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

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

March 10,2022
2:00 P.M.
(All Participants Appear Via Zoom or Telephonically)

APPEARANCES

Sheila Schuster
CHAIR

Mike Barry
T.J. Litafik
Valerie Mudd
Steve Shannon
TAC MEMBERS PRESENT

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APPEARANCES
(Continued)

Leslie Hoffmann
Judy Theriot
Angela Parker
Erin Bickers
MEDICAID SERVICES

Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

DR. SCHUSTER: Since we have a quorum, let's go on and we'll open the meeting. This is the Behavioral Health Technical Advisory Committee meeting.

It says January 13th. It's actually March 10th but these are the correct agenda items. I think I had sent out the correct items but the wrong date on it.

If we might have the voting members of the TAC introduce themselves because we have a new coordinator from the Department for Medicaid Services. Erin, do you want to introduce yourself, please?

MS. BICKERS: Hi. I'm Erin Bickers. I am going to be your new Sharley. And I will drop my email address in the Chat so that if anybody needs to reach out to me, and I look forward to working with everybody.

DR. SCHUSTER: Thank you very much, Erin. We appreciated all the work that Sharley did with us for years but we look forward to working with you in that same capacity.

MS. BICKERS: Thank you.

(INTRODUCTION OF TAC MEMBERS)

DR. SCHUSTER: So, we have a

quorum. We're duly authorized to do business.

The first order of business is the approval of the minutes of our January 13th meeting and those were circulated to you all. So, I would entertain a motion from one of the voting members of the TAC, please.

MR. SHANNON: Steve Shannon. So moved.

MS. MUDD: I'll second.

DR. SCHUSTER: Is that you, Val? I'm sorry. Who was seconding the motion?

MS. MUDD: That was me. Sorry. Yeah, it's Val.

DR. SCHUSTER: Okay. Great. Any additions, corrections, revisions? All right. All those in favor of approving the minutes from the voting members, please signify by saying aye. And opposed like sign and abstentions.

All right. I apologize for the way I worded this next agenda item because I made it sound like we were still waiting on data from Medicaid and that is not the case. The Medicaid Department was very responsive and great about meeting with us and explaining what they had.

So, we have the data. Our little

workgroup has not had an opportunity - I'll blame it on the Session interfering - to look at that data. We will intend to give you all a status report on the data and analysis of that data at our May meeting. So, that was the agenda item.

And, again, my apologies. I'm sorry I confused some of the DMS folks because it made it look like we were still waiting for data and that was not the case.

The next item is an update on claims payments for services to dual eligibles, and I don't know if there's anybody from Medicaid who has an update.

MS. HOFFMANN: Sheila, this is Leslie, if I may share with you. I sent an email earlier. I've been working on getting you a good report for that.

What I have seen so far that's been floating around is really like a change order that's not real user-friendly.

So, I have taken it on today and we have reached out to get our systems folks to help us pull that together and, then, let us get it in a nice nutshell for you and give you a narrative to go with it.

I didn't feel comfortable sending out what was in the change order, if that's okay, but I will take care of that for you, Sheila.

DR. SCHUSTER: All right. Would it be possible for you to pull that material together and get it to me so I can distribute it sooner than our next meeting?

MS. HOFFMANN: Probably so. What I would like to do is if I can get - I'll try to get approval just to go ahead and post it as well as to provide it to you, too.

DR. SCHUSTER: Okay.

MS. HOFFMANN: But we've already reached out. I'm just waiting for them to pull it together in a nice Excel spreadsheet that's understandable. System changes are hard enough for us to understand. So, I want to make sure that it's readable and understandable.

DR. SCHUSTER: I did hear from Kathy Adams of the Children's Alliance that they did get access to the list for billing purposes, the bypass list. So, that was very helpful.

You might include that when you send out the materials when they're posted, Leslie.

MS. HOFFMANN: Kathy, do you know?

You might have received something that looked very technical and looked like a change order. I think you might be one of the folks that received that one that's floating around.

MS. ADAMS: No. The one I received did not look like a change order.

MS. HOFFMANN: Okay. Good. Good, good, good. Okay.

MS. ADAMS: It came from I think Lee Guice.

MS. HOFFMANN: Lee Guice. Let me see if I can go back and I'll make sure that we reach out to her, too. Kathy, do you mind just to send me the one that you have and I can just compare that to what I'm working on?

MS. ADAMS: Absolutely. I'm happy to.

MS. HOFFMANN: Appreciate that so much. Thank you.

MS. ADAMS: Thank you.

DR. SCHUSTER: I think it would be great, Leslie, if we could kind of settle on something that's real up to date and just uniform so that everybody is working off the same report.

MS. HOFFMANN: We try to keep

those updated. Sometimes they change from time to time. So, it's not one of those things that's - you know, it does change. It does change when things get brought up to us or CMS may make changes. So, it's up to date as you can keep it once we get it going.

So, I appreciate that. And, Kathy, if you will send that to me, I would appreciate that information as well.

DR. SCHUSTER: Okay. And thank you, Kathy, for doing that. I think if everybody has the same information, the bypass list.

For those of you who may be new to this topic, this is really a two-part thing that we've been working on. Actually, Steve and I have been working on this for literally years, right, Steve?

MR. SHANNON: Right.

DR. SCHUSTER: And this has to do with really two categories of people. One are the folks that are eligible for both Medicaid and Medicare. So, typically, those are the folks that we think of as dual eligible; but, then, we also have a number of folks, mostly children, who have both Medicaid and also private insurance.

And, so, Lee worked with us and we had several BH TAC meetings and discussions about

the dual eligibles, Medicaid and Medicare, and that change order was put in. And I think that things have been going along fairly smoothly, is that accurate, Steve, on the Medicaid/Medicare folks?

MR. SHANNON: Yes.

DR. SCHUSTER: Great. So, then, the harder problem was around the private insurance because there are so many more of them, obviously, than the single Medicare coverage, but I appreciate Lee and all of her team continuing to work on that.

And they have come up with a bypass list which would allow the providers to enter certain codes so that they don't get hung up on this kind of never-ending circle of never getting an EOB that you can turn over to Medicaid to show that it's been denied.

So, if we can get this, it would really complete that and we can take it off our agenda, Leslie, is what I'm looking forward to.

MS. HOFFMANN: That's what I said today. I really want Sheila to be able to take it off of her agenda.

DR. SCHUSTER: I'm really looking forward to that. So, I appreciate your help on that.

MS. HOFFMANN: I'll work on that.

And like I said, I've already reached out and I'll try to do that as soon as possible. It will take me a couple of days - you know how that works - but as soon as I can.

DR. SCHUSTER: If we just don't have to wait until the May meeting, I think that would be the goal. So, I appreciate that so much.

MS. ADAMS: Sheila, may I add something?

DR. SCHUSTER: Yes. Who is that?

MS. ADAMS: This is Kathy Adams.

DR. SCHUSTER: Yes, Kathy.

MS. ADAMS: I will say that the Children's Alliance reached out to each of the MCOs individually and we obtained commercial bypass lists from four of the six MCOs. Obviously, those lists aren't the same but it does help. So, there's just two MCOs that don't have a commercial bypass list.

DR. SCHUSTER: Don't have one or have not provided it to you?

MS. ADAMS: They don't have one.

DR. SCHUSTER: Oh, okay.

MS. ADAMS: And I asked that they provide me with instructions on how, then, does someone get paid, what's the process. And we're still a little

bit confused on that because, again, we had several back and forths with both of the MCOs insisting they needed an EOB and me saying we're not going to get one.

So, I've basically told our members with those two MCOs if they follow the process they have given us and they don't get paid to shoot those examples to me so we can go from there.

DR. SCHUSTER: Okay. And, then, you would, in turn, make sure that DMS knows about those problems?

MS. ADAMS: Absolutely.

DR. SCHUSTER: All right. You know, it has always been a mystery to me that it's harder to get paid when people have two sources of insurance coverage than if they only have one. I mean, that's been the dilemma, right, Steve, for all these years?

MR. SHANNON: Right.

DR. SCHUSTER: That they ought to have better coverage, more coverage and it ought to be easier for providers to be sure that they get paid. So, it has been a conundrum, as they say. All right. Well, thank you very much for that.

On the no-show data-gathering panel, I think we were looking for some information.

The last time, the insurers were saying they were not getting all the information they needed, for instance, what kind of visit had not been kept, and I wonder if we can get an update from DMS on that.

MS. HOFFMANN: Sheila, this is Leslie. When I asked about that question, it is my understanding that - and I don't mean to misspeak - that some of the MCOs are going to share some information as well.

