DEPARTMENT FOR MEDICAID
BEHAVIORAL HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 14, 2026
Commencing at 2:00 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 (not present)
Valerie Mudd
Tara Hyde (not present)

DR. SCHUSTER: Are we at the 2:00?

MS. DAVIS: We are. And I will just keep a lookout for TJ.

DR. SCHUSTER: Okay. Thank you very much.

MS. DAVIS: Yes, ma'am.

DR. SCHUSTER: Welcome, everyone to the Behavioral Health Technical Advisory Committee meeting, known affectionately as the BH TAC.

I should start keeping track of the number of meetings we've had, because it's been a lot. It's six a year for almost 10 years, or more than 10 years. That's a lot of meetings.

Anyway, we welcome you all. I'm Sheila Schuster, Executive Director of the Kentucky Mental Health Coalition, and the long-time Chair of the BH TAC.

And Steve and Val, do you want to introduce yourselves, please?

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

DR. SCHUSTER: Great.

And Valerie?

MS. MUDD: Valerie Mudd, NAMI Lexington, National Alliance on Mental Illness and Participation Station up here around peer operated center. I represent folks living with mental illness, like myself.

DR. SCHUSTER: Great. And Melissa, do you want to mention what PAR is, please?

MS. ALLGEIER: Yep. Melissa Allgeier. People Advocating Recovery. I represent people in recovery.

DR. SCHUSTER: Great. Thank you. And we are expecting TJ Litafik to join us, but we do have a quorum.

We have two openings right now on the TAC. Mary Haas resigned about a year ago and we're still looking for a replacement to represent the Brain Injury Association of America.

And recently, Misty Agne, who was representing the Brain Injury Association of Kentucky had to resign because of a work conflict with timing and we do not have a replacement there yet. So, hope to have that

by our next meeting.

I very belatedly sent out very detailed and long minutes of our March meeting. When we have such good discussion, the minutes get longer and longer, but I did send those out to I think everybody I have on my e-mail list. Could I get a motion to approve the minutes, please?

MR. SHANNON: So moved. Steve Shannon.

DR. SCHUSTER: Okay. And a second?

MS. MUDD: Second.

DR. SCHUSTER: All right. Any additions, corrections, omissions, misspellings or otherwise?

(No response.)

DR. SCHUSTER: All right. All those in favor of approving the minutes, signify by saying aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: All right. And those opposed, like sign.

(No response.)

DR. SCHUSTER: Okay. Let's go very quickly to delays in paying claims for the

newly certified CCBHCs. We had this on the agenda last time and we were hoping to have it shaped up by April 1st. And Steve, I'm looking to you to tell us whether that's happened or not.

MR. SHANNON: It's better than it was. There's still a couple waiting to go through the final process to get claims processed. I spoke to one yesterday, and they're hoping, they had a test claim go through that was okay, but they're still somewhat concerned about the process. But I -- but progress has been made since our previous meeting.

DR. SCHUSTER: Okay. When you talk about a test run or something, is that on the part of the MCO or is that on the part of the CCBHC?

MR. SHANNON: CCBHC submits a test claim to the MCO and then, you know, if it goes through. And they were hoping that was -- went through the process. That just happened recently, and they had -- the person I spoke to didn't know the outcome yet, but they were hoping that it would be

processed. So, I think progress is being made. It varies across the new CCBHCs and the MCOs, but it's better than it was.

DR. SCHUSTER: Okay. Well, we like to hear about progress. DO any of the providers or any of the MCOs have any particular comments or questions they want to ask or statements?

(No response.)

DR. SCHUSTER: All right. I'll take that assent that progress is being made. We will put it on the agenda for the July meeting as well, Steve, and hopefully by then we can say that they're all (crosstalk). Yeah. Getting their approval. Thank you.

There have been a number of continuing questions about the rescinded approval of the code for extended sessions, and also the PAs around individual, family, and group therapies.

You will remember that we discussed this at the last meeting in terms of approval by DMS to WellCare to go on and do PAs for those services. We expressed a good deal of

concern. We did submit a recommendation to the MAC that approval granted to WellCare to require PAs for outpatient individual, family, and group therapy be rescinded.

Steve, you were -- you presented that at the MAC meeting, as I was out of town, and you were told at that meeting, I believe, that it had been rescinded.

MR. SHANNON: Yes. Yes, I was. And then I confirmed it again. We had a call with -- some folks expressed concerns that WellCare was still requiring one and that was clarified. Thanks to Leigh Ann Fitzpatrick for that. But I think that will pertain to the group and family therapy.

DR. SCHUSTER: Yeah. I got an actually an e-mail from one of the providers this afternoon saying that they were still having trouble with the family and group. So, I don't know if Leigh Ann is on, but is somebody on from DMS that can absolutely say for the benefit of everyone on that those PAs have been rescinded?

DR. HOFFMANN: Dr. Schuster, this is Leslie and I've got Chelsea on. Chelsea,

do you have an update for us on number -- I think it's number 4 on the agenda. I'm sorry. Yeah, number 4.

DR. SCHUSTER: It is number 4.

MS. AGEE: Hi. Yes. Good afternoon. We do -- we can confirm, DMS can confirm that that was, approval for the H004 PA was rescinded. We confirmed with WellCare that that system configuration, you know, they reverted back to no PA for that, back to the April 1st date.

We have asked them to do a claim sweep to ensure that, you know, when they were operationalizing that recension that no claims or services were kind of caught in that interim period when they were making those changes back from their system.

So, they are going to be doing that claim sweep and providing an impact analysis to DMS to determine if any providers, you know, you need to -- if they need to work with any providers on looking at those authorizations again.

DR. SCHUSTER: Okay. So, it has been rescinded, which is what we had

recommended. And we appreciate that. If any of the groups' providers are still having that problem, what should they do with that information, Chelsea or Leslie?

MS. AGEE: I would advise working directly with the MCO through your provider representative, because, you know, again, WellCare is aware that they are doing a kind of a look back on the claims and services that were requested over the last few weeks just to ensure that anything that, again, was caught kind of in that interim of the system change is being corrected.

MS. SANBORN: Is the recension just for H0004 or was the 90847 and 90853 included in that?

MS. SANTINE: Just the H0004. Oo, I'm sorry.

MS. AGEE: Oh, no, you're good. Yes. Just the H0004.

MR. SHANNON: So, is a PA required for family and group? I thought it wasn't.

DR. SCHUSTER: No, we were told that it was not. Our recommendation was that all of those be rescinded, and we were

told that they were rescinded. And I think that's what you heard back from Leigh Ann Fitzpatrick.

MR. SHANNON: Yeah, it is.

DR. HOFFMANN: Sherri, are you on? Can you assist with this as well?

MS. STALEY: Right. Yes. Hello, this is Sherri Staley, Behavioral Health Supervisor with Medicaid. The original document that was sent for approval by DMS was rescinded. It is my understanding that it was supposed to be the entire document. So, if that is different than what our understanding is, we would need WellCare to confirm that.

MS. SANTINE: The entire document contained, I think, physical health and behavior health codes, so the entire document was not rescinded. It was just the H0004 code that was rescinded.

DR. SCHUSTER: That is not what we submitted recommendation to the -- to the MAC, and it's not what we were told at the MAC meeting had happened. I think I just read to you, Behavioral Health TAC

recommends that the approval granted by DMS to the request made by WellCare to begin requiring prior authorization for outpatient individual, family, and group therapy be rescinded. That's exactly what we sent to the MAC and we were told at the MAC meeting that that's what had happened.

DR. HOFFMANN: Dr. Schuster, let us take this back then and we'll try to get some clarification and get that back out to you. And if we can do it before -- like it doesn't have to wait until another meeting. We'll try to get information to you as quickly as possible.

DR. SCHUSTER: Yeah. I would really appreciate it, because obviously we're all confused and the providers are very confused, because we've been telling them on the basis of what Steve was told at the MAC meeting that that -- our recommendation had been approved, which clearly is for all of those therapy codes.

And that was the basis of our complaint, quite frankly, was not on the extended session. It was on the fact that WellCare is

breaking the mold of what MCOs and insurers have been doing for years, and that is not requiring PAs for individual, group, and family therapy. It's not worth their money. It's not worth their time. And it delays care, which is what our biggest concern is.

DR. HOFFMANN: Right. I remember that. All right, we'll follow up on that one.

DR. SCHUSTER: All right. Can you follow-up in a way that I can absolutely share it out then to all the providers?

DR. HOFFMANN: Yes.

DR. SCHUSTER: And will be sure that all of the providers are made aware, because we really are --

MR. SHANNON: Confused.

DR. SCHUSTER: Again, confused.

MS. HENSEL: Hey, Dr. Schuster, I just -- on behalf of the MCOs, I just wanted to chime in. Completely agree with you. I think historically, there has not been a concern enough around quality of care in the therapy space for it to be a place that MCOs or health insurers have -- have felt the

need to authorize.

That being said, I think everybody is in a heightened state of looking at and exploring fraud, waste, and abuse, as driven by a lot of the federal focus in that area as well. And so, if analysis shows any type of concerns in that space, I think that's typically why you would see, and I know United hasn't gone this path, but just on behalf of all the MCOs, again, I would say typically the reason you see an authorization added on something where it historically hasn't is something has spiked in our analysis that would indicate there might be fraud, waste, or abuse concerns in a code area.

DR. SCHUSTER: So when -- you raised an interesting point, Krista. So when WellCare submitted their document, which of course is blind to us, and actually DMS's response to WellCare was not made known to us directly, did WellCare submit data to indicate why they were asking for this? Was there justification? I guess that's a question for Sherri or for somebody

at DMS.

MS. STALEY: The document did not contain data. The document just contained requests for new authorization approvals.

DR. SCHUSTER: I have a -- I'm sorry, but I have a real problem with this. And I think I expressed it strongly at the last meeting. If all -- if what we were all about is making sure that people get what they need in the behavior health space, and for years and years, as Krista has acknowledged, there has not been PAs for those, you know, therapy services, I guess I have a real concern about DMS approving this without at least asking WellCare what the basis is for, because we know that PAs delays services.

MR. SHANNON: Right.

DR. SCHUSTER: And I guess I'm not asking you directly, Sherri, I guess I would like to have some clarification from DMS about what that process looks like. If people can show data that there's a lot of waste, fraud, and abuse in those therapy sessions or in the numbers of them or

whatever the issue is, I would sure like to see that data.

MR. SHANNON: And Sheila, I'd like to see it across providers. Not one, two, three, five providers in the behavior health field, but, you know, is it pervasive?

DR. SCHUSTER: We had that problem with the psycho-ed.

MR. SHANNON: Yeah.

DR. SCHUSTER: You know, there were many of us that were not doing waste, fraud, or abuse around psycho-ed, but there were some providers that were, and we all got caught up in that.

So, I would just like to go on record as saying I would sure hope that DMS would be asking for some data as the rationalization, as a reason. And Krista raised that issue. And I, you know, I think waste, fraud, and abuse, quite frankly, gets thrown around to be a reason for a lot of stuff, and I would sure like to see the data that it's happening. But we will move on.

MR. BALDWIN: Dr. Schuster?

DR. SCHUSTER: Yeah.

MR. BALDWIN: Just a -- this is Bart. Just a closing thought on that. I think if, in the role of the TAC, I just, you know, that's better than I, but if that's something that's been identified by one of the MCOs, I think the data and a solution to that could be a discussion with this group for education and support for -- I mean, if it's intentional that's one thing, but if you see trends of poor performance, and I think that's something that's -- that groups want to know about. What can we do for additional education or training in the providers. I think, kind of proactively, not -- I mean, I know that if you justify the PA on something or you wouldn't, I understand that if you have the data to back it up. But also, I think there's another way, other solutions to that as well.

DR. SCHUSTER: Excellent point, Bart. And I will make note of that, because I do think that's an excellent -- an excellent thought.

MR. SHANNON: It's provider

education if it's those cases, right?

DR. SCHUSTER: Yeah. Yeah. If there's something that's going on and providers are not -- and we are going to get into this discussion, I think, around medical necessity. Because that's another area where I think providers need to know what the medical necessity criteria are and if they're meeting them and how they're going to meet them.

So --

MS. SANBORN: Dr. Schuster, the Children's Alliance would like to see if the Behavior Health TAC would be willing to make some formal recommendations to the MAC around this -- this was a particular example when this PA came out. The H0004 and the 2 -- the 2027, the psycho-ed, was on a line that -- that said substance abuse treatment. And then the others were on a psychotherapy line. So it wasn't even clear. I think some of our providers thought those things were just for substance abuse treatment, and so we had to kind of seek clarity.

So we would just ask that maybe a

recommendation is sent to the MAC that the MCOs, if they're going to implement new prior auths, that those are current and clear to providers.

