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

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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July 7, 2021
1:00 P.M.
(All Participants Appear Via Zoom or Telephonically)

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APPEARANCES

Sheila Schuster
CHAIR

Michael Barry
Gayle DiCesare
Sarah Kidder
Valerie Mudd
Steve Shannon
Diane Schirmer
TAC MEMBERS

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APPEARANCES
(Continued)

Judy Theriot
Fatima Ali
Angela Parker
Lee Guice
Sharley Hughes
Leslie Hoffman
Jennifer Dudinskie
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

AGENDA
(Continued)

DR. SCHUSTER: We have all of our voting members on, Sharley. What time do you have?

MS. HUGHES: It's 1:01.

DR. SCHUSTER: We've got Dr. Brenzel this morning joining us. Do we have any of the DMS folks on, Sharley?

MS. HUGHES: Leslie Hoffmann is on. I see Angie Parker, Lee Guice, Jennifer Dudinskie, Dr. Theriot. So, we've got quite a few from DMS with us.

DR. SCHUSTER: Do we know if the Commissioner is going to be able to make it?

MS. HUGHES: I don't think she is and the Deputy Commissioner is on vacation. I think you've got the ones that can answer most of the questions.

DR. SCHUSTER: All right. Thank you, and thanks to you all for being here. We'll call the meeting to order.

This is the umpteenth meeting of the Behavioral Health Technical Advisory Committee and we are meeting by Zoom on July 7th, 2021.

I would like to welcome our newest Technical Advisory Committee voting member and

that's Diane Schirmer from the Brain Injury Association of America - Kentucky Chapter. So, Diane, do you want to say hello to folks and give us a thirty-second summary of your life?

MS. SCHIRMER: Hi. Thank you, everyone. I have worked in brain injury for thirty years and I'm the Chair of the Kentucky Chapter here and very involved in brain injury at a state and national level, and I'm very thankful to be a part of this TAC meeting. Thank you.

DR. SCHUSTER: Thanks, and Diane has been an active member of the TAC for many months before now. So, we welcome you. And let me have other TAC members say hello.

(INTRODUCTIONS)

DR. SCHUSTER: I put my email address in the Chat. If you didn't get a direct notification from me about the meeting, please email me with your contact information, your email address and who you're with and I will add you to our group.

I sent out the draft minutes of the May 11th, 2021 Behavioral Health TAC meeting, and I would entertain a motion from one of our voting members.

MR. SHANNON: I move to approve

the minutes. Steve Shannon.

DR. SCHUSTER: Steve. And a second, please?

MS. DiCESARE: Second. It's Gayle.

DR. SCHUSTER: Gayle, great. Any additions, corrections, revisions? Hearing none, we'll call for a vote of approving the minutes as distributed. All in favor, signify by saying aye. Any opposed, like sign. Thank you very much.

Let me go way down actually while we're voting. We have a question before us about whether we want to continue to meet via Zoom or meet in person. You all may have seen that on July 1st, the Capitol and Capitol Annex are now open to the public with showing a picture ID at the front door of the Annex.

I think the seating capacity in the rooms is still about half, maybe even no more than a third of what it was.

So, I guess my concern about trying to meet in person is that we may not have a space in the Annex to accommodate us because we usually have forty, forty-five people at the meetings, but I'd like to hear from the voting

members of the TAC about what your preferences are. There's apparently not a problem in our continuing to meet via Zoom, and I know the MAC has decided to continue meeting via Zoom for the foreseeable future.

So, we have a meeting scheduled on September 1st and, then, another one on November 3rd, 2021 before we get into the 2022 year. So, what are the thoughts of the voting members of the TAC?

MR. BARRY: What do you need a picture ID for? Is there anything out of the ordinary for a picture ID?

DR. SCHUSTER: No, no, just to remind people that they need it, and there's no question about whether you're vaccinated or not. There's no requirement for masks or anything.

I suspect that the lines are a little bit long, Mike, to get in because there has been only one guard at that entryway. So, if you have several meetings that are starting at the same time, I think there's been a little bit of a backup.

The biggest concern, again, that I have is that I'm not sure that - we usually meet in 125. We had occasionally met in 169, but even that, they've taken out about half of the chairs in those meeting rooms.

MR. BARRY: I just want to make sure they weren't barring those Indiana folks from coming in.

DR. SCHUSTER: So far I don't think they're discriminating but I don't know.

MS. MUDD: In my opinion, it might be that we maybe follow the MAC for what they're doing maybe. That would give us an idea where to go maybe. Whenever the MAC decides to meet in person, we could follow suit.

MS. SCHIRMER: It's what's best for the whole group. If we need everybody, it's best it seems like that we continue to follow that as well.

MS. DiCESARE: I agree. I vote for Zoom.

DR. SCHUSTER: All right. Let's go on and get a motion from somebody to that effect. Do we want to follow the lead of the MAC?

MS. SCHIRMER: I move for that. I suggest it.

DR. SCHUSTER: Diane, you move that we follow the MAC. So, for right now, for the foreseeable future, we will meet via Zoom. Is there a second, please?

MR. BARRY: This is Mike. I second.

DR. SCHUSTER: All right. And all those in favor, signify by saying aye. Thank you. I do think that we've gotten kind of used to it. You miss seeing people, but, on the other hand, it probably makes it easier for us to get people to join in to the meeting. So, it's a tradeoff.

So, I will include that in my report to the MAC when they meet on the 22nd of July.

So, Leslie or Dr. Theriot or Jennifer, does anybody have any update on our data request on targeted case management issues?

MS. HUGHES: I actually have some information for you, Sheila.

I contacted Barbara Epperson who is running the report and she said she had gotten through the first phase of it which she said was identifying the targeted audience, and I think she said she had shared that with - did she share it with you maybe, Sheila?

DR. SCHUSTER: No, I don't believe so unless it's hiding in my Inbox which is possible.

For those of you who don't

remember what this is, you remember that Commissioner Lee asked us to put our heads together and come up with a data request to DMS so that we could begin looking at targeted case management, what its outcomes are, who is using it, who is not using it.

And, so, a small group met virtually with Barbara Epperson who is kind of the point person on the Medicaid data and some of her crew, as well as Ann Hollen was on that call with us and Dr. Brenzel was on that call with us.

The focus initially is going to be on adults with severe mental illness and we wanted to look at pre-COVID numbers and, then, at six-month intervals of ER use, hospitalizations, followup on medications, the kinds of things that we think targeted case management helps with.

MS. HUGHES: Her email yesterday just said: We have completed Phase 1 of the request, identifying the target population. We've shared the numbers with select members of the TAC and DMS staff for review and approval to proceed.

We've received approval to proceed with Phase 2 which is pulling the claims-related information from the target population. We're working through this phase now.

So, I assumed with that, she meant with the TAC members that met with her.

DR. BRENZEL: I do recall that I did see that email suggesting that Phase 1 they had identified because one of our concerns was we were looking for folks who received six months of continuous service without interruption.

I think they found a substantial number, didn't they, Sharley, like 1,800 or 1,600 or so? So, that allows them to proceed with Phase 2.

MS. HUGHES: She didn't tell me other than that information. So, when she told me that yesterday, Sheila, honestly, I assumed that you were probably one of the people that received it.

DR. SCHUSTER: And I'll check back. Allen, you might look at that email that you got and see if I'm on there because I apologize if I got it and didn't respond to it.

DR. BRENZEL: Who did it come from, Sharley? I'm sorry to interrupt.

DR. SCHUSTER: Barbara Epperson.

DR. BRENZEL: Epperson. Okay. I'll look for it and send it to Sheila.

DR. SCHUSTER: Thank you. All

right. Well, that's good news. As you all can imagine, just even trying to identify what the population is for them to go back and pull the claims data was a monumental task. So, we very much appreciate the cooperation of Medicaid and the data folks and obviously Commissioner Lee to help us do that. So, we're on the move which is a good thing.

Any questions on that from anyone? All right.

Do we have anybody from Pharmacy that can tell us about any changes in the Medicaid single Formulary?

