COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT OF MEDICAID SERVICES

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

MEETING VIA ZOOM

MAY 12, 2022
2:00 P.M.
ATTENDANCE

TAC Committee Members:

Sheila A. Schuster, PhD, Chair

Valerie Mudd

Mike Barry

Steve Shannon

T.J. Litafik

Eddie Reynolds
MS. SCHUSTER: So we will open the meeting. Welcome to you all. This is the umpteenth meeting of the Behavioral Health Technical Advisory Committee Meeting and we are glad to see you all. If we can have the voting members of the TAC just say hello, so that the court reporter will know that you're here. Let's see, Steve?

MR. SHANNON: Steve Shannon, KARP.

MS. SCHUSTER: Okay. And Valerie?

MS. MUDD: Valerie Mudd, NAMI Lexington, Participation Station.

MS. SCHUSTER: Thank you. And Mike Barry?

MR. BARRY: Mike Barry, People Advocating Recovery.

MS. SCHUSTER: Thank you. And Eddie Reynolds?

MR. REYNOLDS: Eddie Reynolds with the Brain Injury Alliance of Kentucky.

MS. SCHUSTER: Thank you, Eddie. And TJ Litafik?

MR. LITAFIK: Hello. TJ Litafik, lobbyist for NAMI Kentucky.

MS. SCHUSTER: Thank you very much. I'm Sheila Schuster representing the Kentucky
Mental Health Coalition.

So we have a busy agenda today and we will get right to it. I actually sent out two different e-mails and the first one we had the draft minutes of our meeting of March the 10th and from this I made the report to the MAC in March. So among the voting members I would entertain a motion to approve minutes of the March meeting.

MR. SHANNON: Steve Shannon. So move to approve.

MS. MUDD: I'll second. Val.

MS. SCHUSTER: And Val seconds. Any additions, corrections, omissions? If not, all of those in favor of approving the minutes signify by saying aye.

(Members vote affirmatively.)

MS. SCHUSTER: And abstentions/disapproval?

(No response.)

MS. SCHUSTER: Thank you. Thank you very much.

The first item on our agenda is wish -- well, this agenda I had the summary of data from Medicaid on Targeted Case Management Issues. Anyway, we actually
don't have a report yet. We have gotten more information from Medicaid and are excited to being looking at that, and we will be talking with the Commissioner about those numbers and the sense that we are making from them. And hopefully in July we will be ready to give a full report to the BH TAC.

So let me move on then to the presentation by Aetna on reducing SKY members' polypharmacy use. And Cat Jones from Aetna, and I don't know who else you have, and do you want to share your screen Cat?

MS. JONES: Actually, Kelly Pullen is going to be sharing --

MS. BICKERS: Give me just a second, Kelly, and I'll make you cohost. You should be able to share now, Kelly.

MS. PULLEN: Thank you. Good afternoon. I am Kelly Pullen. I'm Executive Director for the Kentucky SKY Program here at Aetna. With me today are my wonderful colleagues Susan Vicars, who is our Quality Improvement Director for SKY, and Megan
Johnson, who is our Quality Management Nurse Consultant. We've got about 20 minutes to spend with you—all today to talk about our Collaborative Population Health Approach to Lower Psychotropic Polypharmacy among System Involved Youth. So quickly, I'm here -- I've got got the easy part which is to introduce SKY.

For those of you that don't know what SKY, that is the Supporting Kentucky Youth Program. Aetna was awarded this whole contract to serve children who have been impacted by child welfare and juvenile justice. So in just a quick summary, that means we cover their Medicaid benefits, but in addition to that we really have a robust high touch approach to care management. It really helps families navigate systems and makes it easier for them to get the resources that they need. (Zoom noise.)

MS. BICKERS: Kelly, can I stop you for just a minute?

When you first come in, can you please mute so that the court reporter can make sure to hear everything, please? Thank you.
Sorry about that, Kelly.

Ms. Pullen: No problem at all.

So we like to walk people through, you know, our purpose for SKY. We have four primary goals within the program and the first is to incorporate youth voice and choice. The second is improve their long-term health outcomes. The third is to achieve safety and permanency for our children, and the fourth is to reduce psychotropic polypharmacy among system involved youth.

In terms of who is eligible for SKY, you can see all the different groups on the screen. Essentially, we are serving kids that are currently committed to foster care, the Department of Juvenile Justice, but we are also serving members who may be receiving adoption assistance and we serve former foster youth up to the age of 26.

For our care coordination model we have a really high touch approach to care management, very reminiscent of what you may see from a provider's perspective being done here at the health plan. Our team members
have experience in training, coordinating
and providing physical and behavioral health
services to our members who are eligible.
All have a background in working with youth
that are impacted by child welfare and
juvenile justice, and they are here to
really help provide a lot of different
services. I won't go through all of them on
the screen, but you can see they are helping
to locate providers and obtain appointments.
We have got some priority providers that are
helping us expedite the scheduling of
appointments for different assessments for
our members. We are assisting with
coordination of covered transportation
services for our members, and really helping
to link our kiddos and their families to
those community-based resources that they
need.

Our care management model is tailored
to meet the needs of each of these kids and
does include some different complex levels,
or tiers, as we like to call them. And how
a member gets stratified into those tiers to
dictate the, you know, level of service that
is being provided is really through our assessment scoring and member risk stratification. So our team is taking that Child and Adolescent Needs and Strength Assessment, combining that information with our Foster Care Healthcare Risk Assessment, our SDoH screener and a supplement assessment that we use here at Aetna. They are also taking into account all of the specific screeners that we provide to our members in determining what tier they should stratify into for care management.

Pop Health is our lowest tier. Incentive Care Coordination is our middle tier. Complex Care Coordination is for our most acute members in the program. And this slide just walks you through a little bit more detail about what that means.

Complex care coordination is for our enrollees that have the highest needs, our most acute case that maybe has had previous behavioral health admission, or those that have health special healthcare needs. And this does include all of the kids that are designated as medically complex by the
Cabinet. Our staffing ratio in this tier is very low. Definitely one that, you know, we are not necessarily used to seeing from an MCO. It is 12 kiddos to one staff member. And you can see the services that they provide. They are providing two face-to-face visits monthly, weekly contact, a minimum of two hours per week of care coordination, a monthly team meeting and care plan update as well. For those kiddos that are in this tier due to behavioral health reasons, their care managers are certified in High Fidelity Wraparound, and are actually providing High Fidelity Wraparound care management to our members.

For those kiddos that stratify into that Intensive Care Coordination tier, those are enrollees that have moderate acuity, but they are not really at risk of crisis at the moment. Staffing ratio still pretty low. It is one staff member to 32 kids. Services provided look very similar with what you see above with the exception of one less face-to-face visit, excuse me, and they don’t have that requirement to have
that minimum of two hours per week of care coordination. Our team members in this tier are not certified in High Fidelity Wraparound, but they are trained and are providing High Fidelity Wraparound Informed Care Management.

And then our lowest tier that we have, we call Pop Health, which is really our prevention and wellness. That's for our enrollees that have limited healthcare needs. That ratio is one to 400, probably more reminiscent of what we see from a managed care management, and with that they still have access to our care managers and our services. They are actually being outreached by our team members on a quarterly basis, but, you know, if any issues arise, our team members are assessing them and able to move them throughout this continuum of care management that we have here for our members.

So it's a very brief, quick, high-level overview of SKY and care management. I'm going to turn it over next to Susan, who's going to walk through
Psychotropic Polypharmacy.

MS. VICKERS: Good afternoon. I'm Susan Vicars. Again, I'm the Director of Quality for the SKY program, and we want to just really, before we share the nuts and bolts of our program -- Kelly set a beautiful stage for SKY in general and now we would love to just kind of lay some groundwork of what does this population really look like, and show you how kind of the challenge of psychotropic polypharmacy has really shown its face in this population.

So next slide, please.

So one thing I'll start with, we, as part of our contract, really were challenged to collaborate with DCBS, DMS, DJJ, and all of our system of care partners to figure out a way to collaborate and help solve this issue among our system involved youth. This is, as you all know, every day just a highly sensitive population. They have -- as you can see, our ACES Assessment Scores and the prevalence of those higher, you know, five, six, seven, eight, nine scores on the ACES is very among our population. We have a
high prevalence of SDoH needs through the assessments that we are doing upon enrollment and on an annual basis with our members. And then each of these members especially those, you know, currently in that out-of-home care, you know, really do experience and have been through the cycle of trauma, as you can see there.

So we also have such a high prevalence of behavioral health diagnosis in their population. We have about 28,000 members, as of this month, and last year, in 2021, we had about 17,000 members who had a behavioral health diagnosis on a claim last year. So we are looking at about 62 percent of our population who are affected, you know, somehow with a BH diagnosis.

Next slide, please.

We also know that psychotropic polypharmacy, with all the good work that's been done in the past five or ten years, is highly prevalent among this population. Our Medicaid insured youth are three times more likely to be prescribed an antipsychotic compared to those on the commercial side.
And then our foster youth specifically are
twice as likely to be prescribed as those
other Medicaid insured youth. We see higher
levels of psychotropic meds, you know,
typically experienced in out-of-home
settings. So this is just a high need and
we see it as a pain point in our system that
we hope we can work together to really, you
know, eradicate is my dream.