Also, when they issued that -- that change, it's not listed on their current list of -- of PAs. And when I was asking about it, I was given a -- a link to an October 2025 list of PAs, and that's what's out on the website. And it's really hard in May of 2026 to look at a list that's -- that's effective 2025.

And so I think when -- the recommendation would be that when a current -- when an MCO implements a new PA, that they update their list on the website so that agencies are clear on what's included as a PA and what's not.

And we would ask that they notify providers of those changes on their website so that they're not requiring the providers to look every single day, several times a day, to find out what's the new and latest thing, right? That there's -- there's time and they're given 30 days to do that.

So, again, clear communication, 30-days' notice, and some kind of format, and then a current PA list. Not a six month or seven month or eight-month-old PA list on their website so providers know. Because today, they just don't know what's current.

DR. SCHUSTER: Yes. I appreciate that, Michelle. And actually a couple of us had talked about the concerns with MCOs putting changes of all kinds on their websites and then really requiring providers to check the websites at least once a day if not several times a day.

And we were looking at a recommendation that they be required to send out an email to all providers alerting them, but I think updating and keeping current the list of PAs added to that. So, we will discuss that later in the meeting. Thank you.

MS. COX: Can I weigh in? My name is Tammy Cox and I am with Aegis Mental Health. I'm on -- in the new business, I'm hoping to be able to address an issue I have with Aetna. But I also agree that the Children's Alliance.

As coming from a standpoint from a provider, we just learned last week that Aetna had implemented a psychoeducational PA back in June of last year that we were not aware of. Nothing -- it was put on the website. We were not made aware that our psychologist would need a prior authorization for his psych evals.

DR. SCHUSTER: Wow.

MS. STALEY: Hey. This is Sherri. I just have to weigh in here. We are making efforts to keep that side-by-side comparison up to date. It certainly has been updated since 2025. It might not be exactly current at this moment, but we are making efforts to do that.

Also, the MCOs have contractual obligations to send out provider notifications about changes. And so people should be getting those from their MCOs as well.

I also would like to just caution folks to remember, if you have a particular issue with one MCO, if you would like to resolve that with the MCO through the proper

channels, and also with DMS if you feel it is a breach of policy or contractual obligations, then you can certainly go through the DMS process as well.

I know that this is an open forum, but it really, sometimes it's best just to go through the proper channels for a specific incident, because it could have been a number of issues that we see. Sometimes people will bring things to me, and when we dig in deeper it was actually just a billing error that could easily be corrected, or there were notices sent out but it might not have gotten to every single person in your agency.

So, I would just ask that people really try to go through the steps to look at the appeals and denial reasons, and start with your MCO reps first. Then if there is no resolution and it is different from the policies that are supposed to be followed, that then they contact the contract monitoring branch at DMS for those specific incidents.

MS. ALLEN: I would also like to weigh in. I'm so sorry. This is Jodi Allen,

Behavioral Health Supervisor with DMS.

Thank you, Sherri. Yes, that is very true, and I have seen many providers that have come through those processes like you were speaking of, and have gotten the help that they needed.

Also, I want you to know that we do hear you. I know sometimes when things don't happen very, very quickly, it can feel like you're not being heard or that we don't understand the issues. And I just want you to know that we truly are, as a team, actively working to address these concerns.

We are reviewing our policies. We are going through the websites and looking at what MCOs -- we are addressing some of the review processes in-house that we have. And I just want you to know that. We do hear you. We do here that these are issues, and we do understand. So, I just want you to know that we are listening, and we are truly working towards resolve going forward.

MS. HENSEL: Well, hopefully when you get to new business and you hear my other issue that somebody from DMS can weigh

in and help me, because I have reached out a couple of times to DMS for this and I haven't gotten any response, so that's why I'm on here today.

MS. ALLEN: Okay.

MS. HENSEL: I don't mean to cause any trouble. I'm just trying to get resolution to a problem that we're having.

MS. ALLEN: I understand. Okay. Yeah.

DR. SCHUSTER: And that's what this forum is for. I will say, in doing the minutes, and I actually went back to the court reporter. I usually do the minutes out of my own notes, but I was having trouble reading them. So, I actually went to the discussion that we had back in March, and provider after provider after provider was saying, we don't know what these changes are, because the MCOs are not sending us e-mails.

And I guess there was some communication from providers that they were getting too many e-mails, so the MCOs, I think all of them decided, we're just going to put it on

the website and then it's up to you to check the website. And that's where, Jodi and Sherri, that's where this is coming from is the frustration around that, because --

MS. SANBORN: Well, and today --

DR. SCHUSTER: -- they're not getting notifications.

MS. SANBORN: Yeah. I looked on the link today around this H0004 and when I go to look on a comprehensive list on the behavior health page, it includes all sorts of medical PAs, but they're all October of 2025. And we brought this issue up in March.

And so in March, when it was back and forth, the website should have been updated so that I know today what the current PA list is for each MCO.

This isn't just one MCO. This would be helpful for all the MCOs, that there's a place, when changes happen, it should be an automatic. And so that I can look at that list every day, if I'm going to have to do that, and I don't get the notifications or whatever. But having an updated list of your

current PAs would be very helpful, because right now the H0004 the 90848 or 90847 and 53, they're not on there, because that was October. These issues weren't even talked about until February.

So, it -- it just would be nice to have current PA lists available, because my providers do not know what's current because of the back and forth. And again, the eight-month-old list that's out there on the website.

MS. ALLEN: Thank you for bringing that to us. And we do hear you and are actively working towards resolve.

DR. SCHUSTER: Okay. thank you. And that's helpful to have that.

I'm so confused about where we are. Are there other -- well, let's go to five. Update on the resumption of prior auths for Medicaid BH services. Clearly, we've already gotten into some of these. And the fact that people -- most providers do not know what the current PA list is, whether it's for psych testing or whether it's for the individual, group, and family therapies or any other

items. What else do we have under this agenda item?

(No response.)

DR. SCHUSTER: You've made your recommendation, Michelle, which I think would go for this as well, to have notification and an updated list, and I think Medicaid is hearing us, and I appreciate that.

Are there any other issues around PAs that anybody wants to bring forward at this point?

(No response.)

DR. SCHUSTER: Krista puts, UHC provider PA list -- I'm sorry, I just lost it. Can you just say that, Krista? I just lost the chat.

MS. HENSEL: Sure. Everybody had the link for the United Healthcare pieces. So there is a Kentucky-specific website that's always kept up-to-date and includes who our provider advocates are, the current PA list. And so I just wanted to make sure if anybody didn't have easy access to it that I put it in this location so you guys

could document it and share with the various provider groups that you represent.

DR. SCHUSTER: All right. Anything? Going once, going twice. Anything else on prior auths?

(No response.)

DR. SCHUSTER: And Leslie, you're going to get back to us about the questions we have with the H0004?

DR. HOFFMANN: Yes. I've asked Sherri to take the lead on that, and she'll work with Leigh Ann and Chelsea.

DR. SCHUSTER: Okay. Thank you. Liz Stearman apparently is putting their link in. But it still requires the providers to go to every MCOs website to get that information.

MS. STEARMAN: That's in addition to the other notices. Sorry, I didn't mean to post that in exclusion. We also send a mailing, an e-mailing, and do verbal updates in our joint operating committees and all meetings with providers.

DR. SCHUSTER: Okay. Thank you.

MR. SHANNON: Including KARP.

DR. SCHUSTER: Including KARP. All right. Okay.

MS. KOENIG: Dr. Schuster, this is Stephanie. And just to kind of provide some -- I mean, and agreement, we do provide similar notice as well out to our provider community with UHC, but just from like an overarching for providers to understand, as MCOs go through the process, we do submit this first to the state for approval.

And so when we're talking about updates to our systems, we have to wait and are dependent on DMS to provide us the approval, which then, you know, there is a timing factor for us to get the information up to date in our system. So just for the providers to be aware, you know, we are expected to give them 30-day notice once it's been approved. And then that hopefully allows us the time to get our systems up to date.

So there is -- there is a delay that sometimes you may not see that -- that information immediately as soon as you see that notice, but just also wanted the

providers to also understand, we have to go, you know, as MCOs, through a -- through a process as well.

DR. SCHUSTER: Yeah. I understand that you have to get permission from DMS for any PA changes. Correct?

MS. KOENIG: Yes, that is correct.

DR. SCHUSTER: Either instituting them are dropping them. Okay. And you cannot notify providers until you have that permission.

MS. KOENIG: Correct.

DR. SCHUSTER: Approved. Okay. And you cannot start implementing it until 30 days has gone by from the time of the notification of the providers, right?

MS. KOENIG: That's correct.

DR. SCHUSTER: Okay. So are you saying there is sometimes there is an additional delay because sometimes your systems are not ready?

MS. KOENIG: No. I'm just indicating sometimes when we're accessing maybe the provider portals, there may be delays on our internal systems to make sure

that that information is up to date. And so I heard some people speaking up. I know that there was a delay for us with our communications team. So, while we've -- we've updated our PA with approval, sometimes it may not always align in our portal. So, I just want to -- I mean, ours is up to date, but I just wanted to ensure that providers understood the process for MCOs.

DR. SCHUSTER: Okay. And have you, Stephanie, if you have a new PA added or one that's been taken down, are you sending e-mails to providers to notify them?

MS. KOENIG: Yes. And then we have a monthly kind of top-of-mind article that providers get updates on each month.

DR. SCHUSTER: Okay. All right. Thank you.

Anything else on PAs? We're all just so excited that they're back with us.

(No response.)

DR. SCHUSTER: Let's go to audits. That's also been a source of great discussion. Any updates in the discussion

around audits?

MS. SANBORN: So, recently we've heard a lot of our providers are getting prepayment audits. Prepayment reviews. And I think we were previously told that that kind of prepayment reviews was a pretty serious offense and there should be a lot of prework prior to our agencies being put on a prepayment review.

And then also, MCOs should be getting approval from DMS before doing a prepayment review.

So I started inquiring, how would our agencies know if they were put on these prepayment reviews, because some of the contractual language that I shared with them, they were like, we have never done that, or haven't experienced that, or I haven't had these conversations.

They gave me copies of these letters and they were all very similar that they were on these prepayment reviews. And then I was told that there's something called a claims edit audit, but prepayment review is still on the letter.

So, just trying to understand what's allowed in regards to our providers providing services and then not getting paid until their -- until a review is done. I just don't think that's a good practice. I don't mind that we do audits and follow an audit process for those that maybe we suspect aren't providing good services. And I certainly don't mind, you know, some prepayment reviews, again, on those egregious organizations. But I had a handful of agencies and none of them were on a prepayment review list.

And then I was told something about some audit claim process that I know nothing about and know nothing about the rights of the providers around that. So just trying to get clarity on what that is.

MS. COX: I would like -- I'm sorry. I would like clarity on that as well, because we are on two prepayments. One with Aetna, one with Humana. And we also just did -- got an audit back from Aetna that said we didn't include a lot of our stuff from Aetna. As far as the TRIS

account, I don't know if you can see this, but right here is everything that we sent as far as each individual TRIS account. They're saying we didn't send a lot of stuff.

Every audit we do, we keep on a hard drive every piece of paper that is sent. They are currently asking us back for $66,000 on stuff that we actually sent that they're saying we did not send.

We're also on a prepayment with Aetna for our CSA services that we were not made aware of. We were given no training, nothing. We just got something in the mail, and we're not even able to contact Aetna right now. The lady, the special -- the SI unit person has failed to return our calls for over a month now on where we're at on getting off this.

DR. SCHUSTER: Who do we have from DMS that could respond to this?

DR. HOFFMANN: Dr. Schuster, I've got Chelsea still on. And I don't know if Jeremy's on, but Chelsea is on.

MS. KENNEDY: I can. Well --

DR. HOFFMANN: Or Corey.

MS. KENNEDY: Oh, I'm sorry. Corey. I'm on phone here. But Chelsea, you go ahead and I'll come in if you need me.

MS. AGEE: Okay. Yeah. I was just going to -- so, you know, for the Aetna concern, I'm -- I'm going to address Michelle's comments first, because I'm not familiar with the Aetna concern.

But the concern that was brought up was a couple of our MCOs were utilizing a vendor. That vendor was putting the term prepayment -- excuse me, in their letters, in their notices that were going out to providers.

And once we did an inquiry with the MCOs, we determined that this was not prepayment as defined in the DMS MCO contract. This was a claim review for medical necessity.

Typically, most of the requests that we received, it was requesting medical records to support codes that were billed, which is not what DMS defines in our contract for the purposes of fraud, waste, and abuse, as prepayment.