MS. HUGHES: Yes. I think I saw Fatima coming on.

DR. SCHUSTER: Dr. Ali, welcome. We're glad to have you on.

DR. ALI: Thank you. So, just in terms of some updates to the Formulary, the only real change there is around the non-PDL drugs.

So, as you all know, we moved to the single PDL in January of this year. The only real change is that the MCO's were currently managing, or, prior to 7/1, were managing any products not on the PDL; but now we've moved to a single Formulary where the fee-for-service drugs are

all in alignment for the MCO population as well. So, all of the non-PDL drugs will be the same across the board.

In terms of grandfathering, we do have grandfathering in place if restrictions go from less strict to more strict. So, by that, I mean that the MCO was covering the drug without a prior authorization and, then, on 7/1, the product is now requiring prior authorization.

So, if that is the case, the member will be grandfathered for ninety days and we'll send a communication thirty days in advance to the providers so that they can proactively work to get a PA in place for the member.

The only other grandfathering exception is for the prenatal vitamins. Those will be grandfathered for an entire year. Any questions?

DR. SCHUSTER: Let me just be sure that I've got this.

So, we're talking about the non-Preferred Drug List, PDL for folks, and those had been managed individually with each MCO having their own Formulary for those, right, Dr. Ali?

DR. ALI: Correct.

DR. SCHUSTER: And now they are

going to be all the same and they will match what has been in place with the fee-for-service Medicaid Formulary, but you've given everybody a ninety-day window for grandfathering and grandmothering only if the requirements would get more stringent.

So, if it had not required a prior auth before and now it does, they would be able to continue without a PA for ninety days. Is that correct?

DR. ALI: Yes.

DR. SCHUSTER: Okay. And prenatal vitamins are exempt.

DR. ALI: Yes. Those will be grandfathered for one year instead of ninety days.

DR. SCHUSTER: Okay. And what about the Suboxone medications because it was passed to remove all prior authorizations for that, and is that in place now as of July 1?

DR. ALI: Yes, that's correct. So, that goes along with Senate Bill 51. So, what we did was we removed all the prior authorizations for the MAT products, so, your Suboxones. All of those are now preferred without PA.

We do, however, have clinical edits in place such as therapeutic duplication,

opioid (inaudible) therapy edits, those types of clinical and safety edits in place from a system perspective; but in terms of drug-specific prior authorization criteria, that has been removed from the MAT products and they'll continue to pay without the prior authorization piece.

DR. SCHUSTER: So, let me follow up and ask you about an issue that Commissioner Lee mentioned in a call that some of us advocates had last week about the change in the way that Medicaid is paying the pharmacies for scripts and her concern that they were hearing from some pharmacies that they were no longer going to carry the MAT products because of that.

DR. ALI: So, in terms of that, what we did was we received data from each of the MCOs and saw what dispensing fee was provided per prescription.

And we came to the conclusion that, on average, the dispensing fee for Suboxone per prescription was averaging about $2, if not $2.50.

So, if you add that up to a few fills a month, essentially with the $10.64 dispensing fee every month, you're getting more across the board.

So, I'm happy to address any further concerns with that but I think the pharmacies should be evening out with the dispensing fees. If not, they should be receiving a little bit more.

DR. SCHUSTER: Well, that was my understanding, Dr. Ali, and I was just concerned because we know how critical it is that people that are on MAT continue to have ready access to the Suboxone or the other medications that are prescribed.

And I had reached out a little bit to some community providers and have not heard that it's a problem and I just wondered if there had been any further feedback to you about that because it sounded like they actually were going to come out ahead.

I think they were doing maybe three Suboxone prescriptions a month which would have been $7.50, let's say, and they were getting $10.64 for the month is the way I understood it.

DR. ALI: Right, exactly.

DR. SCHUSTER: All right. Allen, have you heard anything about Suboxone problems from the pharmacies?

DR. BRENZEL: No, just the same

issue that was raised, but with the explanation, it appears that there's not a huge negative impact on pharmacies unless we're missing something, but it appeared they would do somewhat better because the Kentucky Board of Medical Licensure does require frequent follow-ups.

And, so, most physicians will only write seven days' worth the first time and, then, perhaps another seven days. So, early on in their treatment, there would be multiple prescriptions; however, eventually, folks should settle on thirty-day scripts.

DR. ALI: It really shouldn't be changing any prescribing habits or patterns. The cadence is that the prescription should be written as appropriate clinically, but the dispensing fee, again, will be that $10.64 per month.

DR. BRENZEL: Our only concern is would pharmacists decline to stock and supply it, but, again, we feel like that hearing otherwise, we're not hearing a huge concern or pharmacists refusing to stock and supply.

DR. SCHUSTER: Well, I'm relieved to hear that because when I first talked with her about it or she brought it up, she said that

she had had a call I think from Representative Sheldon who is one of the three or so pharmacists that we have in the Legislature and I believe she said that she had heard from a pharmacy or two that said, oh, no, we're not going to carry it anymore.

So, I was concerned about making sure it's available in the community. So, it sounds like hopefully that little bubble-up has bubbled back down, but I would encourage you all who were on the call to keep an ear out for that, if you're seeing that or hearing that, to let me know so that we can let Medicaid know as soon as possible because we really don't want these pharmacies to misunderstand or not do the calculation and quit carrying the MAT products. That would be important.

I guess the final thing, Dr. Ali, I would ask is you did the changeover to the new Pharmacy Benefit Manager, the PBM, I think on July 1st as well. How did that go?

DR. ALI: Overall very well. Obviously, issues do come up but most of them were able to be resolved very quickly.

We had a couple of nuances. And for any of the folks that speak directly to providers, it's important that the Medicaid ID is

being used for the member ID. Some MCOs have proprietary member ID's for their members prior to 7/1, but, again, the cadence is that the Medicaid ID serves as the member's ID.

But overall I've been hearing good feedback. I've been hearing about additional issues which we've been working tirelessly to address them, but I think overall the response has been positive.

One thing that we do continue to hear is with regards to the MedImpact Call Center, and Medicaid is working very closely with MedImpact to identify any issues and address them as soon as possible; but other than that, a relatively smooth transition.

DR. SCHUSTER: And MedImpact is your new PBM. Is that right?

DR. ALI: That's correct, yes.

DR. SCHUSTER: Okay. So, let me just pause here for a second and see if anyone who is in the meeting has any questions for Dr. Ali while she has so graciously joined us about the switch-over to the single Formulary.

I do want to thank Dr. Ali for her responsiveness when I had gotten a panicky email

from one of our prescribers, and I do appreciate that information and I think we were able to satisfy everyone about the rumors that were out there about changes to the Formulary as it turned out to be the non-PDL drugs. So, I appreciate that, Dr. Ali.

Any questions that anybody has for Dr. Ali?

DR. BRENZEL: The ninety days is wonderful but it really does just push the potential for crisis down ninety days. So, providers need to be educated.

DR. ALI: And one thing I forgot to mention here is that if the ninety-day grandfathering does apply for that product, the point-of-sale pharmacist will receive that messaging and it will say that the ninety-day grandfathering ends on September 29th and it will give them that warning message.

So, when it comes closer to the end of the ninety-day period, they can make the necessary outreach and get that prior authorization in place so that there's very little member disruption, and we'll be communicating that as well.

DR. SCHUSTER: I was just going to say, so, do you send out that kind of information

directly to the prescribers?

DR. ALI: Yes. So, thirty days before, it will be sent to the providers and the prescribers so that they can take that appropriate step.

What we don't want to happen is to send that communication now when it's still almost ninety days out. So, we'll send it thirty days prior.

DR. SCHUSTER: All right. So, we need to remember that that notice would go out at the end of August, then.

DR. ALI: Correct, if not a few days before.

DR. SCHUSTER: Okay. So, those of you who have - I'm thinking of Steve Shannon with the prescribers in the Comp Care system and so forth especially. So, those of you who have prescribers in your agencies, just be aware of that. And, again, we're talking about the drugs that are on the single Formulary that are not on the Preferred Drug List, right?

DR. ALI: Right.