DR. SCHUSTER: Right.

MS. HOFFMANN: So, do any of the MCOs on the call have information they can share with Sheila today?

MR. OWEN: This is Stuart Owen from WellCare. Real quick, I just want to point out, not for the WellCare presentation but, yes, we are getting the information. DMS is including the type of provider and the date of appointment which has been extremely helpful. So, we are getting that and, then, I'll wait for WellCare's turn to talk otherwise.

DR. SCHUSTER: Okay. Great. Thank you, Stuart.

Anthem. Anybody on from Anthem to give us a report? Aetna.

MS. JONES: Hi. This is Cat Jones

with Aetna. So, yes, we got the new reports and we're in the process of updating prior logic that takes that list of Medicaid member ID's, looks at the type of appointment missed and bumps it up against several ongoing monitoring reports that we have.

We have, of course, our - we're pulling in the PCP assigned, if they're involved currently in targeted case management, who that case manager is, if they've had an inpatient admission within the last thirty, sixty, ninety days, if they've had an ER admission due to behavioral health within the last thirty, sixty, ninety days, if they are a SKY member or a SKY Program member, if they're hitting our Guardian Angel report which looks at an ER visit due to overdose within the last thirty, sixty, ninety days.

So, we're in the process of building that out so we can utilize that list and see if they're hitting any of these other reports that we have ongoing so we can prioritize and be strategic in how we're outreaching the members that are showing on the report for targeted case management.

DR. SCHUSTER: So, Cat, are you using some of your other data sources to kind of highlight or prioritize people that might have significant other issues going on?

MS. JONES: Right, that might be at a higher risk so we can prioritize those three hundred and, you know, for example, for March, I think it was 348 members from the missed appointment list so we can be strategic and prioritize members that we know we need to attempt to outreach right away, if they're hitting some of these other critical risk factors and hitting other reports.

So, we're really trying to be comprehensive and make the best use of this information so we can outreach those members that are at urgent need to have case management contact and assist with whatever is going on with them.

DR. SCHUSTER: Okay. Thank you. I don't have any idea what those numbers look like. I guess I'm wondering, is there a way, Leslie, for the TAC to get just literally a report at the end of the month about how many members were referred to the MCOs for missed appointments?

MS. HOFFMANN: I'm not sure. Angie Parker, are you on? Are you able to answer that question or do we need to take it back?

MS. PARKER: There is an overall report, yes, but it's not broken out by - it's an aggregate report for all MCOs.

DR. SCHUSTER: It's not broken down by MCO?

MS. PARKER: I'll have to go back and look on that part but I know there is an aggregate report.

DR. SCHUSTER: Okay. I guess I'm just trying to get a feel. I remember early, early on when you all first opened this reporting panel that Lee, I think it was Lee presented a report that had very, very few people on it. I think it had only been opened maybe the first month or so.

I guess I'm curious about whether we're - I mean, one of the things you would hope would happen with this reporting panel and the MCOs getting more information about the people, what kind of appointment they missed is that we would get a better handle on what that typically looks like in a month and whether over time it goes down some.

I don't know how many of these folks are repeat offenders, if you want to look at it that way is the other thing.

MS. PARKER: While we're on here, I'll see if I can locate the March report to kind of give you that idea.

DR. SCHUSTER: Okay. That would

be great. Thank you. And thank you, Cat, for that report from Aetna.

What about Humana? Is somebody on from Humana to report?

MS. BICKERS: If you're not speaking, can you please mute? We're getting a lot of background noise.

DR. SCHUSTER: Yes. Please mute if you're not speaking, please. And, again, let me ask if anybody is on from Humana?

MS. STEARMAN: Yes. This is Liz Stearman. I'm here for Humana. It's basically the same update that we shared last time, and I sent some notes over so you can share with the minutes as well for the Humana Healthy Horizon approach.

It's very similar in that we are scrubbing that report each month as it comes in those new additions to the reporting as far as being able to identify which missed appointments. It may be behavioral health in nature and it has been extremely helpful in making sure that we triage the members on that report for appropriate outreach.

We continue to see some providers reporting very robustly around missed appointments while there are lots of providers that maybe aren't

necessarily taking the time to fill that out. So, we are definitely following up on the ones that we get notification of.

We do the same thing. We are identifying those that may have multiple missed appointments. We are engaging with those that we see have case management. And those that do not have case management, we are doing outreach to try and enroll them in case management if it's appropriate.

And, additionally, if the barrier that's noted on the report is related to child care or transportation or some of those other social-determinant-of-health barriers, then, we are doing outreach with our population health team.

So, sometimes it could be an employment coach, a housing coordinator, folks like that may be doing the outreach to ensure that we are trying to address the barriers that are keeping them from the appointment in addition to the general, regular case management.

DR. SCHUSTER: Okay. Thank you. Could you picture, Liz - and I'm not just asking Humana but all of you - if you could picture having a report midyear or something, June, after the June report maybe for our July meeting of kind of looking at the first

six months and giving us just an overview of numbers and the kinds of reasons and how many of them are multiple-missed-appointment people? And weighing in on the social determinants and seeing you all make those connections, that really makes sense to me.

MS. STEARMAN: If we can get really detailed specifications on exactly kind of which metrics we want to see, I think it would be pretty easy to get down to that.

Do we want to see folks that were engaged in case management? Do we want to see multiple folks in behavioral health? You may have one person that may have missed both a behavioral health and a non-behavioral health appointment sometimes and, so, just making sure that the request is real clear so we all report out in the same way.

I'll tell you. Since those indicators have been present on the report, we're seeing around 25% of reported missed appointments being behavioral health in nature.

DR. SCHUSTER: Okay. Thank you. That's very helpful and I agree with you. Having delved into the Medicaid data, I'm acutely aware of how important it is to be real specific about what we're asking for for you all to report. That only makes

sense.

MS. PARKER: Dr. Schuster, I have found a report that is broken out by reason and county but not by MCO.

DR. SCHUSTER: So, it lists the county and it gives did you say region or reason?

MS. PARKER: Reason. For example, I'm looking at one right now that says reason no show, no reason provided in Boone County and there were twenty-three of those and transportation issue there were two. So, a total of twenty-five in Boone County.

DR. SCHUSTER: Gotcha.

MS. PARKER: This report was run on March 2nd for February.

DR. SCHUSTER: Yeah. I think that would be well worth our seeing, Angie.

MS. PARKER: I will forward this to Erin and she can get it out to you.

MR. SHANNON: That's a good report.

DR. SCHUSTER: Yeah. I think that would give us a real good sense because we're hoping with telehealth and some other things that we're having fewer missed appointments for one thing. I mean, that certainly was an early report, but I think that would

be a good stick in the ground for February and, then, let's see where we go from there. Thank you.

MS. PARKER: Sure. I just sent it to Erin. If you want to see any of it on this meeting, I can do that.

DR. SCHUSTER: Let's see if we have time as we go along, but thank you for that and, then, we'll get it from Erin. Thanks, Angie.

Passport. I think I saw Liz on. I don't know who is reporting.

DR. McKUNE: Hi. This is Liz McKune. We are starting to see the reports come through now with the member names, as they mentioned a while ago, which has been very, very helpful.

When those come in on the report, our operations team loads those into our system. They get passed over to the case management team.

At this point in time, if we see that a member has missed three or more appointments, we are reaching out to them, especially for the reasons such as transportation or child care.

Those that are already assigned to case management, we put a task in our system so that it shows up for the case manager where they are asked to follow up for any missed appointment.

DR. SCHUSTER: Okay.

DR. McKUNE: We also are working on doing a summary report internally right now and should have some summary data around this by the end of the month. So, maybe if this stays on, we might have something else to report next time.

DR. SCHUSTER: All right. Great. Thank you, Liz.

United. Did I see Dr. Cook is on?

DR. COOK: I am. Good afternoon, Dr. Schuster and everyone.

So, for United, we equally are getting the report. And with the additional information, we are able to use the report in obviously a more efficient way.

So, what we're doing is if the members we're finding have three or more missed appointments - well, actually, on the first appointment, we have follow-up happening. And as they continue and we see them have additional appointments, we refer them, if they're in a behavioral health appointment, then, they're referred to our case management team for that follow-up to happen with that team specifically.

We're also trying to do an analysis of the data to see when we do our follow-up with them, do we actually reach them. Once we reach them, is there a connection to an appointment. We're trying to develop a report to kind of track that as well.

