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

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Via Videoconference
November 13, 2025
Commencing at 2 p.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

BOARD MEMBERS:

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

MS. WASH: Good, good. I'm still clearing the waiting room. Should I give it another minute or so?

DR. SCHUSTER: Yeah. Yes, please do.

MS. WASH: Okay, I will.

DR. SCHUSTER: Thank you very much.

MS. WASH: The only one I do not see yet is TJ Litafik.

DR. SCHUSTER: Okay.

MS. WASH: Everybody else is here, though, and you do have that one vacancy.

DR. SCHUSTER: Yes, and I think we may have some movement on that soon. Hopefully when we start meeting in 2026, we'll have that slot filled. And are we right at -- we've got another minute according to my phone.

MS. WASH: Yes, we have one more minute to go, and I'll let you know if TJ gets on.

DR. SCHUSTER: All right, thank you.

MS. WASH: Okay, mm-hmm.

DR. SCHUSTER: All right, I think the magic 2 o'clock hour has struck, so we'll go on and call the meeting to order. This is

the Behavioral Health Technical Advisory Committee, known affectionately as the BH TAC. So this is where they tell you to get off the plane if you're not going where we're going. So I hope you all are on the right meeting, and we're happy to have you all.

So let me ask the voting members of the TAC to introduce themselves. Valerie, I see you first.

MS. MUDD: I'm Valerie Mudd. I'm with Participation Station and NAMI Lexington, and I'm here to represent --

(inadvertent interruption)

MS. MUDD: Are we okay?

DR. SCHUSTER: Yeah.

MS. MUDD: I'm here to represent folks who live with mental illness like myself.

DR. SCHUSTER: Thank you very much. And I see Tara next.

MS. HYDE: Hi, everyone. Tara Hyde with People Advocating Recovery.

DR. SCHUSTER: Great. Thank you. And Steve Shannon.

MR. SHANNON: Steve Shannon with the KARP Association mental health centers. Glad to be here.

DR. SCHUSTER: Great. And Misty?

MS. AGNE: Misty Agne representing U of L Health, Frazier Rehab Institute, and the Brain Injury Alliance of Kentucky.

DR. SCHUSTER: Thank you very much. And I think we're still waiting for TJ Litafik from NAMI Kentucky to join.

MR. LITAFIK: I'm on, Sheila.

DR. SCHUSTER: Oh, there you are. Go ahead, TJ. Hello.

MR. LITAFIK: TJ Litafik representing NAMI Kentucky.

DR. SCHUSTER: All right, thank you so much. And I should have introduced myself. I sometimes go by Nicola Foreman, so if you see me sign-on under that name, that's my pseudonym. Sheila Schuster, executive director of the Kentucky Mental Health Coalition and a licensed psychologist. Great.

So I was very late getting the minutes of our September meeting out to the

voting members, but I would entertain a motion from one of our voting members to approve the minutes.

MR. SHANNON: So moved.

(inadvertent interruption)

DR. SCHUSTER: Somebody is not muted. Tim, are you muted? Somebody is saying "bulldog, bulldog," and I don't think we have anybody by that name on, so if you would mute if you're not speaking, thank you. Let me go back --

MR. MOORE: Thanks, Sheila.

DR. SCHUSTER: Yeah? Did you want to say something? Okay, you've muted, Tim. Thank you.

All right. I'm back to the motion to approve the minutes.

MS. MUDD: So moved.

DR. SCHUSTER: Val, thank you. And a second, please?

MR. SHANNON: Steve Shannon. Second.

DR. SCHUSTER: Thank you very much. Any additions, omissions, corrections?

(no response)

DR. SCHUSTER: If not, I'll entertain

a vote to approve the minutes as distributed.

(Aye).

DR. SCHUSTER: All right. And opposition?

(no response)

DR. SCHUSTER: And abstentions?

(no response)

DR. SCHUSTER: And we will post those minutes for you all who don't get those.

Barbara, can you post the meeting dates, please, for 2026?

MS. WASH: Okay.

DR. SCHUSTER: We're going to stay with our second Thursday of the month, starting in January. So we'll just go 2 to 4 each time. You know, for a while there, we were going 1 to 3 if we weren't in session. It just gets too confusing, so hopefully you have January, March, May, July, September, and November already set aside. And those are the dates: January 22nd, March 12th, May 14th, July -- what is that -- 9th, September 10th, and November 12th. So if you all would mark

those in your calendar. We don't have the MAC meeting dates yet, but they will be moving to a different month, so we'll have a little bit more time between. Our BH TAC meeting will be in alternating months for the MAC. They will be meeting in February, April, so forth and so on, and into December. And I don't have those dates yet. Thank you very much, Barbara.

MS. WASH: Okay.

DR. SCHUSTER: Let's go back to our agenda. Any updates on the resumption of prior authorizations for Medicaid behavioral health services?

DR. HOFFMANN: This is Leslie. Angie Parker should be on.

DR. SCHUSTER: Oh, thank you, Leslie.

MS. PARKER: Sorry, yes. I have not heard of any issues, so my question is if -- have you all run into any additional challenges with the resumption of the prior authorization?

DR. SCHUSTER: That's a great question, and I'll open it up for anyone who's on to share with us anything. I think

the one that I remember, the bypass list for those who are -- have dual coverage with Medicaid and Medicare was creating a problem before. I'd love to hear from people if that is still creating a problem.

(no response)

DR. SCHUSTER: Wow.

MR. SHANNON: This is Steve Shannon. We've had some problems on our monthly calls with that bypass list. We've also -- I mean, the centers haven't been able to get a copy of it, I think that would help. We were told, you know, "we'd try to get that," and that didn't happen, some more updated list, kind of confusing. But overall, that's not been the big issue, and really, the centers have done fairly well with the PA process after the first maybe eight to ten weeks. So if it was July, by Labor Day, October, that there weren't nearly as many concerns expressed about that process. There's still some communication, some drop-offs between using the clearinghouse, but overall, I think that process is moving forward, and there's still some concerns

have always persisted with prior-auth and response back from MCOs. When do those responses come if there's questions? Sometimes they --

DR. SCHUSTER: Is that a time delay, Steve, in getting a response back from the MCO?

MR. SHANNON: Well, quite often they'll call with questions, and sometimes those calls happen after hours and weekends, and we're not staffing the utilization management function for after hours and weekends. Unless it's like, you know, they call back to the crisis unit that's necessarily a residential model, but routine prior-auth for outpatient services, targeted case management, sometimes those calls come back after hours from the MCOs.

DR. SCHUSTER: And then you all don't get them until either the next day or the next Monday?

MR. SHANNON: Correct. The next morning, yeah. Yeah.

DR. SCHUSTER: Yeah. Okay. I would ask the MCOs to pay attention to that. And,

you know, obviously, if this is an emergency kind of thing, then, you know, for a hospitalization or whatever, that's a different story.

Michelle, I see you have your hand up.

MS. SANBORN: Yeah, we had some problems early on with timing, and that some of the MCOs weren't responding to the urgent -- the urgency, and they were taking five days or even longer. Several of MCOs had indicated that they have five days for all referral -- or PAs, but since then, Medicaid, Angie and folks have helped us to get some information to the MCOs and they're following the urgent response, the 24-hour, you know, PA, and then the 5-day like they should be based on what I've seen lately. So thank you.

MS. PARKER: I'm glad to hear that's cleared up some. There may still have some issues here and there, but like I said, I haven't heard anything, but by all means, if you have continued issues, feel free to reach out.

DR. SCHUSTER: Yeah. And I see in the chat, Taylor, are you on? Do you want to just say this about continued delays and determinations from Passport, even when it's urgent?

(no response)

DR. SCHUSTER: Taylor Tolle with Isaiah House?

MS. TOLLE: Can you hear me?

DR. SCHUSTER: Yeah.

MS. TOLLE: Okay, yes, we are still considering -- continuing to see delays in determinations with Passport. We've had two conversations with them in regards to the delay in their responses, and we have expressed the urgency on the cases that we are asking for updates on. I did speak with them the first time and was told that it was because they were doing services based on reviewing regulations, and that was the reason for the delay. And then they switched over to actually reviewing for medical necessity, but we continued to see a delay in the determinations, even when they were marked as urgent. I just had a meeting

with them again on Monday and was told that there is a plan in place to get caught up, but we still continue to see the delay as of today for services.

DR. SCHUSTER: Okay.

MR. CROWLEY: Hi, Taylor.

MS. TOLLE: Hi.

MR. CROWLEY: Hi, Dr. Schuster, this is David Crowley, BH director with Passport.

DR. SCHUSTER: Yes. Yeah.

MR. CROWLEY: Yeah, Taylor, I will get in touch with you after the meeting maybe, or tomorrow. I'll put my email address in the chat there, and feel free to reach out, and we'll touch base about that.

MS. TOLLE: Yeah, absolutely. I think I've been in communication with Anna Page --

MR. CROWLEY: Yeah.

MS. TOLLE: -- and Kim Pierce the -- most recently, so I can definitely include you on those as well.

MR. CROWLEY: Thank you.

DR. SCHUSTER: That would be helpful, David. Thank you very much.

MR. CROWLEY: No problem.

MS. TOLLE: Yes, thank you.

DR. SCHUSTER: Because I do think that the distinction between the urgent and the kind of regular ones -- and someone from Yonder Behavioral Health is having the same issue with 9 to 14 days before approvals come back. Is that including -- well, 9 to 14 days is long as -- is longer than it should be for any PAs.

MS. TOLLE: Yes, Dr. Schuster, we also at Isaiah House are seeing that. I have had cases that were requested from October 20th that I did not get a response on until this past Monday the 10th.

MS. PARKER: I just have a question. Did they ask for additional information or was this based -- did the time period --

MS. TOLLE: They did not.

MS. PARKER: -- start at the time in which you requested the authorization?

MS. TOLLE: They did not. I was advised that it was due to the backlog in the cases that they have been reviewing. I was told that they initially, before they

were released to review all of the prior authorizations, that they were seeing 300 cases a day, and then once the resumption of the prior-auths happened, they were seeing a total of around 3,000 a day. So they just weren't prepared for the influx of requests that they would be receiving.

MS. PARKER: And it -- and it's -- that's just Passport, correct?

MS. TOLLE: Yes, that's the response that I received from leadership at Passport.

MS. PARKER: Okay. So it sounds like David will address this. And Yonder Behavioral Health, is that Passport also?

DR. SCHUSTER: That's Michelle Maupin. Michelle at Yonder BH?

MR. SHANNON: Yes.

MR. CROWLEY: Okay.

DR. SCHUSTER: Those delays are with --

MS. MAUPIN: Yes, that is Passport as well.

DR. SCHUSTER: Okay.

MR. CROWLEY: Yeah, Michelle, my email address is in the chat there, and

we'll get connected as well.

MS. MAUPIN: Absolutely. Thank you, sir.

MR. CROWLEY: No problem, thank you.

DR. KELLEY: And hi, this is Dr. Kelley. Just quickly, are that -- is that for all the levels of care or (audio breaking up) levels of care?

MS. TOLLE: Yes, that is -- yes, for Isaiah House, it's residential 3.5, 3.1, PHP, IOP, and also for our EPSS psychoeducation requests.

DR. KELLEY: Okay, thank you.

MS. TOLLE: Mm-hmm.

MS. MAUPIN: Yonder it's just 3.5, 3.1.

DR. KELLEY: Thank you.

DR. SCHUSTER: So Dr. Kelley or David, can you give us a little bit of background about --

MR. CROWLEY: Sure, Dr. Schuster.

DR. SCHUSTER: -- why you all were so backed up?

MR. CROWLEY: Absolutely, yeah. Not to oversimplify things, but the significant

increase in volume at the beginning of this month that most TCM requests or the three month off span -- so at the end of -- in October and November, all of those initial TCM requests, we tried to space them out, but the backlog just kept coming in for those continued reviews for, in particular, TCM and peer support and psychosocial rehab. We're continuing to update our staffing models and hired eight additional clinicians to address the issue. So we're hoping to -- to get that resolved.

DR. KELLEY: And (audio breaking up) people coming in to have a -- plus, for TCM, you should not be getting denials at this point in time.

DR. SCHUSTER: Sorry, you were breaking up a little bit, Dr. Kelley, can you say that again?

DR. KELLEY: I'm sorry. I was just saying we have authorization to hire -- just basically what David said. I don't know if you can hear me okay or not, but there should be about 16 more folks coming in to help out, or 16 total. So -- and in the

meantime, there's -- TCM should not be being denied, but I'm happy to also -- with folks to sit with when you connect with David, I'm happy to be there also.

DR. SCHUSTER: Thank you, we would appreciate that because I think -- and I'm glad to hear that TCM is not being denied. I guess the concern is that what's been authorized runs out, and then you need a new authorization, right?

MR. SHANNON: Right.

DR. KELLEY: Correct. So the -- there should be no denial going forward at least through January with TCM until we have full staffing.

DR. SCHUSTER: Okay. All right, well, it's really --

DR. KELLEY: And if it does happen, I would ask folks to reach out to David or I right away.

DR. SCHUSTER: Okay. Are you willing to put your email address in the chat, Dr. Kelley?