So there was concern, you know, and DMS did address with those MCOs, the language that was being used in those letters, because claim -- claim reviews, medical record reviews, that does not fall under what we are defining prepayment review as in our contract.

So, we did work with the MCOs. I can confirm that we received updated information from one of them to make sure that the letter was corrected. And so it does, it removes the term prepayment. And it defines it as what it truly is, which is a claims review.

And so, now if we're talking about prepayment in terms of how it's defined in the DMS contract, that is based on a sustained or high level of payment error that results from an analysis, and it identifies a problem that could possibly relate to fraud, waste, and abuse.

And so, in that instance, yes, the MCOs are required to provide information to DMS about wanting their request to place providers on prepayment review. Our division of program integrity and our Division of

Health Plan Oversight reviews those requests and approves or denies them.

And then the MCO must notify the members of that prepayment review. It is a very clear language that we request that they use in that letter.

It has to have very specific details according to our contract, and it also has to explain how a provider can be removed from prepayment review, which is typically sustaining that error rate, essentially to where they're not having error rates and they can take them off prepayment review and they can continue billing.

So there is a distinction between the types of reviews that we're talking about here, one being more related to the fraud waste and abuse and one which is not a prepayment review, it's that clinical -- or excuse me, it's that claim review.

So, you know, again, the MCOs are correcting that language to make sure that it's clear in the letter what the request is pertaining to.

MS. SANBORN: So, Chelsea, I just

need a little bit of help understanding. A claims review is a prepayment review. They've done a service and now they're being asked to justify medical necessity before they get paid.

MS. COX: Yes.

MS. SANBORN: Versus an audit, which is that an audit is you do the service, you get paid, you get audited, and only to find out that you've not met medical necessity, so there could be a recoupment.

MS. COX: Yes. And we have been told through Aetna --

MS. SANBORN: Excuse me. So, if -- if we're allowing the MCOs to check medical necessity on every claim, that's a prepayment review. It's a prepayment audit. Why don't we implement prior auths for those services so that they could justify medical necessity before I do the service and I'm out the money. Does that make sense?

MS. COX: Yes. Absolutely.

MS. SANBORN: And now my right's to have an audit.

MS. COX: Yes, I -- I agree. And

Aetna cannot tell you what your percentage is. We have talked to several different people, and they'll say it's this percentage, or we don't have a percentage. We've been on prepayment with Aetna, which means we -- they do the service, they send in the notes. Then Aetna says they have 45 days to review the notes. We've been on prepayment with Aetna since September with no way of knowing what our percentage rate should be before we come off.

MS. AGEE: So, again, I'm -- with the Aetna concern, you know, I don't want to address that, just because I don't have the information in front of me. I don't want to say, you know, give you the wrong information. I mean, we have our Aetna partners on here, and I'm sure they'd be happy to talk with you about that.

But as far as, you know, Michelle, what you're talking about, you know, maybe doing PAs instead, you know, the -- the technical part of this in the contract, you know, the MCOs are -- are using Edison audits in their system regarding the NCCI guidelines, and

it's a mechanism to identify potentially erroneous claims, and then, you know, requesting those medical records to further review.

So that is a technical mechanism in the contract that the MCOs have to, you know, have in --

MS. SANBORN: But I'm -- I'm still trying to understand why they can't pay it and then --

MR. SHANNON: Right.

MS. SANBORN: -- and then ask for the documentation and do a recoupment if it's not medically necessary.

MR. SHANNON: Michelle --

MS. SANBORN: I mean, why does a provider have to go without being paid for the services they provided in good faith? That's the question.

MS. COX: And you have to pay your employee that did that service, so if you are an owner or if you're not, you're doing stuff yourself, then you're out paying that person all the way around. I agree with what Michelle is saying, and I have a

therapist sitting in the back. She's on board with Michelle that, you know, just do prior offices for everything then.

MS. AGEE: I'm not -- you know, I'm not sure if just doing prior auths on everything is necessarily the solution, because I know we've just spent a lot of time discussing prior auths and how they can be -- they can, you know, prevent you from -- from providing your services, right? So, I'm not sure that that's -- that's the solution here, but I will just say contractually, the MCOs are within compliance with how they are processing the claims review and the prepayment review.

The part of the issue that we saw that was out of compliance was using that prepayment language in those notices when it wasn't truly prepayment as defined in the contract. Which we have corrected.

MS. SANBORN: Ao, yeah. And so thank you, Chelsea, because I think that's what we're trying to understand is, I'm trying to make some conversation or discussion around these claims reviews, and

is that the appropriate way that we would want our contractual language to be to allow this, or is there other options such as paying providers then doing a post-payment audit where there's a lot of parameters and rights set up for providers, or can we maybe set up clearer maybe discretion and -- and rights for providers for these -- again, it's a prepayment audit is what it is.

DR. SCHUSTER: Yeah, I'm concerned. Michelle, you raise a really good question. I mean, I'm concerned about what's the criteria that the MCO is using in picking this, this, or that, or are they doing it by providers, or are there certain services that it's happening on most frequently?

I mean, it puts the providers in just a terrible situation where they are actually putting in the work and then they're waiting I don't know how long for this to come up after the fact.

MS. HENSEL: I wonder if it could be helpful. You know, we spent a little bit of time earlier in the call talking about fraud, waste, and abuse, and it's the

Department of Program Integrity that has a real mastery of that space. And I'm just wondering if it might be helpful in an upcoming agenda for the BH TAC to hear a little bit from the Department of Program Integrity in terms of what their expectations are across the Medicaid system and the pressures we're seeing and the (indistinct) we're seeing in the fraud, waste, and abuse space. I think that could be helpful for this group, especially in this portion of the conversation.

MR. BALDWIN: Yeah.

MS. HENSEL: So, I don't mean to overstep my bounds, Dr. Hoffman or Chelsea or anybody from the team, but I'm just wondering. That seems to be a missing voice that could be helpful in this conversation.

MR. BALDWIN: Yeah, Dr. Schuster, I -- just real quick. Krista, I agree. I appreciate that comment. I think understanding and clarity is what we're seeking on this, so that providers will know what the rules are. We'll get into that more, I guess, on the next item, but in

terms of this particular piece, one of the things that -- a question that I have, and if you take out the denials or the recoupments for medical necessity, that's a separate, but I think my question is, clarity on what are the grounds for recoupment, when an MCO does a recoupment?

Because my assumption is, it's tied to waste, fraud, and abuse, but what we're seeing is in audits where people are getting recouped funding based on it's supposed to be 48 hours of signature and then happen in 72 hours.

MR. SHANNON: Right.

MR. BALDWIN: Okay. That is an audit finding. I'm not denying that that is out of compliance, but is that something that would be grounds for recoupment? My assumption is, is that if you're going to recoup dollars then you have to show justification of waste, fraud, and abuse, not an administrative, I mean, we're talking about situations where even a prior auth was approved, the service was delivered, the service was documented. It was delivered by

an appropriately credentialed provider, but based on an administrative or clerical issue, recoupments are happening.

I'm not saying it's not a finding, I'm not saying it shouldn't be even a corrective action claim or something (indistinct) provider, but I think that what is the real justification, cause we're seeing, and this is across the board.

(garbled speech)

DR. SCHUSTER: Excuse me, Tammy.

MR. SHANNON: Tammy, can you mute yourself? Can you mute? Thank you.

DR. SCHUSTER: Thank you.

MR. BALDWIN: But I think that's just a question of where is that authority, because it seems an overreach for -- and I'm not saying people can -- not to be compliant, but if it's a finding, then an action plan, a corrective action plan, these are the findings. But if the service was done, met medical necessity by an appropriately credentialed person, then -- then there might be a finding, an action, but should not be grounds for recoupment.

And maybe I'm wrong, but I'd love to, to your question or to your comment, Krista, on the training, you know, clarification on that would be really helpful for the providers and the recipients of services.

DR. HOFFMANN: So, Bart --

MR. SHANNON: Some action before recoupment.

DR. HOFFMANN: This is Leslie. I -- I noticed Liz just put this in the chat too. I believe Jennifer did a presentation. She's the Director for Program Integrity. We can have her to come back if you want to for one of the meetings and then we can have the discussion. But I believe she did a presentation. I thought it was to the Behavioral Health. Dr. Schuster, do remember, could it have been the MAC maybe?

MR. BALDWIN: She did one to the TAC, but she only talked about audits. She never really addressed our request. The presentation -- because this was a couple years ago, she did one around audits and (indistinct). It wasn't the waste, fraud, and abuse that Krista was talking about, but

it was around audits. But it was when Medicaid does an audit, not when the MCO does an audit. And so, obviously --

DR. SCHUSTER: I think it was a piece of it, but it was not this piece that we're talking about, Leslie.

DR. HOFFMANN: Okay. So, Chelsea, can you take that back to Jeremy and talk that through and see if we can come up with something? And then, Dr. Schuster, we could maybe come back at one of the next Behavioral Health TACs and do a presentation.

DR. SCHUSTER: Yeah.

MS. SANBORN: But I think doing the -- doing the claims audits, and again, when I have a group of 12 providers in the room and almost half of them had experienced one in the last month, I wouldn't call that waste, fraud, and abuse. I call that there's a new process in town to determine medical necessity and get out of paying the providers.

Because if all of those providers are truly waste, fraud, and abuse type providers

where they really probably need to be on the prepayment review process, we're in trouble, right? This is a new process without guidelines and without clear rights and -- and rules. We don't know how many days do they have to respond, when do they have to pay, what if we don't provide the right services?

I mean, there's just a lot of questions around these new claims audits that I'd never heard anything about until now. And they're, you know, again, they're not prepayment reviews and they're not being approved, and they're being done widespread. And I think more than one or two codes. I can go back and find out the different codes, but I just -- we just need clarity on that process, because it's just not fair for providers to provide the service and not get paid.

MS. COX: I agree, Michelle. You are absolutely correct. Or they'll tell you to look between their guidelines or the KSR guideline. They'll tell you -- you never know which guideline to go with, because they revert back between the two so much.

DR. SCHUSTER: Yeah --

MS. ALLEN: I was going to say -- oh, I'm sorry, Dr. Schuster, go ahead.

DR. SCHUSTER: Yeah, I was just going to say, I think -- I think what providers are looking for, you know, 99% of providers, I'm going to say, want to follow the rules, and they want to provide the service, and they want to get paid for it, whatever that payment is. But you can't follow the rules if you don't know what the rules are or if the rules keep changing. And I think that's the piece that is so frustrating.

And all through my notes, as I was going back over our long discussions last -- last meeting, and I could have gone back to the court report, you know, for meetings before then, it's the lack of consistency, both between MCOs and within MCOs. I mean, that's what we hear over and over and over again.

MR. SHANNON: And changes over time.

DR. SCHUSTER: And it changes over time. But we have -- I hear from providers

who call me and say, I don't know what to do, you know? I talked to staff person X from MCO Y and they tell me this, and that's what I do, and then I talk to staff person Z from that same MCO and they tell me something completely different.

And we get a lot of that. And the providers are really caught in the middle. So the lack of predictability on the part of the providers -- I mean, it's bad enough that Medicaid is not the greatest payer in the world. Most of the providers that are on this Zoom and the ones that are out there are doing this because that's the work that they do, and this is -- the Medicaid population is the population they want to serve, and they're really trying their best to serve them.

And, yes, there are errors. But when I see some of the clerical errors, Bart said it very well. These are not -- you know, you provided a service that was not what was ordered, or you provided a service that was inappropriate, or you provided a service and it was not done well.

These are people that -- what was the one that you had Steve? They put the address in and they put an S for South instead of spelling South.

MR. SHANNON: Right, and those were denied.

DR. SCHUSTER: And it was denied. I mean, come on, folks. We've got more important stuff. And I would think the MCOs have more important stuff to do than to do that kind of thing. It's increasingly frustrating to me that we're putting barriers up there that don't need to be there.

So, however we can get it done, and I would really like Jeremy or whoever to really zone in on waste, fraud, and abuse.

MS. ALLEN: I'll also take this back to our Behavior Health Directors meeting with the MCOs just for additional discussion to see if there are already things that are being done. I mean, you know, these MCOs are national, a lot of them, and so just to see if there are things that are already being done to help with

this issue.

I'm just constantly trying to think of a way to resolve, and what can we do to move forward. So, I'll take that --

DR. SCHUSTER: Yeah, I agree. I appreciate that, Jodi. And we have always known, and some of us have been in this field a lot longer than others.

MS. ALLEN: Yeah.

DR. SCHUSTER: Behavioral health is very difficult because we don't have X-rays of broken bones and we don't have, you know, some the things that are so much easier on the physical health side --

MS. ALLEN: Yes.