One of the things that we are looking at on the report is when we see a rescheduled appointment, we're not actually counting that as a missed appointment because we feel that if a member has called and rescheduled, then, perhaps they are doing what's necessary to make sure that they get to their appointments, but we are tracking to see if that member pops up again. And, so, that's how we manage it today.

I think to date we had fifty-eight missed appointments and probably about 70% of those - well, based on the provider appointment type, it's probably 28%, but based on the providers that we see reporting, it looks to be about 70% would be behavioral health appointments. So, that's where we are.

DR. SCHUSTER: So, you're seeing more reports, Dr. Cook, from behavioral health providers?

DR. COOK: Correct. So, as we

look at the report, so, the report has an appointment type that will give a behavioral health indication in there. Then it also has a provider name.

And, so, if we just go through the appointment type, it looks like about only 28% is behavioral health. But, then, when you filter it through the provider, about 70% looks like it is coming to behavioral health missed appointments.

So, with that, we are making sure that these members are not already in complex case management but also doing that behavioral follow-up with that case management team.

DR. SCHUSTER: Okay. Thank you. That's helpful. And, then, WellCare, please.

MR. OWEN: Dr. Schuster, this is Stuart Owen. And I want to mention like Dr. Cook was saying also, if we see that they've rescheduled, we think, okay, that's accomplishing - that's good, they're already rescheduling. So, we're not focusing on them at all.

And as we had pointed out in the January meeting about how we had noticed the theme definitely of a BH diagnosis and we're continuing to track that.

We've seen the SMI diagnosis is

about - we looked at the general Medicaid population versus the missed appointment population and it's about two and a half times more than likely to have an SMI diagnosis, about twice as much prevalence of having an SED diagnosis, and co-occurring MH/SUD is three times the prevalence we've seen so far.

And as far as the totals we've had for both - the two months of this year, it's roughly 700. And I looked at the recent one. Of the 700 incidences of a missed appointment, the recent one, there were forty-five members who had multiple. They had at least two missed appointments on that.

And, then, I looked at those, and of those, 82% of those who were having the multiple missed appointments had a BH diagnosis. So, again, as we're all pointing out, that's definitely a prominent theme here.

And what we're doing similar to what others have pointed out is if it's a behavioral health appointment that they're missing, our case management team is outreaching them and they're also contacting those. If the individuals are already in case management but they've missed an appointment, we're contacting them as well.

Like I said, in both months, we

had about 700 incidences, January and February, as far as the volume.

DR. SCHUSTER: Seven hundred each of those two months, Stuart?

MR. OWEN: Yeah. It was roughly the same, yeah. A little bit higher in January. Actually, I think January, it might have been 750, so, a little bit higher in January and it came down a little bit in February.

DR. SCHUSTER: So, that's interesting that you're looking at the prevalence rate in terms of the diagnosis, SMI versus SED versus co-occurring.

So, I guess that makes some logical sense that the more complex - the more the person is affected by the severity of the illness, the diagnosis, or multiple illnesses, the more likely they are to miss.

And I certainly agree also with United if somebody has rescheduled, certainly when I was a provider, I didn't consider that a missed appointment if somebody reached out and said something has come up, I'm not going to be able to make it, so, I want to reschedule the appointment. Okay. That's very helpful.

So, we'll think about looking at Angie's report here in a little bit but also maybe looking toward a midyear report for our July meeting and being very specific about some aggregate data that the MCOs could report on those.

I guess my question, too, and I don't know whether to ask Angie or Leslie, is there any way to get more providers to use the portal? I can't remember what you all have sent out to providers to encourage them to do that or if you've sent out anything recently.

MS. HOFFMANN: I have not. I would have to ask if anybody on our team would happen to know that answer.

MS. PARKER: To my knowledge, there's not been anything recent that's been communicated. I would also have to defer to the MCOs to see how often they are doing the communication with providers about this as well.

DR. SCHUSTER: Good point. Do any of the MCOs want to comment on trying to get more providers to use the reporting portal?

MS. DRAKE: Good afternoon. This is Christine Drake with Passport, but yes, we provide that information. We've done it in our E-News but we

also provide it in our monthly PowerPoint that we present to all providers, all provider meetings and provide that information in a link to try and get that to as many folks as we can.

DR. SCHUSTER: Okay. Thank you. Anybody else? Oh, let me ask you. Is that behavioral health providers or that's all your providers?

MS. DRAKE: That is all providers.

DR. SCHUSTER: Okay. Thank you. Anybody else from the MCOs?

MS. JONES: This is Cat with Aetna. So, we sent that information out via our Tuesday Fax Blast to providers, but I think definitely we need to repeat that and make an ongoing schedule to do that because we're definitely noticing just the same providers, BH providers reporting that information versus what we would expect in reality.

DR. SCHUSTER: Maybe when we get to the end and we're looking at recommendations, we might have a recommendation from our TAC to the MAC that all of the TACs encourage their - have the MCOs and any way that the TACs can encourage their providers to use this. We've got this tool.

I like the idea that people that have multiple issues and multiple missed appointments

would get some additional help and referral on social determinant kinds of connections and case management, if that's what is needed.

So, if we really want our people, particularly our behavioral health people to get to their appointments, it seems like that would be a way to do it.

All right. Thank you very much. We appreciate that.

Our next issue is on the ambulance transportation, and I will tell you and I will talk about this when we talk about the bills, but there is legislative activity around this.

There's actually been two prior iterations of the bill, but the bill right now is House Bill 777 that's trying to attack this problem of ambulances not providing transport to move people from one level of care to another or to be assured that our behavioral health people get ambulance transportation.

That bill just passed the House on March 7th and is headed over to the Senate, but I am continuing - in fact, Steve and I were just on a call with our CMHC CEO's and they were talking about transportation problems and another one of the CEO's said they just had a situation where someone was at a

hospital without a psych unit and they needed them to be moved to a hospital with a psych unit and the ambulance was called. The ambulance driver got there and said I'm not carrying those crazy people.

So, I'm just not having it, folks. I'm really tired of this. So, I would encourage you to reach out to your legislators over on the Senate side and tell them to pass House Bill 777 and behavioral health will have a place.

They're going to develop an advisory committee to look at this issue, and actually the Kentucky Mental Health Coalition will have the opportunity to have a provider on that advisory board.

So, people have been very differential to behavioral health when we tell those stories that are not made-up stories but true stories. People are annoyed, outraged, a whole variety of things.

So, I'm going to keep that issue on our agenda until we can either get this bill passed or get some resolution of it but it is the epitome of stigma. There's no differential payment for ambulances if it's a Medicaid patient or it's a Medicaid patient and whether they have a behavioral health or a physical health problem.

So, I don't know if there's anyone on the meeting that wanted to add anything around that topic or not.

MS. HOFFMANN: Sheila, this is Leslie. Of course, we expect and hope that those folks would be transported. I don't have any updates but I just wanted to share that with you.

DR. SCHUSTER: Thank you. Many moons ago, when this first came up in the BH TAC, and I went back and looked, Leslie, it was 2018 when we started hearing about this - thank you, Marcie - Marcie has just put the link to the bill in the Chat - we brought it up over and over again and we finally got the Medicaid Commissioner at that point in time to say, oh, yeah, well, we talked to the ambulance people and they said they would do better.

I also think that there's a bill out there. It's a House bill from Representative Grunty to create a TAC for the ambulance and the EMS people. I don't know, Leslie, if anybody at DMS is tracking that legislation.

MS. HOFFMANN: I actually do remember something about that, Sheila. I can't tell you any more but I do remember seeing that to develop a TAC.

DR. SCHUSTER: I almost wish that - I hope that that bill passes, and I'll have to go back and look at the number, because it would be another way of getting information to and from that group if they have to listen to us at the MAC meetings.

MR. OWEN: Dr. Schuster, this is Stuart. I believe it's in the same bill. There was another bill, HB 505, that originally had the TAC and was withdrawn, Representative Fleming, and I think they put it in Representative Moser's HB 777 to have the TAC, the Emergency Medical Services TAC.

MS. HOFFMANN: That may be correct because I remember it was Moser.

DR. SCHUSTER: Okay. Well, good. Thank you, Stuart, because that was one of the issues. I think the ambulance folks are like, awe, well, nobody ever told us this, and I'm like, yeah, we did tell you this or somebody told you this. So, maybe 777 would solve several issues.

MR. SHANNON: Regardless, they transport people who are ill. They shouldn't have to be told to transport some people and not others.

DR. SCHUSTER: Yes. That's exactly right, Steve.

And over on the 202A transport

issues - and, Steve, I have forgotten that bill number that's out there.