DR. KELLEY: Sure. Yes, absolutely.

DR. SCHUSTER: All right, thank you.

DR. KELLEY: Thank you.

DR. SCHUSTER: So, yes, we appreciate that, and I think, you know, the whole idea is to get care to people, you know, when they need it, and so we've always been concerned about prior-auths delaying care. And I appreciate Medicaid weighing in and also being helpful on this --

MR. SHANNON: Yeah.

DR. SCHUSTER: -- but I know that Passport will -- if you're hiring a bunch of new people and so forth, that's very helpful as well. And I think --

MR. SHANNON: And Sheila?

DR. SCHUSTER: Yeah.

MR. SHANNON: Ken Burke with VOA indicated they're having the same issue.

DR. SCHUSTER: Yeah, I was just going to say that VOA is in the chat also with those -- with 3.5, 3.1, and IOP. So, you know, apparently until things get kind of straightened out with new staff, I suggest that you reach out directly to David Crowley and to Dr. Kelley. And we will keep this on as a regular agenda item until we, you know,

are sure that we're caught up. Anybody else before we move on to another?

DR. HARPOOL: I have something, Sheila.

DR. SCHUSTER: Yeah.

DR. HARPOOL: This is Dr. Harpool out of -- from Hope and Healing in Madisonville, Kentucky. Two things actually that pertain to the prior authorizations, and both of these happened just within the past week. So when I turn in a prior authorization, sometimes the -- if they want -- the MCO wants additional information, they'll fax something back to my office, and they say that they must have that by the close of business that day or it's going to be denied. And that just seems like not much time --

DR. SCHUSTER: Hmm.

DR. HARPOOL: -- to react to that. I mean, I could get that at, you know, 2 in the afternoon, and by the close of business that day, I'm supposed to have something else into them. So it would be nice if there was a little bit more notice or time

given to provide them with whatever additional information that they need.

The second thing --

DR. SCHUSTER: Well, hold on. Hold on one second, Rita. Let me ask Angie Parker, is that even cricket? I mean, can they do that, Angie?

MS. PARKER: I was just thinking, I was -- I pulled up the regulation, and it doesn't really address that, but I would agree that that does not give the provider enough time to provide additional information.

DR. SCHUSTER: Well, and --

MS. PARKER: The MCOs can ask for additional information --

DR. SCHUSTER: Right.

MS. PARKER: -- if they need it, but a decision -- and they can delay the -- I mean, if they -- if it's nonurgent, five days, they have five days to make a decision, but if they need additional information, I would just go back to that MCO and tell them "I need more time."

DR. SCHUSTER: Yeah.

MS. PARKER: I don't know that that is --

DR. SCHUSTER: It really seems unreasonable --

MS. PARKER: Yes.

DR. SCHUSTER: -- and, you know, a lot of -- again, one of our problems with PAs is that it takes the clinician offline to answer those questions. That's not something that can be delegated to, you know, a staff person just with a rogue kind of response. And if you've got people either in smaller practices or you've got really busy clinicians that are booked back-to-back-to-back-to-back, it's not going to happen that day. And I'm -- I, for one, am going to go to war over this. If you get a denial because you didn't respond within 24 hours, I really do want to know about it and I want Angie to know about it. Because I don't think that's in the spirit of prior-auths, and it's not something --

MS. PARKER: Dr. Harpool, was this just one MCO that you were dealing with that did this?

DR. HARPOOL: Yes, it's only been -- and I couldn't tell you the name of it off the top of my head, I have to go look, but it was one -- one that -- and it just happened this past week, and it just so happened I am a small -- I do have a small practice, and I would was very sick, actually, for two days and was off work. But yeah, the paperwork, it actually says, they put it in writing, that if they did not have the information by the close of business that day it would be denied, so -- and it was denied.

DR. SCHUSTER: Angie, why don't you put your email in the chat, if you would, and ask Dr. Harpool to forward that to you.

MS. PARKER: Sure.

DR. SCHUSTER: Is that all right, Dr. Harpool? You'll be willing to do that?

DR. HARPOOL: Yes, that's fine.

MS. AGEE: Good afternoon. Hi, I just wanted to interject really quick. I had put a chat -- this is Chelsea Agee with Contract Monitoring Branch, DMS. I put our -- the Contract Monitoring Branch mailbox in

the chat, Rita. If you would like to send that example, you can include Angie as well, but just send that example to that email address, include us on there --

DR. HARPOOL: Okay.

MS. AGEE: -- and we can do a little bit of research along with Angie to determine what's going on with that.

DR. HARPOOL: Okay. The second issue, which I have never run into this, I've never even heard of this, and I was shocked, to say the least, so I don't know if this is standard or something, but this did involve WellCare and a prior authorization that I had submitted for TRP services. And they called me, asked me some questions about it, which I have to say, the information was in my notes that I provided to them. And they -- the woman told me that it was not going to be approved, and so I could withdraw -- well, she said she didn't think it was going to be approved, she was going to have to take it to her supervisor, that's what it was. She was going to take it to her supervisor, she didn't believe it

was going to be approved, so I could withdraw it, or, if I did not withdraw it and she took it to her supervisor and it did not get approved, then I would not be able to submit another authorization on this client for 90 days for TRP.

DR. SCHUSTER: Is that allowable, Angie?

MS. PARKER: Not to my knowledge.

DR. SCHUSTER: Yeah, that's just outrageous. I'm sorry.

DR. HARPOOL: I asked her -- I asked her, I said -- I said, "I'm sorry," I said, "I've never heard of that." I said, "Is that a Medicaid stipulation," which I knew it wasn't, but -- and -- and she said, "No, not necessarily Medicaid. It's just WellCare, that's just our policy." And I said, "Well, that's concerning." I said, "I don't know why that would ever be -- I mean, what if this patient, you know, becomes suicidal, ends up in a hospital, gets discharged, I can't provide TRP to her for 90 days?" And that was what she told me, so.

DR. SCHUSTER: I think that needs to go both to Angie and to that provider MCO inquiry email.

MS. SANTINE: Yeah, Rita, this is Beth Santine. I'll put my email in if you want to email me about that case.

DR. HARPOOL: Okay.

DR. SCHUSTER: And Beth, who are you with?

MS. SANTINE: WellCare.

DR. SCHUSTER: Okay. I'm sorry, I didn't recognize your name. Yeah, I would appreciate that because that's -- and I see Susan Turner says that "That kind of thing happens with TCM as well. If it's denied, you can't request again for 90 days."

MR. SHANNON: It doesn't make any sense.

DR. SCHUSTER: It doesn't make any sense is right.

MR. SHANNON: I mean, things change if nothing else.

DR. SCHUSTER: So Susan, I would suggest that if you've got something in writing or you can document where that was

told to you on the phone or something and who it was told to you by, I would also send that over to Angie and to the provider MCO inquiry.

All right, thank you very much, Rita, for bringing those up. We appreciate it.

DR. HARPOOL: All right.

DR. SCHUSTER: And we will, again, keep this on. Angie, if you research these things and have anything that you can send me that is suitable for distribution to the group before we meet again, because we're not going to meet again until January --

MS. PARKER: Okay.

DR. SCHUSTER: -- I would appreciate that.

MS. PARKER: I will elicit Chelsea Agee's branch assistance in this as well.

DR. SCHUSTER: Good. Yeah, let's -- let's get that --

MS. PARKER: They keep track of any issues like this.

DR. SCHUSTER: Yeah. Yeah, we need to keep track of that. Excellent.

All right, anything else anybody

wants to bring up about PAs?

(no response)

DR. SCHUSTER: All right. I thank you all very much. It's important that we get these things and we appreciate, always, the assistance of DMS and the responsiveness of the MCOs if there's some mistake here.

I don't know -- Kelly Lloyd, I don't know who you're with. You're saying in the chat, "All WellCare reviewers tell our staff you can't request again for 90 days if there's a denial, even if it's a clerical wrong issue that was submitted early on as they were trying to learn the process of each MCO and the PA process." So Kelly, are you on? Kelly Lloyd?

MS. LLOYD: Yes, ma'am, I'm on. I'm sorry, I was on mute. So yes --

DR. SCHUSTER: Yeah, who were -- who are you with? Who are you with?

MS. LLOYD: I'm with Intrust Healthcare Counseling Services --

DR. SCHUSTER: Okay.

MS. LLOYD: -- and we work in the same area and region and closely with Susan,

so I just wanted to reiterate what she was saying. So early on, several of the viewers -- or reviewers with WellCare would tell our staff as well that, you know, because you've got to think each -- we were having to train each of our case managers with all the MCOs and the different things each of them were requesting, the time frame required, and all of that type stuff, and them to flip that switch and learn how to do it all --

DR. SCHUSTER: Right.

MS. LLOYD: -- as of 7/1, so it was quite a challenge. And so, as you can imagine, making sure you were doing the correct thing with each MCO for every single client on your caseload to get a prior authorization was quite a challenge. And so we have been told that over and over as well that even if there was, like, a missing piece, you know, like some of them require SMI SED checklist, or, you know, different things that, you know, the other MCOs don't require that, you know, they had X amount of hours to submit in, and if they didn't, the case would be denied, and then they would

not be able to resubmit for 90 days.

DR. SCHUSTER: All right. If you've got anything in writing that you can send, or just to write up that and send it --

MS. LLOYD: I don't, ma'am. It was just all things that were being verbally told over and over by the reviewers to our case managers as they were trying to call in, again, to get PAs on every client and to make sure that they were doing adequately what they needed to on --

DR. SCHUSTER: Right, right.

MS. LLOYD: -- you know, like I said, every client on their caseload was having to -- they were having to go through that on, and some we weren't able to do requests on until that 7/1 date. So -- but it was just all verbal told by multiple reviewers to many -- and we're a larger agency, so, you know, it was told to our case management directors when they would try to call in and try to help lead our case managers in making sure we kind of created a cheat sheet per MCO for all of our CMs of what was required based on the MCO what they were exactly

looking for, all of that kind of good stuff --

DR. SCHUSTER: Right.

MS. LLOYD: -- you know, to give them something to go by. So we were trying administratively to do what we could, but still, as you can imagine, every client on our caseload needing a PA for 7/1 was quite a challenge.

DR. SCHUSTER: Yeah.

MS. LLOYD: But -- so these were all verbal conversations, and nothing would come back.

DR. SCHUSTER: Okay. What I would suggest is that you write a note to that effect and send it in an email to Angie Parker and to Chelsea Agee over at the provider MCO inquiry.

MS. LLOYD: Absolutely, I will do it, ma'am.

DR. SCHUSTER: We're trying to cut the MCOs some slack in terms of, you know, this getting started --

MS. LLOYD: Oh, for sure, right.

DR. SCHUSTER: -- but I think the

providers should be cut some slack, too.

MS. LLOYD: Oh, exactly. Right, and we totally get it, like, it should just go both ways, you know, and --

DR. SCHUSTER: Right. Yeah.

MS. PARKER: So I just want to be clear, the 90-day is just WellCare?

MS. LLOYD: That's the only one, and I want others to speak to that. That's the only one that we've been told that over and over and over again about, you know, if they do have a denial --

MS. PARKER: Okay.

MS. LLOYD: -- even if it's like for a clerical issue, you know, again, like a piece of -- like if they require, like, an SMI SED checklist and, you know, like something like that. Or something wasn't signed off on -- it was signed off on the clinician, but not a person approved in -- like, it was just different things, but it was nothing to do with their clinical need, it was only to do with a clerical -- and I call that "clerical issue," meaning if something wasn't --

MS. PARKER: Right.

MS. LLOYD: -- you know, attached in addition to the treatment plan or whatever, you know, that they might require on that individual. That's the only one that we've heard that consistently back over and over from, but --

DR. SCHUSTER: Yeah.

MS. LLOYD: -- WellCare is our primary MCO, second is Aetna, and so -- third, Passport. And again, you know, we --

MS. PARKER: Okay.

MS. LLOYD: -- have a fairly large caseload, but that is only one that I can tell you with 100 percent certainty that -- because we have MCO calls with our administrative team and our clinicians on a weekly basis just to keep everything flowing and rolling, and us try to keep everything organized and doing what they --

DR. SCHUSTER: Right.

MS. LLOYD: -- so WellCare is who I can consistently tell you we've heard that from.

DR. SCHUSTER: Thank you. And let me

ask, Zachary Cornett says, "same thing with Key Assets Kentucky." Is that with just one MCO, Zachary?

MR. CORNETT: Again, so as previously mentioned, the delays in approval and denial was with Passport. I will give Passport some credit, that is definitely, at least for us, the exception, not the rule, but that has happened several times. The delays in resubmission was with WellCare around the 90 days. We were trained -- and I was just trying to look through my notes in case anybody asks, I cannot remember which MCO trained us this way, but when we initially restarted prior authorization, it was told us in one of the trainings, and I'll get that information in my notes, that the risk that we take by submitting, say, six months of targeted case management instead of three months, is that that that client would then become ineligible at that organization for six months for a resubmission. So I thought that was obviously outrageous, so I wrote that down. I'll have to go and see which MCO that was with, so it didn't really

surprise me when WellCare was saying 90 days. Definitely, I would also need to look at which MCO is requiring same-day submission, but we have run into that very frequently, where they're asking for additional information, faxes that are coming in at 2 or 3 p.m., and they have to --

DR. SCHUSTER: Yeah.