DR. SCHUSTER: -- to mark whether people are improving or not or what the service was. You either set the bone or you didn't. You know, we're dealing with all that soft stuff. I used to say --

MR. SHANNON: And not all interventions are the same, right?

DR. SCHUSTER: And not all interventions are the same.

MR. SHANNON: But it doesn't mean

they're not good or bad, they're just, you know, different approach.

DR. SCHUSTER: And no one patient is the same as another patient --

MR. SHANNON: Right.

DR. SCHUSTER: -- as you all know. Or client. So, yeah, I think we just need to keep working on this, so let's keep this on the agenda and keeping it moving forward for sure.

Do you have anything else on that, on the prepayment that you want to bring up, Michelle?

MS. SANBORN: No. Just more clarity on the claims edits process and the rights for providers, which I call prepayment reviews.

DR. SCHUSTER: Yeah. Leslie, if you could let Jeremy know or whoever from Program Integrity, we do need to know what the rights of the providers are, the types of claims that are coming up or what the type of process, because we really are not clear on that.

DR. HOFFMANN: It sounds like we've

got a couple of issues going on. I was just asking if Chelsea could get with Jeremy and then Program Integrity actually would be Jennifer Dudinskie, but I want to make sure that she, like you said before, what her last presentation was on is maybe not exactly what you were looking for, so maybe if I can get those two to work together, we can come up with -- with a better presentation. Not that Jennifer's presentation wasn't good, but more what you're looking for.

DR. SCHUSTER: No, it was -- it was a piece of it, but not this piece. And I -- Leslie, you know me, I would be happy to talk with you and Jennifer and Jeremy if that would be helpful.

DR. HOFFMANN: Yeah, we've been talking about, if our liaison wants to speak to us, we've been talking about if there's specific things we need to meet with you about on particular TACs if we need to meet to better understand what you're wanting so that we can work on it and get it done so that we're not bringing back something

that's not necessarily what you wanted. So, I did include Behavioral Health TAC as one of those that we might want to have in-between conversations. I know this morning. And IDD TAC. I get lots of questions from the IDD TAC.

DR. SCHUSTER: I think that would be helpful. And I know Danni, I was on vacation, and she was trying to get some clarification on some of our items. And the more that we could let you know what our questions are. And I've been asking people, when they bring something to me, to say, have you let DMS know. I know that Michelle had been in touch with Jodi and some other folks about some of these issues. So, let's -- let's do a little more communicating between meetings in preparation.

DR. HOFFMANN: I think I will reach out to you, Dr. Schuster, for a short meeting.

DR. SCHUSTER: Yeah. Yeah, that would be great. Thank you. Anything else on that before we go?

We've got a good item here on that Bart

and his folks would like to talk about on number 7.

Oh, Tammy, let me get back to you and just say, why don't you reach out to DMS directly. Would it be with -- who would it be with, Leslie? Chelsea maybe?

DR. HOFFMANN: Jeremy's on. Yeah.

MR. ARMSTRONG-DEROSSITT: Yeah. So, Tammy, I'm going to put a contact in the chat for you to be able to reach out and further engage with our internal DMS folks.

MS. COX: Okay, thank you.

DR. SCHUSTER: Thank you, very much, Jeremy.

DR. HOFFMANN: Thanks, Jeremy.

DR. SCHUSTER: And we appreciate your being on and bringing your issue, Tammy. That's what we're here for.

MS. COX: Well, I have one more issue, and I don't know if I need to wait til new business. I was told by -- I don't know if anybody knows who Ivy Livengood is -- this would be the place to address that issue, so I was just kind of waiting to new business to bring it up.

DR. SCHUSTER: Yeah, we've got something else in new business too, but let's wait, if you don't mind, let's wait.

MS. COX: I don't mind at all.

DR. SCHUSTER: Okay. And Jeremy just put the email for you in the -- in the chat.

MS. COX: Thank you, Jeremy.

DR. SCHUSTER: Yeah. Bart and Shannon and -- I just blocked on. Anyway, you all, let's talk about provider access to the MCO medical necessity. Number 7.

MR. BALDWIN: Yes. This is something that -- thank you, Dr. Schuster. This is something that we keep hearing consistently, and it's come up already in terms of the prior auth discussion and the audits, in terms of clarity on what is the medical necessity criteria that services are being reviewed against. Having access to those criteria, and frankly, when those criteria change, what is the notification.

So, that's kind of what we're hearing. We -- Shannon's going to give you a little bit of a review or analysis. Because we've

reached out to -- you know, we've run -- you know, we have ABA advocates and KHRA, you know, a couple of associations that we lobby for, but also have members and have clients in the behavioral health space and kind of reached out to everybody to get their feedback.

We contacted Michelle and she reached out to her members to get feedback.

And so Shannon's going to just kind of give you based on what we heard, really the questions we have at this point. And it -- and it goes back to really much along the same lines, themes we've been talking about or the clarity around the expectation, clarity around when the -- when the requirements or the rules change, how are our providers notified.

So Shannon, do you want to take it from there?

MS. O'CONNOR: Yeah. Thanks, Bart. Yeah, thanks, Dr. Schuster. Yeah, you set up this agenda very nicely, because I feel like this conversation is encompassing of everything we've had up until this point.

And as Bart mentioned, we have a very, very wide range of behavioral health clients in our portfolio. And when reaching out to them heard the same thing from everyone. From folks who were in substance abuse who are community mental health centers or ABA clients, our behavioral health clients, our substance abuse clients.

Everyone is very confused as to how to access medical necessity standards, where to access medical necessity standards. And when they ask, they're not receiving it. And really just want to hear from the MCOs and from DMS what -- what is the medical necessity standard that everyone is supposed to be using?

You know, in the regs, InterQual is listed first, however, in the state contract, MCG and InterQual are permissible.

We've noticed that some MCOs may have switched to MCG, and many of our providers don't feel like they have ever received notice of that change, which, as we have been talking about throughout this conversation, that provider notice may be lacking, and that

this seems like a big one.

But then also what rules? Is it the state contract or is it the state regs? Just would love an understanding of what that expectation is.

And then it does specifically state in the state contract that providers, upon request and on each contractor's website, is supposed to be clear access to the medical necessity guidelines, and we just are hearing consistently that that is not happening.

And so we'd love to hear what is the definition of access, where can we find those criteria, and how can we educate providers and get them this access so that everyone's on the same playing field?

So hopefully we can reduce some of these prior authorization denials and these claim denials and, you know, prepayment review, and, you know, post payment audits. I just, if we can all get on the same page and have some clarity on this issue, that would be great.

I have a couple other thoughts, but I think that's plenty to start with.

MS. AGEE: Hey, this is Chelsea with the DMS. So, just want to clarify, contractually, MCOs, they have to adopt InterQual or MCG. And then ASAM. I think someone is also putting some comments in the chat as well. ASAM for behavioral health services.

The way that the MCO would post that would be either UM policies. So if they had a change to one of those UM policies, they would have to, you know, anything that's public-facing, provider-facing, they have to get those documents approved by DMS prior to posting or issuing. And then they would -- that would require a 30-day notification to the provider if a change had happened. So once that, you know, DMS approves that document for the MCO, they would then, obviously, have to give 30-day notice to the provider network of those changes.

And I do see some of the MCOs are putting in the chat maybe some -- some links to their websites. But I would, you know, let each of them kind of speak directly about their process as far as the notification and

review process. But just contractually, that's the parameters that they're working within.

MS. MARLER: Chelsea, can you speak to if -- how that aligns with the reg that just names InterQual?

MS. AGEE: What are you -- I guess I'm trying to understand. You mean as far as letting them use MCG or InterQual?

MS. MARLER: Right.

MS. AGEE: Um, I wouldn't be able to speak to that in particular. I just know, you know, that's -- I think been in our contract for the last two iterations.

MS. PARKER: Chelsea, this is Angie. I can answer that.

MS. AGEE: Oh, perfect. Thank you, Angie.

MS. PARKER: I'm sorry. I'm not on camera because I'm on my phone, but there was a lawsuit regarding the use of InterQual and Milliman. So, I believe that regulation has changed to allow either/or.

MS. STEARMAN: The regulation has

actually never been updated. It all still references InterQual, which is very confusing, and we've brought that up. Unfortunately, you know, because of the lawsuit, there was a mandate that came out after that that supersedes that -- that regulatory language. Because I believe it has to be corrected through, you know, legislative processes versus the court processes. But -- and Angie, do we still have that memo posted somewhere so that we could maybe reference that when -- when we get questions?

MS. PARKER: That is a very good question, Liz.

MS. STEARMAN: It's like a historic document at this point, so yeah.

MS. PARKER: We can try to locate that. I just know that early on in my beginning with Medicaid that this was an issue and that I didn't realize that it hadn't been updated. I mean, I know that as long as it's approved by Medicaid, InterQual or Milliman or ASAM criteria can be utilized. Also, MCOs can develop their own

based on evidence-based medicine as long as it's approved by Medicaid.

MS. MARLER: That is tremendously helpful. Thank you. We figured there was experience here somewhere.

Is it -- if it would be possible to share that memo, that would be super helpful just so we all understand the framework within that decision-making around which criteria is used.

And I know we're going to get into understanding, but is there any kind of uniform definition of access or accessibility for the criteria that each -- that MCOs are all held accountable for?

MS. PARKER: I don't know if I understand the question. Whether accessibility for the providers?

MS. MARLER: Yes. Since the requirement is that if providers request access to the criteria, they can receive it and that there should be access virtually. What is that standard?

MS. PARKER: The standard is, if you as provider want to see the criteria

that was used to make a decision, you request that of the MCO and they have to give it to you.

MS. O'CONNOR: And that is what we are coming up against. That is not how (inaudible) routinely. And yeah, Ben I see (inaudible).

MR. DAVIS: Yeah. If I may. I actually received a letter from an MCO today. An e-mail that stated that they -- I needed to pay for InterQual access personally. I've been requesting through provider rep, phone call, and website visits for over a month and have not been able to gain access. And that's where my concern comes from as a provider. I think some MCOs are different than others, but as a provider, we've been told even in UM decisions that InterQual is proprietary and that they cannot help us with access.

MS. PARKER: It is proprietary; however, they cannot give you direct access, but they can copy, print out a copy of the criteria utilized within that decision making. So if that would be helpful. No,

they can't give you access to InterQual in and of itself, but they can make a copy of the criteria and send it to you.

MR. DAVIS: That would be beneficial. What's hard is, that criteria, I assume, would change over time as well. And being able to keep up with that, for us, is almost impossible. And we do see other states, maybe like New York, where some MCOs are providing InterQual portal access. And I'm not saying that we need to go to that expense or extreme, but we having to request it, almost is on the same issue that we have with prior authorization earlier. We're not receiving notifications of changes even though our UMs seem to reflect it.

MS. PARKER: Well, typically, changes are made in InterQual and Milliman on an annual basis. Now what type -- what part of the year I don't know. But they are -- it is contractually required that they have the most up-to-date criteria, "they" being the MCOs.

MS. MARLER: Angie -- I apologize. Angie, is there formal written guidance on

how MCOs -- sort of in the vein of what you just said, on how MCOs should respond to requests for access to the criteria so that they do -- so that there is broad understanding that official documentation should be provided?

MS. PARKER: Well, even if something is denied, then in the denial letter it should state that you may request the criteria.

MS. MARLER: And is there guidance on how MCOs must respond to that request specific to what you just said about they should copy and paste the relevant sections and release those to the provider?

MS. PARKER: Well, I don't know. To be honest with you, I'd have to look that up. I don't know if there is specific statute regarding that.

MR. DAVIS: If it help --

MS. STEARMAN: It is in the MCO contract though. So, yeah.

MR. DAVIS: It's also in 97KR 1130, I believe. It's available through website and phone call. But off the top of my head.

MS. KOENIG: And Mandy, I'm gonna drop a link. I mean, it is proprietary for InterQual, however, we do have the InterQual criteria on UHC's portal, so that can be accessed by a provider. So, I will drop in the link to our portal. That is the information that is allowed to be shared. As everybody has been indicated, it is proprietary, so that is the guidelines that are being reviewed. So, I will share that here.

DR. SCHUSTER: Thank you, Stephanie. So those are the criteria for any MCO to choose InterQual as their medical necessity definition. Those would be the criteria used in making reviews of claims, services, so forth. Correct?

MS. KOENIG: Sorry. Yeah.

DR. SCHUSTER: For medical necessity. Yeah.

MS. KOENIG: And the only caveat is, if you're not enrolled or in our network, and you need access, you're gonna have to set up the appropriate access to log in to the portal. So.

MR. DAVIS: Stephanie, that's honorable. As a provider, thank you for doing that.

MS. KOENIG: You're welcome.