So next slide, Kelly.

Before we go really any further, we
want to define what we are considering
polypharmacy and psychotropic polypharmacy
using peer-reviewed literature. Dr. Lohr
from DCBS has really been our guiding force
in this and such a wonderful partner. One
of his -- he and his peers published an
article last summer that really did help us
stratify our members into kind of two
levels. The psychotropic polypharmacy, the
meeting of that criteria with at least two
or more classes, and then a higher level
psychotropic polypharmacy with at least four
classes of psychotropic meds, at least in
the last 30 days during a calendar year.
So, you know, when we started these efforts, we really struggled on how are we going to define this, how are we stratify this population, and these definitions have definitely been helpful in our program and in our approach.

Next slide.

So now that we have kind of defined that, those definitions we can explain that for psychotropic polypharmacy in our SKY population, as of last quarter about 10 percent of our members met that criteria of two or more -- at least two classes of antipsychotics. And then 3 percent of our population met that criteria for high level psychotropic polypharmacy, which is at least four classes.

Next slide.

So another -- you know, as Kelly said when we very first started, that youth and family voice, choice and preference is paramount. It's one of our guiding forces. And I think one of the very, very helpful resources that we have used through SAMHSA were some focus groups and listening
sessions done at the national level among many, many different families and youth, and really share that there's a high concern among families, among youth related to giving these meds. They need their information in lay terms that they can understand when they are discussing this with their providers. They need prescribers really to provide as much information as possible about alternatives to the treatment option of using an antipsychotic medicine, you know, what are the other alternatives, what are the side effects, what are, you know, things that can be done in conjunction with this treatment option. And then the last really main point that was shared was the need for development of young adult and transition-age youth targeted educational materials.

So as you will see when we get to Megan's portion and showing some of our interventions, this has been a guiding force for the development of our program.

Next slide.

Then, finally, you know, you have
to -- you have to use some good framework in order to prop something up like this, especially in the last year, right, Kelly, of developing and implementing our SKY program. And SAMHSA really does provide all of us a framework.

There is a framework for best practice in antipsychotic prescribing, and that really does use a system-based strategy for system-level change, and that really does involve engagement, as we mentioned. It involves multi-modal interventions and approaches, engagement of prescribers. We will show you a little bit about some of that intervention that we started with prescribers. And then just considering the unique needs of this population, which we have, you know, covered just now.

We have worked really hard to coordinate with all of the different systems and sources of care among us, and also looking for that, just, you know, a financing mechanism to make sure this all happens. I think one thing that we have really, really worked hard to reinforce is
that very last column, making sure that all of our interventions are trauma informed, that we are pushing as much evidence-based practice in our system of care and supporting that through Aetna's initiatives, and also being as open and honest as we can about this, and showing everybody that we know that this is an issue that we want to fix together.

Next slide.

So Megan's now going to explain our approach and the programming that we have implemented in the past year.

MS. JOHNSON: Hi, my name is Megan Johnson. I am the Quality Nurse Consultant for the SKY Program, and I'm going to be talking about how we have approached addressing psychotropic polypharmacy in the SKY population.

Our program has some overarching goals that we would like to achieve, and I'll just review those real quick with you. The first would be, of course, to reduce the number of members who meet criteria for high-level psychotropic pharmacy. So that would be
those kids who are on four or more classes of medications. So we definitely want to decrease the number of those. We also want to reduce the overprescribing of psychotropic medications, when a nonmedical clinical intervention is appropriate. So if we can manage symptoms through therapy approaches, we definitely want to push for that.

We want to increase the appropriate metabolic monitoring for those who are prescribed antipsychotics. So we have a lot of kids who are on antipsychotics and haven't completed metabolic monitoring. So we really look at that and we track -- you will see in a few slides we track that over time. Then we also just want to increase education among prescribers, DCBS staff, DJJ staff, caregivers, children and family, and foster parent and then the transition age youth. We want to make sure that they are pushing informed consent and making sure that the prescribing practices are appropriate.

Next slide, Kelly.
Susan mentioned a minute ago about how we stratify these populations. So what we do is we kind of put our kids into three buckets. We have that high level psychotropic polypharmacy bucket and those are the kids that are on four or more classes. Then we have our psychotropic polypharmacy level. Those are kids that are on two or three classes. And then we have our rising risk children who may be on one medication, they're really young, they haven't had any BH visits, their placement has changed several times in the last couple of months, and they may have had an admit to a recent -- to a hospitalization to a -- psychotropic hospitalization. I'm sorry.

Next slide.

In our polypharmacy program we do a lot of different interventions. We have a multi-modal model. We work with DCBS, DJJ, DMS provider networks to ensure that all partners at the table are aware of medications that the members are on and feel that these are appropriate choices. We take a trauma-informed approach and we apply
those principles any time we are working
with members.

We share population and individual
level data and analytics, and drug
utilization reviews are completed on a lot
of these kids. We have our pharmacy team
come in and look at the medications that
children are on. We also have recently
invested to increase access to
evidence-based psychosocial interventions.
So we recently provided some money to
increase the number of providers in Kentucky
who have EMDR training.

We also have created several caregiver
and youth directed education in lay terms.
We call this our Medication 101 education.
This is what Susan mentioned that was needed
in this population. They want to understand
it in lay terms.

And we also work on prescriber
education. So going back to that informed
consent and deprescribing, which Dr. Lohr
explained is just a conversation about the
medications and making sure those are
appropriate.
And then our team, our pharmacy team, and Dr. Lohr does a lot of provider outreach and, like I mentioned before, the clinical pharmacy reviews.

Next slide, Kelly.

So how do we do this? How do we touch these kids? We have a high touch care management approach, and once these kiddos are identified on our internal report, they are stratified, and those that are at highest risk are taken to our case rounds internally. They also may be referred for a consult with Dr. Lohr. Those are one-hour conversations with the interdisciplinary care team that occur on one child at a time. So we have completed several of those in the last little bit. You will have some numbers on the next slide.

Then after we do these consults and these reviews, we go back and look at outcomes after 90 and 180 days. So we want to know have our interventions made a difference or do we need to revisit this kiddo and see if we can change our approach. And then we look at our outcomes and
monitoring, you will see on the next slide, Kelly. Sorry.

Here are some of our outcomes for 2021. I mentioned before -- on the right you will see the graph for metabolic monitoring. In our SKY polypharmacy population we actually have a very good rate of metabolic monitoring for those kiddos who have had both blood glucose and cholesterol testing if they are on antipsychotic. We started at 5 percent in first quarter last year, and preliminary results show that about 45 of percent of our kids who meet criteria did complete both blood glucose and cholesterol testing. We also completed 173 of those polypharmacy rounds that I mentioned, and those DCBS consults. That was from 1/1/21 through the first quarter of 2022.

And on our outcomes tracking system we were able to identify that at 90 days post-rounds/consults, 28 percent of our members have generally successful outcomes, and then when we go back and look at six months, at 180 days, about 44 percent of our
members have generally successful outcomes. 
So we are seeing that the more we work with 
these members and the more time we spend 
with interventions, that we have better 
outcomes. And over in 2021 we were able to 
reduce the pharmacy costs among these 
members by 23 percent. 

Next slide, Kelly.

So future state, we have lots of plans 
for our polypharmacy program. We have a lot 
of future opportunities that are in the 
works. We are hoping to build a community 
round table that would include BH provider, 
DCBS, DJJ EMS, DMS prescribing youth and 
family and pharmacists. We are hoping we 
can get everyone to the table and get some 
interventions in the works. We really, 
really want to have some feedback to make 
sure that we are doing everything we can for 
this population. We also want to increase 
prescriber education on deprescribing and 
informed consent. This is something that we 
are passionate about. Like I said, 
deprescribing is not asking providers to 
quit prescribing. It's just a conversation
about whether or not medications are appropriate.

We also want to want partner with community pharmacies to see if we can get these kiddos at the point of sale. So if we can engage them when they are picking up their medications and hopefully get them in our case management program. We really want to make sure that they have all of the information that they need.

And then we are also in the process of creating some transition-age youth directed programming to address those needs among that population. And like I mentioned before, we are working to increase the access in Kentucky to evidence-based practices with our EMDR programs.

And I think that's everything. Kelly, I can turn it back over to you if there's anything you want to add.

MS. PULLEN: I was just going to add, thank you so much for the opportunity to present to you today. If you have any questions, feel free to let us know. Our team is here and happy to answer anything that you may
have.

MS. SCHUSTER: Thanks so much, Kelly, and all of you on the Aetna team. Will you make these slides available so that everyone who's on can get those?

MS. BICKERS: If you e-mail it to me, I can send it out to the entire grope group and post it on the website, and I will drop my e-mail in the chat.

MS. SCHUSTER: If you will e-mail it to Erin. Thank you, Erin.