DR. SCHUSTER: Thank you so much, Dr. Ali. We appreciate your responsiveness and

your time in being on the call.

This is where I hate Zoom because I can't see anybody. If any of you out there have any questions, now is your chance to ask Dr. Ali.

Actually, I had a question. I know you all did an emergency reg, Dr. Ali, I guess to implement the new PBM.

DR. ALI: That's correct.

DR. SCHUSTER: I'm sorry. It was on payment for medications, I think. So, you all will be coming back with a regular reg and go through the reg review process on that?

DR. ALI: Correct. Yes.

DR. SCHUSTER: Okay. All right. Well, thank you so much.

MS. MUDD: I have a question and I don't know if it's for this meeting or if I should keep waiting until that P&T Committee meets in September, but I know there are several new medications that are out and I'm assuming they will be on the PDL like the (inaudible), for example, for the treatment of TD, TMS treatments.

I assume that will be something to talk about in the P&T Committee and there's really

not a whole lot you could tell me about it right now, I guess.

DR. ALI: Right. It will be discussed then.

DR. SCHUSTER: That meeting is - I had the exact date. Do you remember, Val?

MS. MUDD: I have it written down because I am ready. The 16th of September, 1:00.

DR. SCHUSTER: All right. Dr. Ali, do people who want to attend and get the Zoom link, do they need to let you know or is the Zoom link to the P&T posted on the website? I don't remember.

DR. ALI: So, it is posted on the Magellan provider portal. So, anyone who wants to attend the P&T meeting can access the link there.

DR. SCHUSTER: Okay. I will get that and send it. It used to be that you had to register if you wanted to speak. Is that still the case?

DR. ALI: Yes. For speakers who would like to speak during the meeting, there's a Speaker Request Form on the provider portal as well.

DR. SCHUSTER: Okay. All right.

Thank you very much. We will have a BH TAC meeting, Val, before that because our next meeting is September 1st. So, let's put that on the agenda for that meeting for sure.

MS. MUDD: Are we not meeting in August?

DR. SCHUSTER: No. We meet every other month. The MAC meets every other month. So, we meet every other month. I know these meetings are so much fun and you want to have them every month but you'll just have to wait until September.

Steve Shannon has raised these issues about claims payments on services to dual eligibles, and I think Lee Guice typically is the person who is responding to that. So, I'll turn it over to Steve or Lee.

MR. SHANNON: Go ahead, Lee.

MS. GUICE: Go ahead, Steve.

MR. SHANNON: Larry (inaudible) submitted information and, then, we sent that to Lee and her team since our last meeting. So, that's all we have. It continues to be a problem for us.

MS. GUICE: So, I would like to say this. We've run into a vocabulary issue. I let that information sit for a little bit, then, I opened

it up and realized what the issue was and then didn't back to you on this.

So, when I hear dual eligibles, what I hear is somebody who has Medicaid and Medicare and that's what that means to me. What the information was that I received are members that have commercial insurance and Medicaid and that is an MCO issue, if the MCOs are not paying what you think is the appropriate amount because, as we all know, Medicaid is the payer of last resort.

So, if I have any kind of commercial insurance and my commercial insurance pays $30 and Medicaid would have paid $40, then, there is a bill that needs to come to Medicaid and Medicaid should pay $40. When I say to Medicaid, I mean the MCOs as well.

So, if the MCO is going to pay you $40 if that person didn't have commercial insurance, then, they should make you whole for that $40 by sending you $10.

The information I got said they weren't paying and they weren't paying up to their allowed amount. I can't do anything about that whatsoever because there's a process to go through. You have to talk to your MCOs. You have to sit down

and go through that process with the provider representatives and, then, there's a complaint process to go through if the MCOs still aren't following the appropriate guideline.

I apologize for letting that sit for two months and not getting back to you but that's where we are with that information.

MR. SHANNON: Okay. One, I'll get you Medicare and Medicaid claims. I mean, I thought those were sent to you but I'll confirm they're Medicare and Medicaid, just not commercial.

And the real issue we have, one of them is - and we've had these conversations with the MCOs and we've gone through a formalized complaint process - however, what happens is either with Medicare or commercial, they don't pay for the service, okay?

They don't pay for case management, as an example, or community supports as an example, and we never get, since they don't pay for it, we get no information from those other insurers - Medicare or whatever commercial product it might be - with a denial because they don't deny services they don't provide.

So, we can't get documentation,

right, that this has not been paid because it will never be paid and we keep getting told by the MCOs they're waiting on a list from Medicaid that has those codes that should be paid.

And I will get you Medicare and Medicaid claims because that's the first issue. I want to get them to you because we're on a decade of this topic.

MS. GUICE: You're talking about the bypass list, Steve, right?

MR. SHANNON: Yes. There are some things that are missing on the bypass list.

MS. GUICE: If there are things that are still missing from the bypass list, I could use certainly an email that says what those codes are.

MS. HOFFMANN: Lee, this is Leslie. I'll chime in since we're talking about the bypass now.

We have looked at the bypass list and we have revised it and it is with S.K. to have the information put in the system.

We still had some COVID-related priorities that had to go in before that, and S.K. has offered - and I was working with Steve just on

the CMHC side - but they can contact him if it's a particular code that should be on the list that's not and they've got an inappropriate denial or an EOB that they can reach out to him, and I have his information. I think I've shared that with Steve.

So, again, I was working specifically with the CMHC's but we do have the bypass revisions done, completed and we're waiting for them to be put into the system. Once they're in the system, then, we can let the MCOs know.

MS. GUICE: So, we're waiting until they're in the system to talk to the MCOs?

MS. HOFFMANN: Yes. That's my understanding.

MS. GUICE: Okay.

MS. HOFFMANN: And I can give S.K.'s information again. He said if there was anything specific that folks thought was inappropriate as far as a denial or an EOB that we could contact him directly.

MR. SHANNON: I think it would be helpful to have that contact again. We'll send that out, and hopefully the bypass list addresses the Medicare/Medicaid issue as well. Commercial is a big concern with kids but we still have concerns with

those as well and it really relates to, again, we're not getting an EOB. They're not getting a denial. We're getting nothing, and, then, the MCO says, well, we're not paying for that without some sort of documentation.

MS. HOFFMANN: So, sorry about the back and forth, Steve. It's a little bit of a play on words, depending on what we're discussing, but we call him S.K. but he was very gracious to offer to have a direct contact for you.

MR. SHANNON: Okay. Sounds good.

MS. HOFFMANN: Okay.

DR. SCHUSTER: So, if I might summarize, it sounds like there's movement on getting together this list for the bypass, specifically on the Medicaid/Medicare cases. Would it apply also to the ones that Lee talked about that are Medicaid and private insurance?

MS. HOFFMANN: Lee, I'm not sure on that question. Let me send this email.

MS. GUICE: Generally speaking, if they added the codes that commercial insurance doesn't pay for kids, the process is the process is the process.

So, the bypass list, what that bypass list does is remove the edit that requires an EOB. So, it bypasses that edit.

MR. SHANNON: So, there's not a Medicare bypass list. There's just a bypass list.

MS. GUICE: Well, there is no other audience besides this one that we speak to that has this problem with commercial insurance.

So, it's one of those things where everybody talks about Medicare bypass list but it's really in place to bypass the edit that requires an EOB. So, if somebody has TPL and they're not - third-party liability which is commercial insurance - then, the same process needs to be in place for them as well.

MS. GORDON: Hi, Lee. This is Lori Gordon from WellCare. Can I ask a question?

MS. GUICE: Sure.

MS. GORDON: Many years ago with this Medicare bypass list, we had a communication I think it was from Stephanie Bates that said that this was Medicare only because commercial plans often paid for different things and there was no way to know that one commercial plan would pay for one thing and another would not.

So, could you send - when we get this new bypass list, if that guidance has changed, could you put that in writing, please? That would be very helpful.

MR. SHANNON: I agree, Lori because we heard it as the Medicare bypass list.

MS. GUICE: So, that logic about the commercial plans remains true today, okay, my point being is that if there is something that would apply across the board for commercial plans, then, yes, of course, it will be on the list.