MR. SHANNON: Seven three zero, 730.

DR. SCHUSTER: Seven three zero. So, there's a bill out there from Representatives Bray and Heavrin to look at 202A transportation issues and they are trying to move it from law enforcement to include ambulances and other providers that would be under contract.

And one of the things that some of our advocates - Marcie was on that group and Steve and Kelly Gunning - contributed was that people with a mental illness should be treated like people with an illness. They have a brain disorder and they should be treated as such and not as criminals carried away in the back of the Sheriff's car in handcuffs.

So, the two issues are interrelated in many ways and I think speak to the stigma around mental illness and the fear that people have about violence and so forth.

So, thank you, Marcie, for putting those in the Chat. I appreciate it.

All right. I have not heard from anyone about any issues with the Formulary or with

medications and I don't know if anybody is on from the Pharmacy Department.

MS. HOFFMANN: Dr. Schuster, we had many meetings going on today simultaneously, so, I did talk to Dr. Ali yesterday. She said that she doesn't have any new concerns that have been presented to her unless you had something for her to look into.

DR. SCHUSTER: No, I have not heard, and I always figured with meds that no news is good news because I usually hear when there's a problem.

I want to remind you all because there are lots of folks on here with connections with prescribers and with patients that need to get their medications that if you run into something, please email me.

And, Marcie, if you don't mind putting my email in the Chat - I think everybody in the world has it - but to let me know because Dr. Ali has been incredibly responsive and has been on many of our TAC meetings in the past to answer any of these questions. So, please let me know if there are any problems coming up around access to medications.

MS. MUDD: Sheila, I actually talked to my med manager who is an APRN and we were

discussing the single Formulary and she said the problem she has had personally - and I don't know if it's because she's a nurse practitioner and not a psychiatrist - is they have been questioning her dosages when she's tried to get meds approved, and I told her that I would bring it up to the TAC.

So, that's the issue she has been having, spending a lot of time where they have been questioning what she is ordering and the dosage and she said it's just been a real mess and taking up a lot of her time.

DR. SCHUSTER: Ask her to get in touch with me, Val, because I've not heard that. A lot of you know that I work with APRN's and I've not heard that from other APRN's. There should not be any difference in the type of----

MS. MUDD: And I don't know if there is a difference. I just know that she personally has been having that experience.

DR. SCHUSTER: Okay, and it's around dosages?

MS. MUDD: Yes.

MS. HOFFMANN: Sheila, if you want to forward that to me or to Dr. Ali either one, I'll make sure that we get that followed up on.

DR. SCHUSTER: Thank you. So, Val, if you will put her in touch with me and tell her to give me some idea about what kinds of things. If she can provide any feedback she has gotten with the patient's name obviously redacted, that's really helpful because, then, Dr. Ali and Leslie both have been very responsive. So, let's get that taken care of. Thank you. Anybody else with medication access or Formulary issues?

DR. THERIOT: This is Dr. Theriot. I just wanted to throw out there that sometimes when dosages are being questioned, it's actually at the pharmacy level because that happens to people in our clinic all the time. You write a prescription. It doesn't go through because the pharmacist has a question about the dose and it's covered. It's on the Formulary but for some reason it's kind of halted if there's a new pharmacist who doesn't understand exactly the dosage range. So, I just want to throw that out there.

DR. SCHUSTER: Thank you, Dr. Theriot. That's very helpful.

So, what would the person need to do, Dr. Theriot, if they're getting the push-back or the question? I was assuming it was at the MCO end or

at the payment for the medication end.

DR. THERIOT: And it could be, but I know we get a lot of trouble from certain pharmacies that they stop it because they think the dose is wrong. And, unfortunately, what we have to do is call them, call the pharmacist and say, hey, why didn't this go through, it's covered and, then, just have a conversation and, then, it goes through, but, of course, it's time-consuming.

DR. SCHUSTER: It's very time-consuming, exactly. Well, that's good input.

From time to time - and, again, one of the advantages of having these TACs is that we go to the MAC meeting - and it was easier to do this when we were in person - but very often and the Pharmacy TAC always has somebody.

In fact, they have somebody on the MAC and, then, they also have somebody who gives the Pharmacy TAC reports, and there have been times when we've exchanged information or talked about some things that would be good back and forth between our TAC and the Pharmacy TAC. So, that's another possibility.

And I see Dr. James has his hand up. Tom.

DR. JAMES: You know that I always have my hand up.

DR. SCHUSTER: I thought you were just saying hi to me, Tom.

DR. JAMES: Well, that, too, but as far as pharmacy goes, my very next meeting after this one is with the University of Louisville and the study on polypharmacy.

The problems with drug interactions, with adverse drug events is so significant and the cause of emergency room cases that drug use is a patient safety issue.

So, issues like being described may be at multiple levels along the way, but it is true that pharmacists will often stop things from a patient's safety perspective until they find out what the real issues are and it takes professionals sitting together with scientific evidence to get to the bottom and make some recommendations.

DR. SCHUSTER: I guess my question, Tom, and I appreciate that and it certainly is great that we've got multiple eyes and multiple stages, but as Dr. Theriot mentioned and I hear this from prescribers, both psychiatry and nurse practitioners, that the time involved in trying to

track down on each individual prescription some of these issues just gets to be overwhelming, and I guess you are talking about different pharmacies for different prescriptions.

DR. JAMES: I agree. And because I do see patients, I have those same issues. I think the solution is going to end up being some better technology where questions can be routed back immediately, and unique patient situations that don't fall within a normal algorithm can be adjusted for.

DR. SCHUSTER: I'm also curious because we've worked before with the Children's Health TAC, and I know U of L has been involved in looking specifically at over-prescribing of psychotropic meds for children but particularly children in foster care. So, are you involved with that as well?

DR. JAMES: Since I see patients over at Family Health Centers, yes, I've been bringing that information back and forth.

DR. SCHUSTER: Has it gotten any better I guess is my question? We haven't seen a full report for some time from that U of L group but it certainly is concerning. And, of course, there's a lot of overlap between the Children's Health group and our Behavioral Health group because so many kids are being

seen for behavioral health issues.

DR. JAMES: I can ask that at my meeting at 4:00.

DR. SCHUSTER: Wonderful. I think we would be very interested, Tom. It used to be - I'm blocking out his name - Dr. Lohr.

MS. HOFFMANN: I was going to say Dr. Lohr is still with us. He would be a good contact.

DR. SCHUSTER: So, if he's in your meeting, just ask him that I asked about it.

DR. JAMES: He's not in this one but has been there on others.

DR. SCHUSTER: Yeah, it's been a while since we've had that report but that continues to be a real concern. And as a former child psychologist, I worry about kids getting labeled and over-prescribed for behavior control reasons, particularly foster kids.

MS. BROTHERS: Dr. Schuster, this is Kimberly Brothers with the Aetna SKY Program. I'm Director of Behavioral Health here, and we are very engaged with Dr. Lohr and his team around the reduction of polypharmacy for this population.

Our Quality Team led by Margaret Susan Vickers is doing incredible work, and I believe

in the hear future, we will be able to produce some nice-looking data to our DCBS partners and DMS partners around our efforts in reduction of polypharm.

DR. SCHUSTER: Wonderful. I think we would be very interested, Kimberly, on having you all present to this TAC whenever you have that report ready.

MS. BROTHERS: We're very new in this business but I will let Margaret Vickers know that her data is highly sought after.

DR. SCHUSTER: Yes. And I see from Claire Arant from KHA that Dr. Lohr presented recently to their PsyCD forum.

I just think that, unfortunately, with the high number of kids that we have in foster care all the time in Kentucky - and I'm so glad we have a separate MCO looking at that. In fact, I've heard recently some very positive statements from a number of providers about being glad that there's a single MCO to deal with.

So, put us on your list. When you get your report ready, let's talk to you all about presenting to us, okay?

MS. BROTHERS: Yes, ma'am.

DR. SCHUSTER: All right. Thank

you.

MR. SHANNON: Maybe Dr. Lohr could present on his de-prescribing initiatives.

DR. SCHUSTER: Yes.

MR. SHANNON: I had a good conversation with him earlier this week, and I think it's something we have to pay more attention to.

DR. SCHUSTER: Well, I think the data was to lead to some interventions with prescribers about thinking differently about meds and de-prescribing and so forth. So, good point, Steve.

MS. HOFFMANN: Sheila, if you want to follow up with an email to me, I can reach out to Dr. Lohr. I speak with him on a pretty regular basis.