I have a couple of questions that are more specific because I remember when this information was first presented -- this goes back years ago -- there were a couple of things that really struck me. One was how many very, very young children were on psychotropic meds for which there really is no FDA approval, and I wonder if you have some break down in your data on that issue. Let me tell you what my other issues are and then you can tell me if you got that data. That was one.

The other was an inordinate number of kids that -- again, this goes back six years
ago or so -- who didn't even have a
behavioral health diagnosis, but were on at
least one and sometimes multiple
antipsychotic medications, so I wonder about
that. And then the third thing I remember
about that is what looked like a correlation
between number of meds and the number of
different placements that a child had had,
so it almost looked like every time a child
was put into a new placement and first sign
of trouble or whatever, another med was
added. So I wonder if you have any data on
those points, please.
MS. VICKERS: We have tons of data on all
of those points.
MS. SCHUSTER: I'm sure you do. I guess
what I'm looking for is some hope that
things have improved, all three of those
categories.
MS. VICKERS: You know, I was just saying
to Megan and Kelly that we aggregated our
report so much in the beginning looking at
age, looking at placement. And now we have
used that more as triggers for our member
level interventions. So when we see a
6-year-old that member literally automatically, rapidly, you know, goes into higher tier and goes straight to our rounds. And so we will definitely get that aggregate information to you as far as over the past year how many 6-years-olds. I know that when we have aggregated the utilization population, we have seen that age -- really the 11, 12-year-olds were the highest, kind of in the bell curve. But as far as the prevalence among age six and under, we can definitely get that information to you. And then we also, again, use the Placement Stability Report the DCBS provides us so that we can see how many, let's say, children who have had more than three moves in the last 90 days. If a child is on that -- in our utilization report, that also triggers a more rapid response and more focused intervention in the higher kind of risk stratification. So we can definitely kind of breakdown our latest population report into those categories and definitely get them to you.

And I think we need to look at the
diagnosis. We have that on the report and have never actually pulled the report by diagnosis without -- with the none, you know --

MS. SCHUSTER: I was going to say whether they even have --

MS. VICKERS: Right.

MS. SCHUSTER: -- just amazing to me that we had young kids without FDA approval on a psychiatric medication with no behavioral health diagnosis. I mean that was just -- and I don't know if David Lohr has access to that early, early information. I mean, I would love to see some comparison of where we are compared with where we were before you-all were even SKY, before SKY was even conceived. But I'd like to think that we are doing better by these kids, because that first report was just terrifying. Marcie Timmerman just put in the chat, was absolutely terrifying. And those of us who have been in child clinical work for many years just -- anyway, I'd love to think that we are making some progress.
I love what you are doing in terms of interventions and it seems very comprehensive, so that we have not only the data, but you also have mapped out some multi-modal and multi-systemic interventions, which is really what these kids need. So I'll quit talking, see if we have any other questions from anyone. But I'd appreciate any follow-up that you can give us, Susan. Thank you.

MR. SHANNON: I'd also like to know what class of provider is prescribing it, you know, pediatrician, primary care, child and adolescent psychiatrist.

MS. SCHUSTER: Nurse practitioner --

MR. SHANNON: APRNs, nurse practitioner. Are there other folks who are prescribing those. At one point I saw a list and, believe it or not, ear, nose and throat docs were on the list, probably for sleep, but just to so we really understand who's making the decisions that are being -- you know, these are pretty serious things and who's doing that work. I don't know if you have that data as well.
MS. VICKERS: We have a lot of data. We actually -- you know, the first two quarters of last year when we were really just developing baselines, we did try to take a look at that class of prescriber that was attached to each of the kids on the utilization reports. I think we have some work to do on how to break that down. And I think, too -- and Kelly can help me explain this. I think what we saw at first, we were quick to judge almost, like, well, there's some prescribers out there that we need to look at. Well, actually, you know, when you break it down -- if you take our -- however many thousand kids on this report and break it down by prescriber, many of them just have a high level or high volume of patients. And so it's really hard to kind of pinpoint, oh, there's an overprescriber out there.

MR. SHANNON: Right.

MS. VICKERS: We have done some work, especially with your medical director, if there is. And our care management team has been incredible at this. While they are
reviewing these members on a monthly basis, if they feel those kind of red flags going up or noted some prescribing practices member level, then we are actually going in and looking at that, is this a potential quality of care concern, and addressing it kind of member by member, because when we looked at our big aggregate report, it was really hard to drill that data down that was fair for prescribers and didn't -- you know, kind of unjustly target someone just because they had a big practice.

MS. JOHNSON: And I would like to add too that some of those providers were working in patient and outpatient facilities, so they had a higher volume of prescriptions. And so it was unfair, like Susan said, to say that they were overprescribing when they just had a higher volume of patients.

MS. PULLEN: So I was going to sum up, we have the data in terms of who those prescribers are. We just are very careful not to draw conclusions from it. So we absolutely share the data. Our team is just being careful not to draw those
conclusions just given the nature and the structure of the system.

MS. SCHUSTER: Well, the truth is that as long as we have the dearth of a particularly child psychiatrists in the state, and even pediatric mental health NPs and so forth, we are going to have to look to other prescribers. I mean, there's no way around it. So I think that's a good point.

Do we have any other questions from anyone of the Aetna team?

MS. MUDD: I know personally as a consumer, I often have polypharmacy issues, and I know this is specific to you. I was just curious, when the polypharmacy -- are they using, like, super old meds, are they using a combination of all these different classes? Is it mostly atypicals? What kind of things are they using?

MR. JOHNSON: So we actually don't see a lot of atypicals used in this population, but we do see it sometimes. And I will say that our team, our pharmacy team and Dr. Lohr have been fantastic. If they see
something that doesn't look right to them,
the first thing that Dr. Lohr asks is that
we do a psychological evaluation to make
sure that the meds match the diagnosis. So
that was something you mentioned Sheila.
And I would love to run a report and see if
there are any that do not have a BH
diagnosis. If they have not had an eval in
the last year or two years, Dr. Lohr always
starts there. So we always make sure that
the meds are appropriate for the diagnoses
when we do see that. But we haven't seen a
lot of the atypicals used, I will say that.
Any time I red flag those up, we always go
to our partner Dr. Lohr. He's fantastic at
working with us. He's very responsive,
very involved. And then our pharmacy team
does some outreach, too, to make sure that
the meds are appropriate.
MS. MUDD: I mean, I'm going back to the
Haldols and that kind of stuff when we are
not using atypicals. That just seems a
little odd to me.
MR. JOHNSON: We have actually seen a lower
volume of atypicals, and I don't think we
actually have very many members at all that are on Haldol. And we do break it down usually by member, so we look at each member's regimen instead of looking at overall. We try to do that member-specific approach to make sure that what the member is on is appropriate for their diagnosis and then have they tried -- what have they tried previously. So that's where we start when we do these consults. We start at birth. So we say what's the birth history, were they born early, were they premature, what kind of trauma did they experience. We start at the main beginning and get as much information as we can, so that if we see a kid who's on a med that makes us question things, then we say, okay, what have they tried in the past, is there a reason that we are doing this medication.

MS. SCHUSTER: Thank you very much. And I agree with Dr. Brenzel that this is good work. I'm encouraged by the amount of teamwork that's going into this and with an emphasis on nonmedication interventions, so that we don't go first to a pill or
something like that, but that we really try

to address the challenge and the situation

whether with their family of birth or some

other living situation, to try to do the

intervention. So we certainly applaud the

work that you-all are doing over at SKY and

so appreciate your presenting to us.

MS. PULLEN: Thank you for having us. And

I would say we can't do it with DCBS and

our partner Dr. Lohr. So shout out to

Dr. Lohr and DCBS.

MS. SCHUSTER: I've known David a long

time, and you have got an excellent leader

over there with David Lohr. Thank you so

much. We sure appreciate it.

Let me go next to the next issue and

it's also about medications. I didn't get

any specific issues with the Medicaid single

formulary. I did want to tell you that I

had some follow up with some staff over at

the pharmacy. April Prather is a PharmD

over at DMS, and really was helpful to me in

working with a prescriber about -- this was

something that Val brought up -- with an

issue around dosages and getting Spravado
approved and so forth. And I really
appreciate the back and forth and the help
that we got from the Medicaid staff in that
regard.

Chad Grant is on. There was a bill
passed, a resolution, House Joint Resolution
28 about prescription digital therapeutics.
And he's got someone who can give us a very
brief overview of what PDTs are and how they
are hopefully going to be used in our battle
against substance use disorders and opioid
use disorders.

So, Chad, if you want to introduce
your person there.
MR. GRANT: Yeah, definitely. Thank you,
Dr. Schuster.

Joining us today is Dr. Scott
Schepers. He leads up all of the medical
team with Pear Therapeutics. As many of you
know, and I see a lot of familiar faces on
the call, we have already had a pilot stood
up through Core. We are on our second
pilot. We are working towards trying to
figure out what can we do to get, you know,
Medicaid to reimburse us.
House Joint Resolution 28 itself is asking Department of Medicaid Services to give some formal response from CMS, so we have a few months while that's happening. But I'm just going to hand it over to Scott so he can give you a little bit of introduction as to what PDTs are and then hopefully maybe even come back to Behavioral Health TAC and give a more detailed overview of some of the things we are doing specific to opioid use disorder. So go ahead, Scott.