MR. CORNETT: -- have the information submitted by 5 p.m.

DR. SCHUSTER: Yeah. Again, anything you've got in writing with that is very helpful to DMS, both to Angie, and I'm sure to Chelsea as well, but would really like for you to go back and see. I mean, it sounds like a threat to me when somebody says, "don't go submitting" --

MR. SHANNON: Sheila, this is Steve Shannon.

DR. SCHUSTER: Yeah.

MR. SHANNON: Can we hear from WellCare? I mean, is this their policy?

MS. SANTINE: Hi, I spoke up and said if you could send me some examples, I can

look into that. This is Beth.

MR. SHANNON: Okay. It seems pervasive, though. There's several people reporting this.

DR. SCHUSTER: Yeah. I guess the question, Beth, is, you know, what is the policy at WellCare?

MS. SANTINE: I'm going to have to look into that. I don't want to -- I don't want to, like, assume based on, you know, these, that this is why these actually got denied.

MS. LLOYD: Beth, I think you could probably call in, and -- like, to one of your representatives, and because I've done this myself as the vice president of our company, just to see what I would hear, you know, to make sure, okay, like, how can I guide my staff and my team, or from administrative level on down? I think if you called in as "Beth," and not as "Beth Santine with WellCare," and just ask a question to a reviewer about that you had a question on XYZ, I think you would be told consistently across the board by many

reviewers the exact -- the 90-day rule. Like, it's not just one reviewer saying this, it's multiple across the board. So I would -- to me, that would be a helpful way of doing it.

MR. SHANNON: Yeah, there's two pieces I'm hearing: denial, and then must wait 90 days. So, I mean --

MS. LLOYD: Yeah --

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

MS. LLOYD: -- the length -- that they're denied and ineligible for 90 days --

MR. SHANNON: Yeah.

MS. LLOYD: -- basically is what we've been told.

MR. SHANNON: Well, that's not necessarily -- these are good examples of that. Is that just the WellCare policy, if there's a denial of some service, you must wait 90 days?

MS. SANTINE: And I'm going to have to check into it. And I will, and get back --

DR. SCHUSTER: All right, so we will --

MS. LLOYD: And I'm speaking on case management only, just FYI. Case management only for Kelly with Intrust.

MS. SANTINE: Okay.

MS. LLOYD: And Zachary asked him -- you were probably talking about -- I'll let you speak on your behalf if it was for targeted case management only for WellCare.

MR. CORNETT: Yes, thank you, Kelly. It was for Key Assets, targeted case management only.

DR. SCHUSTER: Well, I have to say that we've had an ongoing issue with WellCare that dates back 10 years --

MR. SHANNON: Ten years.

DR. SCHUSTER: -- talking about targeted case management.

MR. SHANNON: Yeah.

DR. SCHUSTER: And we got data from DMS, actually, to demonstrate that targeted case management is a critical service for people with SMI, and that was under Commissioner Lisa Lee's direction, and we have that study. And I just -- it sounds like that's not been communicated across the

WellCare leadership, so let's get to the bottom of this because that -- if it's WellCare --

MS. SANTINE: I'm sorry --

DR. SCHUSTER: -- and it's going to be about targeted case management, then we've been down this road and had this fight before.

MS. SANTINE: Well, can I -- you just mentioned a nine-year issue, and I think that's separate from this resuming a prior-auth issue, so if you could let me know about the nine-year issue separately --

DR. SCHUSTER: Well, it was about the WellCare representative for years and years and years, at every BH TAC meeting said, "We're not going to keep doing prior -- we're not going to keep approving targeted case management, period."

MR. SHANNON: It's a three-month service. We were told it's a three-month service.

DR. SCHUSTER: And it's a three-month service that somebody should get for three months, and that's the end of it, was

basically the policy that was articulated.

MS. SANTINE: So I'm not sure who that person was or how long ago that was. That's certainly -- you know, each individual case would be looked at. It wouldn't be --

MR. BALDWIN: Okay.

MS. SANTINE: -- you know, medical necessity is considered each time a request comes out.

MR. SHANNON: It was -- I mean, the person who gave the message was Lori Gordon, who's long been gone --

MS. SANTINE: Who's long gone.

MR. SHANNON: -- but I remember there -- but there was a WellCare case management seminar series going back probably the same time frame, that clearly delineated three months was sufficient time to get people connected to the community, and that was the point of targeted case management is connect them to the services, and then they don't need those supports anymore. And we went back and forth many times, Beth, about the SMI population, the

three months to get connected doesn't maintain connections. And I remember there was someone out of Tampa who did this presentation trying to convince us all, three months was sufficient. And then we did the Medicaid data study, and that came back from Medicaid data that there was a cost savings associated with it.

But again, this issue is not just the denial or approval of a prior authorization for targeted case management. It's the ineligibility to receive the service for 90 days, which really penalizes the individual, the WellCare member, not the provider. I mean, the provider's penalized as well, but that individual can't access targeted case management for 90 days. And I appreciate you looking into it, but the way this message is giving, it seems like someone at WellCare directed the folks reviewing prior authorizations to relay this 90-day message. And that's what I'm hearing, and maybe I'm misunderstanding what people are saying, I don't want to speak for them. But it's --

MS. SANTINE: And that's why I want

to investigate it because there's a lot of times, I hear things, and then, you know, we go back and listen to the recording for calls, and we -- you know, I want to investigate this.

DR. SCHUSTER: All right.

MR. SHANNON: Yeah.

DR. HARPOOL: And it's not -- it's not just --

MS. SANTINE: And I can't speak for the past nine years.

DR. HARPOOL: It's --

MR. SHANNON: No, we're not talking nine years. We're not talking -- that was an example, Beth, of targeted case management being an issue with behavioral health providers and WellCare historically. We're not going back to debate the nine years ago. We're just saying this is reoccurring now, and we appreciate you looking into it, but it sure seems like, based on the number of people who reported this, and it's three, four, five different providers with the same message. It seems like, to me, there's a policy --

DR. SCHUSTER: Yeah.

MR. SHANNON: -- written or unwritten. And we've heard it from several people today, so.

DR. SCHUSTER: Yeah, we appreciate --

DR. HARPOOL: And in my case, it was the -- I'm about 95 percent sure it was the TRP that that prior-auth that I was told that about, but I will double check if it -- because case management and TRP -- I'm pretty sure it was the TRP PA that WellCare --

MR. SHANNON: Okay.

DR. HARPOOL: -- gave me the 90-day ultimatum on.

DR. SCHUSTER: Yeah, that would be helpful because I see Ramona Johnson asked if it was happening with TRP as well, so again, we will have this on our January -- and Beth, we appreciate you looking into it. And Steve's right, I was not saying that you're responsible for nine years of this. I'm just saying that this has been an issue with WellCare around at least targeted case management, for sure, for a lot of years,

and it leads me to ask the question if that's a policy decision on WellCare's part. That's the question, and you're going to look into that, so we appreciate that.

Let's move on to our next favorite topic, which is a follow-up on audits conducted by the MCOs. Do we have somebody on from DMS, please?

MS. AGEE: Good afternoon. This is Chelsea with DMS. I don't have any particular updates, general updates, to give on this, but just opening, you know, up for feedback if there are any issues that my team and I need to look into, we're happy to do that.

DR. SCHUSTER: Great. Thank you, Chelsea, and welcome to the BH TAC. Does anybody have any issues about audits?

MR. SHANNON: I have heard from some CMHCs that the prepayment audits have increased since the prior authorizations have been required. And I don't have specific data, but -- and I don't have it by MCO, but just their sense is there's more prepayment audits taking place than there

were before, and, you know, naïvely, I think many of us believed that the prior-auths would decrease the audits, both prepayment and post -- and, you know, overall audits. But that's just, again, what's been reported to me by the CMHCs.

MS. AGEE: Yeah, thank you for sharing that, Steve, and I'm happy -- you know, if there's CMHCs who have any particular, you know, issues that they want to bring up with their MCO -- I will just say about prepayment review, so for prepayment review, part of the MCO process is that they have to submit a prepayment review request to DMS that is vetted through our Program Integrity Division and through the Contract Monitoring Branch. And so those prepayment reviews are, you know, approved by DMS before they go into effect for the MCO and that particular provider. If you're finding instances -- I mean, you should receive an official letter that outlines the prepayment review, that outlines why they're doing the prepayment review, how you can be removed from

prepayment review, and then it should also provide contact information to the MCO so that you can reach out directly to discuss that particular review request. If you're finding that you're not receiving notices and that you're just beginning to get recoupments, or, you know, something of that nature, by all means, we would be happy to work with you and the MCO to determine if they're -- you know, if that was preapproved by DMS, and if not, obviously, the CMB, you know, my branch, we would want to correct that with the MCO if we're seeing that that's in practice happening.

MR. SHANNON: Thank you. I'll share that message with the -- on our next call with the CMHCs. I have not been told, but I'll check if they have received any formal communication.

MS. AGEE: Yes, they should. You should always receive --

MR. SHANNON: I just didn't think to ask that, Chelsea.

MS. AGEE: Yeah, you should always receive a formal communication from the MCO

prior to that prepayment review taking effect. So anytime you're not seeing that, we would definitely, in my branch, want that reported to us.

MR. SHANNON: All right --

DR. SCHUSTER: Yeah.

MR. SHANNON: -- I'll pass that on.

DR. SCHUSTER: Yeah, that's very helpful, Chelsea. Thank you.

MR. SHANNON: Yeah.

MS. AGEE: You're very welcome.

DR. SCHUSTER: Zachary, you're on and saying you've also seen an increase in prepayment reviews. Do you -- do you remember, Zach, whether you got a notification that that was going to happen?

MR. CORNETT: So when I say, "prepayment review," we receive a letter of explanation with which clients and which service date range with a 30-day requirement to submit records, which you're able to do, but that has been massively increased than what we've seen in the past. I mean, it's really one to two clients per week, but we were not receiving that volume at all in the

past.

DR. SCHUSTER: Huh.

MS. AGEE: Zach, this is Chelsea again, if you want to connect with me and my team, I put my team's email -- it's our shared inbox in the chat, I'm happy to look at -- if you have some examples you want to provide on notices, you know, happy to look into that and see what we can find out.

MR. CORNETT: Yeah, that'd be great. Thanks, Chelsea.

MS. AGEE: Yeah, of course.

MR. BALDWIN: Dr. Schuster?

DR. SCHUSTER: Yeah?

MR. BALDWIN: Just real quick, I won't go into detail for the sake of time, but just want to let Chelsea know that I've heard just this week from a provider that's a member of our Kentucky Health Resource Alliance group, some major issues with audit -- with an audit, again, of recoupments over non-clinical issues and creating actually new requirements that we couldn't find where that requirement was. So -- but I took note of your email in the

chat, Chelsea, and so we'll be following up with you with more details on that.

MS. AGEE: Okay. Thank you so much, Bart. I appreciate that.

MR. BALDWIN: Yeah.

DR. SCHUSTER: Yeah, that sounds like the way to go. Thank you for putting it in there, Chelsea. And yeah, you've put it in there again, or Erin put it in. Anybody else with any questions about audits?

(no response)

DR. SCHUSTER: I always figure that no news is good news if we don't have a bunch. Going once --

MR. MARTIN: Hey Sheila, this is Barry.

DR. SCHUSTER: Yeah. Hi, Barry.

MR. MARTIN: I have somebody texting me trying to get into the lobby -- or get out of the room, waiting room --

DR. SCHUSTER: Oh, okay.

MR. MARTIN: -- on the call.

DR. SCHUSTER: Barbara?

MS. WASH: Okay, I was just double checking --

MR. MARTIN: Sorry.

MS. WASH: -- there's nothing -- it just says "unavailable." I did not know whether or not --

MR. MARTIN: Hmm.

MS. WASH: -- someone was trying to get -- what that name was, but I will let them in.

MR. MARTIN: Oh, okay. Thank you.

DR. SCHUSTER: Thank you.

MS. WASH: I get worried about that AI trying to access our meetings.

DR. SCHUSTER: Yeah. Well, we have somebody joining by --

MR. MARTIN: Well, if you let them in, you can always just say, "Somebody just came on board, can you state your name," just to be sure. By the way, his name is Greg Burke.

MS. WASH: Greg Burke, okay.

MR. MARTIN: I'll tell you who he is.

MS. WASH: Okay, that'll work.

MR. MARTIN: He's in.

MS. WASH: Okay, good deal.

MR. MARTIN: Thank you.

MS. WASH: You're welcome.

DR. SCHUSTER: Yeah. Thanks, Barry. And I think, Barbara, that Karyn Haskell from the Alcohol and Drug Counselors Board is going to be joining us by phone. We're going to try to have that peer support discussion at 3 o'clock because that's when she was available. So you might -- if you get a phone call from somebody --

MS. WASH: Okay.

DR. SCHUSTER: -- I think that's probably Karyn Haskell. Thank you.