DR. SCHUSTER: Okay. Great. Thank you, Tom, for bringing that up. That will be a good connection for us and to Dr. Theriot also for sharing the pharmacy side of this.

DR. JAMES: Collaboration.

DR. SCHUSTER: Collaboration. That's what it's all about.

The next item is also a recurrent item and that's the increasing number and requirements of MCO audits.

Kathy, you sent me a note. Do

you want to talk about what you all are seeing at the Children's Alliance?

MS. ADAMS: Sure. Our Community-Based Services Council met yesterday and all the MCO reps joined us. So, we appreciate that and we had a good discussion.

I think we have some very real examples what we consider not just as representative sample but an overkill of requesting records. We had one member that had records for seventy clients requested over a year's time.

Now, each of those clients, it was a specified time period, but you can imagine trying to get the records for seventy clients, and, then, add on top of that that you've probably gotten requests from the other MCOS, at least three or four of them for audits as well.

So, it just is daunting for especially some of the smaller BHSO's and Behavioral Health MSG's to try to respond to these audits.

The MCOs have been very good when we ask for the thirty-day extension to get records to them and granting additional time, but in some of the requests, we're seeing records for an example is they were auditing eleven clients and they wanted all of the

records within five days and it's like that's just ludicrous to think that we could meet a five-day turnaround for that many clients and, yes, reach out and ask for an extension, but why should we even have to go through that exercise? Why can't the turnaround time frames be a little bit more reasonable?

We did get positive feedback from members on audit experiences with two of the MCOs, that it was a very educational experience. It was a positive experience and a learning experience for them but we didn't hear that with the other four MCOs.

And probably one of the biggest complaints I heard yesterday was the fact that there is not routine follow-up and feedback following those audits.

It's one thing to jump through all of those hoops and get all of that information to them in a timely fashion, but, then, you don't get any feedback on the audit - what did they find, what's good, what needs to be improved upon. And, again, that was where we heard the positive feedback on two specific MCOs that it was a good process.

So, I definitely think they're still getting inundated with lots of audit requests. And especially when you're dealing with six MCOs, it

doesn't take much to push you over the edge, but this is at a time when we're all having a hard time attracting and keeping staff. We have very long wait lists for services. So, when we get these audit requests, it just takes up so much time and so much time away from patient care.

So, that's what we discussed yesterday.

DR. SCHUSTER: Leslie, I know we've talked about this and you've explained that CMS is continuing to communicate with Medicaid and all the states that they really need to see that these audits are going on.

But I think Kathy raises an interesting point and I hadn't thought about it before and that is are there some minimum time lines that ought to be in place? I mean, eleven clients within five days seems extreme.

MS. HOFFMANN: I would ask Angie to maybe speak about the particular reports and audits. I do know that without prior authorization being on right now, that may be increasing some audits, necessary audits and that's just on my side. I'm thinking without prior authorizations, that there may be some increases.

Angie, is there a minimum on the reporting or are you aware?

MS. PARKER: There is not a minimum.

MR. SHANNON: I've heard the same thing as Kathy has. It's a ton of information and it's a quick turnaround, ask for an extension and, again, very little feedback ever received and it's just volumes of paper, right, Kathy? It's over and over and over stuff but we understand prior auth has changed things not having that requirement but it still doesn't seem realistic that providers have to stop everything and send stuff to the MCO.

One MCO representative happily said sometimes a lot of these audits may be triggered almost as a whistleblower.

I don't know if that's the case. It doesn't seem like it's all the cases but he said sometimes when there's not a lot of feedback given on an audit, it's because actually someone called and cited something, so, they treat it as a whistleblower. I don't know if that's the case. It seems unlikely every audit would fall under that category.

MS. ADAMS: Definitely agree, Steve, and I think, again, you're an MCO and you're

managing your providers and the services being provided. There's nothing that compels them to consider that that provider is probably contracted with five other MCOs and experiencing the same thing.

So, I think just the simple volume that we've got six MCOs and if you're contracted with all of them, that that is definitely a hardship when you have audits because we also understand the need for them and support the need for them; but I think when, again, there's six different entities that you're getting audited from, it becomes overwhelming very quickly.

DR. SCHUSTER: So, it sounds like we're in a situation where the only way to push back from the provider standpoint to unrealistic either time frames or volumes is to say to the MCO we can't meet that, we're going to need to get an extension of "x" amount of time or whatever.

Is the extension being honored, Kathy, Steve, when it's being made?

MS. ADAMS: Oh, yes. Yes.

MR. SHANNON: But, still, at some point even with an extension, you still have to gather everything. It doesn't change the assignment. It just changes the due date.

DR. SCHUSTER: So, Angie, if there's no minimum time frame, then, I guess there's no possibility of putting a minimum in? I thought I'd ask the question.

MS. PARKER: Something we can look at, Dr. Schuster. I think there are different auditing reasons, whether or not it's a code that sparks an audit or number of claims. There's a lot of different reasons. Leslie did say with not having prior authorization, that is one of the reasons why.

DR. SCHUSTER: Right. Right.

MS. PARKER: But I think Kathy in her ask yesterday in the meeting, which I attended as well, the ask to not, for each MCO to, you know, depending on the number that they're requesting, to not put a five-day turnaround on it, to be a little bit more gracious in the amount of time, depending on the number of audits that is being requested.

DR. SCHUSTER: Okay.

MS. PARKER: But, yes, by all means, if it comes over and you don't have the time to get it turned around in the time period, ask for more time.

DR. SCHUSTER: It sounds like those extensions are being honored by the MCOs.

MS. PARKER: Yes; and if they're not, you can contact me.

DR. SCHUSTER: Well, let me put in a plea to the MCOs who are all on here, I guess, except Anthem. Look at your time frames when you're sending that to a provider and let's try to be a little bit realistic on both sides. I don't know what else can be done about it.

MR. CROWLEY: Dr. Schuster, this is David Crowley from Anthem.

DR. SCHUSTER: Hi, David.

MR. CROWLEY: I joined a little late. I was in another meeting, but our time frame is thirty days on those; and if there's an issue getting it in in thirty days, then, we'll work with you.

DR. SCHUSTER: Okay. Is that true for all your audit requests, David?

MR. CROWLEY: Yes.

DR. SCHUSTER: Okay. Well, let me ask the other MCOs, then, since you opened Pandora's box here.

MS. JONES: This is Cat with Aetna and we have the same time frames - thirty days, and, then, if additional time is requested, we will definitely work with them.

DR. SCHUSTER: Okay. And Humana. Did we lose our Humana person?

MS. STEARMAN: Sorry. I was getting off mute there. So, I believe ours is thirty days but I'm going to check with our auditing team and I'll let you know if that's not the case; and, again, we do have the same in place for requesting exceptions.

DR. SCHUSTER: Okay. Thank you, Liz. Passport?

DR. McKUNE: This is Liz McKune. I'm going to have to confirm. We've had some transition and I just want to make sure I give an accurate answer. So, I will follow up with you.

DR. SCHUSTER: All right. Thank you. And United, Dr. Cook.

DR. COOK: So, our practice management auditing, I know that it's thirty days and they do work collaboratively if there's an extension needed but I do need to follow up for any of our audits to see the time line that they are requesting. So, I can follow up with that.

DR. SCHUSTER: All right. Thank you. And, Stuart, WellCare.

MR. OWEN: My understanding is thirty but I will confirm that as well.

DR. SCHUSTER: Okay. So, it must have been an MCO from outer space, Kathy, that asked for five days.

MS. ADAMS: I'm sure that was the case. I'm looking through the notes now.

DR. SCHUSTER: Or a different kind of audit maybe. Are there - obviously, there's different kinds of audits. There's got to be different kinds of audits, right?

MS. ADAMS: Yes, there are different kinds of audits and I know that this example specifically, they were requesting records on eleven different clients for a year and the turnaround was five days.

DR. SCHUSTER: Okay. All right. Well, thirty days sounds at least more reasonable as a starting place. All right. If you all check and there are other exceptions to that or differences, just send it to me by email if you would. I would appreciate that.

Leslie, this has been on for a long time and I hope we can get rid of it at some point.

MS. HOFFMANN: Well, I do have some good news. And forgive me. I know some folks

were on the meeting with me this morning. So, if I'm duplicating, just forgive me, but I do want to tell everybody that we have had some good news with CMS.

They are now working with us after fourteen months on this amendment that we really started working on it now which is such good news.

They are helping us with the budget neutrality piece. Of course, we completed that budget neutrality, it's been more than fourteen months ago, and really trying to synthesize it now to make sure that it's correct and working with our partners and DBH and DOC to ensure the accuracy and they have been great partners throughout this whole initiative.

