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

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

January 13,2022
1:00 P.M.
(All Participants Appear Via Zoom or Telephonically)

APPEARANCES

Sheila Schuster
CHAIR

Mike Barry
T.J. Litafik
Valerie Mudd
Steve Shannon
Eddie Reynolds
Diane Schirmer
TAC MEMBERS PRESENT

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APPEARANCES
(Continued)

Veronica Cecil
Judy Theriot
Fatima Ali
Angela Parker
Lee Guice
Sharley Hughes
Leigh Ann Fitzpatrick
Jennifer Dudinskie
Jonathan Scott
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.)

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1 DR. SCHUSTER: We will get
2 started. Welcome to the Behavioral Health TAC,
3 Technical Advisory Committee. Thank you to Sharley
4 for engineering all of this as always.
5 We have a change in voting
6 members on the TAC. The representative for NAMI
7 Kentucky, as you all know, has been Sarah Kidder for
8 the last couple of years but Sarah is no longer
9 working in that position with NAMI Kentucky. And,
10 so, NAMI Kentucky has nominated and appointed rather
11 T.J. Litafik.
12 And, T.J., if you want to wave
13 to people or say hello. There you are. Good to see
14 you. We welcome you to the work of the Behavioral
15 Health TAC. Glad to have you on board.
16 Is our court reporter with us,
17 Sharley?
18 MS. HUGHES: Yes, she is.
19 DR. SCHUSTER: Okay. Great.
20 Let's go around and just to be sure each of the
21 voting members of the TAC so you can introduce
22 yourself to T.J. So, Val.
23 (INTRODUCTIONS)
24 DR. SCHUSTER: T.J., do you want
25 to give a second of your background for us?

1 MR. LITAFIK: Yes. I'm pleased
2 to be working with NAMI Kentucky now. I have a
3 lobbying and consulting firm here in Lexington and I
4 started working with NAMI Kentucky last summer in a
5 strategic advisor capacity.
6 And, then, when Sarah had to
7 relinquish the role as the Advocacy
8 Coordinator/Lobbyist, I came in to fill that vacuum,
9 and I look forward to working with everybody to
10 achieve our shared goals for mental health in
11 Kentucky.
12 DR. SCHUSTER: Great. We look
13 forward to that.
14 Sharley, you asked about Eddie.
15 Eddie was added. He didn't replace anybody. In
16 legislation of a year ago, we added the Brain Injury
17 Alliance of Kentucky position as well as the Diane
18 Schirmer position which is the Brain Injury
19 Association of America. So, we increased our voting
20 members from six to seven.
21 MS. HUGHES: Okay. So, I had
22 Gayle as being the Brain Injury Alliance of Kentucky.
23 DR. SCHUSTER: Right. And, so,
24 Eddie had replaced Gayle and I sent you his contact
25 information and that letter from BIAK.

1 MS. HUGHES: Okay. I have
2 apparently overlooked it. Sorry about that.
3 DR. SCHUSTER: No problem. And
4 you have T.J.'s contact information. I'll put my
5 grid together for you, Sharley - I didn't have time
6 today - but I will send it to you and send it to the
7 voting members so everybody has everybody's contact
8 information. Okay?
9 MS. HUGHES: That's fine. And I
10 did get T.J.'s this morning. I did see that one.
11 DR. SCHUSTER: So, the other one
12 was a replacement of Gayle retiring from the Board of
13 BIAK, and, so, they have appointed Eddie.
14 MR. REYNOLDS: That's right.
15 Gayle retired last year.
16 DR. SCHUSTER: So, I sent out
17 the draft meeting minutes of our November 3rd meeting
18 of the BH TAC, and I would entertain a motion from
19 one of the voting members to approve the minutes.
20 MR. BARRY: So moved. This is
21 Mike.
22 DS. MUDD: Second.
23 DR. SCHUSTER: Okay. And a
24 second from Val. Any additions, corrections,
25 omissions, questions? Seeing none, all in favor of

1 approving the minutes as distributed, signify by
2 saying aye. And opposed like sign and abstentions.
3 Just very recently, I got a
4 response from the Department for Medicaid Services on
5 our recommendation that we made to the MAC back in
6 November and that recommendation was to encourage
7 Kentucky Medicaid to gather data on behavioral health
8 services which have been denied for third-party
9 liability by commercial insurance carriers over the
10 past two years in order to determine the top ten
11 services which are not covered by commercial carriers
12 but should be covered by Medicaid so that we could
13 have a systems change to create a bypass to make
14 these claims eligible for reimbursement by Medicaid.
15 So, that's a very complicated
16 way of saying we're still having this problem with
17 what we call the dual eligibles, people that have
18 Medicaid plus some other coverage, and we've worked
19 out a bypass or a workaround for those who had both
20 Medicaid and Medicare, but we're still having
21 problems with Medicaid and a commercial insurer and
22 that's typically our kids.
23 So, it affects those kids that
24 are treated by the Children's Alliance members or the
25 CMHC's and needing services.

1 So, I'm very pleased to say
2 that we got a positive response from Medicaid that
3 they will request the data for further research,
4 evaluation and discussion purposes.
5 So, we thank Medicaid. I'm not
6 sure who is on from Medicaid but I'm very pleased
7 with that positive response.
8 The next is the status of our
9 data request from Medicaid on targeted case
10 management, and this has been a huge issue and we,
11 again, really appreciate the support of Medicaid in
12 really doing a deep dive into the Medicaid data to
13 look at what the impact of targeted case management
14 has been.
15 So, I think at maybe our
16 September meeting last year, I reported that we had
17 had some preliminary data reported from Medicaid; and
18 as you can imagine, it's a huge amount of data.
19 So, we're honing in on the
20 definition of folks with severe mental illness and,
21 then, asking them to also look at all kinds of
22 categories of expenditures because one of the things
23 that we really want to look at is whether targeted
24 case management is helping alleviate or increasing
25 access to services and maybe eliminating services

1 like ER visits, additional hospitalizations and so
2 forth.
3 So, after that first meeting,
4 we had a good conversation with them. We asked for a
5 second run of the data to really hone in and do a
6 kind of pre and post test where they would look at
7 our folks that meet the criteria of having at least
8 six months' worth of targeted case management and
9 they would go back and look at the six months prior
10 to TCM being instituted and, then, look at six months
11 after the individual had had targeted case management
12 for six months so we have that comparison pre and
13 post.
14 And we just got that data from
15 them late on Monday afternoon and we are so grateful
16 to have Barbara Epperson over at OATS where the
17 Medicaid data warehouse is - come in - come in.
18 Sorry. My bug man is here. Hello.
19 We have not had time to really
20 do a good analysis of that data but there's some
21 preliminary stuff that Kathy Dobbins got to take a
22 look at. And, Kathy, I don't know if you're on or
23 not. Are you with us? Maybe not.
24 So, she had pointed out some
25 kind of immediate things that jumped out in terms of

some data that would indicate that people are getting more services when they have targeted case management and that there may be some declines in some of those high-cost things.

So, I'm going to target our March meeting for our little workgroup that's been working on this data to have finished at least a very complete preliminary analysis and make a report back to you all, but my thanks go out to the Department for Medicaid Services, to the Commissioner in particular who really got us started on this well over a year ago talking about wanting to use data to make decisions and wanting to see what the impact of targeted case management has been on the lives of people that meet this severe mental illness definition.

So, that's a comeback for our March meeting but we're very excited to have this data and to have the opportunity to go through it.

So, Dr. Brenzel is in that group. Steve Shannon, Kathy Dobbins, Natalie Cunningham and Mark Kelly and myself. So, it's a range of people that have a lot of experience with this, and, again, my thanks to Medicaid for that. So, stay tuned on that.

1 The next item is something
2 that, again, we talked about a whole lot and that is
3 the update on claims payments for services to dual
4 eligibles.
5 So, I'm wondering - and I don't
6 know if Steve is on yet - I know Kathy Adams couldn't
7 be here today.
8 MR. SHANNON: I'm on.
9 DR. SCHUSTER: Oh, okay, Steve.
10 Great. Have you seen any differences with the bypass
11 in place?
12 MR. SHANNON: Yes. It's getting
13 better. There's still some concerns. Most of my
14 time has been on CCBHC claims, but overall we're
15 seeing some progress made on that bypass list.
16 We still struggle with folks -
17 and this is really a children's issue as well -
18 Medicaid and commercial insurance, but we're hoping
19 that the Medicare and Medicaid one is close to being
20 addressed but we'll see. It will take a while to
21 make sure it goes through the process and those
22 claims are done correctly.
23 DR. SCHUSTER: Yeah. And I
24 don't know if you were on when I reported that DMS is
25 going to look at that data that we had requested on

1 our recommendation back in November.
2 And, again, I can't see who is
3 on from Medicaid. Does anybody have any idea about a
4 time frame to look at that data?
5 MS. HUGHES: Lee and Angie and I
6 think Deputy Commissioner Cecil.
7 MS. PARKER: This is Angie with
8 Medicaid. I did look at it briefly. I did pull it
9 up and kind of looked to see what the comparisons
10 were before and after CCM. I can't say that it was a
11 lot different.
12 DR. SCHUSTER: No. I'm asking,
13 Angie, about the time frame on this new request that
14 we have.
15 MS. PARKER: Oh, I am so sorry.
16 DR. SCHUSTER: No problem. No
17 problem at all. We got the favorable response back
18 dated January 4th from DMS that they would look at
19 that data on the claims, denied claims under third-
20 party liability for the commercial insurers so that
21 we could start working on a bypass in that system as
22 well.
23 And I was just curious about
24 what our time frame out to be to look for some report
25 back on that data, and there may not be anybody on

1 who is in a position to respond to that.