MR. SCHEPERS: Dr. Schuster, would it be possible for me to share a couple of slides?

MS. SCHUSTER: Yeah. Erin, can you help do that please?

DR. SCHEPERS: Thank you very much.

MS. BICKERS: You're very welcome.

DR. SCHEPERS: Let me find out how to do it. It just disappeared off my screen. Oh, here it is.

Okay. So I'm just going to provide a high-level overview on the process to help us better understand what a prescription digital therapeutic is. So I think one way
we can think of prescription digital
therapeutics is just a new modality of
treatment that are being introduced into the
standard of care for patients. So we see at
the bottom of the slide all of the different
types of treatments that have been
introduced to patients over the past 100
years or so. And I think of these as very
similar in the sense that they are designed
to treat serious disease with high unmet
needs. But a prescription digital
therapeutic is also very good in the send
that it's a treatment delivered via software
rather than a pill or protein. But all of
these different types of treatments are
going through a similar process with the
Food and Drug Administration in which they
have safety and efficacy, validated and
authorized by the FDA for their safe and
effective use. They are also reimbursed
through pharmacy and/or medical benefits.
But one of the other differences with a PDT
is that it does provide real-time feedback
to clinicians. So when you prescribe a
blood pressure medication or an
antipsychotic, we don't really understand in many cases how the patient is proceeding with their care, some of the outcomes, until they come back for a follow-up session. But with a PDT we have the opportunity to see that as the patient progresses through their care.

So just a high level on how these therapeutics work through the FDA. They are authorized under a denova or a F10K process as a Class 2 medical device with special control. So these are neurological therapeutic devices with special control, which, number one, requires a prescription and, number two, requires the submission of clinical data validating that this is an evidence-based form of behavioral therapy, and that it's validated as delivered through the digital device. So these are reviewed by the FDA and then once the FDA gives them their stamp of authorization, they enter the post-market surveillance system as well. So like a drug, safety is monitored, patient feedback, complaints, adverse events, are all collected and reported out as required.
by the FDA.

The final thing I'll just share is that is a growing class. It's not -- it's not a deep class at this moment, but we do see these different types of therapeutics entering the market from a variety of different companies. The first three that we see at the top of this slide are from the company I work for, Pear Therapeutics, that we have used and have deployed in the state of Kentucky, Substance Use and Opioid Use Disorder reSET and reSET-O. And Somryst is Pear's prescription digital therapeutic for chronic insomnia. We see some of the other therapeutics from other companies that have been through the FDA process that treat a variety of different conditions, including irritable bowel syndrome, amblyopia. We see some additional chronic pain indications among those as well. So, again, high-level overview. Happy to take any questions or schedule a time for follow-up with the group.

MS. SCHUSTER: Thank you very much, Scott. Any questions? Let me ask you -- I think
Chad told me that you-all are in a pilot with the Core program here in Kentucky. Is that right?

MR. SCHEPERS: Yes, that's correct. Yep, I think we are on the second round. I can let Brad speak to the progress on that as well.

MS. SCHUSTER: Yeah. I guess I was curious about at what point might you be able to give us some report about how successful the use of the therapeutics was in that trial. And Dr. Brenzel is on, he probably knows about it as well. I don't want to rush things, but I would be curious to get, you know, some feedback about it.

MR. SCHEPERS: Yeah, absolutely. There's been one round of -- actually, I think we are on the second grant through the Core process, so there are some existing data and will have some more data as the second batch of patients run through the next round.

DR. BRENZEL: Just to comment briefly. Obviously, this is a prescription digital therapeutic. The issue is the Core was
able through some of its proposals that it received -- some of those grantees chose to use this as an intervention tool. The nice thing about that is it did allow some data collected; not national data, but Kentucky-specific data. But the key issue is for long-term viability and sustainability. Core is a transient grant program, and the challenge is that we build up provider familiarity, we build up demand, and then people spend the time to develop the ability to use this. We need a plan for ongoing, sustainable funding for how this will continue, because Core does not have the resources to fund this eligibility for all Medicaid recipients down the road. So I think that's where we are. Core did have a limited number of projects and we were able to fund those to get some good Kentucky-specific data.

MS. MARKS: And, Dr. Brenzel, I will add if there's anything that Pear is willing to share, Core is willing to share from the Core specific data.

MS. SCHUSTER: Okay. Thank you very much.
I guess my thought is that if you-all are at the point where Core and Pear are ready to present some data, I think we would all be interested in hearing that and the effectiveness. And Marcie asks what about the cost. I don't know what -- how you are handling cost at this point. And I assume that if you get Medicaid -- approval from Medicaid coverage of the cost, you are looking at -- and I don't know how long that process takes.

MR. BURRIS: Yeah, Dr. Schuster, I can address that. The cost for the app is 17.98. We do partner in a number of different fashions, including value-based arrangements, both purchasing pilots, grants, through Store monies and ARPA funds, but for both recent -- recent over the course of therapy does cost 1798. With that, presentation would really look forward to, is to be able to get into some of the control trials that were impressive to the FDA, as well as real-world evidence that does show a dramatic offset to healthcare resource utilization, things
such as ICU stays, in-house hospitalizations, and ER visits. So it more than saves the Commonwealth the initial investment. So it's tremendous ROI, but it's kind of hard to go into something like that without getting the baseline clinical behind it. We would welcome the opportunity. I guess we would rely on Chad to set that up as far as working with your schedules to relay that information.

MS. SCHUSTER: Yeah. And certainly with the input of Dr. Brenzel, Dr. Marks in terms of, you know, when Core is ready to participate. I guess the other question is -- I know the resolution directs our DMS to work with CMS toward approval for Kentucky Medicaid to pay for this. Do you have any idea about a timeline there?

MR. GRANT: The only timeline we have right now, Dr. Schuster, is that because, you know -- is April, mid April, we got 90 days after that for the enactment date. It would probably be sending in the request, or at least what I've heard over from Kevin
at Health and Family Services between July 15 and August 15, and then the report itself is due back to the legislature, and that's both state and federal, by the end of the year. So there is a little bit of a timeline here that we are trying to work within. You know, obviously, there's a lot of data we can share also from Peer outside of just Kentucky, you know. We have a lot going on already in Massachusetts and some other states where we do have agreements set up. So maybe if we did, you know, another overview from a medical type of perspective, we can add in some background also from other states. Maybe that will help.

MS. SCHUSTER: Marcie, do you want to share what you just put into the chat? Marcie is the Executive Director of Mental Health America of Kentucky.

MS. TIMMERMAN: Yeah, just letting folks know that MHA and NAMI all work together on -- I believe there's pending legislation on this, but I know that they have all been very active and advocating for coverage of
these kinds of things.

MS. SCHUSTER: All right. Well, stay in touch, Chad. I know you will.

MR. GRANT: Absolutely.

MS. SCHUSTER: And we are happy to have you back. This is exciting. Anything that can help us better address our opioid use disorders and more general category substance use disorders is something that we are definitely interested in. So thank you very much for being here to tell us about it.

MR. GRANT: We appreciate the time. Thank you.

MS. SCHUSTER: All right. Oh, follow-up question. Val said what was the name of the app for insomnia that you-all have, that Pear has.

MR. SCHEPERS: It's called Somryst, S-O-M-R-Y-S-T.


MS. BICKERS: If you would be kind enough to send me that, I'm happy to send it out to the board members.
MR. SCHEPERS: Okay, great.

MS. SCHUSTER: Yes, thank you.

Next item is our perennial item, Update on Claims Payments for Services to Dual Eligibles. And I guess Steve and Kathy Adams, I'll turn to you and ask where we are. Do we have progress, do we have fewer problems?

MR. SHANNON: I think there's progress on the Medicare side because there's a document that's been made available to the MCOs that really outlines those codes that -- it's really the Medicare Bypass List. Very little progress, I don't know what the strategy is on the commercial side. It appears that's -- and Kathy Adams can talk to that as well. There's so many different commercial carriers, a large number. It's much more challenging, that list. We are still struggling to get that, so it's clear and all those claims are paid, but there is a document that Medicaid provided to the MCOs that clearly -- and the Medicare/Medicaid issue is much easier to address, because, you know, the Medicare
is a fixed thing. The commercial side we still struggle with that on a regular basis.

MS. SCHUSTER: Okay. I think that Leslie yesterday just sent me that code list, so we can circulate that out --

MR. SHANNON: Yeah.

MS. SCHUSTER: -- to folks, so I will do that after this meeting.

Kathy, do you have any update for us?