So, CMS - I think I've told you this before - CMS actually said that their guidance to us could change daily or weekly and just to be patient with them as they are still learning, too.

So, we are supposed to be participating - and when I say we, it's DMS, DOC and DBH are going to participate in a round panel discussion with California and I know their advocacy group related to our initiatives. They seem very pleased with what Kentucky is trying to do and that we've broken down the barriers in trying to work together as a team here in Kentucky.

So, as far as I can tell you right now, we're meeting with them on a monthly basis but we are currently, like today, working on the budget neutrality piece with DOC. So, hopefully, I will be able to give you more information.

Sheila, if I may, I'm just going to tell you just real quick since this is the Behavioral Health TAC that our mobile crisis intervention planning grant is going really well and we are currently working on a needs assessment in Kentucky.

That planning grant runs from September the 30th of 2021 until September the 30th of 2022. We did this in collaboration with our sister agency, DBHDID, and it's going really well. We have the utmost support through this initiative.

I do feel like that this will be something that we will explore after the planning grant and it is to develop a one united integrated crisis model for Kentucky and kind of pulling all of us together. We've all got pieces into the crisis, right, model but not a full like united crisis model. So, that's kind of what we're working towards.

And I just wanted to mention to you as well so that to your knowledge that we are

currently working on the SMI/SED waiver with CMS just getting some guidance. Again, that's something very positive that we're working on, and we will have more information to come to you later.

We are looking at trying to have this drafted sometime by the end of the year. Our other 1115's are due I think for a renewal around 9/30 is when we have to start working on the drafts. So, I just wanted to let you know that, that we're working on it.

And, then, our CCBHC - I'm probably talking really fast - I'm sorry - our Certified Community Behavioral Health Clinics rolled out January the 1st of 2022 and that will roll out for eight quarters through a demonstration until 2024, and we did that in collaboration with our sister agency, the Department of Behavioral Health, again. It's going really well.

We've always got growing pains and we're working through those, but, again, it will run for eight quarters.

We'll probably within the next couple of quarters start thinking about where we want to go after this demonstration. Again, I have the utmost support for that project. So, I do see it going

forward.

DR. SCHUSTER: The goal was fourteen CCBHC's.

MS. HOFFMANN: Yeah. We would like to expand. You remember, CMS had me to base the eligibility of providers based on a 2016 application that was sent in quite some time ago and that only included four of our CMHC's. And, so, yeah, we would like to expand later, at a later date.

And feel free. Anybody can reach out to me with any questions related - there's a lot going on, right, and we're all starting to overlap.

Even on Pam Smith's side with the 1915(c)waivers and the HCBS enhanced FMAP, there's crisis funds in there that can be utilized by anybody and feasibility studies on that side as well.

Housing and residential is a big piece right now and we have many initiatives going on with housing and employment.

DR. SCHUSTER: Okay.

MS. HOFFMANN: Hopefully, we can tie all these pieces together because we're running them at the same time and I need them to meet at some point. So, it's very exciting times for behavioral health.

DR. SCHUSTER: Yeah. If we can get some boots on the ground and get some housing out there for our SMI population that we've been working on for - I keep telling Steve it's been twenty years at least that we've been working on this, on the SMI waiver. So, I love to see that happening.

And certainly after fourteen months with your 1115 on the SUD, good news that CMS is closing in with you. I assume that you see that as them closing in, Leslie.

MS. HOFFMANN: Yes.

DR. SCHUSTER: That they're working with you.

MS. HOFFMANN: Budget neutrality is where we kind of first started seeing as our negotiating. That's kind of our first piece. They've had some very minor questions that were very easy to answer that were already in the waiver amendment itself. So, the budget neutrality is a big piece.

And, honestly, we did that budget neutrality without any guidance because they weren't sure how to help us at the time. We did it over fourteen months ago during COVID. So, we're just trying to make sure that it's accurate and we're gathering information with the Department of

Corrections to ensure that we've got the correct information for it t be successful because we really want this waiver to be successful.

DR. SCHUSTER: Yes, we certainly do, and some of us feel like we've been part of the birthing process - I'm sure you do, Leslie - but with submitted comments and having it out there for actually it feels like longer than fourteen months sometimes, but thank you for that update.

I noticed that Representative Bentley is really big on the mobile crisis units. They have one at Pathways which is his CMHC, and his bill to put some funding in the budget for more of those I think just passed out of House A&R last week.

MR. SHANNON: Correct.

DR. SCHUSTER: So, is that being coordinated with what you all are doing on this planning grant at all, Leslie?

MS. HOFFMANN: I think it will be at some point. Right now we've been really focusing on what we currently have and, then, also including any 988 initiatives that can connect to that.

And really what we're looking at is not just one integrated model but to take what we have and expand it and enhance it and that means that

we have to redefine it, right? So, we will be working with all of our partners.

Sheila, if you've not been contacted, I know that you and Steve were supposed to be contacted related to the needs' assessment. If you haven't already, you will be.

DR. SCHUSTER: I was interviewed. I have been interviewed so many times on these things, I'm trying to remember. Maybe that one was on kids. Is that one on children and youth?

MS. HOFFMANN: No. This particular - I think that might be one of the CA ones. This one would have come from probably Myers & Stauffer related to the mobile crisis and what services you see that we have now and where the gaps are and how we can enhance it for better quality.

DR. SCHUSTER: Okay. I talk to so many----

MS. TIMMERMAN: Sheila, there were two, one for adults, one for kids.

DR. SCHUSTER: Because I talked to somebody from NKU.

MS. PARKER: NKU is the quality strategy, Dr. Schuster.

DR. SCHUSTER: Oh, okay. That's

right because you were on that one with me, Angie.

MS. PARKER: Yes, I was.

DR. SCHUSTER: I feel a little bit like what day is this.

MS. HOFFMANN: I reached out to Angie the other day and I said which one are you working on? There's so many going on right now - the strategies and the strategic planning. There's so much going on right now it's hard to remember and there's Cabinet level, DMS level. So, it's been a little bit hectic to keep up with. So, don't feel bad at all.

DR. SCHUSTER: Thank you. I will have to send you all my bill tracking grid. I almost got it finished and, then, I realized that I wasn't going to make it by the deadline but let me go over a couple of things.

And let me start with a bill that is relatively new and it's Senate Joint Resolution 150 which came out of the Senate just maybe ten days ago from Senator Douglas who is the newest member of the Senate from Senator Buford's place, so, Nicholasville and part of Fayette County and so forth, and it would end the state of emergency around the COVID pandemic.

It actually had the date of March 7th on there. We missed that but it was also upon

passage of the resolution. And it looked like the House wasn't going to take it up but now they've assigned it to State Government and it looks like it's going to move.

So, we had some questions about what happens if this ends the state of emergency prematurely because the Legislature had extended it to April 14th, and this is different - just for those of you who are as confused as I get sometimes about these, there's a state of emergency in Kentucky and, then, there still is the federal state of emergency, and I understand that that's being actually extended to July maybe. I think they have to give sixty days' notice and they didn't do it. So, we assume that it's going to be extended from April to July.

So, the question, Leslie, or for those of you at DMS, is the Commissioner has suspended the prior auths for behavioral health during this emergency period.

So, I guess I'm curious, we're all curious about what happens when the emergency period ends, and particularly if it ends abruptly which is what would happen if Senate Joint Resolution 150 gets passed.

MS. HOFFMANN: Sheila, it's my

understanding we haven't discussed anything specific to those being turned back on for behavioral health.

Angie, I know you were going to speak a little bit about the prior authorization. I didn't mean to over-speak you if you were talking.

MS. PARKER: No. You're fine. No. Leslie is right. We would give at a minimum thirty days regardless of when the public health emergency ends. So, if and/or when prior authorization is allowed for behavioral health, then, all providers will be given at a minimum thirty days' notice.

DR. SCHUSTER: Okay. It's already under which the Commissioner suspended behavioral health. Was that necessarily legally part of being in the state of emergency?

MS. PARKER: No.

DR. SCHUSTER: Okay.

MS. HOFFMANN: Now, it's my understanding, Sheila, that we've just been going over this internally with our Medical Directors on a monthly basis to review to see if we should turn them back on or not. So, behavioral health has kind of been outside the regular process.

DR. SCHUSTER: All right. So, it's not actually tied to the----

MS. PARKER: Right.

DR. SCHUSTER: ----state of emergency and we would be given thirty days' notice.