2 MS. CECIL: Hi. It’s Veronica

3 Cecil with Medicaid. I was also looking to see who

4 might be working on that project.

5 MS. GUICE: I have nothing to

6 offer on this topic at this moment, and I just wanted

7 to say that to let you know that I am hearing you and

8 I hear the question. I will have to go back and take

9 a look at some other information.

10 MS. CECIL: I do think, Dr.

11 Schuster, that the Commissioner actually is pulling

12 the data.

13 DR. SCHUSTER: Oh, okay. That’s

14 impressive.

15 MS. CECIL: This and the

16 targeted case management are important issues to her,

17 but we will go back and make sure that one of us are

18 up to date on what’s going on with it.

19 I know the request has been

20 made. Generally, it can be thirty to sixty days,

21 depending on it is Session. And when we’re pulling

22 data, sometimes requests get pushed down the line

23 based on priority, but we’ll definitely report back

24 to you on that.

25 DR. SCHUSTER: Yeah. And maybe,

1 Veronica, you and I could communicate six weeks from
2 now so I know whether to put it back on the agenda
3 for the March meeting or not, and that's really what
4 I'm looking at. And certainly the Commissioner is
5 looking at it and so forth. That's great.
6 MS. CECIL: I think that's a
7 good plan.
8 DR. SCHUSTER: Yeah. So, we
9 will definitely do that. And, again, we really do
10 appreciate that positive response and having the
11 data. So, thank you very much.
12 We're just zipping through this
13 agenda today.
14 So, the next is I think a
15 report from the MCOs on how the no-show data is being
16 used by the MCOs. We've had this - T.J., you are new
17 to this.
18 The Department has put out a
19 data-gathering reporting system for providers to
20 report when people miss their appointments, and we've
21 expressed some concerns about how that data would be
22 used, wanting to be sure that people aren't - and
23 this would be obviously an unintended consequence -
24 but that people are not being stigmatized or seen
25 negatively because they're having problems getting to

1 appointments.

2 And, so, we understand that

3 that data has been shared with the MCOs. So, they're

4 being told who in their client caseload are having

5 trouble keeping their appointments and are doing some

6 outreach. So, that's what we're interested in

7 hearing from.

8 And I think, Veronica, you sent

9 that request out to the MCOs after you and I had some

10 back and forth about it, right?

11 MS. CECIL: Yes, that's correct.

12 So, each MCO should be prepared to discuss it. So, I

13 don't know if you want to go in any certain order.

14 DR. SCHUSTER: Well, we can

15 always go alphabetically or we could start in the

16 middle. We'll go alphabetically this time. So, I

17 don't know who is on from Aetna.

18 MS. JONES: This is Cat Jones

19 with Aetna. So, we do receive these reports and we

20 are in the process of figuring out a process for case

21 management outreach, but it has been a challenge to

22 get oriented and work through that process because

23 the report includes very limited information.

24 We have the member Medicaid Ids

25 but we don't have any information about the provider.

1 And, so, it's a lengthy list and it's hard to
2 determine how to prioritize maybe those members that
3 need outreach maybe sooner than the others on the
4 list.
5 For example, if we had the
6 provider information, we might be able to tell, oh,
7 this is a behavioral health and be able to look at
8 that member and see, oh, they missed their
9 appointment after their hospitalization and can
10 prioritize our case management work.
11 So, we're trying to figure out
12 how to make that report useful and how we can best -
13 you know, maybe is there other information we can
14 pull from our systems utilizing those member ID's
15 make that list as useful as far as outreach as
16 possible. So, that's where we are at this time.
17 DR. SCHUSTER: Okay. And I
18 don't remember that screen shot well enough. So,
19 Lee, let me turn to you because I know that you're
20 the one that has reported on this or given us the
21 information.
22 MS. GUICE: Dr. Schuster, I'm
23 looking for - we just got those reports. What I
24 believe is that perhaps Cat hasn't seen all of them.
25 There are two different sets of

1 reports that go to the MCOs and I believe one of them
2 has the provider on it; but if you would go ahead and
3 let me find them in my emails, I can speak more
4 definitively on this.
5 DR. SCHUSTER: Okay. All right.
6 MR. OWEN: This is Stuart Owen
7 with WellCare. Sorry to cut in. So, on that topic,
8 we emailed DMS a couple of weeks ago and said that we
9 really need the provider name and we need the date of
10 service.
11 And DMS responded back quickly
12 that beginning with the February report, they will
13 list the provider name and date of service on the
14 report. So, all MCOs should be getting that
15 beginning in February, but Cat is exactly right. All
16 we have right now is member ID and that's it. Sorry
17 to jump ahead.
18 DR. SCHUSTER: That's helpful to
19 know. So, this initial reports that went out gave
20 you a long list of your members but the information
21 that they had missed appointments but that was it.
22 MR. OWEN: Right. It didn't say
23 when, didn't say who the provider was. So, if you
24 call, you say we understand you missed an
25 appointment. Who? We don't know. When? I don't

1 know. But, anyway, beginning in February, we
2 understand that's going to be included on the report.
3 DR. SCHUSTER: Okay. Stuart,
4 did it give the number of times, number of missed
5 appointments for each person?
6 MR. OWEN: Yes. So, DMS sends
7 us a monthly report and, then, they sent us an
8 accumulative one maybe a couple of weeks ago or so.
9 I think this began in July. And, so, that one shows
10 for that period the frequency, how many times each
11 member missed.
12 DR. SCHUSTER: Okay, but I think
13 the example that Cat gave is that if you've got
14 somebody who has missed behavioral health
15 appointments and has a primary mental health
16 diagnosis, that would kind of red flag that - maybe
17 that's a bad term because red flags mean other things
18 in legislation and so forth - but, anyway, that would
19 flag for you that that might be a higher priority.
20 MR. OWEN: Exactly. And along
21 those lines, I don't know if you want me to wait for
22 the "W" at the end.
23 DR. SCHUSTER: We'll go back and
24 forth. Go ahead. Thank you.
25 MR. OWEN: So, we were curious

1 about how many had a behavioral health diagnosis.
2 And, so, because we have the member ID, we can pull
3 that and we can run the claims, and we found out -
4 and I guess this was for - well, this would have been
5 probably for the whole calendar year - but 22% of
6 those that missed appointments had a severe mental
7 illness, compared to the "average" population of 9%
8 that had an SMI, the Medicaid population.
9 Twelve percent had a serious
10 emotional disability compared to 6% average, so,
11 that's more than double. We were curious about ER
12 visits. Ninety-three percent of those with missed
13 appointments during that time period had an ER visit
14 within the past year which is about twice, and also
15 5% had a behavioral health admission. So, that's
16 over three times the average, maybe three and a
17 quarter times the average for the general population.
18 So, obviously, there's a high
19 prevalence of behavioral health diagnoses among
20 those that are missing appointments.
21 DR. SCHUSTER: Right.
22 MR. COOK: This is Dr. Cook from
23 United Healthcare, and I thank you for sharing that,
24 Stuart.
25 I think the other thing that

1 we're looking for with that report is, as we're
2 looking at where the members are missing appointments
3 at, like, the providers, not necessarily in a
4 punitive way but looking at how can we then reach out
5 to the providers and support them in this process as
6 well when we see those missed appointments from the
7 members.
8 So, that extra detail that I
9 understand - I was on a call earlier today - that
10 will come in the February report will really be
11 helpful for us to see trends as well and how we can
12 then work with the providers and the members to try
13 to build around getting those appointments made for
14 the members. So, I just wanted to add that as well.
15 DR. SCHUSTER: Steve, could you
16 take over and chair the meeting for a minute. I've
17 got to take an emergency call here.
18 MR. SHANNON: Sure. What about
19 Anthem?
20 MR. CROWLEY: This is David
21 Crowley, Director of Behavioral Health for Anthem.
22 So, Anthem uses this report and merges it onto one of
23 our internal clinical risk indicator reports. That
24 way we flag the most medically fragile members from
25 our internal data that includes all claims and

1 utilization trends.

2 Once we have those members

3 flagged that are in the highest groups, Groups 3 and

4 4, those are, then, cued for our highest level of

5 intensive case management outreach.

6 And, then, for the members that

7 don't fall into the highest clinical risk indicators,

8 we, then, kind of filter it down to those members

9 that have missed three or more appointments.

10 And although they might be

11 lower risk overall, we engage those members with our

12 community engagement navigators because mor than

13 likely it could be an aspect of social determinants

14 of health that we could try and troubleshoot within

15 our community resources.

16 But it will be really

17 significant in that February report like others have

18 noted whenever we start receiving with the provider

19 that made the report of the missed appointment. That

20 way we can work kind of more collaboratively with

21 those members and providers that have a missed

22 appointment.

23 MR. SHANNON: Any questions for

24 Anthem? Thanks, David. What about Humana?

25 MS. STEARMAN: Hi. Good

1 afternoon. It's Liz Stearman from Humana Healthy
2 Horizons of Kentucky.
3 As far as how we are utilizing
4 this report, every single one of our members that is
5 populated on the report will be receiving a letter in
6 the mail detailing the importance of attending
7 appointments, notifying providers if they miss
8 appointments, as well as including the case
9 management phone number and email address to assist
10 in finding a provider, if they need help rescheduling
11 or removing barriers so that if they are receiving
12 that letter, they will have that easy, quick way to
13 connect with our team.
14 Additionally, if we have
15 identified a member on that report that is already
16 engaged in care management, the care manager will do
17 a one-to-one outreach to help them identify if there
18 are any barriers that need removal, if they need to
19 find a new provider, reschedule.
20 Additionally, we have been
21 filtering for some of those FQH barriers that I know
22 Anthem was just mentioning as well so if we see -
23 there is actually like a reason that the providers
24 are able to notate on that report of why the
25 appointment was missed if they know it.