MS. ADAMS: Yes, thanks. At the last Behavioral Health TAC Meeting we had obtained a copy of the Medicaid/Medicare Bypass List. Hopefully it's the same list you have got, or the one you have got is easier to understand. And we shared that back with Medicaid at the last meeting. I followed up and asked for some explanation on that list, because it was hard to understand, and was advised that they are working on a more user friendly, I guess, for the regular person to understand and a version to post to their website. That was the last that I heard on the Medicaid/Medicare Bypass List.
MS. SCHUSTER: Hold on just a second and let me just say I will send that out. As soon as we get off this, I will send that out to all of you—all who, you know, for whom I have e-mails. If you have not been getting e-mails directly from me about these meetings, please put your name and e-mail in the chat, so I can pick you up that way, or better yet, send me an e-mail at KYadvocacy@gmail.com, so I can get you on the list. But I will send that list out so that everyone has it.

Sorry, Kathy.

MS. ADAMS: No problem.

MS. SCHUSTER: Let's talk about with the commercial list, which is much more an issue I think for the kids.

MS. ADAMS: Absolutely. The Children's Alliance took an approach where we reached out to each of the MCOs, because we knew that some of them had commercial bypass lists, and we obtained copies of each MCOs commercial bypass list, and four of the six MCOs had those. Two MCOs that do not have the commercial bypass list we asked
specifically how do you get paid. What is the process a provider must follow when someone has commercial to get paid. We have gotten one example or a couple of examples from one of the MCOs where a member did not get paid after they did what the MCO said they needed to do to get paid, and they still have not gotten paid. And we're in the back and forth with the MCO and DMS on what needs to happen so that provider -- the provider can get paid, because, again, we they did what the MCO said they needed to do, they got the EOB or a statement where the commercial insurance didn't pay, but because it didn't say that it wasn't covered under their plan, the MCO still wouldn't pay it. And, again, you know, how much control does a provider have over what a commercial insurance puts on their EOB. So that is the concern where we are now. Again, it's two MCOs. The other four with the commercial bypass list, we are doing fine with those. So it's just the two that we are working on. And, again, this has been going on for years, as
Steve will attest to, and these providers just don't get paid when they're providing a service, a medically-necessary service in good faith to a child that had they not had had commercial insurance, the MCO would have paid it. You know, so it's like these children are being penalized because they have commercial insurance. And like you said several times, Sheila, is they should have better insurance coverage --

MS. SCHUSTER: Right.

MS. ADAMS: -- rather than less. So that's where we are.

MR. SHANNON: And a lot of the services that aren't paid, commercial, or even Medicare, never pays for. I mean, that's the real source of frustration, you know. So you end up -- I know we struggled a lot, Kathy, with targeted case management, you know. It's just not something that is paid for. And then, you know -- and then our struggle has been when we need to get EOBs, they don't -- they are not going to deny a benefit they don't cover.

MS. ADAMS: Exactly.
MR. SHANNON: So you don't get that
document and, you know, we've sung this
song too long, and it's not a very good
song anyway. So, you know, it comes and
goes. And I anticipate that in six to nine
months there will be more problems with
folks who are dual eligible. It just kind
of comes in waves, you know. It seems to
be better for a while, then it becomes a
problem, so...

MS. SCHUSTER: Who are you working with
over at Medicaid, Kathy?

MS. ADAMS: I forget the gentleman's name
who has e-mailed me back. I think I have
included both Cherie and Angie.

MR. SHANNON: Uh-huh (affirmative).

MS. SCHUSTER: Angie Parker, yeah.

MS. ADAMS: Yeah. Let me -- I got my PC.
I can't pull up her email right now to see
the gentleman's name.

MS. SCHUSTER: Because originally we were
working with Lee Guice on this, and I don't
know -- Leslie couldn't be on today because
of a family issue. And both the
Commissioner and Veronica, Deputy
Commissioner Cecil, had prior commitments. But let me get with them and see who it is that we need to be talking to over at DMS because this is -- Steve Shannon and I -- this goes back, this is like the SMI Waiver, Steve. This is 20 years of discussion and it's still just makes no sense to me that if you have two insurance coverages you get poor care. Well, you get the care but the provider -- MR. SHANNON: The worst thing that can happen.

MS. SCHUSTER: Yeah, it's the worst thing that can happen. It's almost worse to have dual coverage than it is to not have it.

MS. ADAMS: And it does hurt the client because what ultimately happens is providers quit seeing clients that have commercial insurance, too.

MS. SCHUSTER: Yeah.

MS. ADAMS: Because they can't keep seeing patients and provide the services and not get reimbursed, so they just have to stop, and that's what several of our members have done. I will get the gentleman's name that
I'm working with at Medicaid and send that
to you, Sheila, and then if there's
anything else that you need from me.
MS. SCHUSTER: Yeah, anybody else that you
have been working with. And then I'll get
with Commissioner Lee and Leslie and
Veronica and see. I do remember now that a
couple of meetings ago Diane Schirmer
talked about providers stopping covering
people because they had both Medicaid and
Medicare. Do you remember that, Steve?
MR. SHANNON: Yeah.
MS. SCHUSTER: I think somebody stepped
forward and said, you know, I think we can
work this out on the side, but that is --
that is a very good point that -- and we
can't blame the providers for dropping
them.
MS. BICKERS: Kathy, are you by chance
working with Justin Gehringer? That's Lee
Guice's assistant director.
MS. ADAMS: No.
MS. BICKERS: Okay. I just wanted to --
MS. ADAMS: It's not Justin. But I do
think his name starts with a J.
MS. BICKERS: John Hays?

MS. ADAMS: Don't think so.

MS. BICKERS: I'm out of Js then.

MS. ADAMS: What was the last name you said?

MS. BICKERS: Hays.

MS. ADAMS: Okay.

MR. SHANNON: -- thinks it's Jeremy Armstrong DeRossitt.

MS. SCHUSTER: Kathy, let me know.

MS. ADAMS: I think that's it. I think that's it.

MR. SHANNON: Yeah, I think that's the name I've heard before, too.

MS. ADAMS: He's under Angie's group, so that's probably right.

MS. SCHUSTER: Okay. We just need to come up with an answer to this. So I will do two things. One is I will send you--all out the bypass list that I just got yesterday from Leslie on the Medicaid/Medicare, and let's see how it lines up with what you had in the past, Kathy. And then I will get with the higher ups over at Medicaid and see who is it that we need to work with,
that we really need to maybe have a sitdown on this, because this has gone on and on and on. So thank you very much, Steve and Kathy, for your reports on that.

On the No Show Data-Gathering Panel and How the Data Will Be Used, and we have worked on this for the last couple of meetings. And in fact we made a recommendation to the MAC that Medicaid should send periodic reminders to all providers about the existence of this data-gathering portal and encourage them to use it to report missed appointments and so forth. The interesting thing is if you-all watch the March MAC meeting, there was an item already on the agenda about this, and so there was a lot of discussion and a lot of people on the MAC chimed in that they were not aware of it and had not been encouraging people to use it. So I think our recommendation came at a very timely place, and I think the best that we can do is to continue to encourage providers to use that portal. It is a way to get the MCOs' attention. And I think the reports we got
at the last meeting from each of the MCOs indicated that they were using it in a very appropriate way to reach out, particularly with missed behavioral health appointments, to see what the barriers were, to see whether there was something in the social determinants of health or in their case management that they could assist with, which is really what we want. What we wanted to be sure was that people were not getting stigmatized in any way for no shows, but that they were getting the assistance that they needed. So let's make a concerted effort for those of you who are providers, and who have providers that you are working with, that we really make a concerted effort to use that portal and report the no show data.

Any other questions or comments on that from anyone?

Okay. We also have had several discussions at the last couple of meetings, and I think again, Kathy, this was an area that you had brought up some very specifics about the increasing number in requirements
of the MCO audits. And I wonder if you are seeing any change, any improvement, any responsiveness to some of your concerns?

MS. ADAMS: Yes, we have. At the last meeting you asked each of the MCOs to let you know if there were any that had less than a 30-day turnaround time and they were going to follow up on that. I had examples from our members on where they had audit letters -- one was a five-day turn around and I think the other one may have been a ten-day turn around, with two different MCOs. And so I followed up and shared those examples with each of those MCOs. And the first was Humana and got a response very promptly that they had reviewed their audits, and this was a new vendor that was going to be performing a particular type of audit for them. And so that they had talked with them and they were going to extend that timeframe back to 30 days, so then all their audit letters should be 30 days going forward. So that was Humana.

And then also worked with WellCare, and they only have one audit letter that did
not have the -- at least a 30-day turnaround
 timeframe, and that was the example that I
 had from a member, and it was specific to a
 HEDIS audit, and they have agreed to extend
 the turnaround time on those to 14 days,
 with the option for a 30-day extension. So
 what I've been told is that all of
 WellCare's audits now are at least 30 days,
 except the HEDIS audit you get 14
 automatically, and then you also have an
 option to request 30 days. And as far as I
 know, the other four MCOs I have not
 received examples that they have any audit
 letter less than 30 days, and I'm not
 getting the complaints I was getting either.
 So I don't know if the audit letters have
 slowed down, but -- or it could just be that
 our members are in crisis and they don't
 have time to respond. But I am not hearing
 any complaints, which is great, and a
 special thank you to the folks at Humana and
 WellCare for working with us and being
 collaborative.