Yes, it is always referred to as the Medicare bypass list.

MS. ADAMS: Sheila, this is Kathy Adams. Would I be able to ask a question?

DR. SCHUSTER: Sure, because I know you've been involved with this also, Kathy. So, ask away.

MS. ADAMS: Thank you. One of the things in my mind as I think through this is we have gone through this in the past about whether it's a Medicare bypass code list or whether it applies to commercial insurances.

And then, the other thing that we have found is that the MCOs, a lot of the MCOs

will have their own bypass list and some call it a Medicare bypass list and others don't and they allow us to use those bypass codes for the commercial insurance.

So, my question is, are the MCOs required to have the same Medicare bypass code list that Medicaid has because, as far as I understand, their lists are very different?

MR. SHANNON: Yes.

MS. GUICE: I don't know the answer to that question.

MS. PARKER: As we have just discussed, there is a bypass list that's already out there. There are some codes that are being updated for this list.

All MCOs should be using the same Medicare bypass list that Medicaid has developed. If they're not, then, we need to know who is not.

DR. SCHUSTER: Angie, is that you?

MS. PARKER: Yes. I'm sorry. This is Angie Parker.

DR. SCHUSTER: That's all right. I just wanted to identify for the court reporter.

MS. ADAMS: This is Kathy again. I'm sorry. So, like, one MCO has told us for years now that they do not have a bypass code list. So, they need to be using the Medicaid one as all the MCOs should be using.

MS. PARKER: Correct.

MS. ADAMS: And does that list or does it not apply to commercial insurance?

MS. PARKER: Per our discussion and what Lee has discussed as far as the Medicaid side of things, at this point, it's called the Medicare bypass list. There are certain codes that is known that commercial does not pay for. It may be considered part of commercial as well.

If you all on this TAC know of certain codes that no commercial insurer pays for, that would be very helpful.

DR. SCHUSTER: So, what you're looking for, Angie, as I understand this discussion, is that it's very hard to have a single bypass list for commercial insurers because they vary greatly insurer to insurer which is not the case with Medicare, correct?

MS. PARKER: Correct. Thank you, Dr. Schuster.

DR. SCHUSTER: Okay. So, if our providers, the people that are struggling with this, see a service that 100% of the time is not paid for by any of the insurers that they deal with, it would be helpful for you all to know that and it could possibly be asterisked on this list or something.

MS. PARKER: Yes, that would be great.

DR. SCHUSTER: If there is such a service or services maybe. I don't know.

MS. PARKER: I mean, we understand that if it's a commercial insurer, the expectation would be to bill that commercial insurer to obtain a denial in order to process that claim if it's something that Medicaid would cover, but what I'm hearing correctly is that you aren't getting that.

MR. SHANNON: Correct.

MS. PARKER: It is or is not being billed?

MR. SHANNON: It's being billed.

MS. PARKER: It's being billed but you're not getting that back.

MR. SHANNON: Yes. So, we could probably stop billing it because we get no

communication back. We get nothing in response to that process because they're not going to process a claim for things they don't cover. So, we have no information and, then, we can't go back and, then, the MCOs say, well, can you send us a denial? We don't have the denial. We don't get a denial.

It both affects classes of professionals as well as some services and I think those are challenges that we've had for a very long time now, but I can get you that list and I think Kathy Adams can probably get you a list for children's services as well.

One thing I heard today is it's called the Medicare bypass list but it really is a bypass list, right?

MS. PARKER: Correct.

MR. SHANNON: And I think that's a change. I think Lee alluded at the beginning it's a semantic issue, but I think Lori Gordon had the same communication that she has in something at one time with Stephanie Bates that said this is the Medicare bypass list, therefore, it didn't apply to commercial insurance, but it sounds like, the impression is that it does apply to commercial insurance. It's the code that matters. It's not the

title of the list.

MS. PARKER: If it's been added to that list and we know it's something that a commercial insurer would not cover which is why we need that information from you to help us ensure whether or not that is added to your list or not; but if you want to say it's semantics, it kind of is.

But at this point, because of what Dr. Schuster had mentioned, it is because we don't know because there are so many commercial insurers out there to see what they do or do not cover because there may be some self-funded plans that would cover some of this that----

MR. SHANNON: Correct. I understand you all can't keep track of every plan. It's just I think some communications I've heard from MCOs is this is the Medicare bypass list. There is not anything related to commercial insurance with a similar product available, but maybe this Medicare bypass list might be a bypass list to start.

MS. PARKER: I think what we're saying here at this point is we are looking to expand that further than Medicare. And the MCOs are not right saying it is a Medicare bypass list because that's what it was called, it is certainly called but

Medicaid is working to ensure that all codes that a commercial insurer does not pay for be added to that list.

MR. SHANNON: Okay. Super.

MS. ADAMS: If I may - this is Kathy Adams again. So, the practicality in all this, I totally agree with what's been said and how he has explained it, but the reality is we can't keep billing - you know, a lot of our members bill commercial insurance because it's for children and most of them aren't on Medicaid.

They can't keep billing insurances that are not going to give them an EOB. I mean, that's wasting all kinds of people's time that we don't have. It's wasting resources, but that's what is required to do. You have to give me an EOB; and when they can't, the MCO doesn't pay it.

So, ultimately, what has happened with some of these services is providers just don't provide that service anymore if the kid has commercial insurance because they know ultimately the MCO won't reimburse them.

And that's the really sad part of all of this is that people aren't getting the services they need because they can't do it for free

and that's essentially what it is.

We are so grateful for those MCOs that have the bypass list and that have been so helpful in allowing us to use those codes with the commercial insurance. It has been a huge, huge help and all that allows us to do is that it means that the MCO is going to pay that claim without the EOB because the commercial insurance doesn't provide it and they're not going to give us an EOB.

So, it saves everybody a whole lot of extra work for nothing and ultimately the client gets the service.

MS. GUICE: I would like to offer that perhaps a negotiation with your provider rep and the MCO about some of your patients and what services that you always provide that their particular insurance, you know, ABC commercial insurance plan does not cover and could you get a letter from the insurance company and give it to the MCO? I mean, there have to be pathways forward besides not providing the services.

MS. ADAMS: There used to be a TPL form. I think it's a third-party liability form that Medicaid had that some of the MCOs would honor so that after you submitted the EOB to the commercial

insurance, if you had not heard anything in ninety days, you could complete the TPL form and they would bypass it and pay it; but it's my understanding that Medicaid doesn't have that form anymore, and, so, the MCOs don't honor it any longer either. And not all the MCOs honored it but some did.

MS. PARKER: Yes, I believe that form was shared with all the MCOs and they could use it at their discretion. This is Angie Parker.

DR. SCHUSTER: The third-party liability form was shared with the MCOs, Angie?

MS. PARKER: Yes, ma'am.

DR. SCHUSTER: Okay. So, it still exists. We don't know whether the MCOs are using it or not. Is that an accurate statement?

MS. PARKER: It was provided to use at their discretion. So, I cannot personally say who is using it or who is not.

MS. GUICE: I don't think anybody is on the call, Sheila, that can confirm whether or not Medicaid uses that form anymore.

MS. ADAMS: I think it used to be in the billing manuals and it's not in the billing manuals any longer but I could be wrong. I know there was a place I could go and access it and I

don't know how to find it now. Thank you.

DR. SCHUSTER: Okay. So, next steps. Let me see if I've got this. Leslie, the codes that you all have put together would be entered into the system and, then, the MCOs will be provided with that list.

MS. HOFFMANN: Yes, and I just sent that to Angie and Lee. So, if we need to do something differently, I'll speak with them about that, about letting the MCOs know. I just forwarded everything to them.

DR. SCHUSTER: Okay. Thank you. And, then, Steve, you're going to follow up with specific Medicaid/Medicare issues.

MR. SHANNON: Yes, I will, correct.

DR. SCHUSTER: Okay. And, then, all of us should be on the lookout, I guess, for instances of codes or services - start with services because some of us don't know the codes - that are we think always or not maybe available by commercial insurers to see if there are any that could be added to that list.

