeah. Thank you very much.

Back to the CHILD waiver, you're still accepting comments on the reg until the end of March, is that right?

MS. HANCOCK: That's correct.

DR. SCHUSTER: Okay.

MS. HANCOCK: That's correct, yes.

DR. SCHUSTER: All right. Thank you. Could somebody put in the chat a link to that, Leslie or whoever?

DR. HOFFMANN: Yes, we'll do that for you.

DR. SCHUSTER: All right, thank you. I mean, we had excellent discussion, but we're obviously running a little bit late.

The Medicaid Oversight and Advisory Board, the MOAB, met on January 12th. They gave final approval to the findings and recommendations.

The one of most significance to the behavioral health community was a recommendation to support, or recommended that the CCBHC model goes statewide because of the good things that it was doing.

On February 23rd, we met and heard reviews of a number of bills. What they're doing now is they're using MOAB to listen to, it's not even a vote of approval, but we're having brief, brief, brief presentations about Medicaid-related bills that are filed in the General Assembly.

So, we've had some of those on February 23rd. We've had more of those on March 9th, and then we're meeting again on Monday at 11:00 a.m. on March 16th and we're going to have six more. And I will post that list for you of those bills.

MR. SHANNON: We also had a discussion of the GLP-1 drugs.

DR. SCHUSTER: Yes, we did. But they have decided not to authorize GLP-1s just for weight loss. It's only for the treatment of a medical condition like diabetes or so forth. I think the proposal was actually, you know, a kind of discount that would have saved some money if people -- they really want to the GLP-1 drugs out there.

But lots of bills. I want to bring attention to House Bill 485. If you all on

the behavior health side have not looked at that, that's a major, major overhaul of the KRS 202A. The involuntary commitment procedure.

So if you look at the bill as it was filed, it was quite awful. They were going to let district judges overrule the QMHP about whether the person should get admitted to the hospital or not. They were going to have the judges overrule the discharge plan. I mean, it was just -- it must have been written by a bunch of attorneys and judges is all I can say.

So the bill that passed the House unanimously is much, much more balanced, and I think it does some good things on the behavioral health side.

That statute had not been overhauled in over 50 years. So there's an excellent redefinition of danger, which makes it clear that deterioration of the individual can be a cause for involuntary commitment, not just that imminent danger. So lots of good things.

New recommendations, we've got -- I've got a bunch of things. We've got a bunch

of revisiting things that we need to do from this meeting.

Is there any new business? Anything that we haven't touched on that anybody wants to bring forward?

(no response)

DR. SCHUSTER: All right. Obviously --

MR. SHANNON: In the comments, Sheila.

DR. SCHUSTER: Yeah.

MR. SHANNON: There's a question, 1915(i) RISE participants in Kentucky had a PCSP approval yet? In other words, participants receiving services.

Kentucky River's response was, we've not received any PAs for 1915(i) RISE yet. So, I think people in the -- I guess, Tanya, they're going through the process, right?

MS. DICKINSON: Yep, they're going through the process.

MR. SHANNON: So they'll be getting services soon, we hope.

MS. DICKINSON: Yeah, a number of them have case managers and so they are

(muffled speaking) the PCSPs. And I wouldn't -- that was -- the numbers that I put in there were the last ones from the last week, so I don't have a current number of anybody with PCSP. I'd hate to misspeak.

DR. SCHUSTER: Yeah. Okay. Thank you, Tanya. And the new areas, the Seven Counties region and the New Vista region have now been opened up.

MS. DICKINSON: Right.

DR. SCHUSTER: You've got providers of services.

MS. DICKINSON: And those are regions as opposed to the CMHC itself. It's that region. We had to pick some way to divide up the state so we'd know what we were talking about.

MR. SHANNON: Yeah. The word region helps.

DR. SCHUSTER: That's right. Thank you.

Any formulary issues? We always ask this under old business.

(no response)

DR. SCHUSTER: All right. Our next

meeting is April 2nd, and we will -- I'm sorry, the MAC meeting is April the 2nd at 10:00.

And they're interesting now. If you've been to MAC meetings before, these are interesting because we have members of the BAC, so you have many more recipients of services or family members, and they're asking some really good questions and there's a lot more discussion. I really like the new format. So, well worth tuning in. And of course, those are available online.

And then -- and in fact, we entertain public comment at the MAC now, which we didn't do before.

And Danni, I think that sign-up is on the website, right?

MS. DAVIS: That is correct. It can be accessed on the MAC website.

DR. SCHUSTER: Yeah, can you put that link in the chat real quick for people?

MS. DAVIS: I can. Absolutely.

DR. SCHUSTER: Thank you very much.

All right. And then the next BH TAC meeting is -- oh, after Derby. So after you

all have picked your Derby winners, your Oaks the day before and your Derby winner, so you have maybe made enough money to retire. But if not, we'll hope to see you at the next BH TAC meeting.

So, we're only four minutes late. I really thank you all for your discussion. You know, as several people have said, you know, we're all in this together. And although it sounds kind of cantankerous sometimes, I think we're all working to make sure that people who are Medicaid members get every bit of behavioral health services that they need. So, as long as we all move toward that goal, we will work out these little glitches that come up from time to time.

So, I thank the MCOs for being on, and I thank particularly the DMS folks, and I really appreciate all of the members of the behavioral health community that are here to ask questions and share. And of course, to my voting members. So thank you all very much.

And good luck. Next Tuesday is St. Patrick's Day, and I'm an O'Donnell, so think green. Think good luck. See you all.

Bye-bye.

MR. SHANNON: See you all, take care.

DR. SCHUSTER: Okay. Bye-bye.

(Meeting adjourned at 4:05 p.m.)

* * * * * * * * * *

C E R T I F I C A T E

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

Dated this 31st day of March, 2026.

Theresa Prokop

_____

Theresa Prokop, Certified Voicewriter