MS. SCHUSTER: And I did hear back -- I
think everybody reported at the meeting,
with the exception of maybe one or two MCOs, and I got follow up e-mails, and all of them said that their audits were 30 days. So I think maybe, again, for those of you who are providers, who represent classes of providers or groups of providers, I think the expectation should be that all audits should have a 30-day turnaround time. And, if not, then, you know, get back with the MCO directly. Our understanding is possibly with the exception of WellCare and the HEDIS. But remember, and Angie Parker has said this over and over again, as has Veronica Cecil and Leslie Hoffman, it is the prerogative of the provider to ask for an extension. So instead of killing yourself to get these things in when it's an inappropriately short time, ask for an extension to 30 days, which should be the norm, and you can let me know, or if you're obviously in the Children's Alliance, let Kathy know, or if you're one of the CMHC's, let Steve know, so we can stay on top of that. But I'm glad to see that we have had
some improvement in that.

Have you heard anything otherwise,

Steve, that's different than that?

MR. SHANNON: No, I have not.

MS. SCHUSTER: Good. Maybe we can take
that one off the agenda going forward.

Status update on the SUD Waiver. I
know Leslie is not on, and I don't know if
anybody else from Medicaid is prepared to
give that update.

DR. THERIOT: Hi, this is Dr. Theriot. How
are you doing?

MS. SCHUSTER: Fine, thank you.

DR. THERIOT: There's really no update.

It's still in CMS's hands. And monthly it
is brought up on the CMS meetings, and they
are working through the budget neutrality.
So it's basically the same update as last
month and the month before that.

MS. SCHUSTER: Yeah, thank you.

MR. SHANNON: And that's the update we got
on the Persons Returning to Society from
Incarceration TAC this morning.

MS. SCHUSTER: All right. So I'm marking
that -- I think that waiver was submitted
maybe in July of 2019.

MR. SHANNON: November.

MS. SCHUSTER: November, okay. I was thinking that we had worked on it all that summer. Maybe we were working on the comment part, is what I'm remembering. So we are going on -- we're a year and a half at this point.

MR. SHANNON: Three years.

MS. SCHUSTER: Three years.

MR. SHANNON: Three years in November.

MS. SCHUSTER: Oh, three years in November. Okay. So we keep hoping that there will be positive movement on that and we will keep it on.

For those of you who are not familiar, it is a new direction for CMS to go, because typically Medicaid services are not possible if someone is incarcerated. And this is really an innovative waiver that would allow incarcerated persons, who are Medicaid eligible, to receive SUD treatment while they are incarcerated and, you know, probably even more important or equally important, it really sets up a continuity of
care that the moment that they come out of incarceration, that Medicaid service array continues to be available to them. They are hooked up with an MCO and so forth, so that people don't drop through the cracks. So we are anxious for that to get approved. And Kentucky would be the very first state to have such a waiver. I understand that a number of other states have looked at our application and are trying to mimic it and lean on CMS to also get approved, so we will see. It would be nice to be out there first on something like this.

I sent out late yesterday a kind quick and dirty summary of actions taken by the Kentucky General Assembly related to Behavioral Health. And actually was kind of an upper as I looked at -- these are just bills that were passed. There were many other bills that, you know, had to do with Behavioral Health that came close or had some discussion and did not pass. But you have that list in front of you, ranging from the budget issue to really innovative approach in House Bill 44 that came from
students to have an excused absence for a mental issue. Unfortunately, it was watered down in the senate to make it -- leave it up to each school district to determine if they wanted to do that or not, but it's still -- you know, it was a movement in the right direction. And the fact that it came from a rural-based student and an urban-based student who both came to their legislatures with it and were able to testify in Frankfort on it, very positive.

We continue to see more licensure compacts passed by the legislature. These are the ability of a particular group of providers -- in this case the licensed professional counselors -- to enter into an interstate compact that would ease reciprocity with other states. This was one of the recommendations also from the SMI Task Force.

The year before this session the psychologists passed a compact, so we are moving forward with the idea of easing reciprocity.

House Bill 79 identified PTSD and
provides treatments for telecommunicators. Those are the dispatchers. And, quite frankly, I, for one, had not thought about dispatchers as first responders, but if you think about trauma they are the ones that are getting those calls immediately when a situation is going on. Very often staying engaged by phone with the person who is making the report, and they were able to identify that some of these folks are really suffering then with PTSD following that trauma and hearing about that trauma and then knowing the outcome. So this was a very positive bill.

Representative Duplessis made some changes in telehealth and answered some questions that a number of providers have had. He talked with me about this at the beginning of the session. This, again, came from a constituent. I think it was a youngster with an eating disorder and we know how difficult it is to get treatment. And the youngster was out of state -- I think a college student was on spring break -- and calling back to her therapist
in Kentucky really needing -- really in crisis and needing services, and was told by that provider that they didn't think that they were able to do that, to provide those services if the client was out of state. So this really requires the licensure boards to make telehealth available whether the provider is instate or not and whether the client is instate or not, as long as they are duly licensed -- I mean, you know, appropriately licensed and it's a covered service.

So hold on one second, please. Thank you.

Another bill was a psychology bill that required three hours of CE on social and cultural factors. Really brought about by the telehealth boom. So you have essentially urban psychologists that are now able to provide services to rural Kentuckians. And we have some cultural, language and social mores that are perhaps different and not as familiar to them. We want to be sure that psychologists are up-to-date on social and cultural issues.
Also, allows predoctoral interns to qualify for licensure as licensed psychological associates, so that they can be reimbursed by Medicaid during their internship. We are hoping that this will grow the number of internships for graduate levels, doctoral level psychology interns in Kentucky. We know that if people come for internship, very often they stay where they have their internship. So it's a way to grow the psychology workforce as well.

House Bill 362 was Representative Moser, and many of you remember Casey's Law. Charlotte Whitaker's son, Casey, who died of opioid overdose in early 2000. And she has worked tirelessly to make sure that there's a way to get treatment for someone who really doesn't want to or doesn't acknowledge that they need treatment. So it's been on the books since 2004, and there was some questions raised from a legal standpoint about how the diagnosis was being made and whether it was subject to subpoena or not. So those few technical changes were made to update Casey's law, and it's in
effect right now. It was passed with an emergency clause, which makes it immediately applicable.

House Bill 777. I see that Claire Arant from Kentucky Hospital Association is on. This was a bill that had, I don't know, Claire, two or three numbers previous to this, Representatives Fleming and Moser. And this was an attempt to make sure that all patients, whether for physical or behavioral health reasons, would be transported from one facility to another without an inordinate delays, and so this ended up being a battle between the city governments and the county governments. It was a battle with the ambulance providers. It was a something that the hospital association, the mental health coalition, the nursing homes and hospice all wanted. And we've talked before at these Behavioral Health TAC meetings about ambulances coming and saying we don't have to transport those crazy people and refusing to take people. So hopefully with an oversight board that actually someone from KMHC will be sitting
on will be able to nip those problems in the bud and make sure that people get the transportation that they need.

HJR 28, we just talked a little bit with the prescription digital therapeutics. And, again, this is simply asking our DMS to request guidance from CMS for Medicaid coverage.

Senate Bill 90 is something that Senator Whitney Westerfield made his top priority. He worked with President Stivers and Senator Storm. This establishes actually a diversion program for behavioral health conditions, both SUD and mental health. It would be in ten counties beginning in October of this year and going for four years. And it would allow eligible individuals of treatment alternative instead of incarceration, could result in dismissal of the criminal charges upon successful completion of the program.

A little side piece is -- and I thought it was interesting -- also establishes telehealth services in jails, because we know that there are suicide in
jails. We know that there are many people with mental illness in our jails. So an excellent piece of legislation, was a long time in the making, and we applaud Senator Westerfield for hanging in there, because it many ups and downs during the session.

Senate Bill 102 was Senator Max Wise, who's chair of the senate education committee, and it makes a technical correction to the School Safety and Resiliency Act to include school psychologists and school social workers in the required data collection for school mental health providers. Previously it had been school counselors only. But it puts school psychologists and school social workers. As a side note, they had requested increased funding for school mental health providers, but I don't believe that that ever made it into the final version of the budget, which was unfortunate because we certainly are hearing -- and Steve sent out yesterday a compelling article from the New York Times about Glasgow, Kentucky and pediatricians being overwhelmed with the
number of adolescents needing mental health services, and we certainly are hearing that.

    Senate Bill 140 is a good bill. Val, I think you and other consumers would certainly agree. This, again, is Senator Wise and then Senator Danny Carroll from Paducah, to prohibit insurers from instituting step therapy protocols. This is the old failed first. You know, we are going to try you on the old psychotrophic medications like Haldol and make you fail on that before we are going to give you the more expensive medications, and so this would prohibit that.