Anything else on audits?

(no response)

DR. SCHUSTER: All right. Let me talk just briefly about the -- and Steve, please hop in -- about the Medicaid advisory and oversight -- Oversight and Advisory Board, the MOAB. There have been three meetings since we last met as a BH TAC.

So on October 7th, we did an update on the Certified Community Behavioral Health Centers, the CCBHCs, and that was done by Jennifer Willis at Pathways, Daney Amrine at NorthKey, Liz McKune at Seven Counties, and

Dana Royse at New Vista, and it was very well received. We wanted the MOAB, who has responsibility of taking responsibility for doing some oversight, obviously, and advising of Medicaid, wanted them to be aware of that model and how well it was working in those four areas of the state, and the possibility of some who are going through the credentialing process now, hopefully to be certified, so it was a very robust discussion. I thought it was very helpful, and they were -- heard back from the cochairs that they were pleased to have heard about the CCBHCs.

There also, that same day, was a presentation, it was a little bit disjointed, about the NEMT, the non-emergency medical transportation. So there was a broker who kind of told the story from the broker's perspective, and then Adam Mather, who was formally the Inspector General in the Cabinet is now the President of the Kentucky Association of Health Care Facilities. Those are the nursing homes, basically, the for-profit

nursing homes, and he, you know, talked about some of the problems that they have in arranging transportation and getting the brokers to respond and so forth. And I believe that one of the comments made during the public comment period was also about non-emergency transportation.

The tenor of the legislators on that MOAB is really to kind of look under every nook and cranny to see if there's any money that can be saved on Medicaid, and so there were a lot of questions of the broker in terms of how the broker was paid, and how the subcontractors were paid, and if there was any overage and that kind of thing. I think mostly what we hear about NEMT are complaints from Medicaid recipients who have a difficulty and have all kinds of problems in arranging for that transportation, and there have been some proposals put out there, although MOAB didn't ask for those, about different ways of doing that, you know, maybe changing the broker system and so forth.

There also was a very interesting

kind of tête-à-tête between the legislators and the MOAB and Secretary Stack and Commissioner Lee because they wanted to discuss certain Medicaid-related regs that are currently in process, and Secretary Stack resisted doing that because they are in process and technically you're not supposed to be making comments as the issuing agency because these were all Medicaid regulations. And there was a little bit of tension at that point, but they resolved it by saying that they would talk about the reg process the next -- at the next meeting rather than individual regs. So it was not out and out warfare. Do you want to add anything about that meeting, Steve?

MR. SHANNON: No, I think that's it. You know, a lot of discussion back and forth about the reg process, but.

DR. SCHUSTER: Yes, right.

So the next meeting, which was October 22nd, was kind of a bombshell. They had the auditor and the general counsel from the auditor's office talking about the

special examination they did of the Medicaid program over the four years -- I guess part of it or a lot of it was during the COVID period, and they found hundreds of millions of dollars that were paid out to the MCOs by Medicaid for people who actually were residing in other states and were not eligible to be covered by Medicaid. And there was some -- I think some interesting questions and back and forth, the process of verifying where somebody lives --

MR. SHANNON: Mm-hmm.

DR. SCHUSTER: -- and whether they are eligible or not seems pretty remote. The feds have lots of controls that make it very difficult, I think, to do that. And it also was not clear to me, you know, what role the MCOs play, and, you know, they typically verify eligibility of people, so I'm not real sure. What'd you take from it, Steve?

MR. SHANNON: It looks like there's a lot of people who are on Kentucky Medicaid and other state Medicaid. I think there's one example, supposedly, somebody was on

eight different state Medicaid programs. And the focus was on those folks are receiving a capitated payment, the MCOs are, you know, a number of them are. And no criticism of the MCO, or -- you know, it's just how can we better identify those folks who are on multiple state Medicaid programs? And it was clearly safe that if someone leaves Kentucky, goes to a bordering state, they probably don't notify Kentucky Medicaid, and clearly, they probably don't know to notify Kentucky, you know --

DR. SCHUSTER: Right.

MR. SHANNON: -- things have changed. So I think that was part of the message, how can we -- and there's a federal database that may be more useful. I think it's -- there's several ones, PARIS. I forget the acronym, what PARIS stands for, but it is -- is that a way to identify -- so I think it was -- figure was $800 million total, but that wasn't all necessarily Kentucky dollars. But that was the focus of that presentation.

DR. SCHUSTER: Right. And then we

had some interesting presentations on Medicaid reimbursement rates, and Bart Baldwin presented on behavioral health and he's going to share that with us after we have the discussion about peer support specialists. Stephen Robertson, who's the executive director of the Kentucky Dental Association, had some interesting data, and, you know, there's been a ton of talk about the lack of dental providers in Medicaid. It's been talked about at the MAC, I think, almost every meeting that I've ever gone to of the MAC. And, you know, they raised the dental rates once upon a time for children but not for adults, and I think you have fewer and fewer dental providers.

And then Myers and Stauffer was there and gave a very short presentation about how the rates are set. Of course, as Bart pointed out, the rates -- you know, we get a fee schedule for behavioral health rates, but then that's not what gets paid to the providers of behavioral health, so there's certainly a chasm there.

And then they had the discussion of

the regulations, they called it "for informational review." And Wes Duke, the General Counsel for the Cabinet was there with Secretary Stack, and it was, you know, very cordial. I mean, basically, these were regs that made pretty small changes in I think several of them were about PT and related services. And so there was no great -- I think from the legislatures' point of view, no great "Oh, well, you know, we shouldn't have this regulation because it's going to cost us more money."

MR. SHANNON: Right.

DR. SCHUSTER: So that was that meeting.

And then the meeting that we just had yesterday -- it seems like 100 years ago -- yesterday morning, Dr. Stack and Dr. Langefeld, who's the Commissioner of the Department for Public Health, gave a brief overview of the Rural Health Transformation Fund Proposal that Kentucky sent in. And one of those areas is behavioral health, and they are looking to replicate the EmPATH model that's being done at Eastern State

Hospital by UK in several locations in more rural Kentucky.

There is also a chronic disease focus on obesity and diabetes. There's a focus on the maternal health deserts, which there are many in Eastern Kentucky, and it's not just maternal health, but also the pregnancy and, you know, the year before and the year after a child is born, looking at the health of the newborn.

There were, you know, some criticisms. Senator Meredith was, I think he said, "bitterly disappointed" that it wasn't doing enough to save the rural hospitals. And Secretary Stack had made it very clear that the -- even though it was called a "rural health bailout fund" by many in Congress, the CMS rules made it very clear that you couldn't use the money to provide direct services for one thing, and they wanted you to use lots of technology and do something that was transformational. They only had six weeks to write this thing, which is pretty amazing, but they did get it in on time, and so we'll see. The decisions

won't be made until December 31st, and Dr. Stack pointed out that unlike most grants where you get it and you have, you know, the goals of the grant and so forth, they will be monitored each year about whether they have met certain deliverables, certain goals that they've set, and if they have not, some or all of that money, which could be as much as $100 million, could be clawed back --

MR. SHANNON: Right.

DR. SCHUSTER: -- which is a little bit scary. And he said that, you know, you have to be -- you want to be transformational, but you can't do pie-in-the-sky kinds of things --

MR. SHANNON: Yeah.

DR. SCHUSTER: -- that you can't indicate that you --

MR. SHANNON: But, Sheila, Senator Meredith did not -- he said, you know, "My frustration is not directed at the Cabinet --

DR. SCHUSTER: Right.

MR. SHANNON: -- or the work being

done by the Cabinet. It's not addressing the issue at the CMS level, not the Cabinet level in Kentucky," so.

DR. SCHUSTER: Yes, that's true. Yeah, it's a good point. And I think Senator Carroll, who also is rural, you know, had some similar kinds of comments.

And then there was a presentation by the Kentucky Association of Health Plans, Tom Stevens, the president, and Katherine North, the vice president for external affairs on the MCO delivery model in Kentucky. And Dr. Patel, the chief medical officer at WellCare, was there, and I would say that the panelists got grilled by the members of MOAB, by the legislators, and by some of us other members about a number of things. I raised some concerns that I have had for some time about network adequacy, and there was a reference in their presentation that they were using secret shopper approaches to verify network adequacy, and -- but couldn't answer any questions about who's actually doing those and where the results of them are posted. I

do think secret shopper kinds of approaches have some merit, but if we never hear what the outcomes of those studies are, or those interview periods with the secret shopper, then we really don't know whether you have a ghost network or you have people that are not taking -- Senator Carroll, in particular, articulated his concern that the MCOs are not good partners with the providers, and I think Senator Meredith and Senator Berg also commented along those lines.

Representative Moser asked some questions about the process for doing audits and some of those kinds of things. Steve, you asked for some data, which I thought was excellent. Do you want to tell people what you asked for?

MR. SHANNON: Yeah, there was a lot of comments about the increased cost associated with behavioral health spend. And one comment I made was, you know, they kind of group behavioral health as a single entity. They don't do that with physical health as a single entity, and I just asked

for data about a breakdown by the increase -- by that cost increase they referenced by type of service. You know, let's differentiate, you know, not identify providers, but just see what it looks like going forward so we can really understand where the increase in behavioral health spend takes place.

I was told, one, and they presented this, I think, back in their last session, behavioral health spend over a 3-year period increased by 22 percent. You know, at some point, I'd like to see, did the number of people with the primary diagnosis that fall under behavioral health increase by 22 percent. Was there a specific service that increased that drove that 22 percent? And from a big picture perspective, if the behavioral health spend is 10 percent of the total pot, a 22 percent increase is 2.2 percent. It goes from 10 percent to 12.2 percent of spend. You know, so I think just kind of understanding what the data really is, and not just this kind of across the board -- and they use the phrase

"broadbrush approach," it's an increase of, help us understand what that increase really looks like. And until you really know that detail, it's really hard to understand and have a good dialogue around why is the behavioral health spend increased -- increasing, and an increase in behavioral health spend isn't necessarily a bad thing. It may be --

DR. SCHUSTER: Right. Right.

MR. SHANNON: -- a very legitimate reason.

Obviously, we've had, you know, the number of overdose deaths have decreased, but still 1,400 people died of a substance abuse overdose, opiate overdose in the last reporting period, last whatever year it was, '24, I guess. It's still 1,400 people, you know? So is that part of the increased cost is more focused on addressing the subsidy of the opioid crisis? I don't know. But I just think it'd be good, as opposed to just making these statements and just kind of letting them hang out there, let's understand more about that data and what it

looks like.

DR. SCHUSTER: Yeah.

MR. SHANNON: And we were told that they'd provide that, right, Sheila?

DR. SCHUSTER: Yes. Yeah, there are lots of times when -- and not just in this panel, but there are lots of times when there are questions from MOAB to whoever's presenting, and they always say, "We'll get that to you," and I'm never quite sure whether we ever see it again, but I'm sure you'll stay on top of that, Steve.

Let me wrap this up by saying that there's a very important MOAB meeting that has not been on the schedule, was just recently scheduled, and it is on Wednesday, December the 10th. It's at 11 a.m., and that's the meeting where we're going to discuss recommendations, so I'm glad that there are some recommendations coming, hopefully for the 2026 session. We have not been privy to what they are or what the discussion is about, but we have been told that it's going to be a longer meeting and we're going to have a lunch break, so

they're apparently considering going longer than just the two hours that we've been meeting. So that may be an important meeting for you all to watch on YouTube or KCET or to be there for. So that's December the 10th at 11.

So Barb, we're going to hold off on your presentation until we have this discussion about the credentialing of peer support specialists. So Karyn Haskell, have you joined us?

MR. SHANNON: Yes.

DR. SCHUSTER: Yes? Great. And Phyllis Millspaugh from DBH?

MS. MILLSPAUGH: Yes, I'm here.

DR. SCHUSTER: Yes. And Sherry Staley couldn't be on, and I'm sorry, I've forgotten who's going to be --

DR. HOFFMANN: This is Leslie. We've got Angela Sparrow and Jonathan.

DR. SCHUSTER: Right. Okay, great. So we had quite a lengthy discussion last time, and I know you all have been continuing to meet to try to work through some of these issues. So I don't know who

wants to go first and kind of bring us up to date about where you are in your discussions.

MS. MILLSPAUGH: I can start us off.

DR. SCHUSTER: Great.

MS. MILLSPAUGH: I would say that we, our department, Medicaid, and the Board of Alcohol and Drug Counselors, are continuing to work really closely together to identify ways that we can mitigate 505 and the impact that it's having on peer support services. I think, just to remind folks, that this is primarily a legislative issue. You know, 505 was a bill that we're talking about that none of the agencies that are discussing this today were involved in creating; however, legislators are currently expressing a good bit of interest on pursuing some statutory revisions that would reduce those barriers to service delivery, while ensuring that quality and effective supervision of peer support specialists is occurring. They are the best way to make substantive changes to what currently exists, and it's obviously problematic to

the field.

So, I mean, I think that's the summary of where we are. We are continuing to meet. There's a lot of ideas being floated in terms of what our department, the Behavioral Health and Developmental Intellectual Disabilities, is doing.