1 And, so, if it's indicated on
2 the report that either child care or transportation
3 were the barriers that caused them to miss the
4 appointment, a member of our population health team,
5 so, a community health worker, FQH coordinator, care
6 coach, someone will reach out to them specifically
7 around that issue to try and assist with any kind of
8 resources.
9 And, then, lastly, if an
10 enrollee appears to have a recurring issue with more
11 than three missed appointments, they will also get
12 individual outreach.
13 All of those things are put in
14 place because, as was also said, we're working with a
15 little bit of an information vacuum. And when we
16 have those provider ID's, our intention is to be able
17 to also apply sort of a provider specialty filter to
18 that to be able to triage for those, like you guys
19 have said, that have either a behavioral health
20 appointment or another critical appointment.
21 We're looking at our high-risk
22 OB members. If they are missing their OB
23 appointments, obviously those move up to the top of
24 the list and doing some triage there as well.
25 I know Dr. Schuster has

1 mentioned several times that the concern was being
2 able to use it in a punitive way. I think we're all
3 taking that approach that this is an opportunity for
4 us to get our members that need access to care a much
5 closer tie to those providers.

6 MR. SHANNON: And you guys send
7 a letter. A lot of those folks that we serve at
8 CMHC's, I mean, the mail is necessarily or always the
9 best approach.

10 Is there a secondary strategy.
11 A lot of them don't get mail or don't look at their
12 mail or are reluctant to open mail, especially from
13 an insurer maybe.

14 MS. STEARMAN: Yeah. We are
15 doing that as our baseline. When we get the
16 information and all we have is that provider ID,
17 again - I think someone else talked about the volume
18 of people on the list - we don't want to have to do a
19 phone call to every single person. It's similar to
20 not opening mail. A lot of folks either don't have a
21 good phone number or are not going to answer the call
22 from the insurance company.

23 So, that's just sort of that -
24 that's the bottom-tier approach and that's why those
25 additional calls and identifying the members who

1 already have an established relationship with a care
2 manager are going to get that additional outreach.
3 MR. SHANNON: All right.
4 MS. JONES: This is Cat at Aetna
5 again. So, building off of that, we're looking at
6 text messaging campaigns. As soon as we can get the
7 more detailed information, the more targeted that we
8 can be. A lot of times that communication by text is
9 more effective than a letter or even a phone call.
10 So, that's another option that we're exploring in
11 trying to build into using this report.
12 MR. SHANNON: All right. Great.
13 Anybody else? Passport.
14 MS. GUICE: I'm sorry. I
15 thought you were finished with the MCOs. Go ahead.
16 MR. SHANNON: Passport.
17 DR. McKUNE: Good afternoon.
18 This is Liz McKune. I'm the AVP of Population and
19 Behavior Health Strategy at Passport by Molina.
20 And the strategies that we have
21 in place are fairly similar to what others have at
22 this point. The first thing we do when the list
23 comes in is we attach the assigned PCP because we
24 have that in our data files. Since we didn't have
25 the providers on there, we're attempting to try to

1 figure out who is this person that needs engaging in
2 some way with.
3 And, then, we are going through
4 and looking for those members that are already
5 engaged in case management. We are having a task put
6 into our record file so that the next time that the
7 case manager goes in, they will see for their
8 particular member that an outreach needs to be done
9 to find out what happened and why they might have not
10 shown up for an appointment.
11 If the members aren't in case
12 management, we're stratifying that data. And if they
13 missed for an SDOH reason, for a social determinants
14 of health reason, if that's documented, we're having
15 our community kynectors reach out to try to figure
16 out what happened and, again, connect them to
17 resources in the community to help them to fully get
18 to an appointment.
19 And if they missed more than
20 three appointments, we are also assigning them to a
21 community kynector and those would be people that we
22 might not know why they have missed because it didn't
23 have that it was an SDOH need so that we are doing
24 some outreach.
25 We also have a group that has

1 been meeting that is working on drafting a
2 communication where we were going to send out a
3 letter to all members that were appearing on the list
4 so that there was at least some sort of outreach and
5 contact to every person because the list is rather
6 long.
7 We're looking forward to having
8 more information about them, including the provider
9 on that February file.
10 MR. SHANNON: Thanks, Liz. Any
11 questions from Passport by Molina? All right. Any
12 questions about this issue at all?
13 MS. MUDD:: Just on a personal
14 note with my own provider, what my provider says is
15 that after three missed visits, they call for a
16 welfare check. So, that's what happens with me
17 personally.
18 MR. SHANNON: You haven't missed
19 three, have you, Val, to see what that's like?
20 MS. MUDD: No.
21 MR. SHANNON: I just want to
22 know what happens at a welfare check. I'm not
23 questioning you.
24 MS. GUICE: The police come and
25 knock on the door.

1 MR. SHANNON: That's what I was
2 afraid of.
3 MS. GUICE: Yes. You'd think
4 it's a scary thing.
5 MR. SHANNON: I hope that's not
6 what it is.
7 MS. GUICE: Well, sometimes it's
8 the Fire Department that does it every once in a
9 while. This is Lee Guice again. I apologize. I
10 didn't announce who I was.
11 I knew there were two reports
12 that went to the MCOs. I'm thankful that Stuart was
13 on the phone and on the call and in the meeting and
14 has already made the request to have that report
15 updated.
16 The second report is the reason
17 that the patients/members have given for missing
18 their appointments. And, so, that's where I was
19 confused because I knew there were two separate ones,
20 one with the member's name - identifying information,
21 not the name but their Medicaid number.
22 So, I just wanted to clear that
23 up, and I'm glad we were able to modify the report
24 for February so it's more useful.
25 MR. SHANNON: And I was serious.

1 I would hate to think the police show up, and I know
2 that's a welfare check but I hope there's a different
3 strategy for insurers because that's going to I think
4 chase a lot of people away from services, not to
5 services which isn't the objective of this data,
6 right?
7 MS. HUGHES: I think in the case
8 of what Val was saying is that her doctor doesn't -
9 if she doesn't see her doctor, if she misses three,
10 that they call a well check. I'm pretty sure those
11 are either police or firefighters that come out. You
12 don't know when they're coming or why they're coming
13 but they basically just knock on your door.
14 I've not had one but I do know
15 somebody that has had one. They just came to their
16 door and just said that someone had called them and
17 was concerned about their welfare and just wanted
18 them to check.
19 MR. SHANNON: Okay. Still a
20 concern. A lot of folks who are really mentally ill
21 are not going to respond well to that if that's the
22 approach, right, Val? I would suspect to hear that
23 at Participation Station.
24 MS. MUDD: Absolutely.
25 Absolutely.

1 MR. SHANNON: And I'm sure Kelly
2 Gunning has heard the same story.
3 MS. GUNNING: It's really hard
4 for people that suffer from paranoia and that's most
5 likely - I'm sorry to generalize - but oftentimes
6 those are the individuals that miss appointments due
7 to symptom load. So, that would be a pretty scary
8 thing to do.
9 MR. SHANNON: Yes. All right.
10 Dr. Schuster is back. We got the updates on the data
11 on the missed appointment stuff.
12 The last conversation was
13 Valerie Mudd shared with us, Sheila, that if she
14 misses three, there's a welfare check and we've
15 expressed concerns about for some folks if police or
16 fire show up for missed appointments.
17 DR. SCHUSTER: Does it make
18 sense to keep this on the agenda for March because
19 you all will have the new data sets in February. So,
20 let's revisit this in March. So, you all will have a
21 more finer-tuned - I love the data that - I mean, I
22 don't love the content of it but I love the idea,
23 Stuart, of what WellCare has done in terms of
24 analyzing that data and comparing it to kind of more
25 the typical population to see what we're finding

1 because that's some other pieces that we could look
2 at there.
3 So, I appreciate you all, and
4 we'll bring that back. I also appreciate Medicaid
5 refining that data reporting so that you have the
6 information that you need to make this really useful.
7 Val, you're in a position and
8 some of our CMHC's may be in a position to hear from
9 people if they have had a missed appointment and,
10 then, when you next see them on the provider side to
11 see if they did get some reach-out and how that was
12 perceived.
13 But, Val, you're in a position,
14 I think, with your consumers at Participation Station
15 to kind of hear what the scuttlebutt is on that from
16 their perspective. That would be really helpful.
17 Kelly?
18 MS. GUNNING: Sheila, what we
19 hear a lot of times, and I'm sure Valerie can
20 validate this, is there does seem to be a punitive
21 type of response too often where if you miss your
22 appointment, well, it's going to be six to eight
23 weeks before we can get you another appointment,
24 sometimes even longer.
25 And that just seems ridiculous

1 because sometimes there’s no way to get there.
2 There’s no transportation. It is those social
3 determinants of health that keep them from making the
4 appointment to begin with or it’s symptom load.
5 So, more often than not,
6 Valerie, if this was the case before the new year,
7 I’m sure not much has changed, if anything, and with
8 COVID raging, it seems to be even more prominent.
9 But everybody is dealing with
10 staff shortages and those things, too, but I hope
11 there’s a better way that we can do it besides really
12 putting off appointments for people that have already
13 missed appointments. That’s a recipe for disaster.
14 DR. SCHUSTER: Well, I guess the
15 other piece of this, Lee, when you all get that data
16 - and, again, I can’t remember - but the providers
17 that are putting that data in, do they indicate
18 whether that was an in-person visit or a telehealth
19 visit?
20 MS. CECIL: Dr. Schuster, I
21 think Lee had to drop off for another meeting, but
22 I’m pretty certain it does not capture that.
23 DR. SCHUSTER: It seems to me
24 that that would be a really important thing to
25 capture. Certainly we have so many more telehealth,

1 and I guess we're assuming that people are not
2 missing their telehealth appointments but I wonder if
3 that's the case.
4 MS. GUNNING: They are missing
5 them, Sheila. I can only speak for our group that
6 we're in regular interaction with. And, Valerie,
7 would you say that's the case?
8 MS. MUDD: Yes, I would. Well,
9 besides the fact that people don't like the whole
10 Zoom environment to begin with. With the paranoia
11 issues and all that kind of stuff, that adds to
12 missing the appointments as well.
13 MS. CECIL: I think we would be
14 concerned if they're missing an appointment
15 regardless if it's telehealth or in person. So, I
16 think capturing the fact they missed it prompts, as
17 we've heard from the MCOs which was the expectation,
18 prompts some additional follow-up.
19 And, then, at that time, they
20 can determine is it transportation, if they have an
21 opportunity to actually outreach to the member and/or
22 the provider to see is it a technology issue, is it
23 transportation.
24 We're still digging into non-
25 emergency transportation and why folks don't access

1 it and what can we do to make it more accessible.
2 That’s another area the Commissioner is very
3 interested in is we’ve got this benefit and why
4 aren’t members taking more advantage of it, and are
5 there barriers that are standing in the way of its
6 use?
7 And, again, the take-back from
8 all this is that we hope there is further
9 conversations through the MCOs about what are they
10 finding and what can we do to make changes to help to
11 reduce any barriers.
12 DR. SCHUSTER: The non-emergency
13 medical transportation has been a bugaboo for years
14 and years.
15 MR. SHANNON: A long time.
16 DR. SCHUSTER: A long time and
17 it works in some places and not in others and, then,
18 it works with some transporter and not with others,
19 but I wonder if our behavioral health folks or folks
20 with a behavioral health diagnosis have more
21 reluctance of more difficulty doing non-emergency
22 transportation. Do you think so, Kelly?
23 MS. GUNNING: Our folks - and I
24 think, again, Valerie could vouch for this - it’s
25 very difficult because you have to call so far ahead

1 of time. Then, there's no guarantee you're going to
2 get to your appointment on time. The public
3 transportation in Lexington and Fayette County in
4 particular is very daunting to navigate.
5 We actually have people that
6 that's their job is to teach people how to use the
7 bus and it's not easy and the timing is terrible for
8 a lot of these things and routes and what if your
9 appointment isn't in the schedule of the bus and the
10 Wheels' people didn't show up on time. There's just
11 all kinds of issues that we face with that.
12 MS. MUDD: With Wheels, you have
13 to give a 24-hour notice before you can get somewhere
14 and sometimes that's hard to do. And, again, they
15 may have to stop and pick somebody else up on the way
16 and they may be late for their appointment or
17 whatever. So, it's a difficult situation.
18 DR. SCHUSTER: Somebody was
19 wanting to add something.
20 MR. STUART: This is me, Stuart
21 again with WellCare. That was definitely something
22 we were curious about with telehealth, the expansion
23 of telehealth because of COVID.
24 Even before COVID, we were
25 wondering especially if transportation is an issue,

1 we figured probably a lot of providers are offering
2 services through telehealth now and we were curious
3 about that because that would eliminate that barrier.
4 So, I was just kind of curious. Among you all, are
5 you aware of telehealth being pretty commonly
6 offered?
7 This is just the Behavioral
8 Health TAC, but would you say, do you have any kind
9 of estimate, 50% are offering it or any kind of idea?
10 DR. SCHUSTER: Steve, do you
11 have an idea? I would guess it's upwards of 50%.
12 MR. SHANNON: I know that all of
13 the CMHC's are. They have made it available, even to
14 the extent some actually have an office in person.
15 If the person shows up, they go to an office and
16 there's a person in the building seeing them and
17 everything to make sure there's no exposure, six feet
18 apart and all that stuff, and that really - if
19 there's an upside to COVID which seems unlikely, it's
20 telehealth.
21 It has really changed the
22 dynamics and it has forced the CMHC's for sure and
23 other providers to ramp up and provide those
24 services, and the allowances that the Cabinet has
25 made in the utilization of telehealth has been a game

1 changer as well. So, we're very active in it.

2 We're trying to figure out what

3 the future looks like and the extent of telehealth

4 and how much we're doing and who works well and who

5 doesn't work well. I asked Sheila at one time, or Dr.

6 Schuster contacted folks. Adolescent males really

7 like it. They're comfortable with it and we can go

8 on from there.

9 So, I think it's something

10 we're going to keep doing. We hope to become better

11 at it, and really the challenge now is to match who

12 is really good at providing the services and what

13 groups of folks are good at receiving it and works

14 well and go on to that place and become more

15 strategic in our utilization but right now it's the

16 first choice for a lot of people.

17 DR. SCHUSTER: Stuart, I did a

18 survey, an informal survey, calling people, called

19 the CMHC's, called folks like the NAMI outfits like

20 Kelly and Val and so forth to get some feedback on

21 telehealth.

22 And one of the things that so

23 many of the providers reported was a sharp decline in

24 missed appointments and a sharp decline in no-shows

25 and so forth which was very encouraging. Now, that

1 was from the provider's standpoint. Again, I think
2 there are some people for whom it doesn't work. I
3 think there are some people that are older, less
4 familiar with and less comfortable with the computer
5 and so forth. I think children on the autism or
6 teenagers on the autism spectrum have a hard time.
7 Kids with ADHD, you have a hard time keeping them
8 engaged.
9 And I think the security issues
10 came up a lot. You have an adolescent and you have a
11 kid and they're in their living room with family
12 members coming and going and so forth, and we heard
13 from kids that they were locking themselves in the
14 bathroom so that they could get some privacy while
15 they were having a session. So, there's some down
16 sides to it, too, obviously.
17 MS. MUDD: If they're anything
18 like me, I'm on Medicare and I do telehealth. I've
19 been doing telehealth with my med manager and it's
20 totally free. I'm like, well, heck, I'm not going to
21 get in my car and get dressed and spend an hour to
22 get there or whatever. It's totally free. There you
23 go.
24 DR. SCHUSTER: Well, an ongoing
25 conversation. It looks like we're going to be in the

1 world of telehealth for quite a while here if you
2 look at the COVID numbers and so forth.
3 MR. SHANNON: Kelly has a
4 question, Sheila.
5 MS. GUNNING: Sheila, I just
6 want to say maybe a more targeted approach would be
7 to look at the people that aren't engaging in
8 telehealth. The ones that are, that's great, but
9 it's these cohorts that you just mentioned that
10 aren't prone to engaging in telehealth. So, what are
11 the options there because I think that's going to be
12 smaller cohorts of people, like you said, elderly
13 people and just the populations you just mentioned.
14 So, it's coming up with a
15 strategy for outreach to those groups.
16 DR. SCHUSTER: Yes, I think
17 absolutely and I think there continue to be providers
18 that really are struggling with doing their work via
19 telehealth, depending on the kind of therapy that
20 they're offering and so forth. So, it goes, I think,
21 both ways.
22 MS. GUNNING: In rural areas,
23 there's the issue of bandwidth for even having the
24 ability to connect. So, those are huge issues in
25 those areas as well.

1 DR. SCHUSTER: Yes, and I think
2 once you get real disjointed communication, it makes
3 a therapy session open to possible real hard to
4 establish rapport and so forth with that going on.
5 I would think that the MCOs
6 when they follow up with people are going to be
7 asking those questions in terms of whether this was a
8 telehealth visit or a physical health visit. Val.
9 MS. MUDD: I'll be honest. When
10 I first started doing telehealth, I mean, I had the
11 paranoia feelings about, okay, where is this person
12 sitting, can other people hear my conversations, all
13 that kind of stuff, and I can probably name, I don't
14 know, five people right off the bat that I know do
15 not do telehealth because they don't like the camera
16 and the paranoia is seriously there.
17 DR. SCHUSTER: Good feedback,
18 good discussion. Thank you.
19 I keep putting on the issue of
20 EMS transportation of individuals with behavioral
21 health issues.
22 I will tell you that the
23 Hospital Association has been working with me, with
24 the Mental Health Coalition, with the nursing homes,
25 with hospice to come together behind a bill, and I

1 think we're going to see that filed maybe this coming
2 week by Representative Ken Fleming who is a
3 Republican from Jefferson County, and it's going to
4 look at creating kind of a workgroup actually to talk
5 about these transportation problems which stems back
6 to years.
7 This came up three years ago,
8 four years ago as BH TAC recommendations. We were
9 hearing and at first we thought it was just a rural
10 issue and now we realize that it's certainly an urban
11 issue and it started with ambulance drivers saying,
12 well, we don't have to transport crazy people or we
13 don't have to transport people that have a behavioral
14 health issue and actually is widespread now hospital
15 to hospital. We're finding it from hospital to
16 step-down services.
17 We've heard stories from
18 hospice about patients who were supposed to be picked
19 up at the hospital and taken to a palliative care
20 center or taken home so they can have hospice
21 services available to them before they died and there
22 have been some horrible stories of people that have
23 actually died during this 24-hour waiting period
24 while they were waiting to be transported, that we're
25 that close to the end of life and never got home to

1 have hospice services. So, it has really gotten way
2 out of hand.
3 So, there's all kinds of issues
4 around the way that the ambulance providers are
5 licensed and so forth. So, I will keep you updated
6 about that legislation.
7 And, Steve, do you want to talk
8 a little bit about the 202A transportation issues?
9 MR. SHANNON: Yes. It started,
10 I guess, October, November, and Representative
11 Heavrin and Representative Bray raised the issue that
12 they've had some concerns, heard concerns about
13 transportation 202A about hospitals' wait times for
14 people primarily, stories where folks are actually
15 waiting in the ER for twelve, fourteen, sixteen hours
16 to be transported to one of the four state
17 psychiatric hospitals, whether it's Western State,
18 Central State, Eastern State or Appalachian Regional
19 Hospital.
20 And they met with several
21 groups. They brought people in. I have not seen a
22 bill. I haven't heard back. They wanted feedback
23 from a variety of groups by December 15th, and I
24 think the Hospital Association submitted stuff,
25 (inaudible) submitted stuff, I submitted information

1 on behalf of KARP member CMHC's. I know the
2 advocates submitted information as well, and they're
3 trying to figure out what's the best approach to make
4 sure people aren't waiting to go.
5 Representative Bray clearly
6 stated at one meeting, he didn't understand why
7 someone is waiting sixteen hours for a seventy-two-
8 hour hold. Why is that taking place?
9 Representative Heavrin just
10 wants a solution to this problem. She wants people
11 to get to the hospital as quickly as they can, and
12 their approach was going to be legislative.
13 I haven't seen a draft yet.
14 So, we will get that out to people when it's
15 available; but what is the best way to get people to
16 the state psychiatric hospitals. It's the DeShares
17 that do that. DeShares will tell you they have no
18 training. They have no expertise.
19 I think part has kind of peeled
20 it back. It's a judicial action and DeShares
21 transport people for judges. I think that's how we
22 ended up there.
23 We stated that we understand
24 why. As we all have said many times, mental health
25 is part of health, and the ambulance transports to

1 hospitals, why would this be any different? So, that
2 was our first statement to go forward and I think a
3 lot of folks expressed that same sentiment as well
4 but I don't think there is a great answer before us
5 right yet but hopefully we'll move towards getting,
6 one, prompt care for people who need it - that's a
7 priority - and transportation that's not
8 stigmatizing.
9 DR. SCHUSTER: Well, and you all
10 remember when we were working so hard on Tim's Law,
11 Faye Martin telling her story about thirty-plus times
12 seeing her son who was never a danger to anyone but
13 himself being taken off in handcuffs in the back of
14 the Sheriff's car thirty-four or thirty-seven times -
15 just awful.
16 So, we did make a strong
17 statement and I know, Steve, your group did as well.
18 So, we'll see about that.
19 The original draft legislation
20 that they shared with us we think would be
21 detrimental to the system. It simply said that they
22 could just go to any hospital and drop them off. It
23 didn't even say it had to be a hospital with a psych
24 unit. It didn't say that it had to be a hospital
25 that was trained to take people who were there

1 involuntarily which we know is a very different
2 (inaudible) than people who are walking in and asking
3 for treatment for their mental illness.
4 MR. SHANNON: And I think they
5 heard that message, right, Sheila?
6 DR. SCHUSTER: Yes, I think they
7 did. So, we'll see. I think they're finding out how
8 really complex this is. Kelly.
9 MS. GUNNING: I just wanted to
10 share with you that I've been researching some
11 communities that are doing really good things.
12 And, unfortunately, last
13 evening, my husband and I had the experience of
14 having to be on the phone while our adolescent
15 grandson was committed involuntarily to a hospital in
16 North Carolina.
17 And when they got the
18 magistrate to sign the order, immediately a crisis
19 intervention team was notified and they were given
20 the choice for the crisis intervention team to come
21 with an ambulance or to send police officers with a
22 cruiser. And, of course, they chose the ambulance.
23 So, there was a crisis team
24 officer, a CIT-trained officer with a paramedic and a
25 social worker that came in an EMS vehicle to their

1 home instead of a police cruiser which would have
2 ignited the neighbors.
3 So, there are communities that
4 have mobile outreach teams that are doing this very
5 well.
6 DR. SCHUSTER: And that was for
7 a youth.
8 MS. GUNNING: Yes. This is for
9 an adolescent, sixteen years old.
10 MS. CECIL: Let me add.
11 Medicaid just got the mobile crisis planning grant
12 and these are some of the issues that we definitely
13 are going to be considering and hopefully developing
14 solutions for as part of that planning grant.
15 DR. SCHUSTER: We had heard, I
16 guess, from a briefing that Steve and I had with
17 Leslie Hoffmann and some other folks, Veronica, about
18 that grant coming in.
19 Is there opportunity for public
20 input on that or at least a select group of people?
21 I mean, obviously, you're hearing a lot now but it's
22 the tip of the iceberg in terms of the people that
23 are on the ground experiencing these things being
24 able to give their feedback. So, I hope that will be
25 the case.

1 MS. CECIL: Yes. There will be
2 a lot of stakeholder engagement as part of that
3 because the solution is in the community and we need
4 to know what's going on in the communities and we
5 want to look at this more broadly across this is law
6 enforcement.
7 I mean, we're going to need to
8 get a very comprehensive approach and all the
9 different sectors that touch this in order to develop
10 a really good program for Kentucky, and we are
11 looking at other states and what they've done in
12 other communities and what's going on with them
13 because we're trying to learn those lessons, too.
14 DR. SCHUSTER: Great. Maybe
15 Kelly could send you her research, particularly with
16 her family's recent brush up against the system, but
17 I'm really glad to hear that.
18 I do think that the mobile
19 crisis units, mobile response, crisis response is so
20 much a part of what needs to be happening, whether
21 it's Tim's Law or it's 202A or if legislation goes
22 forward on the crisis aversion and rights retention
23 which is remove a gun in the midst of a crisis if a
24 person is in danger of hurting themselves or a
25 suicide or hurting somebody else. I mean, there's so

1 many places where we really need to have that up and
2 running and very functional. So, it's exciting.
3 Thank you for sharing that.
4 MS. HUGHES: Can I interrupt
5 just one second?
6 DR. SCHUSTER: Sure.
7 MS. HUGHES: Leigh Ann just sent
8 me a note that she has to drop off early for a 3:30
9 meeting and she is giving the update on the SUD
10 services to incarcerated persons. Could she go next
11 on your agenda?
12 DR. SCHUSTER: Yes, absolutely.
13 Thank you, Sharley. Thanks, Leigh Ann, for being on.
14 I didn't see Leslie on.
15 MS. FITZPATRICK: Leslie is not
16 feeling well, so, I will be doing it.
17 One thing on the mobile crisis
18 planning grant, I am working on that, and tomorrow we
19 should be sending out our survey to our stakeholder
20 members. And, then, we are working on our community
21 stakeholders.
22 I'm going to put my email in
23 the Chat, and if you would like to be a part of the
24 community stakeholders, just send me an email and I
25 will be glad to add you on that.

1 We're looking for a couple of
2 weeks out on that because we just finished the state
3 information and we'll get on our community providers'
4 lived experience as well.
5 DR. SCHUSTER: Wonderful. Thank
6 you.
7 MS. FITZPATRICK: And on our
8 1115 SUD incarceration amendment, things are moving
9 along. CMS has asked several questions about our
10 budget neutrality and we're working on that. It's a
11 heavy lift; but with them asking questions, it's
12 looking positive.
13 We did meet with CMS earlier
14 this week. They're still not sure of policies and
15 procedures around what we're asking for. We're
16 asking for Medicaid to pay for services behind the
17 wall.
18 Currently, our DOC program,
19 Department of Corrections, they offer SAP AND SOAR
20 SUD treatment to those inmates which, of course,
21 federal states that we cannot offer any services and
22 pay for benefits for someone who is incarcerated.
23 So, we're asking for that rule to be taken away.
24 And, then, we're also asking
25 for an average of thirty days post-release that we

1 can get that inmate to their MCO of their choice and
2 work on setting up appointments, whatever needs they
3 might have.
4 There have been several states
5 that have turned in an 1115 for that portion, for the
6 thirty days prior to release to get hooked up with
7 the MCO and have the benefits turned on so that they
8 can go and do their assessments and what they need to
9 help them get back in to the community after they are
10 released. That MCO worker would work with that
11 individual for twelve months post-release as well.
12 So, questions are being asked.
13 It is moving a little slowly but we're getting a
14 little bit of progress, a little bit here and there.
15 Does anybody have any questions?
16 DR. SCHUSTER: I was pleased to
17 hear from Leslie on another call I was on with her
18 that you all have actually heard back from CMS and
19 asked questions because we have had this on our
20 agenda to ask about for, I don't know, for a year,
21 however long it's been.
22 MS. FITZPATRICK: Correct.
23 DR. SCHUSTER: It seems like
24 every two months, you all are saying, no, they're
25 still encouraging but no movement. So, it's got

1 movement. It’s got to feel good that they’re at
2 least coming back and asking about it. And I’m sure
3 that the budget neutrality is a tough piece. That’s
4 a tough barrier to get over.
5 MS. FITZPATRICK: Right. Yes, it
6 is. We’re working on it.
7 DR. SCHUSTER: Okay. Any
8 questions for Leigh Ann?
9 MR. SHANNON: We appreciate the
10 movement, Leigh Ann. Thank you for that.
11 MS. FITZPATRICK: You’re very
12 welcome. Thank you.
13 DR. SCHUSTER: Sorry that Leslie
14 is not feeling good and sorry that she couldn’t
15 report that good news to us. I’m sorry. Did
16 somebody else have a question or a comment?
17 MS. HUGHES: No. This is
18 Sharley. Thanks for letting her go ahead and
19 present.
20 DR. SCHUSTER: And I see that
21 Leigh Ann has put her email in the Chat. So, please
22 email her if you would like to be a part of the
23 community stakeholder group that would be involved in
24 the mobile crisis grant.
25 MS. FITZPATRICK: We also have

1 an email box set up, too. So, I'll give you both of
2 those.
3 DR. SCHUSTER: Okay. Thank you
4 so much, and tell Leslie that we are hopeful that
5 it's not COVID and that she feels better. Thanks.
6 I think that we are at Number 8
7 which is our update on any changes in Medicaid single
8 Medicaid Formulary, and I don't know if we have
9 anybody on from that part of Medicaid.
10 DR. ALI: Hi, Sheila. This is
11 Fatima Ali.
12 DR. SCHUSTER: Hi, Fatima.
13 Thank you very much for being on. Do you have any
14 update to report to us, anything new and different or
15 going on, any problems, any good things?
16 DR. ALI: I do have one change
17 to report and that is the antidepressants' cost. So,
18 with September P&T changes, we went ahead and moved
19 brand Wellbutrin, Pristiq, Effexor and Zoloft Oral
20 Concentrate to Preferred and the generics were moved
21 to Non-Preferred. And, then, after further
22 consideration, we decided to move it back.
23 So, that's hot off the press.
24 We made that change yesterday. So, that change has
25 gone into effect on the MCO end and Magellan is

1 working to move those generics back over to
2 Preferred. So, at the end of this week, we should see
3 those changes across the board.
4 DR. SCHUSTER: Okay. So, let me
5 be sure I understand this. So, the original change
6 was to put the name brand drugs on the Preferred Drug
7 List and move the generics to Non-Preferred. And,
8 then, as of yesterday, it’s back to the old way----
9 DR. ALI: That’s correct.
10 DR. SCHUSTER: ----where the
11 generics are the Preferred.
12 DR. ALI: Yes, that’s correct.
13 DR. SCHUSTER: And that’s only
14 for the antidepressant class?
15 DR. ALI: Yes. So, we made
16 those brand generics which is back after September
17 P&T. So, we made those switches and, then, after
18 further consideration, we’ve switched it back.
19 DR. SCHUSTER: So, we’ve had
20 these questions before about the shift that we found
21 in going to the single Formulary, that there was this
22 shift from generic to name brand as the preferred
23 drug which I never did quite understand; but at least
24 in this one class, you have now taken it back to the
25 way it used to be.

1 I guess the question is, do you
2 anticipate doing that for any of the other classes of
3 psychiatric medications?
4 DR. ALI: At this time, no. So,
5 it will apply to those antidepressants.
6 DR. SCHUSTER: Okay. And what
7 was the rationale for making the change back, if I
8 may ask? And if that's proprietary or something, I
9 understand, but I'm just curious because I never
10 understood the change the other way, I guess.
11 DR. ALI: So, the change to
12 Preferred brands is really around cost-savings and
13 the rates that offset the up-front costs of those
14 medications. So, that's the general gist of why we
15 prefer brand-name medications.
16 We were hearing a lot of
17 feedback from pharmacies about preferring the brand
18 over the generic. Especially since the generic has
19 been out for sometime for these products, it was a
20 little difficult for pharmacies to access through
21 their wholesalers, but this was a unique situation.
22 We do make brand generics which
23 is I wouldn't say often but we do make them. So, a
24 culmination of all that really got us to where we are
25 today.

1 DR. SCHUSTER: Okay. All right
2 and thank you. Does anybody have any issues around
3 the Medicaid Formulary? This is an opportunity to
4 ask Dr. Ali about any of those. Anybody? No.
5 Have you heard anything, Steve,
6 from any of your Medical Directors?
7 MR. SHANNON: I have not.
8 DR. SCHUSTER: Okay. All right.
9 Well, hearing none, we will move on to the next but
10 we do appreciate your being on, Dr. Ali. That's
11 always helpful to have you available.
12 Obviously, access to the right
13 medication and the right dosage at the right time for
14 our people has always been our number one goal. So,
15 anything that we can do to make sure that there are
16 not barriers to having that happen is really what we
17 want to see happen. So, thank you.
18 DR. ALI: Thank you.
19 DR. SCHUSTER: Veronica, I think
20 that we had this question at the last meeting about
21 an increasing number and requirements for the MCO
22 audits. Do you remember that discussion?
23 MS. CECIL: What I can tell you
24 is that obviously we don't have prior
25 authorizations on behavioral health services.

1 And when the pandemic started,
2 certainly Medicaid indicated in working with the MCOs
3 that we wanted to put a hold on audits except for
4 fraud where there was clear indication of potential
5 fraud.
6 But I will tell you that CMS
7 throughout the - from actually the beginning of the
8 pandemic and throughout the last year and a half or
9 so had continually asked the State when we were going
10 to re-initiate them because some states never stopped
11 and some of the CMS' contractors never stopped.
12 So, the State, we were
13 definitely put in a little bit of a - given a little
14 pressure to make sure that we are appropriately
15 auditing.
16 We've tried to be very clear
17 with the MCOs that they shouldn't just be auditing
18 for auditing sake. They should definitely be just
19 doing algorithms and where there's been identified,
20 you know, something of concern, that they should be
21 issuing audits for that, but they should definitely
22 work with providers in response times.
23 We understand that still with
24 the mail being delayed at times, missed letters or
25 delayed letters or additional time is needed because,

1 again, you guys are on the front-line healthiness to
2 fight COVID, that if time is needed to provide the
3 records or information, that those requests should be
4 granted and MCOs should work with providers around
5 that.
6 So, we are trying to monitor
7 it. We certainly understand that the last thing we
8 want to do is overwhelm our providers with audits;
9 but the other side to that is they are necessary. We
10 are required to ensure that services are medically
11 necessary. That's a requirement of CMS, but we still
12 think that this is a time where providers and MCOs
13 and certainly with DMS oversight is that it's being
14 done appropriately.
15 And, Angie, I don't know if you
16 have anything else to offer.
17 MS. PARKER: I think you
18 answered that, Deputy Commissioner. Not really. You
19 hit on everything.
20 I believe some of the
21 complaints that I have heard is that the MCOs are
22 only giving ten days, and my response was ask for
23 more and they should be able to give you more. Ten
24 days is a very quick turnaround time, depending on
25 how many they may be asking for.

1 So, they should be giving you
2 an ample amount of time. So, if there's any concerns
3 that you feel like they're not listening to you, by
4 all means, you feel free to contact me.
5 DR. SCHUSTER: I appreciate
6 that, Angie, and I think that was the message that we
7 heard when we talked about this back in November.
8 I think one of the issues that
9 came up was an MCO asking for a large number of cases
10 or extending the number of audits at one time.
11 So, it was not only the short
12 time frame but it was really an inordinate number of
13 cases and is there some appeal for that or some
14 response that a provider can do with that?
15 MS. PARKER: Well, some of it is
16 based on how you are contracted with the provider and
17 what your language does say about audits. So, I
18 would recommend that you look at that.
19 Depending on your office, five
20 could be too many at one time. My assumption would
21 be that there should be some common theme to the
22 audits, as the Senior Deputy Commissioner had
23 mentioned, that it's not just auditing for auditing
24 sake.
25 So, you can always push back

1 with the MCOs and you should if you have challenges
2 with meeting any time frames that they have set up
3 because we need to make sure that the patients are
4 taken care of.

5 MS. CECIL: I will add, I don't
6 mind sharing that Kentucky Medicaid just had a
7 Program Integrity audit, and we certainly heard from
8 the representatives from CMS is that they would like
9 to see more auditing, that they were a little
10 concerned that there's not - what we try to avoid is
11 arbitrary numbers, so, just go out and audit this
12 many providers.

13 I think there have to be spot
14 checks and some of that has to happen just for due
15 diligence sake, but I think what we tried to explain
16 to them is that we work very closely with our MCOs
17 and our providers and we tend to be selective and
18 ensure that we're just truly identifying those cases
19 where there is a concern for fraud, waste and abuse.
20 So, we try not to just do them arbitrarily.

21 DR. SCHUSTER: Okay. Well, I
22 think that's helpful. I mean, I hear you all saying
23 audits are the cost of doing business in some ways
24 and the cost of doing business with CMS and with DMS.

25 I think one of the concerns

1 because I think the correlation that we heard from
2 providers was that when no more prior auths were
3 being allowed on behavioral health services, the
4 number and scope of the audits went up very much at
5 that time.
6 And I don't know whether that
7 really makes sense. It felt punitive, let's say, for
8 the providers. Steve, do you want to chime in?
9 MR. SHANNON: Yes, that's what
10 we heard and it was a large volume. It was a lot of
11 records and a short turnaround.
12 And I think the Deputy
13 Commissioner - we've given the message back - push
14 back. Let's figure out how to get this, but at times
15 it was a lot of records and paper records. So, it
16 was administratively onerous.
17 We're all kind of remote and a
18 lot of the staff who would gather information was
19 working from home. Some people were coming in and
20 having to do that. So, I think that's what we were
21 hearing.
22 Truthfully, we've had two
23 meetings with CEO's in December and January and
24 Sheila participates. These things hadn't come up.
25 So, maybe we've made some progress since we haven't

1 heard about that but there's still frustration over
2 just the volume of it and how to get a letter and ask
3 for this huge amount of records in a short term with
4 no indication prior this is coming.
5 DR. SCHUSTER: So, we will
6 continue letting providers know that it needs to be a
7 reasonable time frame and a reasonable amount and
8 that they can contact Angie if there's some question.
9 We appreciate that very much.
10 And we understand that you are
11 getting your marching orders from CMS at the same
12 time and everybody is burned out and everybody's
13 caseload is higher than they want it to be.
14 We have people out like the
15 hospitals do that are just not there, people that are
16 typically in charge of some of these things. And
17 with people out with COVID and related things, it's
18 just a tough time. So, we appreciate that.
19 MS. CECIL: The other thing I
20 would mention is that if they are seeing an
21 increasing number, it's probably because we had put
22 them on hold. And, so, they are starting back up.
23 And the other thing is you
24 restart these things thinking, you know, at one
25 point, we were thinking, oh, wow, are we seeing the

1 end of this and, then, a variant comes along and here
2 we are again.
3 And, so, again, if we continue
4 to receive complaints about short time lines or MCOs
5 aren't granting requests for extensions, that's a
6 concern to us and something we certainly would want
7 to do something about.
8 DR. SCHUSTER: Okay. Well, and,
9 again, we appreciate that and I think we're all in
10 this together and we need to figure out how to make
11 everybody happy with what's going on, but we
12 appreciate your being supportive of the providers in
13 this particular point in time. Thank you for that.
14 The task forces have ended in
15 the interim, final reports, and I think I sent you
16 all the final reports and recommendations from the
17 SMI Task Force which was the one, of course, that we
18 followed the most closely.
19 So, they had a dozen
20 recommendations, number one of which something that
21 Steve Shannon and I had worked on for I'm saying
22 twenty years, Steve - that's probably an under-
23 estimate - to get a waiver for our folks with SMI
24 that would provide supported housing and supported
25 employment.

1 There were a number of other
2 excellent recommendations that would require funding
3 besides the waiver. Kelly Gunning and her Judge and
4 Phil Gunning presented beautifully from Lexington
5 about the mental health court. And we certainly
6 heard and the task force responded with a
7 recommendation that there be more funding to get
8 mental health courts out across the Commonwealth.
9 They are a mechanism to get
10 people into treatment rather than into incarceration.
11 We would like to move things upstream so that people
12 don’t get to the point where they are not compliant
13 with their medication and their treatment and, then,
14 commit a crime which typically is a disturbing the
15 peace or that kind of thing but we want more mental
16 health courts out there.
17 They also recommended that
18 there be more funding to get Tim’s Law out across the
19 Commonwealth. And we know that DBHDID has the SAMSA
20 grant. They’re in the second year of it.
21 It’s been slow going because of
22 COVID but they are working with Central State
23 Hospital, Western State Hospital and the community
24 mental health centers associated with those two
25 hospital regions and we need to see Central Kentucky

1 and Eastern Kentucky, Southeastern Kentucky also have
2 access to Tim's Law.
3 Also, there was a bill that was
4 heard in committee today with some change in language
5 that came from Judge Stephanie Burke in Jefferson
6 County as a District Court Judge who has probably
7 been the biggest supporter, the most outspoken
8 supporter of Tim's Law from the Judiciary and it
9 cleans up some language in 202A where examination and
10 evaluation are used in different ways in different
11 parts of the statute and where the time lines are not
12 real clear.
13 So, it might say such-and-such
14 hearing has to be held in six days but it doesn't say
15 what the starting point is. So, it could be any six-
16 day period.
17 And, then, she had some very
18 specific recommendations about some change in
19 language specifically on Tim's Law removing the term
20 anosognosia which is the person's inability to
21 realize that they are sick and it's really a brain
22 disorder and removing that language and replacing it
23 with somebody who has had at least two involuntary
24 hospitalizations in a 48-month period or two arrests
25 for dangerous behavior on the basis of their illness.

1 And she feels like it would
2 open up Tim's Law and make it easier for people that
3 really qualify and need those court-ordered patient
4 services to get that treatment.
5 So, Tim Fleming had that bill
6 and it's House Bill 127 and was heard in Health and
7 Family Services today and passed unanimously. So,
8 we're on the move with that.
9 There also were recommendations
10 that came out of the HCB 1915(c)Waiver Task Force for
11 essentially significant increases in pay for those
12 front-line workers, those personal service workers
13 that provide those waiver services. And there is
14 money in the House Bill 1, the House budget, to
15 increase that.
16 So, that's kind of the status
17 from the Interim Session Task Forces, and I really
18 want to thank those of you who are on this Zoom or
19 whose agencies participated.
20 We had excellent testimony to
21 the SMI Task Force about the full range of services
22 needed and some excellent testimony by persons with
23 lived experience and family members, and I always
24 think that that's what gets the most attention from
25 legislators. So, we thank you all for that.

1 As I've done in the past, I've
2 got a bill grid that I finished up at about 11:00
3 today. So, I will send it out after we conclude this
4 meeting but I thought it would be helpful to you all
5 to see some of the behavioral health bills that the
6 Mental Health Coalition has been supporting, and some
7 of these are about certainly supporting everything
8 that came out of the SMI Task Force, both in the
9 budget as well as in other policy changes.
10 We're interested obviously in
11 making sure that the CMHC's and the other quasi-
12 governmental agencies are kept whole in meeting their
13 pension obligations. We want to see the SMI waiver
14 and other recommendations funded.
15 There will be language coming
16 from the school psychologists, school social workers
17 and school guidance counselors for more funding under
18 the School Safety and Resiliency Act that passed as
19 Senate Bill 8 in the 2020 Session to put double the
20 amount of money in there to get more mental health
21 providers in to the schools.
22 And, then, a really important
23 piece that you all may not be all that aware of is
24 the 988 line.
25 So, one of the bills that was

1 passed during the Trump Administration - in fact, I'm
2 told by Marcie Timmerman who is an expert on this
3 that it was the only bill that was passed unanimously
4 during the Trump Administration - establishes a 988
5 line which would be parallel with our 911 line.
6 So, instead of having the
7 National Suicide Prevention line which is, as you
8 know, a number that people have to remember, all they
9 have to remember is 988.
10 We have a real advantage here
11 in Kentucky over some of the other states because we
12 already have a statewide system through the CMHC's of
13 answering those calls, and one of the important parts
14 about making 988 both viable and useful that they be
15 answered close to where the person that's calling
16 actually lives.
17 We don't want this to be farmed
18 out to somebody who is in Alaska or Florida or a
19 foreign country or anything else. We want it
20 answered by those CMHC crisis line workers who know
21 the resources, who can direct somebody to those
22 resources locally.
23 So, we need to do a couple of
24 things. The Governor is putting some money in to
25 launch the 988 line and to make sure - in fact, he's

1 putting some additional money in, we were delighted
2 to hear yesterday, to fund 170 additional staff
3 members for those call centers. So, that's a huge
4 piece and, then, we need to keep it going.
5 And, so, a number of us, Marcie
6 Timmerman from Mental Health America, Megan Cole from
7 the American Foundation for the Prevention of
8 Suicide, Kentucky Chapter, and myself are working
9 with a legislator to file a bill that would put a 70-
10 cent-a-month fee on every mobile phone line and that
11 $8.40 would be enough to fund the line and keep it
12 sustainable.
13 So, this is a national
14 initiative. That line will be rolled out on July
15 17th of this year. So, we need to get these funding
16 pieces in place, and it would be a suicide prevention
17 and mental health crisis line.
18 You are aware that in some
19 jurisdictions - I'm thinking of Jeffersontown which
20 is a part outside of Louisville - they are using
21 social workers. The City of Louisville is going to
22 begin having social workers go out on calls with
23 police.
24 What they'd like to do is to be
25 able, like they deploy the CIT teams, to

1 differentiate calls that are coming into 911 and
2 really should be 988 calls where you don’t need a
3 police response but you may need a crisis counselor
4 or mobile team to respond. So, that’s another piece
5 of this.
6 So, I will send this tracking
7 document out to you. If there are mental health
8 issues that you’re tracking and would like to see it
9 on there, I’m happy to add them.
10 As we get those filed, for
11 instance, we’ve talked about there may be a bill on
12 easing the EMS transportation problems from facility
13 to facility, we may also see legislation on the 202A
14 transportation. So, we will add those for your
15 consideration. I think you all have found that
16 helpful in the past just as a way of kind of checking
17 what’s going on in the Legislature.
18 I guess I will ask and I
19 haven’t seen anything, Sharley or Veronica, I haven’t
20 seen any updated prior auth guidance. Is that
21 correct?
22 MS. CECIL: That is correct.
23 It’s status quo.
24 DR. SCHUSTER: Status quo. We
25 like status quo, right? That’s easy. So, the status

1 quo remains. No prior authorizations on behavioral
2 health services except on medications.
3 MR. SHANNON: Sheila, what about
4 the state of emergency? Is that due to end?
5 DR. SCHUSTER: Yes.
6 MS. CECIL: Yes. So, the public
7 health emergency currently is scheduled to end on
8 Saturday. We've not received confirmation of the
9 extension though it is expected.
10 CMS did tell us that we would
11 be given a 60-day notice prior to the end of the PHE
12 and that has not happened. So, that is why we're
13 pretty optimistic that that is going to be extended.
14 I don't know why they have us
15 all sitting at the edge of our seats on this because
16 we'd like to see it in writing, but, yes, we're
17 monitoring that.
18 DR. SCHUSTER: I think, though,
19 that the emergency orders that were issued originally
20 by the various licensure boards to ease reciprocity
21 to allow licensed professionals to perhaps be able to
22 practice without some of the licensure restrictions,
23 those also are due to go away on Saturday.
24 MS. CECIL: That's correct.
25 DR. SCHUSTER: And my emergency

1 was that I had to take a call from a legislator
2 because there are rumors flying all over Frankfort
3 about whether it's going to happen or not.
4 Quite frankly, the last I heard
5 was that it's not going to happen. So, we shall see.
6 This is a bad deal if that's what happens because
7 we've got people - there are a number, for instance,
8 of nurses that have been able to come in to Kentucky
9 and provide services without having to jump through
10 hoops in terms of licensure.
11 I think there are psychologists
12 and other mental health professionals that have been
13 able to work across state lines much more easily than
14 will be the case if these go away.
15 So, I'm really upset to hear
16 that it may not happen. They are not going to meet
17 tomorrow in Session. So, it either is going to
18 happen today before midnight or it's not going to
19 happen. So, I'm pessimistic.
20 MR. SHANNON: I had heard Senate
21 Bill 25 extend it in committee sub.
22 DR. SCHUSTER: Well, it did and
23 it passed the House State Government at noon today
24 but there are some pieces that were taken out of some
25 of those Executive Orders.

1 And even though that also has
2 the NTI days in it, those nontraditional instruction
3 days, which every school superintendent, every parent
4 is waiting to see how many of those NTI days may be
5 happening, the last word that I heard was that even
6 if the House passed it, that the Senate was not going
7 to pass it for unknown reasons.
8 DR. BRENZEL: Sheila, excuse me,
9 just to add to the importance to staffing and
10 allowing that flexibility, we just learned that the
11 Supreme Court upheld the CMS vaccine mandate for CMS-
12 funded facilities which now means that folks who are
13 in our facilities who are unvaccinated will no longer
14 be able to stay employed. So, we're really very
15 concerned.
16 Obviously, we fully support
17 vaccines. We believe it is the answer. We believe
18 folks should get vaccinated, but we have only 64%
19 vaccination rates at some of our facilities. If we
20 lose 40% of our staff, we'll be unable to operate
21 some of our facilities at current capacity. So, this
22 out-of-state flexibility just became very much more
23 important.
24 DR. SCHUSTER: And I'm afraid
25 that we're going to lose it today, Allen. So, that

1 was the ruling from the Supreme Court.
2 DR. BRENZEL: Correct.
3 MR. SHANNON: Wow. They upheld
4 the OSHA. They, I guess, ruled against the OSHA
5 requirement. The CMS one, I guess, is the problem.
6 DR. BRENZEL: It's not the
7 employer mandate. It's the CMS-funded federal
8 facilities. So, it's nursing homes, psychiatric
9 hospitals and ICF's.
10 DR. SCHUSTER: Anybody that gets
11 CMS funding, right?
12 DR. BRENZEL: Correct.
13 MR. SHANNON: Certified CMS
14 providers.
15 DR. SCHUSTER: Certified. Okay.
16 Oh, well, how much other bad news? Thank you, Allen.
17 I know you didn't want to report that but wow.
18 MS. HUGHES: I told you, Sheila,
19 not to say your day couldn't get worse.
20 DR. SCHUSTER: Well, I just had
21 said that. See, I really jinxed us. Bart told me.
22 He was over there going, no, no, no, no, don't say
23 that.
24 Do we have any recommendations
25 for the MAC?

1 MR. BALDWIN: Shelia, just real
2 quick on that last subject that Dr. Brenzel was
3 talking about because that's just kind of coming out.
4 I was just kind of seeing that, too.
5 Upholding the CMS requirement,
6 it seemed like we discussed at a recent CMHC CEO
7 meeting that CMHC's did not fall under that because
8 they didn't meet the federal definition. Has
9 anything changed on that?
10 DR. BRENZEL: I think there may
11 be one that does but I'll have to recall because they
12 have facilities. I'm not sure the legality of state-
13 operated hospitals or certain levels of programs.
14 So, we'll have to double check on that.
15 MR. SHANNON: But the certified
16 facilities, and even if you get Medicare or Medicaid
17 funding, you're not necessarily a certified facility
18 and that's the distinction, but, yeah, I would think
19 that would be a concern for River Valley unless their
20 hospital is independent somehow organizationally.
21 MR. BALDWIN: But state
22 hospitals and a PRTF and----
23 DR. SCHUSTER: And nursing
24 homes, right, Allen?
25 DR. BRENZEL: All nursing homes,

1 but I don't think our CMHC's operate nursing homes at
2 this point.
3 DR. SCHUSTER: Yeah, I know but
4 I'm----
5 DR. BRENZEL: But it definitely
6 applies to nursing homes primarily. That's what it
7 was targeted at primarily.
8 DR. SCHUSTER: Right. Wow.
9 MR. BALDWIN: And the PRTF as
10 far as you know?
11 DR. BRENZEL: I don't know if
12 they're Medicare-certified. That's the piece.
13 MR. BALDWIN: I mean, they're
14 federally defined but I don't know that they're----
15 MR. SHANNON: And the CMHC is a
16 federal definition, but the certification part if
17 they operate a partial hospitalization program and
18 certified to do that specifically. They may have
19 them for kids and such but it's not that process or
20 it doesn't apply except for maybe River Valley with a
21 hospital, right, Dr. Brenzel?
22 DR. BRENZEL: Yes.
23 DR. SCHUSTER: But it's
24 definitely going to be your hospitals and your
25 nursing homes.

1 MR. SHANNON: Yeah, and Central
2 State, Eastern State.
3 DR. SCHUSTER: And ICF's.
4 MR. SHANNON: Yeah, and ICF's.
5 DR. SCHUSTER: Wow. So, if I'm
6 right, if Senate Bill 25 is not going to go, then,
7 you don't have any of the flexibility for bringing
8 people in from other states. And if you have any
9 APRN's that have been operating without what we call
10 a CAPA-CS and that was suspended, see, that's going
11 to go away, too.
12 DR. BRENZEL: We need to make
13 sure people are aware of that additional
14 complication.
15 DR. SCHUSTER: Well, and it's
16 going to happen on a Saturday of a holiday weekend
17 during one of the biggest spikes of COVID that we've
18 seen, I guess the biggest in the state.
19 DR. BRENZEL: Right. We have
20 for sure the highest numbers of COVID. We have
21 facilities that 40% of the patients are positive now.
22 DR. SCHUSTER: Wow. Wow.
23 MS. GUNNING: Shelia, is there
24 any way there could be an emergency regulation
25 because of the reasons that you guys just said?

1 DR. SCHUSTER: Well, that's what
2 these EO's, these Emergency Orders, were written to
3 do.
4 MS. GUNNING: I know, but, I
5 mean, can another one be issued or no?
6 DR. SCHUSTER: There'S nobody to
7 issue it I guess would be the problem.
8 MS. GUNNING: I was just hoping.
9 DR. SCHUSTER: Well, and, you
10 know, in the Special Session back in September, there
11 was a lot of discussion about these Executive Orders
12 and that's when they set this January 15th as a
13 completely arbitrary date. It has nothing to do with
14 the national CMS-designated emergency period or
15 anything else but they tied their own hands and it's
16 just really mind-boggling that they're going to do
17 this.
18 MR. SHANNON: And prevent the
19 Governor from extending it, right?
20 DR. SCHUSTER: Right. There's
21 not going to be anything that the Governor can do
22 because they've taken away his emergency power.
23 MS. GUNNING: That was my
24 question.
25 DR. SCHUSTER: I don't think

1 there's any way out of it. So, all the school
2 principals and the superintendents and parents that
3 have been waiting to see about NTI days and, then,
4 everything in health care, mental health and physical
5 health, is just absolutely up in the air and down the
6 tubes probably with this.
7 MR. BALDWIN: Until Tuesday.
8 DR. SCHUSTER: Until Tuesday,
9 yeah.
10 MR. BALDWIN: Maybe.
11 DR. SCHUSTER: Well, and, then,
12 how do you get people back in? We've had this thing
13 once before where we say if you on an emergency basis
14 close down a unit or whatever, you can't just flip a
15 switch and turn it back on.
16 Lots of things happen when you
17 turn it off. And, so, if you've got people that have
18 been working here and no longer can, what do you say
19 to those patients? I mean, we really have to think
20 about patient care here. Wow.
21 I don't have any agenda items
22 for the March meeting. Do any of the other voting
23 members of the TAC have any agenda items, or, I'm
24 sorry, recommendations to the MAC?
25 Maybe we should recommend to

1 the MAC - well, you know - Emergency Orders need to
2 be re-instituted but that's outside. That's not
3 something that the MAC has any power over.
4 MS. CECIL: I think what you
5 should recommend is everybody call their legislator.
6 DR. SCHUSTER: Yeah. Well, we're
7 going to end this meeting pretty soon. You can go
8 call your legislator now and say what are you
9 thinking?
10 So, we've got lots of carryover
11 items for the March BH TAC meeting and we will carry
12 those over. And if anybody that's on the call wants
13 to email me at kyadvocacy@gmail.com or you get emails
14 from me, let me know what other items you want to
15 add.
16 And, then, the MAC meeting is
17 the 27th of January, 10 a.m. to 12:30 and that's via
18 Zoom.
19 And, then, our next BH TAC
20 meeting is March 10th. Remember we've gone to the
21 second Thursday of the month and that will, again, be
22 at 2:00 so that we can let the legislative committee
23 meetings happen.
24 MS. MUDD: I guess everybody has
25 heard about our recent losses. We lost Larry Forgy

1 and our dear advocate friend Bernie Block.
2 DR. SCHUSTER: I went to that
3 visitation. It was at the same funeral home and so
4 forth where his son David had his visitation after he
5 had successfully completed suicide. So, so sad.
6 Bernie was a great warrior, a great guy and willing
7 to talk about his son's travails and tried to do
8 something about it.
9 So, he's sorely missed but his
10 family was glad that there were a number of the old-
11 timers. The old-time NAMI Louisville people were
12 there and it was good to see them. They're very
13 excited about the prospect that we could get an SMI
14 waiver this Session. When I told them that that was
15 a possibility, they were all just so excited about
16 that. It made me feel good that they were there to
17 honor Bernie.
18 But you're right. And those of
19 you who know Senator Alice Forgy Kerr, of course,
20 that's her brother, her beloved brother, and I'm sure
21 that she is deep in grief. So, prayers for both of
22 those families.
23 And if there's no further
24 business, we will adjourn the meeting by acclamation,
25 and I thank you all for being on.

MEETING ADJOURNED