    Senate Bill 178 with Senator Raque Adams, became what we call a Christmas tree bill. It started out as a very, very simple bill that addressed some need for more licensed alcohol and drug counselors to be able to provide supervision immediately. There's been such an influx of applicants to get that credential and the required supervision was not being able to be met, so they lifted some requirements for those supervisors. But then a number of other I
think good pieces of legislation got
attached to it. One was from Representative
Joni Jenkins to allow licensed narcotic
treatment programs to use with buprenorphine
products. Another, establishes an
opportunity for a new mother giving birth to
a baby with neonatal abstinence syndrome to
participate in drug treatment to provide
avoid termination of parental rights. So
right there at the hospital once a baby is
born and is diagnosed as having NAS, the mom
doesn't automatically lose parental rights
at that point if they are willing to agree
to an evaluation and participation in drug
treatment. And then something that's not
just behavioral health, but something that
many of us have been working for for years,
requires Medicaid coverage of healthcare for
mothers for 12 months postpartum, which I
think is going to be a real godsend.

There were several bills I can think
of that were not successful that addressed
postpartum depression, which is a growing
concern, and one that really shows the
health inequity. The incidence of
unfortunately successful suicides by black
and brown moms is I think twice as much as
for white moms, and so the whole I think
maternal health is a theme that we saw
through this legislation or legislative
session. So the Christmas tree bill had
some good things on it.

As you all know, we talked quite a bit
about the task force on severe mental
illness, and so I listed these separately.
Senate Joint Resolution 72, Senator
Alvarado, requires the Cabinet to apply for
a Medicaid waiver for Kentuckians with
severe mental illness to provide supported
housing, including staff residences,
personal care homes, group homes and other
residential options as well as medical
respite, and also including supported
employment services. And it was signed with
an emergency clause so that goes into effect
immediately. This was the number one
recommendation of that task force and
something that some of us had been working
for, I don't know, 20 years or so.
Something that is much needed in terms of --
particularly the supported housing piece.

House Joint Resolution 5,
Representatives Fleming, Willner, Bentley, Prunty all were on the task force, and then Representative Palumbo. Encourages the licensure boards to either get into reciprocity agreements to join compacts or to reduce reciprocity requirements to include -- to increase the mental health workforce in Kentucky.

House Bill 127 also came out of that task force and it made recommendations put forward by Judge Stephanie Burke from Louisville District Court, who's been one of the few Tim's law cases, to make it more broadly applicable and to rectify some timing issues.

A huge success, something that NAMI has worked on since 2008 -- it only took us 15 years -- the passage of House Bill 269 to exclude individuals with a documented diagnosis of SMI, whose symptoms were present at the time of the serious felony offenses for being subject to the death penalty. So that's cause for great
celebration as far as I'm concerned. We had
done that for people with intellectual
developmental disabilities, and also for
youth 16 and 17 years of age. So not to
have done it with people with impaired
ability to make reason, decisions, has
really been criminal.

House Bill 645 started out at as 645,
but it passed as House Bill 604. And this
was the baby of representative Danny
Bentley, who was on the task force as well.
His Comp Care Center, Pathways, has mobile
crisis units that go to homeless shelters,
that go to rural areas where it's difficult
for people without transportation to get to
both physical and behavioral health. They
are equipped, some of them, with a
behavioral health person at one end of the
trailer, and physical health needs at the
other end of the trailer. So it was
attached to House Bill 604. That was passed
after the veto session on the last day of
the session. And the governor did veto some
line items, but not the ones that had to do
with the mobile crisis unit funding.
And then the final piece, House Bill 730 from Representatives Bray and Heavrin. Really initiated some discussion that needed to be had around the transportation of involuntarily committed individuals to a state psychiatric facility. So it reduces the time for detaining the individual and requires the Cabinet to monitor and maybe review the assignment of counties to each of the state's psychiatric facilities.

So those are the ones that came to mind. If anybody has others that I missed, I'm happy to hear from you, or if you have any questions about any of these, happy to try to answer those.

All right. Hearing none, I'll see that as approval of the list. Thank you.

I also sent out a updated guidance document, prior authorization guidance, effective July 1st, 2022. PAs will be required for SUD residential and inpatient treatment services of the various ASAM levels. Can you put that up there, Erin? Do you have that?

MS. BICKERS: I don't, but give me just a
second.

MS. SCHUSTER: Thank you. I think it's important to realize that this is only about SUD and it's only about residential and inpatient. I got a question from someone who said, oh, oh, it's behavioral health, and I said -- or mental health. And I said, no, no. It's SUD. So I just want to make sure that people -- what I don't know, and I don't know, Steve, if you or somebody from DMS, what are the different provider types that are listed there? Are you familiar with them, 02, 03, 06? Okay. Is there anybody on from --

MS. JONES: So 03 is your BHSO. Your 02 is going to be your psych hospital. And 06 is going to be your CDTC, your chemical dependency treatment center.

MS. SCHUSTER: Great. Thank you very much.

MS. BICKERS: Can you see it now?

MS. SCHUSTER: Yes.

MS. BICKERS: I apologize, my computer was running slow.

MS. SCHUSTER: Thank you. And I should have let you know that we wanted to see
that.

The second point that's bolded is just a reminder that all other Behavioral Health and SUD services continue to be waived, meaning the prior auth, for all of those continuing to be waived. And, Claire, thank you. And, Claire, thank you. Claire has just put up a provider type reference into the chat for us. Thank you very much.

So we appreciate whoever is on from DMS getting these on a regular basis and being able to circulate them so you—all have that. And it goes into the specific services and so forth that would be required. But, again, this is SUD only and it's residential and in patient treatment services only.

Any questions from anyone about that? I probably won't be able to answer, but you can ask the question and then we will see if anybody will be able to answer. All right, thank you very much. Erin, I appreciate it.

Any new recommendations to the MAC? I don't have any. I don't believe we got any feedback from DMS on our last one, which was
about making sure that providers know about the no show portal.

MS. BICKERS: I haven't received your MAC recommendation back yet. Looks like they have been out of the office with a family emergency. As soon as I have that I will get it out to you.

MS. SCHUSTER: All right. Thank you. I will send it out.

I do have an announcement to make since we are talking about the MAC, and that is that I received a call from the Governor's Office of Boards and Commissions, and I have been appointed to serve on the MAC.

MR. SHANNON: Yeah.

MS. TIMMERMAN: Yeah.

MS. SCHUSTER: It is the first time that we have ever had a specific behavioral health provider on the MAC, so I'm thrilled to be in that position. And my first meeting will be the May 26 meeting. So just remember you have a friend on the MAC. Thank you for your support.

Any recommended agenda items for
July 2022. I'm hoping that we will have a report to share with you about the Targeted Case Management Data, and I do appreciate the work of the DMS data team in working with us, because we had lots of very detailed questions. And then we get new information and we change our mind about what it was that we were asking about and so forth. So I really do appreciate everyone's work on that.

If not, then just a reminder that the next MAC meeting is May 26th, 10:00, and I will send the Zoom out. I really recommend for you-all to join those MAC meetings. The Commissioner and the staff give regular updates and you get a ton of information right there, very concentrated, and you also get a sense from hearing from the different TAC groups what different provider groups and advocacy groups, like the Consumer TAC and the Reentry TAC are working on, the Children's Health TAC, for instance. So if you have that time available from 10:00 to 12:30, they are open via zoom, and it's posted on the website, but I also always
send it out to people ahead of time. Really encourage you to do that.

And then our next meeting will be July 14th at 1:00, and we are back on a 1:00 to 3:00. We will be on 1:00 to 3:00 timeframe for the rest of the year. We only do the 2:00 to 4:00 during the legislative session. There was unfortunately a little confusion because the website still had us in May 2:00 to 4:00, but Erin was Johnny-on-the-spot and got to that and corrected it, so we appreciate that.

Is there any other business to -- oh, yes.

MS. BICKERS: -- regarding your next meeting, if you have just a moment. I've been trying to put it on all the TACs' radars. At this moment I'm not currently in the conference room. People who outrank me needed it, so I stepped into a private office. So we are putting on the radar with the TACs who may want to come back in-person. I know so far we have had a lot of hybrid options, that have kind of been preferred. As far as I know right now, we
are still having the option of the Zoom, but I did want to throw that out there if there are anyone who does want to come in person, we will always provide the Zoom link for people, you know, throughout the state who want to join. So I'm just kind of putting that on everybody's radar and letting them kind of discuss amongst themselves which they prefer.

I don't know how many of you may travel from out of town. I was able to -- Steve, he did actually get to see the conference room today. So I'm going to pretend they are behind me. We have got about 12 seats, or ish, if we all squeeze in. But it may just have to be an option with especially some of the larger TACs, where it's kind of split up a little bit. I know so far a lot of feedback I've gotten, if people don't have to drive to Frankfort, they prefer not to, but may pop in here and there if they are in town or maybe just to have an in-person interaction. And so I'm just kind of putting that on all the TACs radars and kind of getting some feedback of
where you guys stand.

MS. SCHUSTER: Thank you, Erin. Let me hear first from the voting members of the TAC and then we will open it up. I wonder, Steve, Valerie, TJ, Eddie, Mike, what is your feeling about in-person versus hybrid versus staying strictly with Zoom.