Let's start there. We'll keep this on the agenda.

MS. ADAMS: I just wanted to put that out there.

DR. SCHUSTER: Thank you. So, I think this is an issue that we need to keep on for September. We'll see where we are. Hopefully the new "Medicare bypass list" will be updated and in the system at that point.

Lee, I think you were the one that suggested negotiations or communications with those MCOs that are simply not providing either a bypass or some way around this.

I think it's a bad situation if people are not prescribing the services that somebody needs, particularly a kid, quite frankly, because we can't get the reimbursement worked out.

Kathy, let's get some more information from you about the kinds of services that those are. Can you do that before the next meeting?

MS. ADAMS: I sure will.

DR. SCHUSTER: Okay.

MR. SHANNON: I'll reach out and do that. It's just kind of ironic to me that people with two insurances aren't a lot better off than people who are uninsured.

DR. SCHUSTER: Yes, or the

people that have Medicaid only. We've said that for years. I'm sorry. Somebody started to say something.

MR. BALDWIN: That was me. This is Bart, Sheila. I think I heard this but I just want to clarify on the bypass code list that Leslie referenced that they're updating and going to get out soon. Thank you all for updating that and adding codes, the necessary codes to it, and we'll try to get, if there's any ones that need to be added, that information to you from other groups.

But the clarifying question is once that goes out and sent to the MCOs, that is a requirement that they follow that or that's just something that Medicaid is sending to the MCOs?

My assumption would be that that's a new requirement, but based on the conversation today, I'm not 100% clear that it would be.

MS. HOFFMANN: Angie, once we notify the MCOs of the approved list from us, how is that looked at?

MS. PARKER: Once we provide the bypass list to the MCOs, yes, they are to follow.

MR. BALDWIN: Okay, because

basically this is communicated to them the codes that that they don't - to remove that edit that require the EOB, right. So, the purpose of the list is to communicate to the MCOs to remove that requirement.

MS. HOFFMANN: Yeah. And, Bart, the name and information I gave you in the Chat, in between time, if there's new codes that haven't been or the revision piece hasn't been entered into the system, he said that you could send that information to him directly. So, he'll work on those for you.

MR. BALDWIN: Okay. Great. Thank you all.

MS. HUGHES: Leslie, when you posted that in Chat, you put it privately only to myself.

MS. HOFFMANN: Sorry, Sharley. I probably did because I was talking to Sharley earlier. I'll send it to everyone. I apologize, guys.

DR. SCHUSTER: No problem.

MR. BALDWIN: Thank you, Leslie and Angie.

DR. SCHUSTER: So, that's S.K.

MS. HOFFMANN: Yes.

DR. SCHUSTER: The famous S.K.

that you're talking about.

MS. HOFFMANN: Yes. I'm sorry. Yes. I had put it in earlier but I only sent it to Sharley. I'm sorry.

DR. SCHUSTER: No problem at all. Okay. Good. I feel like we're finally making some progress on this. We've had it on here since the beginning of the year.

The issue on limitations on the use of 99214 and 215 is again going to have to roll over to the next meeting. That's Dr. John Sullivan who is a child psychiatrist in Louisville and he wants to be at the BH TAC to discuss that and he's having clinical duties that call and we want him to do his clinical duties. So, we'll roll it over.

I wonder if Dr. Abner Rayapati is on?

DR. RAYAPATI: I'm here, Sheila.

DR. SCHUSTER: Great. Hello, Abner. How are you?

DR. RAYAPATI: I'm well. How are you?

DR. SCHUSTER: Just fine. So, you asked me to put on this issue of the policy on lock-ins for pharmacies and providers. So, the floor

is yours.

DR. RAYAPATI: I did, and thank you for the time, Sheila. My name is Abner Rayapati. I'm a psychiatrist here in Lexington at UK and also serve as Director of Oliver Winston which provides urgent services here in Lexington.

We ran into a couple of occurrences of the lock-in with both pharmacy and provider which had an immediate impact on patient care and I brought a couple of examples, one at my UK office.

I got a letter in the mail from WellCare and it said that a patient - and I had to look this up in the record - that I took care of on the inpatient unit was locked into me for controlled substances and at a pharmacy in another town, and I haven't seen this patient beyond the acute care I provided within the hospital floor and told us there was not - that it did not have controlled substances associated. It was an antipsychotic provided.

The one I have a bit more detail on within the Oliver Winston system and the MAT Program was a patient that had been consistent in treatment for an extended period of time, over a year, if not more, had been compliant but had been

switched providers because of the system changing providers to a point where the most recent change which occurred I think a month or two ago, the prescription provided was not honored because the patient was locked into the previous provider who is no longer within that program, and, so, that was the immediate issue.

The follow-up with that is the patient called the insurance and said that they had a new provider and the lag associated, of which they were given a claim number, told it would take up to seventy-two hours which it took almost five days for when this patient's prescriptions would need to run and they could get medicine from the provider that they were seeing.

And, so, that was something that I thought was important enough to bring to this group to get an understanding if there's other cases similar.

I do have another example in which the pharmacy who had filled the patient's controlled substance two cycles tried to fill it on the third visit and was unable to because they were locked into another pharmacy and that, too, took some time to resolve which impacted direct patient care.

So, that's what I wanted to bring to this group to get some clarity, maybe some understanding of individuals in the weeds on how we can advocate for patients, get past these issues of being given numbers.

I think one of our case managers did advocate for the patient, talked to an immediate supervisor which also got the response that there's nothing they could do which is concerning.

DR. SCHUSTER: Dr. Ali, are you still on the call?

DR. ALI: Yes, I am.

DR. SCHUSTER: Can you speak to us about what happens with a lock-in and why it happens?

DR. ALI: So, there are a few reasons why a member could be locked into a pharmacy. It's really to avoid the doctor-shopping or the pharmacy-shopping issues that some members might try to get done.

There could be instances where a certain member goes to multiple prescribers or multiple pharmacies trying to fill things like controlled substances.

So, what the plans will do is

that they will lock in a member to a specific pharmacy so that member can only fill their prescription at one specified pharmacy.

DR. SCHUSTER: When you say the plan, you mean the MCO does that?

DR. ALI: Correct, yes. The MCO is still responsible for lock-ins, and any overrides in terms of the lock-in program are still completed by the MCOs.

DR. SCHUSTER: Okay. Can you address any of the instances that Dr. Rayapati has described?

DR. ALI: I apologize. I was in between other emails. Can you repeat some of those?

DR. RAYAPATI: I'm happy to. Probably the most specific example I gave is a patient that was in an MAT program, compliant with care and had been seen for an extended period of time within the same practice.

The practice changed providers a couple of times and with the most recent provider assuming this patient's care, the patient was locked into the previous provider that was no longer providing care in this setting.

DR. SCHUSTER: And that

resulted, I think you said, Abner, in a significant delay in the patient being able to get the MAT, correct?

DR. RAYAPATI: Not to get dramatic, but when we think about opioid overdoses and such, this patient did not get their medications for several days because of this.

DR. ALI: Do you remember which MCO this member belonged to?

DR. RAYAPATI: I've given three examples. Two were WellCare and one was Molina Passport.

DR. ALI: If you can send me some of that information, I can triage that over to the MCOs and see what the underlying issue was there.

DR. SCHUSTER: I'll send you Dr. Ali's email, Abner.

DR. RAYAPATI: Thank you, Dr. Ali.

DR. SCHUSTER: I guess maybe a broader question, Dr. Ali, is what does the provider do when they realize this is what has happened? I mean, do you call the MCO? Who do you call who at the MCO and say this is a mistake? They're in the same practice. They just have a different provider.

I mean, how does it get unlocked, I guess is the question?

DR. ALI: They would have to contact the MCO and the MCO Call Center rep would have to triage it appropriately. I'm not too familiar with the details on that process but I can certainly inquire with the specific MCOs and see (a) what happened for those specific members, and, (b) what their process is around it.