MR. BALDWIN: And I think the other layer of that is, I think it was mentioned earlier that MCOs can develop their own medical necessity guidelines beyond, without limited to that, and sometimes that makes a lot of sense if there's something that's not particularly, service that's not adequately addressed in the criteria or if there's reasons. You know, it could be other reasons or clinical guidelines to add more. And I think that it kind of falls into the same area of what those are and what -- and when they change, how does the provider know?

I mean, we don't want medical necessity or other guidelines driving clinical care. We want the clinician driving clinical care, but we -- they also need to know what guidelines they are getting reviewed under, whether it's prior auth or audits. And so it's just a matter of clarity and

transparency is what we're really seeking here.

MS. PARKER: Now, I believe, and you'd have to ask -- call each MCO, but any criteria that they develop, it should be on their websites. That is not proprietary.

MR. BALDWIN: Right. Well, the other piece is the access issue that we're -- which it's inconsistent. I mean, we can see just by the chat here that we're (indistinct) inconsistency. So, and I think that's why Mandy was asking what is the -- what is DMS's guidance and expectation on that.

MS. MARLER: Right. I think that would be -- I mean, we know there's contractual language that requires this, but since we are getting inconsistent application, how might we provide further detailed guidance about how to meet that standard.

UHC posts online in a portal. Is that the standard? Is that what it means when we say post online? Does it mean we will copy relevant portions and send those upon

request? Does it mean both of those things? I just wonder if there's opportunity for us to maybe get a more detailed understanding.

MS. HENSEL: The other thing I would just highlight is whether it's Milliman or InterQual there's a high percentage of overlap between the two, right? There is not -- because it is set on evidence-based guidelines primarily by the large various medical associations and stuff represented, but the overlap is really high. So, I don't want folks to walk away from this conversation thinking that it's 100 percent different in terms of the guidelines. I don't know the exact percentage off the top of my head, but when we've looked at it in the past, it is a very high percentage of overlap. So, I think for the majority of providers practicing up-to-date, evidence-based guidelines, billing to that guideline, this becomes a non-issue.

So, recognize that it sounds like this is painful for a small few and want to make sure we're addressing around the margins

versus reinventing things that are, you know, again, at the margins.

MR. BALDWIN: Right. Yeah, we're not advocating for one or the other. We wouldn't, you know, necessarily, or good or bad. It's just a matter of accessing it.

MS. MARLER: Yeah. I don't think providers are creating -- having confusion operating within between the two, because there is such significant overlap. I think the inconsistency among what happens when they request access to the criteria is where we're getting a lot of challenge.

MS. O'CONNOR: And lack of notification of any change or updates.

MS. HENSEL: Our legal team would say, like, our legal team would say, we can't fully just like give a provider the guidelines, in part because InterQual also sells their tool to providers, right? So their business decision and the license agreements that providers sign with them, the license agreements that payers sign with them, prohibit a full sharing of those licenses. We share where we can.

To Angie's point, we absolutely share when there's a denial that comes out, to articulate specifically here was the gap between what we did not see in medical records to make this approval, so that that ongoing learning can take place, right?

Our goal is that over time there's fewer. But it is not good for a payer either to have to do the administrative work. So it is a collaborative way, but again, from a legal perspective we can't open the gates fully, because we're prohibited by the InterQual license agreements.

MS. MARLER: No, Krista, completely understood. And I think, you know, what you've just described as kind of the gold standard for what we would hope the response is when access is requested. I think my push, Angie, is, again, and then I'll drop it, is just to see if we can get some more detailed definition and explanation of operationally what it means to post that on your website or to provide it when providers request it so that we do get something consistent across the board.

MS. HENSEL: Yeah, and providers are, you know, perfectly, you know, welcome to purchase the guidelines from InterQual or Milliman as well, right? And I get that that's different in the behavioral health space, but we see in our large medical space is they built it into their EMRs and it really, they build it that way. I think, obviously, the behavioral health space is a much different provider environment in terms of technology and practice size, et cetera.

DR. SCHUSTER: Yeah. Very much so.

MR. DAVIS: If I may, on that, as provider, one last thing. And again, I also will drop it, is that that still means we are aiming utilization attempts at a -- can be or seem to be kind of a blind threshold. And I've not had experience with you, Krista, or UHC, but like I have had that experience with other MCOs. And the particular, you know, kind of instance of their expecting. I had one a while back that told me that I'm not allowed to recommend so much because they're in school. And we don't know where those criteria are

coming from, often. And that's part of the concern we have with this. And again, we do see other states that allow and pay for provider access for the full criteria. New York, I believe, being one of them, and maybe as well as Ohio. And I don't think that's full what we need, but, again, just some guidance.

MS. KOENIG: And I guess from the provider community I would offer up -- Stephanie from United Healthcare. I mean, I think all of us have a peer-to-peer review process, you know? And I think that is always an opportunity for providers. And so, if through the Utilization Management, a Med Nec review, with that submission, you know, that is part of the provider's rights to request that, you know, and I'm not saying that is the ideal solution. That is still administrative on both ends, but, you know, I think if we're still all new to the prior authorization space, thus far where we are today, that may be, you know, the opportunity to do some collaboration when we're walking through that process.

MS. O'CONNOR: Yeah, Stephanie and Krista, I really appreciate it and appreciate your willingness to contribute. I would just like to note, there are other MCOs here, and we're experiencing this across MCOs. And so, while it seems that United is -- is doing a really great job sharing these criteria and maybe have some internal policies, we are just not seeing this happen consistently, and our providers are telling us that there are changes from peers to peers and from different utilization managers that different criteria are being applied to the same services that they are requesting.

And so just any -- I think to Mandy's point, any consistency that can be applied to the expectation that the MCOs have for sharing this criteria, interpreting this criteria, and implementing it, and then provider communication from the MCOs when those changes occur, is what we are most asking for.

(Crosstalk)

MR. CHAPMAN: (indistinct) really

quick.

MR. CROWLEY: Go ahead, Jeff.

MR. CHAPMAN: Thanks, Dave. So, I went and put in the chat. We do put all of our clinical and reimbursement policies on the website, so any of those clinical policies that were specific to Passport by Molina would get posted on there. And we do try to include a reference and citations to the medical guidance that's published out there as well as the regulations if it's a reimbursement.

And then to what Krista was saying, so, we use MCG, it is, of course, proprietary, but MCQA does require us to provide any sort of denial reasons when you do receive those adverse determination letters. So, they'll give you the criteria on what wasn't meant and what would have been there, what they're looking for, and then I would say you could always use that information to go ahead and correct and resubmit a new application or modify the existing one. Whatever is easiest for you all.

But if there's any sort of question or,

I guess, like in-depth information that you're looking for, or best practices, I know one ABA provider recently sent me their like treatment plan draft that they had updated and asked if we could look at it. So, I looked at it, shared it with our ABA team, sent some feedback back to it, say, here, here's what we're looking for. That way we can both save some time, because we don't want to review it twice either. And I know you don't want to submit it twice.

But if you have specific questions, and I know Dave Crowley was on here, behavioral health related. Dave can always meet with you all. We can pull denials if you're looking at any information there. Look at examples. So, I think if there's anything that we can provide, we certainly will. And go individually through notification we'll publish a notification on our website. And then we do incorporate those into our JOC decks.

So, I will put the contact information too for our provider reps in the chat see you all have that link. But you're welcome to

request like a monthly meeting with your provider rep to see if there are any updates or just put it in the books and cancel it if you don't have any questions. But, yeah. So, I'll leave it at that. Let me know if you have any questions though.

DR. SCHUSTER: Yeah, thank you, Jeff.

Who else do we have on from the MCO world?

MS. JONES: Hi, there, this is Kat Jones. We too also have a link if you're one of our PAR providers that can't access the MCG criteria. And I'll pop that link into the chat.

And we also publish all of our reimbursement and clinical policies on our Aetna provider website. We have -- we do have Constant Contact as our provider notifications and all providers are free to sign up for those -- for those communications. Any changes to or additions to reimbursement policies or medical necessity criteria do have to be approved, as has been said by DMS. And we make those

notifications at least 30 days in advance. The notification is posted on our website. Also sent out via Constant Contact to our provider network. And also posted at that time on the provider resources page.

DR. SCHUSTER: Thanks for that, Cat.

MS. STEARMAN: Hey. This is Liz Stearman from Humana. Similar to other folks here, I've also placed our link. Humana uses MCG criteria except for Substance Use Disorder, which we use ASAM. We publish any Humana-specific guidelines, like I said, on that link. And if anything on those change, we give between a 30 and 60 sometimes a 90-day notice if we're getting, really ahead of ourselves there on any changes that might happen, and those go out to all impacted providers.

As of today, Humana has only -- uses one -- has only one additional clinical criteria policy outside of MCG and ASAM and it's for psychoeducation. So it will be retired in the next couple of months. And that website you go to will be completely blank for

behavioral health.

But again, if you have questions or concerns, give us a call. We do not currently post the portal, so if you're -- if you have questions about the MCG criteria used, there are -- there's information on the denial letters. It says exactly how you can request that. And we will print off and send a copy to you or you can just go to Aetna's site, since Cat already said they've posted the portal for MCG. So that's fantastic. And like we said, those are national standards.

To the point about, you know, them getting updated, I feel that pain too. Sometimes I'm like oh, we updated the criteria, I did not even realize that. But one of the things that we can do even if you are not -- because those are national standards that change, you know, MCOs are not necessarily going to send out -- everybody's not going to send out, oh, ASAM criteria got updated, because that is not our criteria necessarily, but you can always set those Google or I know that's a back-end way to do

that, but just trying to figure out how to get you guys more clued in on some of those things that do happen kind of in the environment that aren't specifically like managed by an MCO to MCO.

Our own criteria we absolutely notify about.

DR. SCHUSTER: Very helpful, Liz. Anybody have any questions for Liz or for Cats or for Jeff?

MR. CHAPMAN: If I may, I have one for Beth Santine's provider. I received guidance from WellCare on a national level today that CPBH 104 is the current medical necessity criteria. And, to be fair, this is one of the MCOs I've had a concern with.

Beth, could I maybe follow up with you directly on that or could you provide me with someone where I -- someone who I can, because your link indicates CPBH 500. Any advice there would be helpful. Thank you. I'm sorry to detract.

MS. SANTINE: I'm going to have you follow up with our UM manager, and you can reach out to both of us for that one.

DR. SCHUSTER: What criteria is WellCare using?

MR. DAVIS: Thank you, Beth.

MS. SANTINE: Sorry. Forgot. Sorry, I just answered his question and forgot. We use InterQual and ASAM. If there is a criteria that is not covered by one of our clinical policies, which I put the link in there for InterQual or ASAM, we would look to LOCUS or CALOCUS.

And all of our clinical guidelines are approved in advance of being posted, and there is advance notice of those.

Same with what everybody else said. We would not be able to provide advanced notice of changes or criteria that is not something we have written.

DR. SCHUSTER: Okay. Thank you. So I think we've heard from all of the MCOs. We appreciate that.

Anything else, Bart, that you or -- and I'm sorry, Mandy that I blanked on your name earlier. I had an old age brain fart, I think. But you and Shannon.

MS. MARLER: There's only 100 of

us, Sheila. How could you forget?

DR. SCHUSTER: And think how many years I've been doing this. How many names I've learned. 120. So anything else that you all want to put out here for discussion? This has been an excellent discussion. I think very helpful.

I guess I wonder if we want the reg to be updated. It would seem to be reasonable that the reg would be updated.

MR. BALDWIN: Yes.

DR. SCHUSTER: Yeah. I think we'll make a --

MR. BALDWIN: (indistinct) Clarity.

DR. SCHUSTER: Yeah. I think we'll make a recommendation to that effect. Do you all have that reg number available? I bet you do.

MS. MARLER: Shannon, put it in the chat. I'll double check.

DR. SCHUSTER: Okay. All right. So thank you --

MR. BALDWIN: Thank you.

DR. SCHUSTER: Yeah. Thanks very much.

Do you all want any follow-up on this? Do you want it on the agenda in two months?

MR. BALDWIN: You know, I think that -- I know we've gotten some words, from just kind of part of this discussion today, and a lot of kind of on-the-fly, you know, stuff in the chat, which I really appreciate the responsiveness and sharing that. But you know, maybe we can think about it as a topic in the future, just a more formal presentation on this. And really to Mandy's point, maybe from DMS about what is the -- what is the clear expectation for notification and some consistency. So, I think that that -- I think that would be a nice next follow-up and we can see where things are at that point.

But, you know, I think just the -- certainly we've captured all the links that have been shared in the chat, and we'll be getting that notification out to providers so they have access to that if they don't have it already. So, I think that's a good next step.