MR. SHANNON: The Reentry TAC met this morning and Erin raised this issue then. I listened in on the Primary Care TAC last week to discuss. And we talked about it this morning. And we have 12 members. I'm not convinced 12 fits in the conference room comfortably. I think it would be okay, but not great. Also, we have folks who, you know, coming from obviously, like this TAC, you know, far away places essentially, two and a half, three hours away, people on Central time. We meet at 9:00. It's really hard for them. We made a decision for the hybrid model. So the Zoom is available. You know, I would obviously, I think the rule has always been, Erin, that if you are a member of the TAC you need to be on camera so we know you
are actually there as opposed to just
someone turn your computer on zoom but I
think we are going to stick with that
hybrid approach. I think I will attempt to
attend in person regularly as the chair of
that TAC just to be there. I know there's
another TAC member whose office is in
Frankfort. There's a good chance that
person goes to the CHR building for the
meeting. But the consensus we had this
morning, and I heard last week at the
Primary care TAC, was to maintain the
hybrid model as long as possible. And so
you have the Zoom option available, but
people who want to attend in person may
attend in person as well. So, you know,
but the conference room -- I don't think
it's the new conference room. It's in the
same space. And, you know, there are some
chairs on the outside. It would be really
hard -- you know, we used to meet at the
LRC Building, Sheila, you know, the 125.
We'd have I don't know how many people
there. Today we had 60 plus, you know. So
the in-person is challenging for sure, but
the hybrid makes the most sense, and it
does cut down on travel obviously for
people.

MS. SCHUSTER: Yeah.

MR. SHANNON: It becomes a two-hour
meeting. There's a gentlemen on the TAC
that we had this morning at 9:00 who lives
in Owensboro. To be there at 9:00, he's
leaving his house at 5:30 a.m. He prefers
not to do that. Right now there's no
requirement to do it in-person. It's still
available. So my recommendation is the
hybrid model makes most sense. And if
folks want to be in-person, you know, we
get to hang out with Erin for a bit in the
CHR building. I'm sure that's a thrill for
Erin.

MS. BICKERS: Sitting in that big old room
alone this morning. I'm not opposed to
company. The only thing I need to know --
and I went over it with the TAC this
morning -- is if anybody wants to come in
and be in-person and hang out with me in
the meeting room, just let me know a couple
days ahead of time so I can let our
security desk know. And then that way also
too, they can let me know when you are
here, so I can come down and greet you and
walk you up through our Medicaid maze,
instead of just hoping you find us.
MR. SHANNON: And that gives Erin enough
time to get her Starbucks order into that
person as well.
MS. BICKERS: I knew I liked you, Steve.
MS. SCHUSTER: So, Erin, you have a regular
conference room. What floor is that?
MS. BICKERS: We are on the sixth floor.
We have been trying to work with the
cafeteria conference room, and the issue
down there is there is no phone line for
virtual things. And I think -- I can't
remember if it was this morning or if it
was the Children's TAC the other day. We
do have this equipment that does help
record, and when I first heard about it I
thought it was a little recording system.
It's probably bigger than my TV, and if I
broke it I can't afford to replace it. So
I'm hoping to not have to move that too
much. Public health with the really large
rooms have really cut down on only letting their staff use it. So if we get to a point where more people are wanting to come hang out in person, I can start trying to figure out what we need to do as far as getting us a bigger space and still being able to comply with all the open records and recording. I'm sure you guys all know, I try within a couple days to have this uploaded to our YouTube site, so that way if you miss something you can go back and physically watch the whole meeting versus having to just go through and read all the minutes. Or if you are interested in other TACs, they are always posted as well.

MS. SCHUSTER: Yeah, thank you.

MS. MUDD: Will it not be an option to meet at the Annex any longer? I know we were kind of rebellious and we kept meeting there even though the Commissioner at the time was very reluctant to letting us do that.

MS. BICKERS: I would have to reach out to LRC if they are opening their spaces right now. So I would just -- if that's what you
guys would like.

MS. MUDD: Like they said, we have such a large group, number one, you know, and we just like that space. We always have liked that space, so...

MS. SCHUSTER: Yeah, I think that's -- and I think -- Erin, I don't think you need to reach out right now until we get more of a sense of a groundswell of people that, you know, want to meet in person.

I think our numbers have been very good during the Zoom time. Actually not a whole lot different. We probably had 40 to 45 people in person when we met at LRC, but probably what more with Zoom.

I wonder, Mike, or Eddie, or TJ, any thoughts about the meetings and how you would like to see that happen?

MR. BARRY: I'm for hybrid.

MR. LITAFIK: Absolutely, I think this day and age, you know, some things are going to be residual from Covid even when it's winding down and I -- you know, for efficiency purposes, I think it's absolutely the right way to go.
MR. REYNOLDS: I agree with that.
MS. SCHUSTER: All right. I guess what we want ought to do, Erin, is when I send out notices and so forth, is to let people know if they do want to come in person, it would be at the CHR building, and they need to let you know a couple days in advance.
MS. BICKERS: At least a day in advance so I can let the security desk know so they don't fuss at me.
MS. SCHUSTER: I will tell you that as of right now, I'm still -- my daughter's a nurse. She keeps reminding me that I'm high risk, which means that I'm old. And I've done very little in-person stuff even during the session, so I'm going to stay Zoom. I'm happy if Steve or anybody else wants to be there in person, but let's just leave it with the hybrid then at this point, but thank you for bringing that up.
MS. BICKERS: You're very welcome.
MS. SCHUSTER: And we do have one other thing. Erin, can you put that Basic Health Program Provider Notice up for a minute, the BHP?
MS. BICKERS: Hold on one second.

MS. SCHUSTER: Sure. This, again, was something that I sent out last night because we had just gotten it. It's the Basic Health Program Provider Notice, which I was -- I heard just little bits and pieces about, but not much. I'm guessing that I think this came out of HJR 57 from a year ago, the development of a Basic Health Plan. It also is, I think, being set up, and I welcome input from anybody from Medicaid who is on, Dr. Theriot or others. We know that with the decoupling or the unwinding, rather, once the federal emergency period goes away, that there will be a lot of people who are going to lose their Medicaid coverage. They had Medicaid and the feds required that if you were going to keep your Medicaid during the emergency period, that no one could lose their Medicaid. So we know that there are people for whom there has been changes in income and so forth and there we go. Thank you so much.

MS. BICKERS: Sorry about that.
MS. SCHUSTER: Yeah, this is a bridge with coverage between a Qualified Health Plan and state-based exchange.

    Hold on one second.

MR. SHANNON: You are muted, Sheila.

MS. SCHUSTER: Sorry. I have to talk to my granddaughters for a minute.

MR. SHANNON: Okay.

MS. SCHUSTER: So I understand that this is being developed. It's not been completely fleshed out. And I understand that from Veronica Cecil via text today they will keep us in the loop as we go forward. I think one of the questions -- and, Steve, you asked a question and got a response about benefits.

MR. SHANNON: Yeah. I think it's going to be similar to the standard plan behavioral health benefit. I'll find that e-mail. I reached out to Commissioner Lee last week about this and that was her message, as well as we will be in touch.

MS. SCHUSTER: Okay. I think the other question that's come up is if providers are going to be contacted, I guess by the MCOs
to be in the network, then are those payment rates going to be negotiated by the MCOs, which is what I understand. Is there anyone from Medicaid that can share a few words about this or is this what we know at this point?

DR. THERIOT: Hi, this is Dr. Theriot again. That is basically what we know. A lot of people are working pretty hard on trying to get this done so it's up and available, because we don't want anybody to lose coverage when we start with the certifications. And so we need to, you know, have something for people to go to. But I don't really have any more than what you have already said.

MR. SHANNON: And the message from Commissioner Lee, when I asked her last week, is that the Basic Health Plan or Basic Health Program has to provide the ten essential health benefits, including mental health parity. So I think that's the guide from the exchange. And there will be stakeholder engagement coming soon.

MS. SCHUSTER: Okay. Well, we are
delighted to hear that it will have the MH and SUD coverage and it will be at parity. And I think Dr. Theriot, if you don't mind taking back the message that certainly those of us on the BH TAC are happy to be of whatever assistance we can be, either, you know, in communicating with the work group or in getting the word out or having some of our consumers go through. We have done this before. And Kentucky Voices for Health as well has gotten consumers to look at something and give you some feedback about the readability and understandability of it. So in any way that we can be of help, we are happy to be of help.

DR. THERIOT: Thank you. Thank you very much.

MS. SCHUSTER: Okay. Thank you. So that is all that I have. Is there any other business to come before the BH TAC? I'm still letting you out a little early, folks, just not as quite as early as I thought.

All right. Well, we will adjourn the meeting at roughly 2:50. And, Erin, thank
you again for all of your assistance.

Thanks again to the SKY Program at Aetna for an excellent presentation, and to Pear Therapeutics, and for good interaction. I appreciate it, and we will see you-all in two months.

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THEREUPON, the Meeting was concluded.

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STATE OF KENTUCKY   
COUNTY OF FAYETTE   

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, certify that this transcript is a true and accurate record of the Behavioral Health Technical Advisory Committee Meeting.


IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 13th day of July 2022.

JOLINDA S. TODD, RPR, CCR(KY)
NOTARY PUBLIC, STATE AT LARGE
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