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: Okay. Great. And I'm hoping that with the report in May on the data which is partly what prompted that deep dive into the data, the data would be part of that decision-making as well. That's my hope.

All right. Another question about that. Kathy, this was your question. I'm not sure that I understand it actually.

MS. ADAMS: It was kind of to Marcie. Marcie made a comment that Senate Joint Resolution 150 just got passed while we were on this meeting and it was heard today by House State Government and was passed by House State Government Committee. So, I was just----

MS. TIMMERMAN: It came on to the floor at 2:00 and it passed.

MS. ADAMS: They had already had their three readings on it?

DR. SCHUSTER: Yeah. They had done the readings before they sent it to committee.

MS. ADAMS: So, it's passed. And,

so, does the Governor sign a Senate Joint Resolution?

DR. SCHUSTER: Yes. It has to be signed by the Governor. It does have to go to his desk for signature. So, he will have ten days to decide whether to sign it or to let it become law without his signature or to veto it.

So, you've just got the update, folks, hot off the press, and we'll have to just see what the Governor is going to do, I guess, at that point, then.

MS. ADAMS: An interesting point from the discussion at the House State Government Committee was it was never clear whether ending Kentucky's state of emergency would affect federal funding. There were arguments on both sides, that it would and that it wouldn't. So, that was interesting.

DR. SCHUSTER: Yeah. I think that the Center for Economic Policy, KCEP - it's now called Kentucky Policy - I think Dustin Pugel, who is one of their senior policy analysts, had put out a blog or an email.

Their analysis was that it would affect federal funding and would cause the loss of significant amounts, particularly on the SNAP side, food stamps. Millions of dollars that now go to

grocers and to support that program would be lost. So, I guess the Governor will have to decide what to do with all of that.

Speaking of the SMI waiver, we had Senate Joint Resolution 72 and it passed the Senate unanimously and was heard in House Health and Family Services today and passed unanimously. So, it should be voted on in the House.

There was an amendment in the Senate that would spell out the kinds of housing that could be included. And, so, it will have to go back over to the Senate for concurrence or agreement, and Steve gave sizzling testimony. So, we thank you for that, Steve. It was so good that it burned the airways, so, we couldn't hear it.

MR. SHANNON: The secret is don't open your mouth if it's going to pass.

DR. SCHUSTER: That'S for sure. These are some of our priority bills out of the SMI Task Force.

So, House Bill 127 which is Ken Fleming's bill brought by Judge Stephanie Burke, Jefferson District Court Judge, who is the only one who has actually done some Tim's Law cases, had some changes to the statutory definition that would open it

up to more people - please mute if you're not muted - and it passed the House unanimously and was in the Senate Health and Welfare Committee and has gone to the floor of the Senate for a vote not held yet.

Representative Fleming also took another recommendation out of that task force to require the licensure boards for the mental health professions to either enter into a compact or to ease their reciprocity restrictions and it passed the House unanimously and I think passed Senate Health and Welfare Committee yesterday.

So, so far we, I think, have unanimous votes on all of these SMI Task Force bills. I don't think we've had a single no vote which is wonderful.

Marcie, do you want to say a word about 373 which is the 9-8-8 funding mechanism?

MS. TIMMERMAN: Sure. It's kind of stuck in Health A&R right now but it does set up a 70-cent fee per line for cell phones equal to that that we pay for 9-1-1 statewide.

That fee would be managed by a multi-stakeholder committee. So, the funds for that do not go to the General Fund and get decided on every time we have a budget which I think would be great and

really it's a both in with the General Fund dollars and that's been a message that seems to have gotten left off at times. We want to make sure that that's a both in. We need the General Fund dollars that are asked for as well as the 70-cent fee to really sustain 9-8-8 in the long run.

For those who are not familiar with 9-8-8, the National Suicide Prevention Life Line, the 800/273-8255 (TALK) will be changing to 9-8-8 in July per 2020 federal legislation.

So, it's changing whether we want it to or not; and once people remember it, right, it's an easy number to remember, we're definitely going to see an increase in call volume.

So, if anyone has questions, fund988@ky.org - I'll drop that in the Chat - that's our website for information, and if you have friends on House A&R, we would love to have you ask them to please hear this as soon as possible.

DR. SCHUSTER: Great. Thank you. And for those of you who may not be familiar because of the regional distribution of the Community Mental Health Centers, each of them staffs a Call Center that receives those National Suicide Prevention calls as well as all kinds of other crisis calls.

So, they would be the ones that would be receiving the calls from 9-8-8. So, Kentucky is really in the catbird seat in terms of having these calls answered locally where there are local resources to connect a person to if they need that.

So, your call to 9-8-8 would not be answered in New York or Miami or someplace else. So, part of that funding goes to make sure that those Call Centers are appropriately staffed.

MS. TIMMERMAN: Yes. Thanks, Sheila, for that.

DR. SCHUSTER: So, I mentioned House Bill 777 which is the improvement to the ambulance transfer and apparently there would be a TAC for the ambulance drivers, and, again, we would have a behavioral health representative on this advisory group. It passed the House 77 to 15.

There's been a lot of controversy. In fact, this bill that's been filed, there were two other bills before this. So, they've been withdrawn and a new iteration has come. So, the latest is 777. And I think sevens are supposed to be lucky, so, hopefully, we'll have a little luck getting this thing passed.

Senate Bill 140 is a bill that

would look very carefully at the use of step therapy, and we know that that sometimes creates a problem for people getting access to their medications. It passed the Senate and has passed the House Banking and Insurance Committee and is posted for passage maybe today actually.

House Bill 174 is a bill that had been out there for a while and didn't have much traction filed by a Democrat, and, then, Representative Moser signed on as a co-sponsor and the thing has really taken off, and House Bill 174 would require Medicaid coverage for twelve months postpartum.

So, if you think about that 48% of the births in Kentucky are to moms who have their health coverage through Medicaid and, then, that Medicaid coverage goes away I think six weeks postpartum.

So, there's an increasing concern about postpartum depression which I understand now is supposed to be called perinatal depression and anxiety disorders because it's not just depression but thoughts of anxiety, and a lot of those moms don't really recognize the symptoms and reach out for help until at eleven months after the baby is born.

So, we really want to get this

coverage by Medicaid, and it passed the House unanimously on February 18th. It has gone over to the Senate.

There's a bill looking at telehealth, House Bill 188, and it came up - this is Representative DuPlessis' bill - came out when a constituent of his whose daughter has an eating disorder and was being seen by one of the few providers for eating disorders in the state actually - it was in Louisville - and the student, was a college student, was in another state for spring break and needed to talk to a therapist and the therapist said, I think I'm prevented from delivering services to you because you're in another state and I'm only licensed in this state.

So, it raised all kinds of questions and I think the various licensure boards have looked at these issues kind of in varying and different ways, but this bill would actually prohibit the licensure boards from stopping the provision of those services if either the provider of the services or the recipient is located in a state outside of the state of licensure which could be very helpful, I think, to some of our folks.

So, those are the ones I'm going

to highlight. You'll see that we have lots of other bills.

I will point out one. Another one is House Bill 7, and you can tell from the number that it's a priority bill for the House. It is sponsored by the two top-ranking House members, Speaker Osborne and Speaker Pro Tem Meade, and it is of great concern to those of us who would like to see people maintain their Medicaid coverage and maintain their SNAP or food stamp benefits.

It puts a whole lot of hoops for people to jump through and we're going to get to a period when the federal emergency period for COVID ends. There's going to be I think the number is well over 100,000, maybe 170,000 Kentuckians who are going to need to recertify their Medicaid coverage because their income may have changed and so forth, and this would make it extremely difficult for those people to maintain either Medicaid or food stamps.

So, I draw your attention to House Bill 7. There are lots and lots of groups that are creating a drumbeat in opposition to House Bill 7.

So, I will send that grid out to you all. The BH TAC doesn't formally endorse but those are the bills that I've heard about from the behavioral

health community that have been top priorities.

Any others that anybody knows about that they want to add? All right.

MR. SHANNON: House Bill 7 has been given one reading as well.

DR. SCHUSTER: Yeah, and it's not gone to committee yet, right, Steve?

MR. SHANNON: It's gone to Health and Family Services.

DR. SCHUSTER: Yeah, but it hasn't been heard there yet.

MR. SHANNON: No, it has not been read.

DR. SCHUSTER: What they're doing, if you don't follow legislation, the way the system is supposed to work is that a bill gets introduced, gets assigned to a committee.