You know, moving forward beyond 505, I think we've shared before that we are currently in the process of revising the three peer support regulations that currently exist under our department. That's adult, youth, and family peer support, and modernizing that system through a really comprehensive overhaul of those regulations and the credentialing process. I think the revised regulations, which we'll see probably after the session, really do strengthen those quality standards, it clarifies supervision, it really enhances the ethical requirements that may have been missing in some cases, and aligns the training and certification with SAMHSA's national model standards. We've worked very hard to align ourselves with as much of the

Board of Alcohol and Drug Counselor's standards are for the registered alcohol and drug peer support specialists, so that was done with that intention in mind to make sure that there was some equivalency, or at least as much as possible. So I think that will create some update -- those updates will create some consistency across those peer support categories, and it's going to improve the verification of applicants, the accountability of those individuals, and a better way to track workforce. So together, I think these efforts position our department to oversee a more transparent, credible, and sustainable peer support system statewide.

So that's a little bit of what we're doing, you know, currently, which as I mentioned, is still in discussion. And then moving forward, you know, we've been working on improving those regulations as much as we can. I'm going to let my colleagues talk about pieces that they want to add to that conversation. I will say that our conversations have been very positive. I

feel like we're collaborating really well. It's -- we haven't gotten to an outcome just yet, but that's still a conversation that is ongoing and of great interest to most everybody here in the room, I'm sure. And so I'll let them speak to any additions that they'd like to add to that conversation.

DR. SCHUSTER: Thank you, Phyllis. Karyn, you want to weigh in from the board's perspective?

MS. HASCAL: Yes. So I want to echo what Phyllis said about the collaboration that's going on across agencies. It's been really encouraging that we're all looking for a solution to the challenges that we all see in this.

In the meantime, the board continues to do its work to credential peer support specialists, and we've added about 530 to our rolls in the last 6 weeks. So, you know, that's kind of all we can do about that, but we do it as fast as we possibly can, which is not really fast. But we're hopeful that, with the Cabinet for Health and Family Services, we will get to what, as

Phyllis said, is a reasonable path forward for a solid workforce and an accountable workforce that is where the scope of work is clearly defined, and folks are held accountable and are able to access this work so that we can continue to serve our clients.

DR. SCHUSTER: Yeah, Karyn, have you had any discussions with legislators about changes to 505 or what the reg -- the statute is now?

MS. HASCAL: I have not. I was invited to a meeting that I wasn't able to attend. The Public Protection Cabinet is really extremely cautious about meeting with legislators, and they basically kept our hands tied in the short term until we, you know, get permission from them to have a conversation. We were invited to speak before a committee that Representative Flannery is the chair of, and that was canceled, so that would have been our only direct opportunity.

DR. SCHUSTER: So you've not been able to talk with, say, Representative Moser

about any changes --

MS. HASCAL: No.

DR. SCHUSTER: -- that you're looking at?

MS. HASCAL: No. No. As I said, I was invited to a meeting that I wasn't able to attend.

MS. MUDD: Sheila, I have a question. So do you foresee that substance use folks who are doing peer support, do you foresee that they become CADCs?

MS. HASCAL: Well, that certainly is a part of a career ladder. It's a bit of a challenge because they're two totally separate buckets of work. So while peer supports are providing advocacy, coaching, mentoring, that sort of thing, CADCs are doing clinical work, and our regulations require that one have supervision as a peer support specialist or a clinician. So it would be difficult for people to do it at the same time. What they can do is get some work experience time under their belt as a peer support specialist, and then decide to go down a clinical road, if that's what

they're interested in, and some folks are doing that. We have some folks who are transferring over to clinical work. The challenge is doing both at the same time is not really practical.

DR. SCHUSTER: Okay. Thank you, Karyn. Let's hear from DMS at this point about where -- because I think there's some questions about billing and so forth also. Is that you, Angie?

DR. HOFFMANN: Angela, yeah.

DR. SCHUSTER: Angela, I'm sorry.

DR. HOFFMANN: Angela Sparrow. That's okay.

MS. SPARROW: You're good. So again, I think we currently, DMS, you know, does have a mechanism to reimburse for the registered peer supports. We have for quite some time, so that is -- you know, that is an option. We, again, still currently have the mechanism to reimburse for the certified peer supports, so again, just to echo what Phyllis and Karyn had mentioned, you know, the work that all partners are doing to improve the services, and, you know, the

scope of work for the peer supports, again, we know that that is something that is taking time and does take time to do. And so we know that all providers and partners, again, are working towards that, so I think in the discussions is looking at options, you know, for potentially to have an extension on that timeline for those providers and for those individuals to be registered, and for, again, you know, with working with within the AODEs.

Again, we currently have the mechanism to continue to reimburse for those certified as we continue to move forward and in those individuals becoming registered. So again, you know, if we have that mechanism to continue that forward, past January or not, is part of the discussion there.

DR. SCHUSTER: Right. I got an email from Liz McKune from Seven Counties. Are you on, Liz?

DR. MCKUNE: Yes.

DR. SCHUSTER: Okay. Do you want to go over -- because your questions, I think,

are very pertinent, and they're along the lines of what others have raised as well.

DR. MCKUNE: Yes, thank you. And thank you for all the work that's gone into this. We recognize how greatly important the peer support services are to helping people sustain and maintain the recovery.

One of the questions that we were curious about was the -- was for the peer supports that are working with youth and families who have substance use disorder. On the frequently asked questions list that was provided by DMS through TRIS, it states that individuals would not need to have the registration to deliver those services, but we have received clarification from the Alcohol and Drug Counsel Board that you do. So we are just trying to navigate and be as best prepared as we could and wanted to seek clarification in regards to will those peer supports working with youth and families need to be registered?

That's one question. Do you want me to go on to a second one, or?

DR. SCHUSTER: Well, let's see if we

got an answer to that one.

MS. SPARROW: And Liz, apologies, did you say for those youth and family that it was specific to substance use, are they working in our AODE licensed facilities?

DR. MCKUNE: I don't know if it would be a license -- yes, it would be a licensed -- I was thinking residential when you said the word "facilities," but yes, they are AODE sites.

MS. SPARROW: Okay. I think we would have to take that back --

DR. MCKUNE: Okay.

MS. SPARROW: -- because you're correct, the language there in the bill, we'll need to look at that and do a follow-up, unless others on the call --

MS. MILLSPAUGH: I think it has to do mostly with the, you know, the setting in which they work is kind of where we have been trying to make some of those decisions, but -- and as everybody in the room knows, it's pretty gray. We've been trying to parse this information out in pieces for some time now, and have tried to provide the

best answers that we can, but we recognize that there's a lot of ways to look at and interpret 505 and how it needs to be implemented, which I think is what causes, you know, the number of questions that we've had. They're all really great questions, and they have a different impact for everyone here.

So I think the best way for us to respond to that is to try to come together again, the three agencies, to get some consolidated response so we can be consistent. And so as Angela said, I think we should probably talk a little bit more about it and try to offer some more clarity on that moving forward. So we can do that.

DR. SCHUSTER: Yeah, I think --

DR. MCKUNE: Thank you.

DR. SCHUSTER: I think you had suggested, Liz, that there was kind of a -- I think Alcohol and Drug Counselor Board had said that the age does not matter, so it's not a matter of whether, you know, it's the youth peer support specialist or one dealing with the family. And I guess their response

was any peer support specialist working with an individual regarding substance use disorders must have the RAD issued by the ADC. So if we're --

DR. MCKUNE: Right, and --

DR. SCHUSTER: -- picking up on that deadline and that gets to be -- I mean, that deadline is very firm, 1/1/26.

MS. HASCAL: This is Karyn. I can weigh in on that. We only have one peer support category, if you will. We don't have peer supports broken down for youth, family, or even co-occurring. Ours is much more narrow. And the response was really about whether or not the individual is working in a BHSO or an AODE, because it's our understanding of 505 that if you are working in an AODE or a BHSO, that you have to be credentialed under the ADC board. The ADC board does not have peer support credentials for youth or family categories. We only -- we have temporary and registered.

And that's part of the challenges with implementing 505 because it -- we're not talking about apples and apples; it's

apples and oranges. And Phyllis and other partners and I have had multiple discussions about how we try to sort through these things, and this just brings up another one of those challenges.

DR. MCKUNE: Yes, I think for those of us in Community Mental Health Centers that are also Certified Community Behavioral Health Clinics, we all have our AODE, and so if we are working with someone and they are co-occurring, while that may not have been how the relationship started, they end up working with someone who also has SUD. We find ourselves caught in between, so just trying to seek clarification so that we can be compliant with whatever the directive is.

And then the second question, and may not be as relevant, if there is an opportunity to extend while people are certified and navigating that process, I appreciate the volume. I've served on a license board. I understand, you know, the level of work that's likely gone into a volunteer position when you have been reviewing hundreds of applications. But we

have a significant number of peer supports with our agency. We are -- the majority of them are navigating the process at this point, and there will be very few that have completely passed every hurdle come the first of the year. And was just curious how other agencies are going to handle that gap that may occur when we have certified that are not yet registered. That means suspension of peer supports services. Just was curious if there will be anything to address that gap as we are all working to comply, but just the nature of holidays and volunteers, how -- you know, I think everyone has the best of intentions, but if we're still caught in that process, I was curious how we are expected to handle that.

MS. MILLSPAUGH: Well, I think, Liz, you bring up, you know, one of the questions that we have -- don't have a good answer for just yet because, again, it's a really nuanced question where, you know, you can look at it through a variety of lenses that -- and you can get a different answer. I think, you know, finding a way to bridge,

you know, what happens on January 2026 and getting individuals fully registered through the temporary process, it's just not resolved yet, and I don't think we have a concrete, simple answer for you yet because we haven't figured it out. And I know that's not what you want to hear, but it is definitely where we are. We want to provide the best guidance that's accurate and legally sound, and we haven't figured all of the angles out yet.

I think, you know, we have to just go by what is interpreted currently around, you know, what 505 says, and that is, you know, in those two settings, AODEs and BHSOs, they must only hire, you know, a temporary or registered alcohol and drug peer support specialist, and follow the processes that currently exists under those regulations for the board. So I know that that doesn't narrow the gap, but -- and we're aware of that. So that is one of the things we're trying to find a bridge to fill that gap, and, you know, as soon as we are able to do that or have some assistance in interpreting

that accurately, we absolutely will do that.

Someone mentioned earlier, you know, if we've had any opportunity to talk to Representative Moser, and the board was unable to attend that particular meeting, but, you know, we were, as well as Medicaid, and we did have a very fruitful conversation with Representative Moser who seems very willing and interested in finding a solution to how this is playing out. So I do think that there are opportunities on the table that we can explore, and we'll continue to discuss, but don't have them that I can share with you at this point. But I will say that it is hot, as everybody knows, and there's a lot of interest from her as well to make sure that we find a solution. They're very aware that the impact of this legislation could result in a lack of services to individuals who need peer support services, as well as an impact to the peer support specialists themselves, and whether or not they're able to stay employed in the agency in which they work.

MR. SHANNON: Right.

MS. MILLSPAUGH: So it -- we know that it's hugely important, and we're going to work to figure that out as best we can.

DR. MCKUNE: We have nearly 50 --

MR. SHANNON: And there's a couple --

DR. MCKUNE: -- at this point that are in that predicament, and we have, at this -- as of right now, one that's made it all the way through. The rest are all in process, but that's a significant number of people that are unsure if they'll be able to work from 1/1. So that's just -- and I appreciate that, you know, it's a lot of factors outside of everyone's control coming together, but it has real consequences for some individuals.

MS. MILLSPAUGH: Absolutely. Absolutely.

MR. SHANNON: Yeah, both for peers and individuals served and supported. I mean, it's just not -- you know, it's bigger than the peer. But Medicaid doesn't represent a temporary licensure; is that correct?

MS. SPARROW: That's correct, yes.

MR. SHANNON: Okay, so however long that takes, and I've heard different times, so it has to be to register. The other question is should peer support specialists upload their temp licensure and any CEUs into the TRIS account?

MS. MILLSPAUGH: I don't know that it's necessary because they're two different systems.

MR. SHANNON: Oh.

MS. MILLSPAUGH: We don't really manage the registered side. I think, as I mentioned earlier, we're moving toward a different level of certification that will be taught through a co-occurring lens. I neglected to mention that. The training will approach it from that angle, and that new application process, I think, would allow and would benefit from whatever trainings and supervision that a registered individual might get through where they're currently working into the TRIS system in support of, you know, becoming a certified one. So I do think that will, in the future, have more benefits. It doesn't hurt

to do that now, but TRIS doesn't really communicate with the board. They're two separate systems --

MR. SHANNON: Yeah.

MS. MILLSPAUGH: -- that, you know, the board would just have to ask us what's in the system, but they would need to submit it to the board to go through their process if they want to become registered. That's -- that's just the best way forward on that.

MR. SHANNON: Yeah. And just so everyone understands, it does require a legislative fix or something, right?

MS. MILLSPAUGH: Yes.