DR. SCHUSTER: Okay. Do any of the MCOs----

MS. HUGHES: Do you have any - I'm sorry, Dr. Schuster. Angie, is there anything that you could maybe add on the lock-in? Maybe not.

DR. SCHUSTER: I was going to ask. I know Lori Gordon is on from WellCare and I assume we have somebody on from Molina Passport. Can you tell us what the process would be if somebody gets locked in or locked out?

MS. GORDON: This is Lori Gordon from WellCare. So, for any member that is locked in and there is a problem with the lock-in, either wrong prescriber, wrong pharmacy, that can be handled through our Customer Service line.

And, so, Provider Customer

Service would be the number to call and, then, they can triage that over to our pharmacy team that could then address whatever the lock-in issue is.

DR. RAYAPATI: Thank you, Lori. The patient did call and got a reference number and we had one of our case managers follow up and they were given a second reference number with the knowledge that they were able to see the first.

Lori, I spoke to Dr. Houchins about this as well. He always asks me to reach out to him and he saw that we had the right contacts.

MS. GORDON: Right. My contact is lori.gordon@wellcare.com. We're not hard to find because of the first name/last name, but if I can be of any help. Our local pharmacy team can address that. Our pharmacist is Dr. Thea Rodgers, and, so, hers is thea.rodgers@wellcare.com. So, we can address that through the pharmacy team as well.

DR. SCHUSTER: Would you put those in the Chat, please, Lori? That might be helpful information for folks.

MS. GORDON: Absolutely.

DR. SCHUSTER: Thank you. And do we have anybody on from Molina Passport, Passport by Molina?

Dr. McKUNE: Hi, Sheila. It's Liz. This is Liz McKune, and I would think that we would follow a more process where if they want to call in to Customer Service, we'll get them over to the pharmacy team, or if you're having difficulty getting through there, if you want to reach out to me directly, I'll connect you to the pharmacy team.

MS. GUICE: I would think that it's important to note - this is Lee Guice, by the way - the provider would be a good person to make the first contact. Folks who are drug-shopping and are doctor-shopping often can call Customer Service and say, no, no, no, it's not me, but it can be much more persuasive if the provider calls first. Would that be fair, the professionals?

DR. THERIOT: Yes, ma'am. I was just going to bring that up. That's a great idea.

DR. SCHUSTER: Okay. And, Liz, would you put your email address in the Chat also?

DR. McKUNE: Sure.

DR. SCHUSTER: Thank you. This is a good item, though, for us to - I don't think we've talked about this before. So, I appreciate your bringing it up, Abner. It's done for a reason from the part of the MCO.

I do agree with Lee that probably the provider, at least the case manager making the call helps since the purpose is to prevent doctor- and pharmacy-shopping and particularly with the MAT medications I would think is a much bigger issue.

So, let's keep an eye on it, not just you, Abner, but other prescribers and see if we're hearing any other problems, we can come back and touch base on it again at our next meeting.

And, thank you, Dr. Ali. I know you have to leave this meeting soon but we appreciate your being on.

I apparently forgot my numerical order and we'll go back to Number 6 which is the no-show cancellation fee. Lee, you sent an email out about this and about the ability of the providers to enter missed or cancelled appointments.

We are hearing from providers that it takes more than just a few seconds to complete that form. Have you heard that from other folks?

MS. GUICE: I have not.

DR. SCHUSTER: So, apparently, there's a good deal of information that needs to be

entered about the individual which leads me to my next questions which are how is this data being used? I guess I worry a little bit. We talked about it at another meeting.

I don't want to see our folks get somehow labeled as not good Medicaid recipients. If they have a number of no-shows or cancellations, I don't want them to get on somebody's bad list.

MS. GUICE: I think, Dr. Schuster, the point of this is to be able to pull reports and send information to the MCOs so that their care coordination or care management teams can review the information and do some outreach and try to assist whoever it is that's having an issue getting to appointments, and that's what the information is for.

We don't have a good and bad list, well, not officially.

DR. SCHUSTER: Well, that's my point, I guess, and I'm being a little bit facetious but not really.

MS. GUICE: No. Sure. I understand exactly.

DR. SCHUSTER: We already struggle with stigma always even among providers

sometimes and among payers sometimes. And, so, anything that might add to that is a concern to us.

So, at what point or in what way, I guess, do you gather that data? So, let's say Sheila Schuster is a Medicaid recipient and I have three missed appointments in a two-month period or something. Do you have some criteria about when you send that over? Does it go over to the MCO the first time I have a missed appointment?

MS. GUICE: Angie, do you know any more about the reporting schedule because I'm afraid that I did not come prepared with that information in the meeting about how often reports are going to go? I believe it's going to be automated so that that information would go periodically.

MS. PARKER: Right, and I haven't heard anything. I'm not sure it's - I mean, it's in development. I don't think it's ready to go yet.

MS. GUICE: Right. The reporting piece is still in development. I'm sorry. I didn't say that, did I?

DR. SCHUSTER: All right. I'm going to put this on the agenda for next time. And,

again, I understand the utility of having that information. We just really want to be protective of our folks, quite frankly.

MS. HUGHES: Dr. Schuster, I know I think it was the Consumer Rights TAC, maybe another TAC, Commissioner Lee was there and commented about what we wanted to use this data for.

I don't think it was ever intended to harm anybody, but if we looked at the data and we saw that Sharley Hughes was no-shows and it was due to the fact that I had no transportation, that we would be able to possibly reach out to Sharley Hughes and say we understand you're missing a lot of your doctors' appointments because you don't have transportation. What can we do to assist you getting the transportation where you're able to get to your appointments?

So, I think that's the type of information that Commissioner Lee is thinking this is for, nothing that----

DR. SCHUSTER: Believe me, I am in no way thinking that anybody at DMS or any of us are doing anything that would be harmful but there are unintended consequences sometimes.

MS. HUGHES: I understand.

DR. SCHUSTER: So, we worry about somebody's name continually popping up and so forth. So, maybe by the time we meet in September, you all will have a better idea about the frequency of reporting and that kind of thing.

MS. GUICE: We'll make sure to come with that information, Dr. Schuster.

DR. SCHUSTER: Okay. Thank you very much. And I wonder if, because I'm not a Medicaid provider, so, I'm not on this portal, does it ask the reason why somebody has missed or no-showed?

MS. GUICE: I have been in possession of screen shots but have not really unfortunately paid attention to that. So, I will bring more information for you all to look at next time.

DR. SCHUSTER: Okay. Thank you.

MS. GUICE: If you will put it back on the agenda again.

DR. SCHUSTER: Yes, I will and thank you very much. And, again, I'm certainly not in any way thinking that there are - I'm just concerned about unintended consequences.

MR. SHANNON: Sheila, I just

want to weigh in as well. I have heard also that it takes longer than people thought it would take to go through the portal and fill out the form.

The staff at CMHC's are pretty busy as is. So, I just want people to realize that it's not - it takes a little bit longer than they want to spend is what I was told.

DR. SCHUSTER: Thank you, Steve. Nina.

MS. EISNER: Just real quick. I look forward to seeing some of the data and understanding it, and I've told my staff you've got to enter it because if we don't have the data, I think we'll be less apt to be able to make some of the changes to ensure that people can get to those follow-up appointments and so on and not no-show.

You know, to what extent is transportation an issue, for example, which is really big on the Hospital TAC agenda in terms of people being able to access care, or if transportation is the biggest barrier, what does that do to help support that some of the telehealth flexibility that's been added to the pandemic continue to be supported?

So, I have heard as well that

it's a little bit cumbersome to put it in. It's not quite as sufficient, and maybe the Cabinet can help us figure out a way to make it a little more efficient to put in; but I'm still hopeful that people will do it and kind of get through this process because I think that the data - and I hear what you're saying, Sheila, in terms of the list and how it gets used - but if it's used appropriately, in my mind, it would help to point out problems and barriers to being able to access care and also perhaps activate the case management component a little bit more from the MCOs to make sure that that gets done.

So, I know it's cumbersome. I guess I'm saying I don't want to throw the baby out with the bath water.