It used to be that we would have at least one week's notice when a bill was going to be heard in committee. It's called a Posting Notice. And, then, you could kind of gather your troops to either get the word out to support it or oppose it. You could gt people there to testify against it and so forth.

Well, they've changed so many of

those rules now. Most of the bills in the House are not being assigned to a committee, particularly if they're being introduced by a Democrat. So, very few of the bills introduced by Democrats are even being given a chance to be heard in a committee.

So, you will see on this grid when I send it out, it will say introduced, not assigned, and those bills are just simply left there to die.

They've dropped the posting rules so at the most, we get twenty-four hours' notice that a bill is going to be on the agenda which doesn't give us much time to get the word out either pro or con.

And the other thing that should happen is the bill would come out of committee, and if it passes, then, it would go back to a chamber and it would be given its first reading.

By Constitution, you're supposed to have three readings before a bill is voted on and that gives everybody in the General Assembly a chance to, number one, examine the bill and get familiar with it because obviously not everyone is on the same committee, and, number two, file amendments if they want to do so and, then, you would have a deliberative process where you discuss and vote on the bill.

What they're doing when they want to fast track a bill is that they're giving the bill its readings before it ever gets assigned to or heard in committee. So, if they want to move House Bill 7 quickly - it happened with the budget bill, of all bills - House Bill 1. They gave it its readings and, then, it went to the A&R Committee.

The A&R Committee voted it out at I think 1:55 in the afternoon and they went across the street to the Capitol and went into Session at 2:00 and it was there for the entire House to vote on.

So, you get very little opportunity for the members, the legislators who are not on a particular committee, without the posting rules, you don't get any heads-up of how the committees sub and they can rewrite a bill and, then, present it at the committee without anybody knowing what's in the new language.

So, it's very, very difficult this Session to track and have time to rally the troops one way or the other, either to support or oppose a bill.

Has there been any updated prior authorization guidance, Leslie or Angie? I don't think I've seen anything since----

MS. HOFFMANN: Angie, I think the last one is April 16th or something like that.

MS. PARKER: Well, as far as behavioral health, there are no changes.

DR. SCHUSTER: Okay. All right.

MS. HOFFMANN: The last FAQ, I think, goes through I wanted to say April 16th.

DR. SCHUSTER: Okay, and no changes as we talked about before.

New recommendations for the MAC. So, does anybody who is a voting member of the TAC have any recommendation that you think that we ought to be making to the MAC when it meets on March 24th?

I mentioned the one earlier to recommend that the MAC and the other TACs encourage providers to use the I'm calling it the no-show data-gathering panel - it may have a more formal name than that - to report missed appointments. Is that what it's called, Leslie? Does it actually have a name?

MS. HOFFMANN: I'm looking. I think it was the no-show gathering panel. Angie, I might need to ask you again. I'm sorry. Is that the correct terminology?

MS. PARKER: Wait a minute. I'm getting it. It is called the missed/cancelled

appointments.

MS. HOFFMANN: Thank you.

DR. SCHUSTER: Missed/ cancelled----

MS. PARKER: Appointments.

DR. SCHUSTER: Appointments.

MS. PARKER: Appointment.

DR. SCHUSTER: And does the provider go to is that considered a portal to enter the information?

MS. PARKER: On KYHealth.Net.

DR. SCHUSTER: Okay.

MS. PARKER: It's been a while since I looked at how all this works, so, I would probably need to get an update or re-educated on the process on how providers go in and update that.

DR. SCHUSTER: All right. Do any of the voting members of the TAC want to make that motion, assuming that we get the right name for the thing, the missed/cancelled appointment portal on KYHealth.Net?

MR. LITAFIK: Motion.

MR. SHANNON: Second.

DR. SCHUSTER: Who was the first? T.J.?

MR. LITAFIK: Yes.

DR. SCHUSTER: Okay. Thank you. And Steve seconded?

MR. SHANNON: Yes.

DR. SCHUSTER: All right. Any discussion? All those in favor of making that recommendation to the MAC, signify by saying aye. All right. Motion carries.

Anything else for the MAC for their March 24th meeting?

For agenda items for May, we're going to report on the targeted case management data. Aetna put in the Chat that they could make a report on their polypharm report. Any other items other than a carryover of some of these?

All right. The next MAC meeting, March 24th, 10:00 to 12:30.

And our next Behavioral Health TAC meeting, May 12th, and we'll go back to the 1:00 time. So, note that. We went to 2:00 to not conflict with the legislative committee meetings. So, we'll be back at 1:00.

Anything else to come before the TAC?

DR. McKUNE: Dr. Schuster, it's

Liz McKune. I wanted to report back that I confirmed that for a standard audit where they might be investigating payments that's gone out is thirty days. There's other types of audits where it might be a prepayment audit. That is forty-five days.

DR. SCHUSTER: Okay. Great. Thank you. Appreciate that.

All right. I appreciate - oh, and Humana has confirmed in thirty days also. Appreciate the input from all of our MCOs.

David Crowley, are you still on?

MR. CROWLEY: I am, yes, Dr. Schuster.

DR. SCHUSTER: You missed it. Early on, we were asking the MCOs to report on how they were using that missed appointment data. Are you all getting that at Anthem and can you give us some idea about what you're doing with it?

MR. CROWLEY: Sure. We are receiving that. So, we stratify that by an internal risk indicator. So, we run that report up against our clinical risk indicator report. So, that prioritizes the outreach. So, those that are in the highest indicators, like a Group 4, that the highest risk, we outreach those folks as a priority first and work our

way down to Group 3 and Group 2.

And then, we also prioritize the outreach based on how many appointments they've missed. If they've missed three or more appointments, those are also moved up in priority.

DR. SCHUSTER: Okay. Excellent. That's very similar to what we're hearing from the others.

Erin, do you want to post that chart or whatever it was that Angie sent you about the missed appointment?

MS. BICKERS: Give me just a minute.

DR. SCHUSTER: All right. Thank you. Since we're finishing early, I hate to give people an extra fifteen minutes to further away.

MS. BICKERS: Can you see it?

DR. SCHUSTER: Yes. So, then, does it just go page by page for each county?

MS. BICKERS: That's what it looks like. I can just scroll slowly and you guys----

DR. SCHUSTER: Why don't you go to Fayette or one of the bigger counties if you can just to get an idea.

MR. SHANNON: Can this be sent to

us?

MS. BICKERS: Yes. I'll email it to you guys as soon as we're off the call.

DR. SCHUSTER: Okay. Thank you. I'm just curious. So, just thirteen no show, no reason provided. And, Angie, remind me, what does the Other mean?

MS. PARKER: It means that there is no other category, that they don't know why and they just didn't show up and they gave no reason because they didn't call to say we have to whatever. It could just be something that the provider is putting in. It is a little bit subjective, depending on who is entering the information.

DR. SCHUSTER: I'm not sure that I understand what the difference is between Other and Unknown.

MS. PARKER: It could be transportation. Like I said, I'd have to look at all the reasons they have to choose from again, re-educate myself. That's probably something we could send to you all, too.

MR. SHANNON: That would be helpful. You'd think thirteen for Fayette County doesn't seem to be a good number.

DR. SCHUSTER: Yeah, I'm surprised at how few that is.

MS. DOBBINS: It's hard to believe that's a complete number. Maybe not everybody is entering the data.

MS. PARKER: This report is only as good as those providers who utilize it.

DR. SCHUSTER: Right, and this is not just behavioral health. This is all missed appointments, right?

MS. PARKER: Correct.

DR. SCHUSTER: I think that's our point, Cathy. People are not - was that Kathy Dobbins?

MR. SHANNON: Yes.

DR. SCHUSTER: People are not using it. So, let's gin up a little enthusiasm for using it.

Erin, if you would send it out, I would appreciate it. Angie, it seems like maybe Lee did this early on. Was there a screen shot that she showed us that showed us what the choices were?

MS. PARKER: I think somebody did. It probably was Lee or she probably got it from someone within our IT area. So, I will find it and we'll get it out to you.

DR. SCHUSTER: Okay. That would be helpful.

MS. PARKER: Because I don't like talking about something that I should know about and I need re-educated on.

DR. SCHUSTER: That was some time ago that we first talked with her about this. So, it's a little foggy in my mind, too.

All right. Well, thank you, Angie, for sending that over. If you could give us a little more information, that would be helpful.

MS. PARKER: I will.

DR. SCHUSTER: And, Erin, good to have you with us. We appreciate your assistance and look forward to continuing our work with you.

MS. BICKERS: Thank you. You as well.

DR. SCHUSTER: All right. You all have a good day.

MEETING ADJOURNED