MR. SHANNON: And it could have an emergency clause that accelerates the process so when it passes both chambers, it becomes law, so that could cut it down. But if that doesn't occur, you're looking at July 1 when the legislative fix will take place. So I'm sure there's folks, you know, attending to push to get an emergency clause added to it to hopefully move it up, you know, maybe till April. There's still going to be, as Dr. McKune said, a problem

January 1 till whenever, and individuals won't access services, and peers, and peers I know don't know what's going to happen to them. You know, will they keep their job? Will they lose their job? Will they kind of be -- not suspended, but you know, "We'll keep you until you get your registration and you come back to work, but we can't have you not doing anything specifically." And there's also peers who become intimidated by the process and have opted not to be peers anymore, peer support specialists. They've gone and done some other work. So I think this is clearly unintended consequence when this bill was done, I guess, in the '23 session, '24 session, and it's coming up now, right?

MS. MILLSPAUGH: Yep.

DR. SCHUSTER: Karyn, you mentioned a big number of people that have gotten registered. Do you have any -- and I know that having served on a licensure board, it's hard to have those board meetings as the holidays get close and so forth, but do you anticipate -- do you have any idea what

kind of number might still move through before January 1st?

MS. HASCAL: No, not really. So we are all reviewing applications pretty much daily, so we've got upwards of 100 every week. We're not waiting until the board meeting to review the applications. We just simply can't --

DR. SCHUSTER: Yeah.

MS. HASCAL: -- it's not humanly possible. And one of the actually good things that 505 did because we only had 4 board members previously, and 505 added 6 or 7 board members, so we've got some new hands-on deck. They're getting trained, they're not really up to speed yet, but, you know, there's a possibility that we could get several hundred more before the end of the year. As I said, we had -- I think we had like 90 when we started this, and we're up to 530 now. Those are all temporary. We still only have 30 fully registered peer supports, so -- but we have 530 temporaries now.

DR. SCHUSTER: And remind me, what's

the -- how long is that process of being a temporary, is that a time thing?

MS. HASCAL: They have to renew every year.

MR. SHANNON: But the temporary to a registered --

DR. SCHUSTER: How long are they a temporary before they become fully registered, is my question.

MS. HASCAL: Oh, okay. Well, they have to have 25 hours of supervised experience. They have to have 500 work hours, and most of the folks that we're seeing have been working in the field for a while, so the 500 work hours is not a problem. What is a problem are the 25 hours of supervised work experience as a peer support specialist, and the supervision has to be done by a credentialed alcohol and drug counselor, and then the additional 21 hours of training. So the Cabinet for Health and Family Services had a training protocol that required 30 hours, and ours requires a total of 51. There are a number of providers out there who are offering

those 21 hours of additional training, so -- but the thing that takes a little time is the 21 hours of -- or 25 hours of supervision.

MR. SHANNON: Yeah.

DR. SCHUSTER: Because the additional training are the courses, and, you know, suicide prevention and that kind of thing, right?

MS. HASCAL: Yeah, there are domestic violence -- domestic violence, HIV, and ethics.

DR. SCHUSTER: Yeah. And you're getting some people to offer those courses?

MS. HASCAL: There are several organizations out there offering those hours virtually, so they're not requiring people -- there are some that are doing it live as well, but most of them are virtual.

DR. SCHUSTER: Yeah.

MS. MILLSPAUGH: Karyn, it's suicide prevention as well, right?

MS. HASCAL: Yeah.

MS. MILLSPAUGH: Okay.

MS. HASCAL: The suicide prevention

is a little iffy because you have six years to get that, so I can't remember -- I'm trying to add those numbers up, but yes, suicide, HIV, domestic violence, and ethics total.

DR. SCHUSTER: But it's the supervised experience that is really --

MS. HASCAL: Yeah, it's time-consuming.

DR. SCHUSTER: It's time consuming, and it's --

MS. HASCAL: Well, as I said before, I don't remember if I said it to this group or not, but the infrastructure -- and Phyllis and I, of course, have talked about this at length -- that the infrastructure really didn't exist for this to happen. And one of the challenges has been to have enough supervisors for these folks because supervisors are limited at 25 per supervisor, so there just aren't enough human beings to get this work accomplished.

MR. SHANNON: Yeah.

DR. SCHUSTER: Yeah.

MR. SHANNON: And you've taken those

folks offline. They're not doing clinical services when they're supervised. I mean, it's just the reality --

MS. HASCAL: That's exactly right. That's exactly right.

MR. SHANNON: -- you know? So, you know, this is problematic, and again, it's no one on this call's fault, but it takes experienced people offline, it takes experienced peer support specialists offline, and ultimately, it decreases access to services to individuals with substance use disorder.

MS. HASCAL: Absolutely. It's a nightmare.

MS. ANNA: I have a question.

DR. SCHUSTER: Yes.

MS. ANNA: To my understanding, they also have to take a test before they get registered, correct?

MS. HASCAL: Correct.

MS. ANNA: What are we looking at as far as timelines on being able to test? Is that something you guys can give us an idea about?

MS. HASCAL: It generally only takes -- once they're approved to take the test, it generally only takes maybe a week or 10 days to get the test scheduled.

MS. ANNA: Okay.

MS. HASCAL: It's virtual -- it's also all virtual, so, you know, the test is administered by the IC&RC, the National Oversight Organization, so that's generally a thing that can be done fairly quickly.

MS. ANNA: Okay, thank you.

MS. HASCAL: Sure.

MR. SHANNON: But they can't register until you approve them, right?

MS. HASCAL: Correct.

MR. SHANNON: And what does that entail?

MS. HASCAL: Well, it's a review by a board member. So firstly, they're temporary, and then once they've gotten all of their 500 hours and 25 hours of supervised experience and all of that stuff, they submit their application for registration. It's reviewed by the board, and then they're approved to take the test.

And as I said, we're -- I've already approved about 20 applications today, this morning, before I had coffee.

DR. SCHUSTER: Hmm.

MS. HASCAL: So we're doing them every day as fast as we can.

DR. SCHUSTER: Yeah. Karyn, there was a question in the chat, "Where can we find a list of those providers that are offering those trainings?" Is that posted on your board website?

MS. HASCAL: No, no, no. Most -- no, most of them are -- so where I'm seeing them is on social media. We do not have a list of approved training providers on our website. I've asked for that, but they haven't done it yet. And it changes all the time. Somebody can submit a request to provide training, and they do all the time. There's -- so I can tell you that there are some automatically -- or not automatically, but they're consistently approved. CE4Less; Relias; Jeff Wilson has a sort of a training academy thing, his are all approved; Tim Cesario's hours are always approved; there

are a couple of new organizations, I don't remember the names of them. I can email those to you and let you know who those are, but there is not a published list of approved providers.

DR. SCHUSTER: Okay. Yeah, if you could send me something, we can put it out there.

MS. HASCAL: Yeah. Yeah.

DR. SCHUSTER: Yeah, that would be great, Karyn. Thank you.

MS. HASCAL: I can do that, sure.

DR. SCHUSTER: Any other questions?

MS. MUDD: Okay, let me just go over this one more time because I was not even aware of all of this that's available. Maybe that was just dumb on my part since I'm a peer specialist.

Okay, so it takes 25 hours of supervision, and then you said $500 -- or excuse me, 500 of work experience, and then 21 hours of SUD; is that what you said, or did I mishear all of that?

MS. HASCAL: No, no, it's -- it's a total of 51 hours. Most folks have already

had 30 hours --

MS. MUDD: Okay, yeah.

MS. HASCAL: -- of training through CHFS.

MS. MUDD: Yeah, the 30 hours, mm-hmm.

MS. HASCAL: Right. And then it's an additional 21 hours, but those 21 hours are broken up into 2 hours of domestic violence, 3 hours of HIV, 6 hours of suicide, identification prevention, treatment, and ethics.

MS. MUDD: Okay, what did I hear -- what did I hear you say was 500?

DR. SCHUSTER: That's the work hours.

MS. HASCAL: That's 500 work hours.

MS. MUDD: Okay.

DR. SCHUSTER: Twenty-five hours of supervision.

MS. HASCAL: It's all -- if you go on the ADC board website, if you look under forms and documents, there is an application packet there, and all of this is described in the application packet.

MS. MUDD: Okay, can you drop that

into the chat? That would be very helpful.

MS. HASCAL: Yes, I'll pull over and try to do this.

MS. MUDD: Okay, thank you.

MS. HASCAL: Uh-huh.

MS. SPARROW: Karyn, I think we can get it for you and drop it in there.

MS. HASCAL: Oh, thank you, Angela, I appreciate it.

MS. SPARROW: You're welcome, we got it.

MS. HASCAL: I was at the Implementation Council meeting, so I'm driving back. Thanks, Angela.

DR. SCHUSTER: Yeah, Melissa Allgeier put an ADC link in there, I don't know if that's the right link. That's your board link, isn't it, Karyn? Adc.ky.gov.

MS. HASCAL: Yeah, that's it. Yeah, that's our website. Yeah. And then when you go to that website, it says, "forms and documents," and all of the application packets are there, and it describes all that stuff.

DR. SCHUSTER: Okay. All right.

Well, we appreciate very much you all being on, and Karyn, I hope you're driving safely while you're talking to us. And we will pray, I guess, that things get resolved legislatively as quickly as possible with something that gives us all a little bit of clarity and a little bit of breathing room, so that we don't lose these services and lose these people. I think those are the two goals here.

One last any other questions?

(no response)

DR. SCHUSTER: We certainly do thank Phyllis at DBH and Karyn and the board, and all you good folks at DMS that have been working so diligently on this. That's really important. Thank you very much.

Bart, we'll go to you to give your presentation on the Medicaid provider reimbursement and network adequacy. Two very important topics.

MR. BALDWIN: Yes.

MS. WASH: So Bart, I'm going to stop sharing so you can share your screen.

MR. BALDWIN: Okay, great. Thank

you, Barbara. I will try to do that.

MS. WASH: If you can. I have it up, so.

MR. BALDWIN: Yeah, actually, if you've got it, why don't you do it. I think that'll -- if you don't mind, I can just tell you when to click through; is that okay?

MS. WASH: That'd be fine.

MR. BALDWIN: Yeah.

DR. SCHUSTER: Thank you, Barbara.

MR. BALDWIN: That way we won't run into my operational glitches.

MS. WASH: All right, there we go.

MR. BALDWIN: Okay.

DR. SCHUSTER: Yeah.

MR. BALDWIN: Great, thank you. Thank you, Dr. Schuster, for the invitation to share this information. I'm not going to go through the entire presentation that I did at MOAB. I just want to have this as a reference point. So this is the same PowerPoint deck, but I just wanted -- and I will go through here. I want it to be a reference point for folks on this Zoom, and

before jump in, I just want to make a couple overarching comments just because I know that we have a really broad array of folks on this Zoom that attends the BH TAC in terms of consumes to advocates to providers to, you know, MCOs, DMS folks.

You know, we -- network adequacy is -- just wanted to kind of mention why we have that. It's somewhat obvious in the terms of the name, but, you know, when we have these requirements that I'm going to mention, are requirements from the federal level and at the state level that are requirements of DMS, Department of Medicaid Services, and then via their contract with the MCOs, those requirements are passed on to MCOs as well. And to me, network adequacy and parity are kind of two sides of the same coin. Essentially, access to services, just ensuring Medicaid recipients have access to services. And so how our system is set up in terms of -- you know, in terms of managed care organizations have the per member per month, and then providers contract with the MCOs to provide services,

and are supposed to be, you know, negotiating rates, reimbursement rates, in order to have an adequate network. And we brought this up because we really don't feel like that is happening at the level to ensure compliance. So Barbara, you can click through to the next slide.

Yeah, and you can skip back by that. That's just the clients I work with that -- so to start off with, this is a state statute, Kentucky statute, that defines requirements for managed-care plans on network adequacy, and as you can see in there, the requirement for travel is 30 miles or 30 minutes if you're in network, or 50 miles or 50 minutes if you're out of network. So that's essentially for a Medicaid recipient how far, in order to comply, they must travel to access services. You can click to the next slide.

But in that statute, previously we don't set out a time frame on how long you might wait for those services. So this references -- this slide here references a state regulation where we, at the state

level, have defined what is a reasonable time frame in order to access services. And that's not to exceed 30 days, 30 calendar days, in terms of once you've requested services. And, you know, as you can see here, this is behavioral health as specified, but these network adequacy standards are not -- I know that's the focus, certainly, of this TAC and this discussion and my point, but this applies across the board for all provider types. And you can go to the next slide, Barbara. Thank you.

So these are some of the federal requirements. I will point out that if you follow this through, the federal requirements on the state are state level statutes and regulations, and then the language in the actual contracts between DMS and MCOs, it's kind of a thread that follows all the way through to -- there's consistency throughout on those requirements.

And I want to point out, you know, a couple of things here, that there are new

standards, compliance standards, that have been approved at the federal level in this federal regulation, but their effective date is still a couple years down the road. And I'll note, as it's highlighted, that it's going to be no longer than 10 business days as opposed to our state-level reg now, 30 business days. So that's not in effect yet, but it will be unless it changes at the federal level within a couple of years. So we've got work to do to meet the 30-day, we certainly have work to do to meet the 10.