DR. SCHUSTER: Okay, great. Thank

you. And thank you for bringing this up.

Let's go to the status of the psycho-ed service code. Which has been -- that's H2027, which has been back and forth.

Steve, do you want to bring us up to date on this?

MR. SHANNON: Yeah. I mean, House Bill 470, you know, it was removed as that code. It was not captured in the emergency clause. That section was not included in 470. That's the peer support bill. And it did have an emergency clause. So, appreciate that.

But a communication was sent out psycho-ed would end April 10th. But then I think another communication was sent out would not end until the effective date, which is July 15th.

So, as I understand it, it's July 15th is when that's would then be -- psycho-ed would be discontinued. No longer a billable code.

MS. STALEY: That is correct.

DR. SCHUSTER: And did that communication from Commissioner Lee, which

is dated April 24th, did that go out to all behavioral health providers?

MS. STALEY: Yes.

DR. SCHUSTER: Okay. Everybody should have that. Yeah.

MR. BALDWIN: Am I correct that billed as an individual code, it is no longer accessible, but as part of an intensive outpatient program you can still -- that could be one? Do I have that correct?

MS. STALEY: It is just a service that should be incorporated into individual therapy, group therapy, family therapy, PPHP. Anywhere that a clinician would see fit. It's just not going to be a stand-alone paid for service.

MR. BALDWIN: Okay. Thanks, Sherri.

DR. SCHUSTER: Yeah. That's helpful. Because I think that's the way a lot of clinicians were using it. I mean, they were billing separately, they thought. They saw it as part of their clinical service. But, thank you, Sherri.

MS. HENSEL: There is a concern that I just want to raise to this group for an awareness perspective. We had heard rumblings in the market that some providers, probably none of which are on this call, were contemplating since it's on non-covered code, leveraging the non-covered code language to bill the receiving member patient directly for those services, which, obviously, we find very concerning that someone would want to bill a Medicaid member. So I would just, especially for those of you that are very plugged in in your local communities, if you hear of that, I think the faster we raise it up after July 15th so we can figure out a way to ensure that that does not happen. I really do not want to see Medicaid members that are going through mental health or substance use treatment to then receive a bill from a provider. So, just a courtesy heads-up and a request to help keep us posted if you see any of that happening.

MS. ALLEN: And, Krista, we have had a few reaching out in the DMS issues box

and have been able to address that accordingly. So, I'm glad that you brought that up, and we are continuing to respond in that way.

MS. HENSEL: Thank you. We're definitely making our call centers aware of how to support members through that.

DR. SCHUSTER: I appreciate that so much, Krista, because I think those of us who work with family members, for instance, and other people, that that's aware were going to hear it. And so we really need to, you know, I agree with you that I think the providers, you know, that typically come to the BH TAC and so forth are not likely to be going in that direction. But we do not want that to happen.

MS. HENSEL: Correct.

DR. SCHUSTER: And we can certainly get that word circulated that that is not appropriate and should not be tolerated, and should be -- and I guess I would ask, Jodi, should it be reported to DMS when we hear about it? Who should we be letting know about it?

MS. ALLEN: I mean, I think, definitely sending to the DMS issues box if there's something that's a concern, to start with. And then if it's something that's more of a reportable issue, then we can connect you with other areas within DMS.

DR. SCHUSTER: Okay, because I do think that we need to be on the lookout for that, and I appreciate that heads up, Krista and Jodi.

MS. KOENIG: Dr. Schuster, can I ask Jodi a question really quick in response to like what has been DMS's response back? Because, you know, in balance billing, my concern is, you know, with written consent. Not all members, really, at the time of walking into rehab or sub-residential or an inpatient mental health, they're really understanding all the information they're signing, right? And so, that's probably the concern when I think about from a member standpoint.

MS. ALLEN: No, that's a good point, yeah.

MS. KOENIG: And so, does DMS

anticipate a response? Because, again, I don't think our members, I mean, I'm not saying that this is -- I shouldn't make the general assumption, but are probably as familiar with House Bill 470 as we are.

MS. ALLEN: Oh, absolutely. Yeah. Yeah.

MS. KOENIG: You know, and so they may not understand the implications to that. So, I didn't know what DMS's response back is.

MS. ALLEN: Sure. I will say that we haven't -- I mean, I haven't seen that particular issue with what they're signing. It's just more of an inquiry about are we able to charge our Medicaid members for services that are not billable.

So, I don't know that I have a particular response unless anyone else on my team does.

DR. SCHUSTER: So you've been basically saying, as of July 15th, no?

MS. ALLEN: Correct.

MS. STALEY: Right. We have been saying we would expect that this be

incorporated into the regular therapy codes.

DR. SCHUSTER: The regular services, yeah. And not billed separately.

MS. STALEY: And not a standalone service.

DR. SCHUSTER: Yeah, I think that's a great perspective.

MS. ALLEN: I'm not sure I understood Stephanie's question.

MS. KOENIG: No, you're fine. I think you both answered the question. I think more than anything I was coming from the perspective of understanding balance billing. And many times if there's written consent, that the member understands that the provider has the ability to balance bill.

MS. ALLEN: Right.

MS. KOENIG: But many of our providers, I don't think at the time of this treatment, you know, are really thinking through all the, you know, the, you know, the documentations they're signing. And knowing, you know?

MS. DAVIS: Yes. Yes. But, yes,

that is our response, what Sherri was saying, that we expect by the date in July, that that would no longer be a standalone billed service.

DR. SCHUSTER: Yeah, and I would just point out that the Commissioner's letter says on or after July 15th. So it also includes any services on July 15th. So, sometimes we get kind of crossways about when things start, you know, after, before, that kind of thing. But it's very clear. Not on or after.

All right. Thank you very much. Let's see. We had information provided in the chat about the 1915(i) RISE SPA. So, please check that for your information.

What about reentry waiver and CHILD Waiver. Do we have some reports there, please?

DR. HOFFMANN: I think Angela's on for reentry. And for CHILD, I believe Carmen put -- oh, she's put waitlist in the chat as well. But Carmen's on for CHILD. So Angela for reentry and Carmen for CHILD.

DR. SCHUSTER: Okay, great. Thank

you.

Angela, what's goin' on? We went live, right?

MS. SPARROW: There is a lot. That's right.

DR. SCHUSTER: Bravo. Bravo.

MS. SPARROW: Good to see everyone. Again, I'll always start off and say, in terms of the projects, we couldn't do it without everyone's support on this call. So thank you all again, and thanks to all of our partners always. This has been a truly -- a team effort to get this implemented. So, we did fully implement on April 1st. We do have individuals in our Kentucky state prisons and our Youth Development Centers enrolled in their prerelease eligibility period, which, as a reminder, is 60 days prior to release.

We do have our DOC and our DJJ partners contracted with our managed care organizations.

We did deploy our systems. We are still working through some of those system changes, some of those system updates, making sure

that we are getting the information, accurate information to the managed care entities. And so in terms of those eligibility segments, what services, they're again, what kind of category of services, if you will, that the individuals fall into when those start dates are, when those end dates are, when they're releasing. That is also really driving, with our MCOs, the case management component of that. The MCOs who are providing case management inside of our state prisons. So, again, really trying to staff up.

I know they've done a great job in getting those case managers trained ahead of implementation, getting them to our locations across the state, our state prisons. So they are making in-person visits. We've had those occur. We do have communication and collaboration between DOC discharge planners, our reentry coordinators, and are MCO case managers.

We, again, have had some challenges in terms of locations, correct addresses, getting some information to the MCOs around

expected release dates, but we are working through that, and they have been very, very patient in doing so.

So we are six weeks in. It is still very green at this point in time, but we're very fortunate. Just to give you a few numbers, since April 1st, we've had over 800 individuals roll into prerelease eligibility.

What we've talked about with our partners is, what we have to remember is, a large portion of our adult population in state prisons, they are deemed eligible on their earliest expected release date, which may be a parole date. So, that individual, again, may go in front of the parole board. They may not be granted parole. There is a chance. They can or they may not.

A large number of those individuals, again, will not be released. Will not make that parole date, and will be pushed out to a later date. So, when that does occur, they will often fall outside of their prerelease eligibility period. And so, although we've had a higher number of individuals fall in that prerelease, a large number have fallen

outside of that. So, we've actually had, I think, 170, near 170 releases. So that, again, will kind of give you an idea of the volume there that do fall outside.

That is challenging. Certainly challenging for our MCOs, for our DOC partners. We are really trying to talk through, work through how we can prioritize those releases. And, again, when we know that a high volume may not fall -- who may not actually be released.

So, we are working through those. We've had, I think, over 100 individuals enroll in case management services. We have had some denied. It's been a lower volume, and kind of working through that. This is still a new program, trying to understand the program, trying to build trust, rapport.

So that, again, we are tracking and monitoring. Our MCOs, collectively, have made over 100 in-person visits to the state prisons. So, they are getting inside the walls, if you will.

Their case managers, again, are becoming more familiar. It's certainly a transition

period for all, but so that's kind of where we are today. Working through, again, some of those systems. Making sure our MCOs, our partners, have the most up-to-date information to make sure that we're able to provide services for those individuals. And then, again, follow them in the community. But overall, I know we've heard some great success stories.

Again, it is still new. We will continue to move forward. We'll continue to make improvements, but we're excited to be able to launch and be able to start making those connections.

DR. SCHUSTER: Wonderful.

And Steve, you had your TAC meeting this morning, so I guess you all were celebrating.

MR. SHANNON: Correct. We were all very excited. Good work done by Angela and her team and our MCO partners. So, we actually spent two years talking about this, right, Angela? We're now in a place where folks are getting services, which is what it's all about, really.

DR. SCHUSTER: Yeah. That's

interesting about the parole issue.

MR. SHANNON: Yeah.

DR. SCHUSTER: There may be a time when this program gets to be more known, where the parole board may see that as a positive if people are enrolled in a program like this.

MR. SHANNON: I was wondering that as well. That may be something --

DR. SCHUSTER: Obviously, we're brand-new, and I can see the issue where they might get released, so you've got to put them in as pre-release, but then when they get denied. But, you know, hopefully over time, as this program shows that it's working, and it sounds like the MCOs are doing a great job in getting people out and into the prisons to meet with the clients.

MR. SHANNON: Yeah.

DR. SCHUSTER: That's great. Thank you. That's very uplifting. Exciting.

MR. BALDWIN: Dr. Schuster, I have a quick question.

DR. SCHUSTER: Yeah.

MR. BALDWIN: Yeah, just also

echoing, it's been a long time coming. And certainly congratulations on getting this off the ground. It's really exciting and groundbreaking.

The only quick question is, is, as they're rolling out or being released, are they -- how do you know which MCO they're going to? Are they just being auto-assigned or is there a history there? Just curious, just when you were talking, Angela. I just, a thought that went up.

MS. SPARROW: You've got a good question, Bart. Like you said, there is a history there. So, again, all individuals, they're screened for Medicaid eligibility at the time that they are -- that they enter their correctional facility into the state prison. At that point in time, if they are eligible, they are suspended.

They're enrolled. So, if they've already been enrolled within MCO, they are suspended with that MCO. They do have an opportunity. It follows, again, very much the same policy. They can elect any MCO at any point in time prior to pre-release.

Excuse me.

We are trying, since it is a very short period, not to change during that pre-release period at this point in time. That they are electing that before they're eligible, just because of the time frame and the way that, again, that the process is working.

So, at this point, we are kind of monitoring that. But, yes, you are correct. If they do not select one, then they are auto-assigned.

MR. BALDWIN: Thank you. Appreciate it.

DR. SCHUSTER: All right. Thank you very much, Angie. Appreciate that. And Carmen, the CHILD Waiver, please.

MS. HANCOCK: Yes, ma'am. Hi, Dr. Schuster. And hello, everyone.

DR. SCHUSTER: Hi, Carmen.

MS. HANCOCK: Hello. Carmen Hancock, Division Director for Long Term Services and Supports with Medicaid. We did kick off our CHILD Community Health for Improved Lives and Development waiver January 1st. The total capacity of this

waiver is 100 youth. So that would be youth up to the age of 21.

At this point, we do have 51 unique applicants that have applied for the waiver. Twelve of those have been approved. We do have some active PAs out there, which is -- it's been fantastic developing that provider network, getting everyone up and running. Actually seeing services getting started. So, that is very exciting.

We do have several that are still in review. They're, you know, we've requested additional information where we have a lack of information. We've got four kiddos out there that are waiting for assessments, but again, 12 approved participants of that 51 unique applicants.

And making some good progress on providers as well. We've received 15 provider applications, and that's across all of the services that are being offered with the CHILD Waiver. And we do have a handful that are, you know, for instance, statewide case management or statewide clinical therapeutic services, so we've been really

excited about that.

Of those 15 that have applied, 10 have been certified, and we have had to deny three providers just because they either, you know, they weren't ready, they didn't have the appropriate infrastructure just yet. So, but we're moving along steadily and just very excited to actually see some -- some active PAs out there and kiddos getting services.

DR. SCHUSTER: Great. Again, that's -- that's good progress since January for a brand-new program. So, thank you. We'll keep you giving us a report every couple of months. That's helpful, Carmen.

MS. HANCOCK: Yes, ma'am.

DR. SCHUSTER: And you put the -- the waiting list information in the chat for me?

MS. HANCOCK: I can drop that in the chat for you. Yes, ma'am.

DR. SCHUSTER: Thank you.

MS. HANCOCK: Would you like for me to go through it as well or just drop it there?

DR. SCHUSTER: Just drop it there,

if you don't mind. We've got limited time and a few other things on the agenda.

MS. HANCOCK: Not a problem.

DR. SCHUSTER: I always say, I'm always optimistic that we can get through the agenda. So, thank you very much. I appreciate that.

MS. HANCOCK: Yes, ma'am, thank you.

DR. SCHUSTER: Okay. Medicaid Oversight and Advisory board. I believe, unless I've repressed it, Steve, correct me. I don't think we met in either April or May. Is that right?

MR. SHANNON: Yes. I don't think so.

DR. SCHUSTER: Yeah, that's what I thought. You know, the legislators got very busy with the session and actually we were just as happy. I think our last meeting was late in March, and we went over, again, a number of bills that were being proposed.

But the interim schedule has been set. I meant to have those dates out for you. We have a meeting every month June through

December. Most of the time it's on a late Wednesday of the month and at 1:00, but I will -- if you don't have that interim calendar -- and, of course, it changes almost daily -- I'll get those dates out to you.

There is one date which is in July, where the meeting is on a Friday at 1:00. I think it's the 17th of July. The other meetings June through December are all in -- on a Wednesday. So, we will keep you posted.

It's a little bit unclear. We do know that House Bill 2 put in a -- essentially, a Medicaid waiver waiting list that is going to be meeting under the auspices of MOAB, and I believe Steve is going to serve on that. And they're continuing to look at those issues. So, we're glad that they're taking a continued look at those issues.

Do you have anything else on MOAB, Steve?

MR. SHANNON: I don't think so. We don't really know what the next agenda's going to be.

DR. SCHUSTER: It's always a surprise. But we'll see when we get to it.

A couple bills of interest from the 2026 session. One is that, obviously, we had a budget, and the budget was not very favorable either for Medicaid or for Behavioral Health, unfortunately. They were $400 million short of what had been in the budget before for Medicaid.

There is a Medicaid lockbox that was put in for $290 million, but nobody's sure how it can be accessed or under what conditions. And so, if you count that as not really being Medicaid funding, then you're up to $691 million shortfall.

KYpolicy, if you go on their website, has a very good analysis of what all of that could mean.

We were disappointed. We had been working for over a year on funding. We have six new CCBHCs, certified community behavioral health centers, and they need funding for the last quarter, or the last half of the second year of the biennium and the amount of $12 million. And we got 2.4 million, which certainly leaves us short on that.

School mental health professionals got their usual 7.4 million, which doesn't buy what it did when it was first put in there maybe three budgets ago.

MR. SHANNON: Right.

DR. SCHUSTER: So, it's short changing them. There were no increases in, you know, any of the agencies.

VOA got some money to do some work requirement kind of help.

I think we should all be concerned about a really significant shortfall in DCBS. I think of all of the CHFS agencies. They really got hit the hardest. And they, as you all know, maintain the call line, so that's a real problem when people are calling and needing to get help. So, the budget was, again, not -- not good.

HB 2 was the revamp of Medicaid that was put out there by Ken Fleming. The version that was initially filed was very problematic, I think, for most of us, because it started co-pays and work requirements immediately upon passage of that bill. Much, much earlier than HR 1 was going to have

them.

And the co-pays were $20 a service, which, I guess, Representative Fleming thought was very reasonable. And those of us who know Medicaid families know that that's far from reasonable. So a lot, a lot of advocacy work was done, and a lot of things were changed.

The good news is that the -- all of the implementation timelines, like community engagement, the six0month redeterminations and the co-pays were moved back to align with the federal requirement. So that's a huge relief.

The prohibition on self-attestation for age, income, and residency was removed. Again, good.

A process for handling return mail was lengthened, and requires a good-faith effort to contact enrollees using more than one method.

You know, our Medicaid has been fabulous in the renewal process after the COVID suspension ended. And so, this bill was going to really limit how much contact was

around how much effort could be made to keep in touch with people.

Co-pays were reduced from $20 to $5 for services. And $1 for prescription. The federal bill actually calls for co-pays of only $1 for everything. So, I think we still have some work to do, but it certainly is better than $20.

And the data checks are still going to be a problem. We know that any time that people have to respond to something and file something and do something, it's going to be a problem.

The Cabinet is prohibited from providing Medicaid benefits that are not expressly authorized by the legislature or required by federal law. And I am not quite sure what the implications of that are, but it could be very negative.

And again, DOA received $5 million each year in the fiscal year, to establish a community engagement program.

Do you want to talk about House Bill 470, Steve?

MR. SHANNON: Yeah. That was the

peer support legislation. We already touched upon the psycho-ed piece. And the SUD, Substance Use Disorder peer supports, there's a registration process to be a registered SUD peer through the Alcohol and Drug Counselor Board, and there's also the certification process through DBH. Department for Behavioral Health, Developmental and Intellectual Disabilities.

That certification process ended December 31st. So, you had to be registered. Not everyone got registered. You know, complicated. A lot of people just didn't get there.

So what 470 did with an emergency provision for this piece of it, effective April 10th, the DBH certification process listed on TWIS is in effect through the end of this year, this calendar year. I was hoping for a bit quicker movement than April 10th. We were hoping to get this done sooner than that, but if they're on TWIS, they're up-to-date with DBH, they are now eligible, the certified folks. So, the work force crisis really, cliff that happened January 1,

we're not there now. They can go to work now. They're billable now. We'll move forward.

And it also creates a work group to figure out the next step for the SUD peers. I think an e-mail went out today if people are interested in serving on that. It is an application process. It's going to be kind of coordinated through the Department of Behavioral Health. Sorry, Department of -- yeah, Behavioral Health, and go on from there. They have to get a recommendation by November 1 about what does it look like.

There's some advocates who want to have their own peer support board. There's many licensure boards, right, Sheila? This would create a peer support board. Go on from there and see how that happens.

I think this area has been pretty confusing the last couple of years of what's eligible, what's not allowed, what's in, you know? Are you registered, are you certified?

I would hope that the board mechanism phased in over a couple of years to give people a chance to really figure out where

they're at. I would hope there's a grandfathering provision built in, so those folks, you know, aren't going through the application process again.

And I also think that there's some people who think this board ought to include community health workers, all Peer Support Specialists. Maybe case managers as well. Targeted case managers. So, we'll see how -- what that looks like, but the objective was to get people back to work as quickly as possible and, you know, ensure access to services and supports that peers are invaluable, and that those peers don't lose their job. So, right now they're back to work, but many left the field.

One provider I spoke to at CMHC lost about half of their SUD peer workforce during the intervening period.

DR. SCHUSTER: It's been a rocky road for sure.

Just very briefly, House Bill 485 did not pass on its own, but it was incorporated into Senate Bill 122 along with House Bill 418. And 485 is the revamping of KRS 202A.

I'll plan at the next meeting to go into a little more detail, because there are some changes, and many of you may have people who provide that QMHP service and the evaluation part, but it basically, we got rid of the courts overriding the evaluations of the QMHP, which is what the original bill called for.

But there is going to be more involved in the courts, and there are going to be more opportunities for the court to follow people after they get out of the hospital and also those who are deemed to have a mental illness but are not seen fit to put in the hospital. So they could -- you're going to see more referrals for assisted outpatient treatment or AOT. And I think more referrals for outpatient treatment in the community, which is not defined. So, we're going to have to figure out what that looks like.

There is some good language, I think that family members have wanted for a long time, that looks at deterioration of the individual. Psychiatric deterioration of the individual. And there are some criteria now

for what we hope to happen as a result of treatment under this statute. So, I'll plan to put that on the agenda for next meeting.

As far as new recommendations for the MAC, voting members of the MAC, I think we ought to make a recommendation that MCOs be required to send an e-mail out to all of their providers notifying them of a significant change that is also posted on their website, and include a link to those changes on their website. So that would be my motion. Is there a second for that?

MR. SHANNON: Second.

DR. SCHUSTER: Any discussion from the voting members of the TAC?

(No response.)

DR. SCHUSTER: All those in favor of making that motion, signify by saying aye. TAC MEMBERS: Aye.

DR. SCHUSTER: All right. And opposed, like sign.

(No response.)

DR. SCHUSTER: I think we also ought to recommend that the medical necessity regulation be updated to reflect

both InterQual and MCG as possible choices, since those are possible choices now. Is there a second to that?

MR. SHANNON: Second. Steve Shannon.

DR. SCHUSTER: All right. Any discussion? All those in favor, signify by saying aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: All right. We will make those two recommendations. Thank you.

MS. SANBORN: Sheila, is it possible for you all to make a recommendation around having their prior auths list current on their website?

DR. SCHUSTER: I don't have any problem with that. So, let's make another recommendation that the MCOs keep a current list of their prior authorizations on their website.

MR. SHANNON: Second.

DR. SCHUSTER: All in favor, signify by saying aye.

TAC MEMBERS: Aye.

DR. SCHUSTER: All right. Good

idea, Michelle, thank you.

Is Dr. Rob Simon on?

(No response.)

DR. SCHUSTER: He was going to join us with an issue that he had about giving kids -- difficulty in getting kids into a treatment facility in Danville where he is a supervisor. But he may not have been able to join us. I'll get back in touch with him and tell him to get in touch with, I think it's Aetna that he was having the problem with, so I will recommend that he -- would that be you, Cat, that he ought to contact?

MS. JONES: Yes, absolutely. I will put my e-mail is in the chat.

DR. SCHUSTER: Right, thank you. I will pass that along to him.

And Tammy, you wanted to bring something up in new business.

MS. COX: Yes. I'm not sure I'm in the right place, but I was directed to come to this meeting today by our credentialing professional, Ivy Livengood out of Lexington. We got a letter from Aetna stating that we were being dropped from

their network without cause.

I got a call from Abby Wilson on April the 24th that said we'd done nothing wrong, that that we are just, due to new changes and new CEO, they are dropping providers from their network.

That's concerning to us, because when our clients have to go other places, it's just not like picking your medical files up from a PCP and going. You have to start your trauma all over again. You don't just go and pick up where you left off with one therapist. You've got to go through your biopsychosocial again. You've got to go through your treatment plan again. You've got to relive all of that trauma again.

So, if we've done nothing wrong, we're just concerned for our patients, because some of them have said they will just drop services, and they've come so far. They don't want to relive the trauma, relive everything again.

DR. SCHUSTER: So, let me ask DMS, because I don't know what the answer to this is. Are MCOs allowed to drop providers?

MS. COX: It says without --

DR. SCHUSTER: When it says without cause. It says without cause?

MS. COX: Yes, ma'am.

DR. SCHUSTER: I don't know who's still on from DMS.

MS. SANBORN: Several of them jumped off, so I don't know if anybody still on or not.

MS. COX: And, Dr. Schuster, I also have another question from a provider that is leaving us because of this. And they are afraid that they won't be able to be credentialed through any other place because they were -- because they were a billing provider with us and they were -- and if they go anywhere else to be contracted or credentialed, they won't be allowed. I don't know how any of this works. That's why I was directed here.

DR. SCHUSTER: Okay. It looks like our DMS folks. Tammy, my e-mail is KYadvocacy@gmail.com.

MS. KENNEDY: Dr. Schuster, this is Corey Kennedy.

DR. SCHUSTER: Corey Kennedy, okay.

MS. KENNEDY: I'm Assistant Director in Program Integrity. The best thing I can say for them to do is to e-mail Jeremy and them's group at the e-mail that he provided to do a complaint, so we can work with the MCO and the provider to get the answers to those questions.

MS. COX: Okay. I will do that as well.

DR. SCHUSTER: You got that, right? But contact me also, Tammy, just so I can keep tabs on this and see, make sure that you get in touch with people and get some answers, okay?

MS. COX: Yes. Can anybody answer the other providers' questions that they had that the ones that are leaving, and when they go to be credentialed with another group if this will affect them from being credentialed with another group? I mean, one of our main providers is leaving.

MR. BALDWIN: Dr. Schuster, Chelsea's still on.

DR. SCHUSTER: Oh, Chelsea.

MS. AGEE: Hi. Yes, thank you. I just wanted to say, you know, obviously, Tammy, we're -- we're happy to -- to look into any inquiries that you send to our provider inquiry box. I put that e-mail address in the chat.

But I will say, anecdotally, you know, DMS does not get involved in contract arbitration between providers and the MCO. We stay out of that.

So, the only thing that we do, like from a contractual perspective when it comes to enrolling providers, is obviously looking at network adequacy, access and availability, those type of -- of areas. But the actual contracting itself, we would not be able to get involved in the arbitration of your contract. That's just not something that we -- we do.

MS. COX: So, that's just something we need to e-mail Jeremy about.

MS. AGEE: Jeremy, he is my assistant director. So I can, you know, I'm pretty confident to speak -- speak for him here. You know, we just don't -- we

don't -- that's not part of our process is getting involved in the individual contracts.

DR. SCHUSTER: But what about my question, Chelsea, which is, can MCOs just simply drop providers?

MS. AGEE: IT all depends on what's in your contract. So, that's why, you know, if there is a clause in your contract that you signed with the MCO that states that they can terminate you without cause and you signed that contract, then they do have that ability, contractually.

So, I would really encourage you to make sure, you know, when you're contracting, to really go through them with a fine-tooth comb to make sure that you're not, you know, unaware of some of the clauses and then, you know, kind of in this -- this space where you're not sure on the path forward.

MS. COX: Okay.

MS. AGEE: I don't know about -- there was an additional question, I think, about is that going to affect enrollment when they go to other groups.

MS. COX: Yes.

MS. AGEE: Again, I wouldn't be able to say for sure. It just -- it's really dependent on that contract that you have with the MCO directly.

MS. COX: Okay, so it does say in our contract that they can terminate our contract without cause. It does state that.

MS. AGEE: Okay.

MS. COX: So, does -- when it states, does that -- I'm still not understanding, I guess, if I have another provider leave our group to go to another group, that should not affect them by being credentialed under another tax ID --

KRISTA: Hi, Tammy. This is Krista at Optum. I mean, as a provider advocate, we get providers leaving practices all the time. As long as she don't have any pings or anything against her, you know, like fraud or cases or anything. If she signed in under a new tax ID, I don't think it should matter.

MS. COX: Okay. Okay. She was just worried. She was just worried

(indistinct) to ask.

KRISTA: Was it Ivy? Was is Ivy?

MS. COX: Ivy's the one that sent me to this group to try to get some clarity on what to go for.

KRISTA: Oh, okay.

MS. COX: But I have another provider that's been with us for five years, and because Aetna has pulled their contract and her clients are mostly at Aetna, she's going to leave because she doesn't want her clients to have to go through everything again.

KRISTA: Well, if she has questions on the United or Optum side, just -- Sheila can send you my e-mail and she can reach out to me directly.

MS. COX: Okay. Okay.

Dr. Schuster, I'll also keep you updated. I think I have Cat's e-mail. I wrote it down. I'm going to e-mail her to see if there's anything we can do. I mean, if we had done something wrong, I could understand it. But we were told we did nothing wrong. They were just -- just

because of a new CEO and new strategies is the reasons we were given.

DR. SCHUSTER: Okay. Yeah. Let's stay in touch, Tammy, thank you.

MS. COX: Yes, I will e-mail you as soon and I get an update on all of this. And I appreciate you guys for -- for listening and directing me on the right path to take to try to get this resolved, if we're able.

DR. SCHUSTER: I hope you can get it resolved. Thank you.

MS. COX: Thank you, Dr. Schuster. And thank you, Krista, too.

DR. SCHUSTER: Any formulary issues, because we always put that on in case there are. But since we've been on the new PBM we've not had any. So, okay.

Next MAC meeting is June the fourth. I think it's well worth your while. Those are 10:00 to noon via Zoom. You get a whole different perspective, because you get the very broad perspective, and the commissioner's always on. And, you know, they're just for attending.

Our next meeting will be July the 9th. And I need to do my civic duty and remind you all that early voting started today in most places, and the primary election is on Tuesday. And there are some very hot and contested primaries, so I encourage you all to fulfill your civic obligations and go vote.

Cameron, you had a question.

MS. REDDIX: Yes, sorry. I had a very similar question as Tammy as a behavior health provider in kind of the same region. As extending a request to contract with WellCare and being denied due to adequate provider network, expected utilization was a reason of the services we offer, and the healthcare of the population were the reasons I got. So, I didn't know if that was the same type of follow up as Tammy just now, where are contracts allowed to be denied before they're given for these reasons as well for [Inaudible] providers at-will in Kentucky, an at-will state, for contracts.

DR. SCHUSTER: But you were

applying to be a new provider under WellCare. Is that right? You don't have a contract with them.

MS. REDDIX: Yes.

DR. SCHUSTER: So, your question is, and if we've still got DMS people on, that an MCO actually can pick and choose among providers if they are already meeting medical necessity or adequacy of network, I assume. I guess that's the question.

MS. REDDIX: Yeah.

DR. SCHUSTER: Because they're saying they don't need you. They've already got an adequate network, right?

MS. REDDIX: Adequate providers, anticipated enrollment, expected utilization of services, and the healthcare needs of the population were the reasons given. And the number of network providers, of course, which is a common one, and geographic location. But as a rural healthcare center, I just, I didn't see.

So I provided some data and some feedback in my follow-up, and then really received no response. Requested a phone call

and haven't received any response.

DR. SCHUSTER: Where are you located, Cameron?

MS. REDDIX: Somerset, Kentucky.

DR. SCHUSTER: Yeah, well, I sure here about, you know, more services needed down there.

MS. REDDIX: Yeah.

DR. SCHUSTER: Which is what you're saying, right?

MS. REDDIX: Yeah. Of course. So, I just kind of wanted to request a follow-up phone call, answered e-mail, or if that's even allowed, I'd understand. But, yeah.

DR. SCHUSTER: I would, you know, I'd send a question to that e-mail that was --

KRISTA: Yeah, and Cameron, you might want to just, just as a provider advocate, you might want to try to find out on their website who the provider advocate is and ask them if they can get you, you know, more information. You don't have to be a provider with them just to e-mail them and find out.

MS. REDDIX: Yeah. Because I was in constant communication with a girl named Melanie Pool. I'm not sure if that's a -- I think that is actually a contract negotiator network development.

KRISTA: Okay.

DR. SCHUSTER: Yeah, but that's a good suggestion, Krista, to look for their provider advocate.

KRISTA: Yeah, sometimes they can, you know, they can get with the network contract team to find out if maybe they had already met the adequacy for that area.

DR. SCHUSTER: Right.

MS. REDDIX: And I mean, I've credentialed multiple providers. I do that on the side. And so, giving this as a reason is usually the next process is the appeal and all of that. So, I'm familiar with the process.

KRISTA: And it might be temporary too. You said they had a new CEO? I mean, maybe they're just kind of making some changes.

MS. REDDIX: That's a different.

That was -- that was Aetna.

KRISTA: Okay.

DR. SCHUSTER: Yeah. Let me go to Sydney, because we're running -- we're over our time. Sydney, you had a question?

MS. AYERS: Painted Grove and Cedar Grove Recovery and we're a residential substance use. I had a question that hasn't been addressed, as far as I know, that's come up real recently in our facilities.

We are getting some patients who have dual coverage with Medicare and Medicaid, and we've been getting mixed information from the MCOs on whether or not they'll even process those claims even if we do get auths, because we're nonparticipating with Medicare. Is there any guidance on that officially anywhere?

DR. SCHUSTER: I'm sorry, I'm kind of chuckling because Steve Shannon and I have fought this dual eligible issue for all the years we've been together, which is about 30 years that we've been fighting this. It never has made any sense to me that you have people that have coverage by

two insurers and they gets less access to services. Where are you located, Sydney?

MS. AYERS: (muffled speaking)

DR. SCHUSTER: I'm sorry?

MS. AYERS: Louisville.

DR. SCHUSTER: Louisville. Okay. I don't know. Steve, what's the best way to even find out some of these questions? I mean, we've worked with the MCOs, Herb Ellis, at Humana's been great about how you even bill.

MS. AYERS: Yeah.

DR. SCHUSTER: Medicare is not going to send you something that says they denied the service, because they don't deny it because they don't offer it. I mean, this is what we run into all the time. So there's supposedly a bypass list.

MS. AYERS: Yes. We found that.

MR. SHANNON: Right. But you're not a Medicare provider.

MS. AYERS: We are not, but we do take Medicaid.

MR. SHANNON: Right. So the bypass list probably isn't applicable.

KRISTA: Yeah. It seems like you could submit that to submit a claim to Medicare, get a denial, and then send that over.

MS. AYERS: We can't submit to Medicare because we're nonparticipating.

KRISTA: But wouldn't they send you something and still say you're not a provider, you're out of network? Okay.

MS. AYERS: No. They just completely reject the claim.

KRISTA: Okay. Well.

DR. SCHUSTER: I think we've always been dealing with providers that are both Medicaid and Medicare.

MR. SHANNON: Right.

DR. SCHUSTER: But even so, it's been an incredible hassle.

MR. SHANNON: Herb Ellis, are you still on?

(No response.)

MR. SHANNON: I guess not.

MS. STEARMAN: No, I believe he dropped since we're supposed to be wrapped at 4:00.

MS. GRAHAM: Yeah.

DR. SCHUSTER: I'm sure.

KRISTA: Did you do an appeal on it? I know I don't work for that company, I'm just trying to think of --

MS. AYERS: It's been really inconsistent, honestly. Sometimes we get the claims hit, and sometimes we don't. We almost always get the authorizations, it's just whether the claim will pay or not is inconsistent. And I was kind of hoping for some direction on what is supposed to happen, because --

KRISTA: Have you reached out to their provider advocate?

MS. AYERS: I just did today and I've not heard back yet.

KRISTA: Oh, okay.

DR. SCHUSTER: Yeah.

MS. AYERS: I just didn't know if there were any rules as far as Medicaid themselves were concerned or anything like that.

DR. SCHUSTER: What do you think, Steve? I can't even think of anybody at

Medicaid who would actually is the person to go to.

KRISTA: Could she not use the bypass codes? Isn't there bypass codes?

DR. SCHUSTER: She's not a Medicare provider.

MR. SHANNON: So she's not bypassing.

MS. AGEE: This is Chelsea from DMS. I wonder if this would be a question for our TPL branch, because they help with coordination of benefit questions quite often, and so I can take this back to that branch to see if they have any insight on to what you might be able to do. Sydney, do you mind to put maybe your e-mail --

MS. AYERS: Yeah.

MS. AGEE: -- in the chat for me, and I will make sure that you get follow up.

MS. AYERS: Thank you.

DR. SCHUSTER: Thank you, Chelsea.

MS. AGEE: You're very welcome.

DR. SCHUSTER: What is the TPL branch?

MS. AGEE: Third party liability.

MR. SHANNON: Third party.

DR. SCHUSTER: Third party liability.

MS. AGEE: Yeah, they help with coordination of benefits with when there's different payers and stuff, and so they may help.

DR. SCHUSTER: That sounds like the place to go. Thank you so much. That's very helpful.

MS. AGEE: Yeah. No problem.

DR. SCHUSTER: Thank you, Sydney.

MR. SHANNON: And Sydney, I'll try to reach out and get an answer from somebody maybe.

MS. AYERS: I appreciate that. Thank you.

DR. SCHUSTER: Steve is very good at getting answers too. And Herb Ellis may still be somebody that can give us some information. He's the one that did all the --.

MS. STEARMAN: I was going to say, I just pinged Herb, but that question is incoming, and we're going to need a response. So he's -- he's working on it.

Yeah.

MS. AYERS: Thank you.

DR. SCHUSTER: Yeah. All right. Well, we are going to let you all go. And I appreciate everybody being on.

If you want to send me an e-mail, Sydney, just to keep me in the loop so that you get an answer, it's KYadvocacy@gmail.com.

MS. AYERS: Okay, thank you. I will do that.

DR. SCHUSTER: Yeah. I'm happy to kind of make sure that communication.

This has been a very productive meeting, and we appreciate you all. And hope you have a good Memorial Day weekend and so forth, and we'll see you in hopefully June 4th for the MAC meeting and then July 9th for the BH TAC. Thanks very much and we will adjourn at this point.

And thank you, Danni, for keeping us on track, somewhat. It's not your fault that we ran over. I didn't mean that. Thank you.

(Proceedings concluded)

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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 5th day of June, 2026.

Theresa Prokop

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Theresa Prokop, Certified Voicewriter