DR. SCHUSTER: And we're not suggesting that. I appreciate that, Nina, and I do think that it fits in with our feeling that case management, particularly targeted case management for people with more severe illness, is helpful and this may be a good example of that.

So, we will definitely put it on and, Lee, we'll look to you and Angie and whoever. It might be helpful for you to bring a screen shot

next time so we could put it up for those of us who are not providers and don't go on the portal.

MS. GUICE: I've already made myself a note.

DR. SCHUSTER: Great, just to see if there's maybe some streamlining that could be done. So, appreciate that.

Leslie, if you're still on, when are we going to have our waiver?

MS. HOFFMANN: So, every time I meet with them, they're not ready to discuss. And, of course, I told you - I may have told you this the last meeting, Sheila, that last month when I met with them, they told me that their administrative changes actually only occurred in May.

So, I thought that their executive staff had been put in place before May but they said that that only occurred at the end of May. So, they were waiting for guidance on policies and a path forward - that's what they told me - and not just with the incarceration amendment but just in general with everything they're working on with their new Administration.

I did want to tell you that I do have another call with them on the 12th, and, of

course, I've asked for that to be on the agenda again.

So, that would be my next opportunity to discuss the amendment with them. Again, they've never said anything negative towards the amendment. It's just that they've not gotten guidance to move forward yet, and I think part of that is because we would be the first state in the nation to try to get this through.

We are continuing to work with AOC, Administrative Office of the Courts, to get some training and resources out there at a local level. We have that tentatively set for the end of August, but I think AOC has asked to maybe change that date today. So, I will continue to work on getting that training out there.

And, Sheila, I think I can go over Number 10 if you want me to just to stay on.

DR. SCHUSTER: Yes. That would be great. Thank you.

MS. HOFFMANN: So, I'm going to read some of this because some of it is new to me. So, I will just read it, if that's okay. And I did send this to you in an email so that you have it personally.

So, as far as the task forces go, we participate in the MOAC and we participate in the Health and Welfare and we anticipate and participate in some additional work forces that were created in the recent months.

The first one is HJR 57 Task Force and that was passed during the 2021 Regular Session and that's the one that talks about Cabinet entities including DMS to participate in a Bridge Program. It's a Bridge Entrance Program.

So, we are participating in that one. I think the first meeting was this week, Tuesday, and we'll continue to participate in those.

The second one I have is the Severe Mental Illness Task Force and that task force was created by LRC after the conclusion of the 2021 Regular Session.

One meeting has occurred and I think that was June 15th, I believe. DMS did not present during that first one but we will continue to participate, and I think the next meeting on that one is July 20th, and, again, I sent all this to you, Sheila.

The third task force that I've got written down is the 1915(c)Waiver Redesign Task

Force, and that task force was created by LRC after the conclusion of the Regular Session.

One meeting did occur on June 21st. Commissioner Lee and Pam Smith both presented at that task force meeting. And, of course, we're looking forward to working with this task force, and the next scheduled one will be July 26th at 1:00 p.m.

So, if you need to share any of that, like I said, I sent it to you in the email and you can send that out.

DR. SCHUSTER: Thank you very much.

MS. HOFFMANN: You're welcome. I'm glad that you asked us to do this because it was good for me to learn as well.

DR. SCHUSTER: So, typically, these task forces are set up by statute because we get a resolution that is passed during the General Assembly, and we've been working with Representative Moser on a joint resolution to establish this SMI Task Force for the last two Sessions and both times it has passed the House unanimously and, then, it gets held up over in the Senate.

Last year it was for COVID. I think the Senate is less inclined to do task forces

and, so, they just kind of go, oh, no.

So, I was able to express the need for this to some folks that are in Senate and House leadership, and what they've been doing the last two Interim Sessions, which are June 1st to December 1st, is that the LRC Commission, which is the leadership of Democrats and Republicans in both the House and the Senate meeting together, is that they've gone on and has appointed some of these task forces. So, we were thrilled that the SMI Task Force was appointed to meet.

The downside is that our legislation would have had DMS and DBHDID and all kinds of Executive Branch personnel represented on the task force, as well as some other entities, and all of these task forces are legislators only.

So, the SMI Task Force is co-chaired by Representative Danny Bentley who is a pharmacist from the Morehead area up near Pathways and has been very connected with this mental health center up there. And the other co-chair is Senator Alice Forgy Kerr from Lexington who has been a huge supporter of mental health issues at NAMI Lexington and so forth.

It's a really good assortment

of folks on that task force - Senator Alvarado, Senator Meredith, both of whom are very active on the Medicaid Oversight and on the Health and Welfare. And, then, Senator Dr. Karen Berg is the Democratic representative.

On the House side, it's Representative Ken Fleming who runs a mental health center, Kilgore Mental Health Center in Louisville, and Representative Prunty from Western Kentucky whose background is in physical therapy and also youth work in her church and is very interested in mental health issues, and, then, the only licensed mental health professional in the Legislature, Dr. Lisa Willner. So, it is an excellent group of legislators.

So, the first meeting was on June 15th and they made the mistake of letting me go first, and I was supposed to talk for twenty minutes. Steve is nodding because he never got to give his testimony, but I had a kind of an impossible task.

I was supposed to give an overview of severe mental illness and policy and legislation over the last sixty years or so. And, so, I spoke for about forty-five minutes instead of twenty minutes, and that was recorded on YouTube. I don't know that that's been made available and I may

be able to find that link.

Marc Kelly from Pathways gave an excellent presentation on rural mental health issues that was particularly I think helpful because we had some rural legislators on that and we have always known that there's some differential.

And, then, Steve is going to give his presentation when they meet again on July 20th, but actually Steve spoke for a few minutes and probably made the most impact because one of the things that the legislators kept asking us was, well, give us some recommendations, put it in writing, what should we be doing?

So, Steve went to the table with two documents that he held up. One is the 1966 Pattern for Change which is about an eighty-page document that laid out when the Comp Care Centers were new what needed to happen next, all the issues around medication and housing and so forth.

And then he held up a document also about eighty pages written in 2001, I guess, Template for Change, and that came out of the House Bill 843 Commission on Mental Illness and Substance Use Disorders.

And essentially he said to them

I've been there, done that. We've laid out these recommendations over and over again.

So, one of the things I tried to do was to lead them to the conclusion that we really need a Medicaid waiver for people with severe mental illness that would at least include supportive housing and supportive employment.

So, those materials are available on the LRC website and those meetings can be accessed on the YouTube channel, and I'll send out those links for the next meeting.

I thought Commissioner Lee and Pam Smith did an excellent job at the HCB 1915 Waiver Task Force meeting. And, then, Diane Schirmer, who is on our TAC, and Mary Hass, presented on the ABI issues. Steve Shannon did a great job in kind of summarizing all of the issues around the Navigant redesign. And, then, Amy Staed from the Kentucky Association of Private Providers talked about workforce issues. So, it was an excellent meeting.

That one is co-chaired by Senator Julie Raque Adams and Representative Steve Riley, and they did a similar task force last interim. So, they're very familiar with these issues. So, I'm sure that there will be more

discussion.

One of the things that we'll be looking for is that Medicaid will be submitting to CMS the recommendations about how to use this additional enhanced FMAP that's coming to the state through the American Recovery Plan Act that's about - Steve, is it $92 million or $96 million, somewhere in that ballpark?

MR. SHANNON: Right, and they'll submit that next week, July 12th I understand.

DR. SCHUSTER: So, several groups had made recommendations to them about how that money could be used. And, so, we'll be anxious to see it. It will be nice to have a little bit more money, although it's one-time money and it has to be spent in the next three years, but money is money and we're happy to have it.

So, those are task forces that I think would be of interest to this group.

The other new thing that's happening during the interim is a new statutory committee called the Commission on Race and Opportunities that was established by Senate Bill 10, Senator Givens, and it's trying to get a dialog about what's happening here in Kentucky in terms of racial

disparities and so forth and creating opportunities for equity.

So, that's a group that will be meeting not just during the interim but will be meeting like our Reg Review meets or Capital Projects meets and so forth. So, that's the other one.

And, then, I'm glad you brought up, Leslie, the House Joint Resolution 57 because that's looking at what we call a Bridge Program.

We've talked about what they call the cliff where people made too much money to stay on Medicaid but not quite enough to get a good plan. And, so, there's a cliff that they fall off of. And, so, there's, I think, been some real interest on both sides of the isle in the Legislature to create what they call a Bridge Plan. Thank you for that update.

Are there any questions? Steve, do you want to add anything or Diane? I know you've been active on these.

MR. SHANNON: No. I think you've covered them all.

DR. SCHUSTER: Thank you.

MS. HOFFMANN: Sheila, I do have one thing to add. We had talked in the past about

looking at an SMI type of waiver or an amendment and those kind of things, and I told you that there is some technical assistance out in the federal world for us to take a look at, but when we're ready to start it, we only get six technical assistants and we wanted to make sure we're ready to go.

And I told you, I hear you, Sheila, I hear you. And, so, we did finish interviews for a staff person last week. So, we're really close of probably making a recommendation within a couple of weeks. And, of course, that person probably professionally would have to give at least a month's notice, but I wanted you to know that we have gotten that far with this.

DR. SCHUSTER: Great. That's really encouraging. I think Steve and I had lost count. We think it's about fifteen years that we've been advocating for an SMI waiver.

MS. HOFFMANN: I was smiling when you were talking about the 843 because I think I worked for Steve at DBH during that time that we were looking at that. It's been a long time ago.

DR. SCHUSTER: Absolutely. At this point, once you get final approval, Leslie, for the SUD incarceration waiver, our pitch is that the

SMI folks are the only population that has not had a waiver created for them and they really have been last in line for a long time.

So, time to move on that, but that's exciting that you're interviewing and ready to hire a staff person.

MS. HOFFMANN: We're ready to make a recommendation in the next couple of days. So, that's very positive for us.

DR. SCHUSTER: Great. Any questions from anyone?

Diane, we got some responses back to each of the workgroup recommendations from the ABI Waiver Workgroup. Are there any things there that you want to highlight for us or want to bring to our attention?

MS. SCHIRMER: Mary and I had a subsequent meeting with Secretary Friedlander and representatives from both DMS as well as Division of Aging and Independent Living that were quite encouraging.

And, so, I think we're looking forward to additional discussion about how we could move forward to include some of these things and changes to the waiver, and I think there's some

discussion about some of this may be training opportunities for us.

And, so, we do have some differences of opinion about some of these but I don't need to comment on those right now because we were encouraged by the last meeting that we had.

DR. SCHUSTER: Wonderful. I'm glad to hear that. You all did a ton of work on this and I thought the responses from DMS also indicated that they had very thoughtfully considered your recommendations and were responding to those.

So, I'm glad you had this follow-up meeting. That's very hopeful.

MS. SCHIRMER: I think we feel the same and are encouraged. We want to all collaborate for the same goal, the people that we serve. So, thank you.

DR. SCHUSTER: So, I don't believe we've got any updated prior auth guidance which I guess means that when DMS met, because I think they meet monthly and review that, they would let us know if there's any changes and I assume that means that there are no changes.

MS. PARKER: You are correct, Dr. Schuster.

DR. SCHUSTER: Wonderful.

MS. PARKER: No news is good news. There is no date right now on when behavioral health services will require a prior auth. We do review them for that possibility but you will be given at least thirty days' notice prior to that happening.

DR. SCHUSTER: Great. I appreciate that, Angie, and we appreciate the thirty days' notice on that.

And we've taken care of future Behavioral Health TAC meetings.

Kathy Dobbins just put something in the Chat. How much federal Rescue Funding has actually come in to Frankfort? Oh, that's to me privately.

MS. DOBBINS: That's okay. I'm just curious if we have a number. In the Metro Louisville area, we talk about how much money has come in and how much might go toward developing housing and the need for addressing homelessness.

So, yeah, there's like $380 million that has come in to Metro Louisville. So, I'm just curious at the state level, do we have a number?

DR. SCHUSTER: There have been so many different reports given, Kathy, at the different Budget Review Subcommittees on little pieces, it's hard to look at it in total.

There was a slide that Cara Stewart did on Tuesday at the ThriveKY webinar that looked at the funding from ARPA, the American Rescue Plan Act, and I think laid out how much had come in and how much of it had been spent.

So, let me look for that and I'll send it out to the group if that's what it shows. And I don't know if it, for instance, has this $92 or $96 million that comes just on the HCB waiver. You know, there's these little pockets of money that have come for very distinct pieces but that's a good question. Let me see if we can come up with that for you.

MS. DOBBINS: And what I would add to that, Sheila, is I know there is a time line, a ticking clock, as we all know, on that money. So, I was wondering if there's priorities that have already been identified or what the process is for identifying them?

DR. SCHUSTER: Yeah, and I don't know. That may be a separate discussion for us to

have as well.

The A&R Committee, the Budget Review Subcommittees are starting to meet in all those different areas and we've heard from legislators that the A&R Chairs, Jason Petrie on the House side and Chris McDaniel on the Senate side, are telling their fellow legislators let us know what you want to see in this budget.

We are hoping that there's going to be much more money to spend than there ever has been in those budgets, but how much of that is some of this COVID money, some of the ARPA money and how pigeonholed it is. I just simply don't knows but we'll have to look for that.

MS. DOBBINS: And sustainability being a big issue for all of it.

DR. SCHUSTER: Right. That's a lot of wealth all at once but not for very long is the problem, right?

MS. DOBBINS: Right.

DR. SCHUSTER: Let me turn first to our voting members of the TAC to see if there are any new recommendations for the MAC for their July 22nd meeting. Anybody have any burning issue?

MR. BARRY: No.

MR. SHANNON: I don't think so.

MS. SCHIRMER: I don't think so either.

DR. SCHUSTER: Okay. I didn't have anything coming into this meeting. I think we're working well with DMS on our information that we need and we continue to do that.

And we have a number of agenda items that I think we will carry over. I think we've talked about those.

And, then, Adrienne Bush from the Homeless and Housing Coalition of Kentucky asked me to put on our agenda in September medical respite for houseless or homeless people, and she is going to provide some information for us to discuss that as well. So, we will add that along with some of these carryover items.

And if you all have items that you want to add, I put my email in the Chat. So, please do not hesitate to shoot me an email and suggest something that you would like to see.

So, the MAC meeting is July 22nd and I'll send out the Zoom. It runs from 10:00 to 12:30. And, then, our next BH TAC is the very earliest day in September - September 1 - from 1:00

to 3:00.

Any other items to discuss or bring up before we adjourn? We're giving you back about eighteen minutes of your day.

MS. MUDD: I was thinking about Tom Buford real quick.

DR. SCHUSTER: Yes. If you all had not heard, our good friend, Senator Tom Buford, thirty years a Senator from Nicholasville, passed away suddenly yesterday and he was a great guy, very, very helpful on behavioral health issues, on general health care issues. When he was Chair of Banking & Insurance, he was always somebody that you could engage in discussion and action. He had a wonderful sense of humor. And, so, we send our condolences to his family.

MR. BALDWIN: Sheila, this is Bart, just real quick. One comment on Senator Buford. In the past, I worked on autism insurance mandate legislation, and national groups now recognize Kentucky as the first state to have one because the bill passed back in '97, I think, '97, '98 of a $500 benefit.

So, once they shared that with him a few years ago, they've kind of changed their -

it used to be (inaudible), but, anyway, so, that's something that is part of the legacy of Tom. And, of course, I worked with him both times when we got that legislation passed in the last decade or so.

DR. SCHUSTER: Right, and, then, we went back and updated it in 2010, and then he came and did the parity part of it. He was very open, always open to the people issues. He knew insurance but he had a real soft spot and he was pretty easy to get to.

So, I'm glad you brought that up, Bart. That's a great legacy of his and we have so many newly diagnosed all the time kiddos and young adults with autism, so, really an important issue and benefit.

Thank you all for your attendance and your input and we will see you in September.

MEETING ADJOURNED