Also, there's an enhanced requirement at the federal level to have a quantitative network adequacy standard, so basically, enhance the way that we measure network adequacy. I think at this point, it's mostly around a secret shopper mechanism, and we'll touch base on that at the end a little bit with a couple of comments, but -- so I think that I look forward to, you know, a more quantitative, more direct data-driven way to ensure network adequacy. And then you can read for yourself kind of that -- how -- a letter from CMS that we requested

on behalf of our client, ABA Advocates, on these issues with CMS, you know, how they described what the requirements are. You can go to the next slide.

So no surprise to this group, I don't think, in terms of providers and individuals, this is just some data that we collected, the Children's Alliance did, from a provider survey recently that -- and we also did with our ABA, that, you know, not only is it not within 30 days, but broadly, it's 77 days on the ABA side, which I also work with, it's several months and over a year. I've heard from several providers over the last -- especially in the specialty, the ABA source, that they just stop putting folks on a waiting list. That they just really feel that it's inhumane to give them false hope that they're going to get access to services with any reasonable amount of time. And so I think that's telling. That was a new -- and I just bring that up because this is an issue we've been working on for a number of years, and that's something that's new that I've heard within

the last few months that we're, like, we're just not doing it because we can't give this family false hope that they're going to get accessed services within the next 30, 60, 90 days, and oftentimes, it's a year or more. Okay, next slide, Barbara.

So I don't know, you know, again, for the sake of time, even though it's the most important aspect here, is the impact on children and families when they don't get access to services. I know this group knows that all too well because you live it and you talk to those family members on a daily basis, but it really isn't a -- it's the life-long and potential impact of negative outcomes when you need access to healthcare services, certainly when you need access to some of these important mental health services, you need it now, you don't need it nine months from now, six months from now. And in the meantime, oftentimes, those needs escalate, and end up with, you know, ER visits, negative outcomes, interactions with the law, you know, the police and other things that are really, you know, human

costs, which are much worse than the actual financial cost. We can go to the next slide, Barbara.

So this is -- we'll skip over this. This kind of gets into some details in terms of some of our recommendations on how to ensure an adequate network, and then just point out from a rate perspective, and this is specific to the outpatient behavioral rate fee schedule that is only for a subset of the behavioral health providers, as a policy in the state that we take the Medicare reimbursement rate and immediately reduce it by 25 percent. I'm not really sure why we came to that approach because the cost to deliver the service is exactly the same regardless of who the payer source is. So, yeah, yeah, I see that, Liz. I realize you -- that those are combined at this point. So next -- you can go to the next slide.

Yeah. Okay, you can take it down at this point, Barbara. I kind of went through that pretty quickly, but I wanted to just make a couple of additional comments and see

if anyone has any questions, or, Dr. Schuster, if there's anything else that you want to talk about in terms of this presentation. But the main thing, you know, that, like I said before, parity, which is something that comes up a lot here in behavioral health, but also, the network adequacy is just really about getting access to services, and it's mostly tied to lower reimbursement rates that we feel doesn't allow providers to recruit and retain the necessary staff in order to meet the needs -- meet the access needs. It's just basic economics when we are -- you know, have seven surrounding states and so much of our population sits on those borders, and we are below -- you know, when individuals can drive across the river or drive across the state line and get paid substantially more because the reimbursement rates are higher in those states, then it's really tough to -- for our Kentucky providers to maintain and recruit and retain the number of staff they need to -- you know, to meet the need. So -- and I will say that -- and that's what

this is ultimately all about. I don't think that there -- at least my experience in hearing from providers, there is not an active or open negotiation with providers on rates. We have a fee schedule. I will point out that that fee schedule is set by Medicaid for the purpose of fee-for-service. MCOs are not bound to that. As a matter of fact, that was a slide I kind of skipped over for the sake of time, but they're not bound by that, and the requirement and expectation is to negotiate with providers in order to have an adequate network.

So our approach -- and I think that I want to point out that I think in this space and certainly in terms of the needs -- meeting the needs of our provide -- of our Medicaid recipients, that there's just not enough providers. I mean, I kind of heard that over the years consistently, and I, for one, just don't accept that as a reason not to try, as a reason not to advocate. We may -- while we may not be able to fully meet the needs with the number of providers we have -- and by providers, I mean

organizational providers, but also just the clinicians. I mean, it's all about, you know, access to the clinicians, the peer support, the, you know, TCM folks, the case managers, in order to meet the needs. You know, there was a report within the last two or three weeks from the governor's Team Kentucky update, where I think it was said we had doubled the number of mental health practitioners in the state over the last five years. Somebody can check me on that, I'm just basing that on memory, but it was a substantial increase. So I think that, you know, we're training and graduating folks, and we're not able to keep them in the state. And I think that we have the opportunity to bring them back if we can be -- you know, the basic economics to be competitive for themselves.

So that's where -- that's kind of my comments. I do have -- if we can have any questions, and then I know Commissioner Lee dropped the report in the chat, and at the end, I'd like to just ask about that. Is that what -- is that kind of what you were

looking for, Dr. Schuster?

DR. SCHUSTER: It is, absolutely, Bart. Thank you. And I think the other thing -- and this came up in our testimony on a mental health parity bill, I said to legislators and Nicole Sartini, who has this Mental Health Insurance Reform Task Force group, said more and more behavioral health providers are not taking insurance of any kind.

MR. BALDWIN: Yes.

DR. SCHUSTER: You know, Medicaid has always been at the bottom of the list for so many providers because it's low pay compared to commercial, but we're hearing more and more. And it started out it used to be just the psychiatrists who were not taking insurance at all, and then it was the doctoral level psychologists, and I think it's really across the board. And I think part of it is the low reimbursement rates, and part of it is the hassle factor --

MR. BALDWIN: Yeah.

DR. SCHUSTER: -- on audits and clawbacks and recoupments and so forth

really don't help. So it's multifaceted.

The only other thing I would say about network adequacy, and I have said this to the people at DOI, and have said it to the MCOs, one behavioral health provider is not the same as another behavioral health provider. It's kind of what Steve said when he said, you know, behavioral health gets all lumped together and they don't do that with physical health. There is a difference between what doctoral level psychologists do and what psychiatrists do, and what ABA people do and what counselors do. And I think that different professions deal with different needs of our population, and I just think that we really need to be paying attention to that. I've always felt like the network adequacy ought to be: we have these many behavioral health prescribers, which would be your psychiatrist, your physician assistants, and your nurse practitioners; and we have these many that do psychological testing, which is a niche, but it is sometimes needed; and then we have these many that offer ABA, which is

obviously niche. So I just think there are lots of those pieces that we're not addressing in the overall network adequacy.

But I thought the presentation was good, and I wanted to share it with the group. So I thank you for that, Bart, and we're almost out of time. Let me just touch on --

MR. BALDWIN: Dr. Schuster, just real quick, and maybe we can get an answer on this or more information, the report that Commissioner Lee dropped in, it was a result of the secret service -- secret shopper survey done in 2025, and it shows a 60.5 percent compliance for routine appointments, and a 40 percent compliance rate for non-urgent appointment calls for behavioral health services.

DR. SCHUSTER: Where did she drop it -- where was it dropped in? I missed that.

MR. BALDWIN: It's in the chat, a few minutes ago.

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

MR. BALDWIN: Just while we were

talking -- I think it was while we were doing peer support.

DR. SCHUSTER: Oh, okay.

MR. BALDWIN: I was trying to do a little multitasking.

DR. SCHUSTER: Oh, all right.

MR. BALDWIN: But I think that's something that -- if I'm reading that correctly, that we're -- that really absolutely just confirms that we're not in compliance --

DR. SCHUSTER: Yeah.

MR. BALDWIN: -- and so I was just curious if I'm reading that correctly or not. I may not be -- just with a quick review, I may not be reading that correctly.

DR. SCHUSTER: All right. Well, we will get that and get it out to people so that we can all look at it because I sure did miss that. Thank you, Commissioner Lee, for dropping that in.

MR. BALDWIN: Yeah, thank you.

DR. SCHUSTER: I had asked about that at the MOAB meeting, so I'm delighted to see that. Thank you very much.

DR. HOFFMANN: Dr. Schuster?

DR. SCHUSTER: Yeah.

DR. HOFFMANN: I think she had to drop for another meeting, but you can reach out to her, or we can let her know the outcome of that as well --

DR. SCHUSTER: Yes.

DR. HOFFMANN: -- if you have questions.

DR. SCHUSTER: Yeah, thanks.

MS. PARKER: Just so you know, this is Angie Parker, that survey is done by our external quality review organization, IPRO.

MR. BALDWIN: Mm-hmm.

MS. PARKER: We do different secret survey --

MR. BALDWIN: Secret shopper --

MS. PARKER: -- secret shopper surveys annually --

MR. BALDWIN: -- yeah.

MS. PARKER: -- via our external quality review organization, and we do different provider types. And this was the last one that was done -- they start in October of '24, and this was posted in April

2025. All of our access and availability secret shopper surveys are posted on our -- in the Medicaid under our quality and population health page and the Quality Branch. So there are others --

DR. SCHUSTER: So that's good to know.

MR. BALDWIN: And I --

MS. HENSEL: And it's --

MS. PARKER: -- it's not just behavioral health; there are others as well.

MS. HENSEL: Yeah, and Dr. Shu -- oh, go ahead.

MR. BALDWIN: Yeah, Dr. Hoffmann, I guess the question on that is, am I reading that correctly -- are we reading that correctly, and if so, then what's being done about it? Because that's clearly out of -- would be, the way I'm reading it -- and again, it's just a quick review, I've never seen that report, so I tried to look at it quickly, but I think for this discussion is, what actions are being taken for compliance?

MS. PARKER: And I can take -- I can tell you, when we get these reports, they

are submitted back to the MCOs for their -- for any corrections that may need to be obtained. Obviously, as you've recognized and discussed earlier, there is a network adequacy issue --

MR. BALDWIN: Mm-hmm.

MS. PARKER: -- so it -- it's twofold, and -- or more, maybe more than that. But, yes, those reports are shared back with the MCOs, and they are to address them. Information is taken from their provider directory that is on their website, so if there's any -- they need to make any corrections to their website if they're not accepting. So there is a lot that goes into that after we get it. Obviously, it is not a fix-all report. It's, you know, making sure that we know these things are going on and how we can work towards improving those adequacy issues as best that we all can. It's -- it can be very enlightening.

DR. SCHUSTER: Yeah.

MS. PARKER: And Krista has her hand up.

MS. HENSEL: And I would just add

that those reports are in addition to the reports that the MCOs do on a regular basis and report quarterly, and the -- what was it, PSN09 or something like that, but all of that work then does result in our provider advocates, our network contract teams reaching out to those providers and saying, "Listen, you failed the secret shopper. You will be resurveyed." If they continue to fail, then there ends up being some type of corrective action downstream with the providers as well, which can include removing from the network. We really try to avoid, where we can, removing folks from the network because we know there's access constraints. So it's a real challenge to try to make sure that what we're reporting is accurate, that we've got providers that are willing to see our members and kind of holding up to their contractual standards, and really trying to avoid pure network terminations because we know it's much more challenging to get someone to rejoin the network if we have termed them in the past. So we try to fix it in relationship with the

provider first, lean in, understand what constraints are, if we can be of assistance and point out the deficiency, whether it's demographic information that has shifted on their part, a change in phone number, if it is staffing issues, they're having, they moved down the road. Any number of things that could cause some of those secret shopper failures to occur, we try to work it out as best we can.

MR. BALDWIN: Well, so perhaps I'm misreading this report because that sounds like a secret shopper on the compliance of the provider, not their -- my understanding is the secret shopper is a part of the compliance standard for network adequacy on Medicaid and the MCOs.

MS. HENSEL: Yes, and downstream we pass those compliant -- like, if we are contractually required to have 30 days or 10 days --

MR. BALDWIN: Mm-hmm.

MS. HENSEL: -- that lands in our provider agreements with our providers as well, and we have a responsibility to

oversee that provider behavior. And so it is both DMS holding us accountable to make sure we've got network and directory accuracy in our reporting, downstream, we are trying to hold providers accountable to make sure they're reporting any changes to their status in terms of demographic information, willingness to accept provider -- accept patients, whatever their after-hours phone response processes are, etc.

MR. BALDWIN: Okay. Well, that's a whole other discussion, I guess, because -- that we need to have. And I know we've gone way over time, I apologize, Dr. Schuster.

MS. HENSEL: Yeah. Yeah, but I'm happy to have a conversation offline, Bart.

MR. BALDWIN: Yeah.

MS. HENSEL: It is a sticky, sticky widget -- is that the right colloquialism --

MR. BALDWIN: Yeah, wicket?

DR. SCHUSTER: Wicket, yeah.

MS. PARKER: Wicket.

MS. HENSEL: -- that we're all I think trying to fix --

MR. BALDWIN: Yeah.

MS. HENSEL: -- and it's incredibly complicated. We're trying to pull in the same direction, I think, across DMS, the MCOs, and the provider community when there are some real challenges, especially, we know, in our rural communities and workforce challenges. And Dr. Schuster, also fully appreciate the nuances of folks' different specialties, subspecialties, and making sure we're navigating our members, your patients --

DR. SCHUSTER: Right.

MS. HENSEL: -- to the right provider at the right time for their care.

MR. BALDWIN: Yeah.

DR. SCHUSTER: Yeah, well, this has been a very fruitful --

MS. HENSEL: It's not easy, but we're all in it for the right reasons.

DR. SCHUSTER: Yeah. This is a very fruitful discussion, and I appreciate, Bart, you bringing this forward. And we will continue that discussion because I do think it's at the -- we've got to solve it, and

one of the ways to solve it is to I think increase reimbursements for the services and to decrease the hassle factor, just to be blunt about it, but --

MS. HENSEL: I would also just challenge us to figure out if there's ways we can drive efficiencies across the program, because what we do know, right, from OB3 passing on July 4th, is there's going to be headwinds to the state Medicaid budget. So how do we continue to make sure that people are getting the right care at the right time, but we also have to figure out if there's efficiencies across the system because we know the money is going to be very constrained in the coming years --

DR. SCHUSTER: Yeah.

MS. HENSEL: -- and we don't want members or patients to suffer due to that.

DR. SCHUSTER: Yeah. And that's coming very quickly. I mean, we're going to see what our legislators are going to do about it in the budget session coming up, and that's very quick, January 6th.

MS. HENSEL: Yeah, and I think the

most --

DR. SCHUSTER: And I heard --

MS. HENSEL: -- we can do is continue to educate those legislators, Dr. Schuster, in terms of, you know, when they make those big policy decisions, it can have real big impacts, and we all know how complicated the industry is, those of us that have worked in it a long time. And so we need to try to do our best to educate the trade-offs when those decisions are being made.

DR. SCHUSTER: Yes, and I will just say that the chair of the Senate A&R Committee, Chris McDaniel, was quoted -- was on the clip that I saw from the chambers preview of the session, and he flat out said, "Don't look to us to fill the gaps that were created by that federal legislation." Period. And I didn't hear --

MS. HENSEL: Yeah.

DR. SCHUSTER: -- any, you know, except in this case or in that case or whatever, and that's pretty scary, so.

MS. HENSEL: Yeah, as my grandparents used to say, there's no money tree in the

backyard, so.

DR. SCHUSTER: Yeah. Well, we have lots of money in our rainy-day fund, and I think we might need to remind the legislators that it's raining already.

So very quickly, let me just say that the BAC finally met, the Beneficiary Advisory Council, and they met on October 13th. So they are going to be meeting in the months of January, March, May, July, September, and November. And a month later, the Medicaid Advisory Council met for the first time, it's now the committee, and so we will be meeting in the alternate months. So the MAC meetings have not yet been set, but they will be set to meet in February, April, . . ., and we will keep you -- we're doing a survey right now of the MAC members. So as soon as we know that we will get those dates out to you.

But we still have someone on I think it was going to be Derek and maybe Leslie on the 1915(i).

DR. HOFFMANN: Yeah. Derek should still be on.

DR. SCHUSTER: Great. Because we always want to know about that.

DR. HOFFMANN: I said "still," but it is after 4. Derek, are you still on?

MR. VINCENT: I can be.

DR. SCHUSTER: Thank you, Derek.

DR. HOFFMANN: Do you want to give a short update, and then I can help you out if there's other questions?

MR. VINCENT: Okay. I'm Derek Vincent, program manager 1915(i) RISE Initiative. Here's a quick update.

Certification team continues to work with providers getting their questions answered and reviewing information to move towards certification. We continue to offer weekly office hours every Monday at 3 p.m. that's open for anyone who wants to ask questions related to the certification process. They're every Monday from 3 to 4. A link to register, I just put it in the chat. It's at our main website page at the top.

Here's a provider update. So far, we've had a 5 certified as of today, 4 are

in the initial review after verifying all documents were submitted, 3 are in the formal review process for regulatory compliance for certification, 2 are setting up pre-service reviews before starting their 6-month certification and moving to Medicaid provider type 51 enrollment, and a partridge in a pear tree. I had to throw it in there.

DR. SCHUSTER: Yeah, good.

MR. VINCENT: It's late in afternoon and I know we're all ready to go. Participant interest, we have been receiving a lot of interest calls, emails to our inbox. We've taken down names, contact information to follow back once we begin participant referral process. As of today, last time I checked, we have 63 individuals have given names, contact information, but we'd like everybody to keep in mind many of those individuals have multiple referrals they would like to send, so we're probably looking in the hundreds of potential referrals as soon as we start.

And so right now, I'd like to turn this back over to the Deputy Commissioner

Hoffmann.

DR. HOFFMANN: I was just going to mention, and it sounds like Derek included most things, and Derek, I don't know if you mentioned the regulations, but they have been approved. I don't know if you mentioned that.

DR. SCHUSTER: I think we had heard that from Ann at our last meeting.

DR. HOFFMANN: Yeah.

DR. SCHUSTER: Yeah, thank you.

DR. HOFFMANN: That's the only thing I probably had. We're just very excited, you can imagine, about getting this rolled out, and, you know, just taking the next step. We're so ready, right?

MR. VINCENT: Yeah.

DR. SCHUSTER: I'm going to ask you a question that you may not be able to answer, but what's the tipping point here? How many providers do we need to have enrolled before we're going to be ready to start onboarding participants?

DR. HOFFMANN: So Sheila, I'm going to start that conversation, Derek might have

something else to add. We want to make sure that the participant has choice, right? And so we have been looking at a couple options. It may be rolling out regionally where we had providers in that area and knew, you know, that they could provide all services, and letting the member know that, you know, "if you're interested, we've got this provider in your area," but we have to ensure that the member has choice. So, you know, oftentimes, certain areas, certain CMHCs or other providers may have folks that may rotate around that are very well-known and might -- that work with them and have, you know, a really good rapport, and we think that those providers and those members might be more willing to start out in a regional kind of approval to get started. That has not been approved by our executive leadership but should be soon. I feel like that's the best approach to really get us started in any type of phase.

DR. SCHUSTER: Yeah. All right, well, that makes sense, and I think that gives us some hope.

DR. HOFFMANN: Yep.

DR. SCHUSTER: So I appreciate that. Nice to meet you, Derek, and thank you very much. I like the partridge in the pear tree as well.

MR. VINCENT: Yeah, I'd like to add that our very first provider that's certified is actually on here today, Dr. Rita Harpool, so.

DR. SCHUSTER: Oh, wonderful.

DR. HOFFMANN: Thank you, Derek.

DR. SCHUSTER: Yeah.

MR. VINCENT: Yeah.

DR. SCHUSTER: Congratulations, Rita, that's wonderful. And that's up in the Madisonville area, I think. That's great.

DR. HARPOOL: Yes, thank you. We're excited.

DR. SCHUSTER: Yeah, good.

All right, what about the Reentry Waiver? Who's going to talk about that?

MS. SPARROW: This is Angela.

DR. HOFFMANN: I've got Angela Sparrow on for that one. Sorry, Angela.

MS. SPARROW: No, you're fine.

You're good.

DR. HOFFMANN: Making sure you're still on.

MS. SPARROW: A quick update on -- I am. A quick update on reentry, we continue to move forward, moving along. You know, again, we're just very thankful that our partners are continuing to come to the table. So we are really, really heavy into systems right now working with all of our partners, all of our vendors around timeline for testing. So again, each partner has been standing up and developing their systems, so we're coming together, again, to start testing across systems, which is exciting. And we -- again, that's really the big step that we need to be able to move forward in order to provide services and determine eligibility, etc. So a lot of work around systems that will continue, again, through the end of the year and into the first of the year.

We're working with DOC and DJJ on some of the provider enrollment initiatives, so they're individual practitioners and

prescribers that haven't been enrolled with Medicaid. So some of these prescribers, again, may have worked in the correctional field, may not have, you know, typically billed Medicaid or insurance, and so may not have ever enrolled. So working with them to enroll those individual practitioners and providers, again, started and kicked off that work with DOC and DJJ, and we'll continue that, again, hopefully wrap that up end of the year, first of the year.

And credentialing -- excuse me -- contracting with the MCOs, so thankful for our MCO partners to come together. We're trying to, again, develop more of a standardized provider agreement for DOC and DJJ to contract with the MCOs, so that's been under review to start that contracting process. Working -- again, we'll be working with our partners in the upcoming weeks around billing. So, you know, many of you all, if you've been familiar with the healthcare field, our partners, again, aren't, you know, used to billing for services. You know, services are provided

in a different manner, so you all, I know, can understand where they're at right now. So they will be billing for fee-for-service and MCOs, so working through that.

We've worked with our finance around the pre-release services and those capitation payments with the MCOs to have those in place for the new year. And so, again, also working with the MCOs, we've got a few items to close the loop on the pre-release case management policy with our partners and the MCOs who will be delivering those services.

So lots of work still going on. Our implementation plan is still pending with CMS. We have gotten feedback from CMS, which is good news. You know, it's a good thing that we have heard from them. We feel like we're getting pretty close there. So I'll pause and see if you all have any questions.

DR. SCHUSTER: Are we still looking at April, Angela, for go live?

MS. SPARROW: We are. So one thing real quick, it was exciting that we did get

to -- DMS, behavioral health, Van Ingram, DJJ representatives, we did meet with our learning collaborative, so Kentucky's been participating in that learning collaborative with seven other states who are implementing. So we had a wrap-up meeting, in-person meeting, and that was a good opportunity to see where all the states have come over 18 months. I know we provide updates, and it seems like things might be moving slow, but again, it's a large project. So it was good to hear from other states, you know, where they're at. Only three other states have implemented, so Kentucky's not behind at all, and so again, you know, we were able to talk through some of those challenges that we're consistently seeing around systems and so forth.

So -- but that was -- that was a good opportunity, so yes, we are still targeting and on point for full implementation in April, and again, you know, we've had a couple of other states to look towards. Many of those are still even just rolling out in phased approaches as well.

DR. SCHUSTER: All right, well, that sounds very good. Thank you very much. We're excited, and I'm sure Steve Shannon is excited so his TAC --

MS. SPARROW: I know. I know.

DR. SCHUSTER: -- can actually have things to do.

MS. SPARROW: That's right. That's right.

DR. SCHUSTER: Last thing, 1915(c) waiting list numbers?

DR. HOFFMANN: Carmen, are you still on?

MS. HANCOCK: I am. I'm still here.

DR. HOFFMANN: Okay.

DR. SCHUSTER: Okay.

MS. HANCOCK: I'm still here. Okay, so for our 1915(c) waiting list numbers, our ABI Acute and ABI Long-Term Care, as well as our Model Waiver II have no waiting list at this time. The Home and Community-Based Waiver -- hang on, I think my earpiece is going out. Let me see if I can -- can you all still hear me?

DR. SCHUSTER: Yeah.

MS. HANCOCK: Okay. Home and Community-Based Waiver, the waitlist right now is 5,598. Michelle P. Waiver is 9,738 and Supports for Community Living is 3,801.

DR. SCHUSTER: And are those -- do you consider those duplicated or unduplicated, Carmen?

MS. HANCOCK: Those are duplicated. So the total there, Dr. Schuster, is 19,137. The unduplicated number is 16,525.

DR. SCHUSTER: Okay. We keep going up. We've been right about 16,000 I think at the last time we talked. So thank you very much.

Is there any update on the ABI Waiver access to therapy services? I'm assuming that that's still a status quo.

MS. HANCOCK: Still status quo, yes, ma'am.

DR. SCHUSTER: Okay. Thank you very much.

MS. HANCOCK: You're welcome.

DR. SCHUSTER: And for our voting members of the TAC, are there any recommendations that you want to make to the

MAC -- to the DMS through the MAC?

(no response)

DR. SCHUSTER: Hearing none, I'm going to assume, no.

And I think there was -- I'm sorry that we went late, but I think there were some very heady and heavy issues, and lots of things to keep working on, so I appreciate this as a place for people to come together and to get some answers. And super appreciate all of the DMS staff that are there and provide us with contact information and answers and so forth, and appreciate our MCO partners as well as we try to, you know, make sure that people get the services that they need in a timely fashion by providers who are getting paid enough to continue providing services. So I thank you all very much. I'm grateful for you, and I hope that you all have a wonderful Thanksgiving and Christmas or holiday, whatever you celebrate. We will not see you again until the new year, 2026. And we'll have a meeting in January. Just remember that the session opens on

January 6th, so be in touch with your legislators, I'm going to suggest, and tell them to really be paying attention to the fact that it's raining, and we ought to use some of those rainy day funds. So I thank you all, and Barbara, thank you very much --

MS. WASH: You're welcome.

DR. SCHUSTER: -- and we will be in touch.

MS. WASH: Okay.

DR. SCHUSTER: All right.

MS. WASH: Thank you, everyone.

DR. SCHUSTER: Uh-huh.

MR. BALDWIN: You all have a good evening.

DR. SCHUSTER: Bye-bye.

Bye-bye.

MR. SHANNON: Thank you. You all take care.

(Meeting adjourns at 4:26 p.m.)

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C E R T I F I C A T E

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

Dated this 24th day of November, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR