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

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

_____

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

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APPEARANCES

Sheila Schuster
CHAIR

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

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APPEARANCES
(Continued)

Veronica Cecil
Judy Theriot
Fatima Ali
Angela Parker
Lee Guice
Sharley Hughes
Leslie Hoffman
Justin Dearinger
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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DR. SCHUSTER: We have a quorum. So, I think we will go on and call the meeting to order. I think it's 1:03 or something like that on the 1st day of September, 2021. Welcome to you all.

We have with us voting members of the TAC - Valerie Mudd representing Consumers of Mental Health Services, Diane Schirmer representing the Brain Injury Association of America - Kentucky Chapter, Sarah Kidder representing NAMI Kentucky, Steve Shannon representing the community mental health centers through KARP, and I'm Sheila Schuster representing the Kentucky Mental Health Coalition.

And, Gayle, if you have joined us, speak up and we'll introduce you. So, we have a quorum.

I distributed the minutes to you all, the draft minutes. So, I would entertain a motion from a voting member.

MR. SHANNON: I motion.

MS. HUGHES: Gayle is in. Sorry.

DR. SCHUSTER: What did you say, Sharley?

MS. HUGHES: Gayle just joined.

DR. SCHUSTER: Okay. Great.

Hi, Gayle.

So, Steve made the motion to approve the minutes. Is there a second?

MS. KIDDER: Second.

DR. SCHUSTER: And who was that, please?

MS. KIDDER: Sarah Kidder.

DR. SCHUSTER: Sarah. Thank you very much. Any additions, corrections, omissions? All in favor of approving the minutes, signify by saying aye. And opposed and abstaining? Thank you.

I'm not sure who all we have on from DMS - Leslie Hoffmann, I think. Dr. Theriot, the Medical Director, is with us. Who is going to do the update on our data request from Medicaid on targeted case management?

MS. HUGHES: I think Leslie Hoffmann has that.

MS. HOFFMANN: This is Leslie. So, I talked to Barbara. She has the data, and, then, I've emailed you, of course. We're going to schedule probably a 90-minute meeting sometime next week, if that works for you, Dr. Schuster.

DR. SCHUSTER: Yeah. I've sent it out to our little workgroup.

MS. HOFFMANN: Okay. And as soon as you can get me some dates, then, I will help coordinate that and get it scheduled for you, okay?

DR. SCHUSTER: Yeah. So, that makes it sound like we should be able to present some data at our November meeting, then.

MS. HOFFMANN: Yes, ma'am. I haven't seen the data but Barbara felt pretty confident that she had enough to give you that would answer some questions that you all had.

DR. SCHUSTER: Wonderful. Thank you very much.

So, for those of you who are new or may not remember, Commissioner Lee, Medicaid Commissioner Lee a year ago at this point when we were talking about targeted case management and the importance of it as a covered service for people with severe mental illness really urged us to dig into the data, of which Medicaid has a lot - tons, in fact.

And, so, Dr. Brenzel from the Department for Behavioral Health, Developmental and Intellectual Disabilities volunteered and we pulled in a couple of other folks who have been particularly up on this issue of targeted case management to join on this little workgroup.

So, what we're looking at is the Medicaid data and we're trying to look at people with severe mental illness before they got targeted case management and, then, after they got targeted case management to see what the utilization of services was and also to see what kinds of hospital or ER visits, whether people filled their prescriptions, some of those things that we know really make a difference.

So, that's exciting. I'm very happy about that, and thank you for coordinating that, Leslie.

MS. HOFFMANN: You're welcome.

DR. SCHUSTER: Sharley, I think when we get to the medical respite, which we're going to get to here in just a minute, I think that Tom Walton, we have to make him a co-host so that he can share his screen.

MS. HUGHES: Yes. What was his name? Tom?

DR. SCHUSTER: Tom Walton. He sent you an email with it earlier this morning.

MS. HUGHES: I don't think I got it but I've made him co-host. So, he will be able to share.

DR. SCHUSTER: Yeah. It's tom.walton@louisville.edu.

MS. HUGHES: I didn't get anything from him.

DR. SCHUSTER: Huh. Okay, but as long as he can when we get to it.

MS. HUGHES: Yes.

DR. SCHUSTER: Thank you. I think Lee Guice was going to pick up on this next item, the update on claims payments for services for people who are dual eligibles.

MS. GUICE: Yes, ma'am, and good morning.

DR. SCHUSTER: Good morning. Good afternoon even.

MS. GUICE: I can't show you my face today. I'm sorry. Once I open the Zoom meeting, I can't get it moved off of the screen it's on.

The claims payments, what we're looking for is the bypass list, right?

DR. SCHUSTER: Right.

MS. GUICE: Certainly, it is in process right now. On Friday, I have another meeting on Friday that is a meeting where we prioritize the

release dates for all of our change requests, and that change request will be on the list, but I do not know what the - I can send an email to you, Dr. Schuster, on Monday about when we anticipate it to be implemented, okay?

So, we're looking right now - it's September - so, it would probably be no sooner than October for it to be implemented.

DR. SCHUSTER: Okay. And let me just be sure that I understand, Lee. This is the list that would tell people how to code so that they could bypass that requirement to have a denial from another insurer.

MS. GUICE: It's not necessarily how they could code but it's something that we put into our system so that the claims won't deny payment.

DR. SCHUSTER: That's even better.

MS. GUICE: Right. Right.

MR. SHANNON: Sheila, this is Steve Shannon. And, Lee, the MCOs will get that as well?

MS. GUICE: Yes.

MR. SHANNON: Okay. Is this the

Medicare bypass list but this is the bypass list, right?

MS. GUICE: It's the Medicare bypass list.

MR. SHANNON: Medicare. So, we still struggle with commercial insurance.

MS. GUICE: You're going to struggle with commercial insurance. It's my understanding that Medicaid members have hundreds of different commercial insurance plans, and we just do not have the ability to give a listing and code that listing into our system on the commercial side.

So, when I said something about commercial I think it was to this group, you should have - now, go back in your mind and picture me opening my mouth and sticking my entire left leg in there because that was an inappropriate use of the word commercial.

MR. SHANNON: We still struggle with that issue. I don't know what the resolution is. I guess we'll keep at it, but targeted case management is not a covered service with anyone but Medicaid.

I don't know if Kathy Adams is on but it's a kids' issue as well. Kids have

commercial insurance that pays for some things and Medicaid that pays for other stuff and this has been a decade. I don't know what to do when they expect us to have an EOB and we're never going to get an EOB for services that the commercial carrier doesn't cover. So, I don't know. Keep at it, I guess.

MS. ADAMS: Steve, I'm on. This is Kathy Adams. And, yes, it's a continuing issue. We do have a few members that are making some progress, so, you and I can talk.

But I think one clarification I'd like from Lee is I followed up with all of the MCOs following our last meeting because about two years ago, a year and a half ago, we had gathered bypass lists from each of the MCOs; and before I shared any of that information, I wanted to go back to the current MCOs and see if they had one and compare their current one to their old one.

Several MCOs, when I asked for their recent bypass list, provided me two lists and they said this is the Medicaid bypass - this is DMS' Medicare bypass list.

So, what you're telling me is the two lists they provided saying that those were DMS' Medicare bypass lists, those are the currently

existing. They are not the new ones because the new ones haven't been implemented yet. Is that correct?

MS. GUICE: I don't know what they gave you, Kathy. So, I can't comment on that.

MS. ADAMS: I forwarded it to you all a couple of times.

MS. GUICE: Okay. I just haven't had the opportunity to take a look at them to compare them.

MS. ADAMS: Have the new lists been shared with the MCOs yet?

MS. GUICE: Angie, do you happen to be on this call?

MS. PARKER: Yes, ma'am, I am. There is a Medicare bypass list on our SharePoint site that the MCOs have access to. I can't verify your list and the new list; but if the new list is out there, then, yes, they have that.

MS. ADAMS: And that's what we don't know. We don't know if it's the new list or the old list, if you all have shared the new list with them yet because, again, our members are taking those lists and, then, having their third-party biller implement the bypass code list for that.

So, we don't want our members

spending money to have the old list done if the new list is coming out in October. Does that make sense?

MS. GUICE: Okay. I'm not talking about the list, Kathy. I'm talking about implementation in the system. Okay?

MS. ADAMS: Okay. So, is there a list available, a new list? So, the new list exists but it hasn't been implemented in the system. Is that what you're telling me?

MS. GUICE: I'm not the person who puts that list together. So, Leslie, are you the - I'm sorry. I'm sorry.

MS. HOFFMANN: I'm on and I'm trying to figure out how to answer the question. I know Ann said - Ann had worked on a list for system changes. I don't believe that was implemented yet because, even as of last week, I think she was still getting questions about additional things that needed to be added.

So, as far as I know, it has not "been released" in the system yet. So, I can follow up with Ann,

MS. GUICE: I know it's not released in the system. Okay?

MS. HOFFMANN: That was my

understanding. And as of last week, she was still getting emails and questions about certain things that we were having to follow up on to ensure that they were included or weren't included or a modifier maybe that needed to be included.

MS. GUICE: So, I think, then, we can say, Kathy, that the list that is posted is not the new list. We've had a Medicare bypass list for a while but it's not the new list. Is that fair, Leslie?

MS. HOFFMANN: Yes, ma'am, I think that's fair. And I know that's not what everybody wants to hear, but I can tell you that at least it is being worked on, which it's a big endeavor for her to have taken that on and she has been diligently trying to get it completed.

MR. SHANNON: This is Steve Shannon. I'm trying to understand because I'll get the same questions Kathy will get, I'm sure, from our members.

So, on Friday, there's a meeting to do the system changes that will probably happen in September and will go live for Medicaid in October. What is that information?

MS. GUICE: Okay. What I was

trying to tell you is that I can't give you a time line for when the system changes will be made.

There is a change order already in process which is how we make our system changes. Okay? I have checked all of the relevant material I have, and I can tell you that the group that sets the release dates, which is what we call implementation, meets on Friday morning, this Friday morning as it happens, and we will set a release date for that - I will make sure that a release date is set for that change order this Friday and then I will know.

It's too late for it to be September, particularly if Ann is still working on additional changes. So, the earliest I believe that the system change will be made could be October, the end of October. That'S for the system change.

MR. SHANNON: Right.

MS. GUICE: We'll have to get back with you on when we believe the list itself can be posted.

MR. SHANNON: But the system change is driven - the change is the list. Is that true or not?

MS. GUICE: Yes.

MR. SHANNON: So, when Ann

finishes her work, right, Leslie - and it is a huge job - that will be the change made to the system is that list?

MS. GUICE: Yes.

MR. SHANNON: Okay.

MS. HOFFMANN: Yes, that's correct, Steve.

MR. SHANNON: So, there's two pieces. There's the change order time line and, then, there's the work by Ann to really - the change will be driven off of Ann's work. Is that correct? So, those are the two things that need to happen?

MS. GUICE: Yes.

MR. SHANNON: Okay. So, Ann finishes her work and, then, the system gets whatever, and we're hoping maybe that's October. Okay.

DR. SCHUSTER: And, Lee, you would notify me after you have your Friday morning meeting?

MS. GUICE: Yes. I'll send you an email.

DR. SCHUSTER: About a date. Okay. Thank you very much. Somebody else had a question.

MS. ADAMS: Yes. This is Kathy again. I'm sorry. I just was curious if you all had any idea the differences between the lists? Are we talking just a few tweaks? Are we talking major changes?

Again, I assume we can go ahead and implement the list that's posted on your SharePoint website. That's what is in the system now, correct?

MS. HOFFMANN: This is Leslie. Whatever is posted right now would be your best bet. I can't tell you myself today what the changes were between the two lists or two system changes.

MS. GUICE: If you all would like to see that, if you could put it on your next agenda so that we could have some time to prepare that, we would be happy to do that for you.

MS. ADAMS: That would be awesome.

MR. SHANNON: I agree.

MS. ADAMS: Thank you, ladies, so very much. We know it's a lot of hard work but, again, working off the old list, I think, and being able to get those codes to bypass when you provide those services is helpful.

And, then, maybe once we figure out what the new changes are, it won't be as drastic for our members to implement the new things if they're identified.

MR. SHANNON: Right. And Lori Gordon asked in the Chat - go ahead, Lori. Sorry.

MS. GORDON: I was going to ask it out loud. Hi, everyone.

So, I have two clarifying questions, I think. One, are we calling what you all are referring to as the old list the 12-17-20 list or are you referring to the 2016 as the old list? Like, how old are we talking for the old list?

MS. HOFFMANN: This is Leslie. I'm not sure which one is posted right now. And, again, I can ask Ann and we can follow up on that.

MS. GORDON: Okay.

MS. HOFFMANN: Or, Angela, if you're able to tell us which one is posted.

MS. GORDON: Okay. And, then, the second part of that question is, so, if the new list is coming out, which I'm assuming is like what you all are working on now, then, if the change order is entered in October, is that when the MCOs will be notified?

And, then, just as a reminder, if that is when the MCOs will be notified, then, they will also take some time to implement, just as a reminder.

MS. GUICE: I believe that we are required to give you thirty days' notice, aren't we, Angie? So, we wouldn't wait until it's implemented in our system to give you notification on that.

MS. PARKER: Right.

DR. SCHUSTER: I would hope that if you all set a change order date on Friday and it's Halloween - that seems to fit this topic - then, as soon as you knew that, you would give the MCOs a heads up. Does that constitute the notice that they need?

MS. GUICE: We have to be able to give them the list, Dr. Schuster. We have to be able to give them the list. So, we have to have the list finalized.

DR. SCHUSTER: Okay.

MS. GUICE: At that point, then, I believe we would give them notice.

DR. SCHUSTER: Okay. All right. So, it's not like a full thirty days after the point

at which it gets into your system, I guess is my point. It could happen earlier than that.

MS. GUICE: Yes, ma'am.

DR. SCHUSTER: All right. Great. And in terms of our November agenda, Lee, since you have offered to do this, are you prepared to come and talk, then, about the new list and the process and so forth? Is that what you were suggesting?

MS. GUICE: Well, I'm prepared to make sure that we can show you a chart or a file that has a comparison between the last posted Medicare bypass list and the newest one and that someone will be here to talk to you about it, whether it's me or someone who knows a little bit more about coding.

DR. SCHUSTER: Or Ann or somebody. Okay. That would be great.

So, not to beat a dead horse, but I want to go back to the commercial plans for a minute because I understand the problem in trying to have some kind of a bypass list that takes in every kind of commercial plan that somebody might have.

But I think Steve raised a really good point and that is that there probably is

not a commercial insurance plan that pays for targeted case management.

And if we were to find that that was the case, I guess my question is, is there some way that the provider can indicate that I'm going to try to bill the insurer but I'm sure they're not going to. They're not going to get an EOB because it's not a covered service and can go to the MCO at that point.

MS. PARKER: Dr. Schuster, this is Angie Parker, and I'm not going to speak for the MCOs on how they handle that, but I guess I have a question. For example, you as a provider provides targeted case management. Do you bill that to the commercial plan?

MR. SHANNON: No.

MS. PARKER: So, if you were to bill it to the commercial plan, then, you would get a denial back, correct?

MR. SHANNON: No. We would get nothing back.

MS. ADAMS: You get nothing back.

MR. SHANNON: They're not denying the service they don't cover.

MS. ADAMS: You can't get EOB's for a lot of the behavioral health services because they don't cover it. So, it's not technically----

MR. SHANNON: They don't cover care support. They don't cover community supports. So, they won't deny something they don't cover because denying it is the implication that it is covered. We're just not paying for it in this situation.

What our experience has been, we don't receive an EOB and, therefore, we can't send that. And I think Kathy and I think Art and some of my members have the same thing.

Here is a list of codes that our billing folks, our third-party if you go through a clearinghouse, maybe would help with, but the reality is we get zero information.

It's much like sending a dental claim to your car insurance. They're not going to deny that dental claim because they don't pay for it. So, we get nothing in response. We get nothing from Medicare or hopefully that's addressed. You get nothing from commercial insurance for those services they do not cover.

And, therefore, our friends at

the MCOs, they don't want to pay for something as the payer of last resort without a denial. We can't do that. We're just never going to get a denial for those services.

MS. PARKER: That's odd. I mean, I'm sorry. I can't believe - I mean, I'm sure you're correct. It's just that you would bill something and they just ignore it because it would be a benefit exclusion, so, they would have to----

MS. HUGHES: Having worked for an insurance company, they typically will send you a denial when the code is not a covered service.

MS. PARKER: Right. I'm amazed that that doesn't happen with the behavioral health.

MR. SHANNON: Many years we have been discussing this topic with our friends at the MCOs. You can ask. Lori Gordon and I have probably said meaner things to each other than any other person around this table and that's the reality.

We do not get them. And whether their expectation is they'll send an EOB, not a covered service, that's not happening. If it happened, we wouldn't have a problem.

MS. ADAMS: And this is Kathy with the Children's Alliance to just say that Steve

is 100% accurate. My members experience the same thing. They do not provide you an EOB and the MCO will, then, not pay you for that service.

So, thus, that's why some of our members may have stopped providing services to people that have primary commercial insurance which, as we noted in our last meeting, which is horrible that people that have two insurances are actually getting fewer services than those with just one.

DR. SCHUSTER: Bart, did you want to say something?

MR. BALDWIN: Yes. Thank you, Sheila. Just a couple of quick things.

One is it's across all provider types. I mean, CMS (inaudible) those multi-specialty groups on, you know, we work with all of the above and they all experience the same thing of not being able to get the denial.

The other thing is that I was the one working on this last week and nothing I sent in wasn't already on there, so, it's not going to delay things, just to clarify that.

But she also said that if you're billing Medicaid, straight Medicaid, there's a form in the MMIS billing manual for the provider type

to fill out if the code is not on there, and that's only if you're doing - and that's for commercial, my understanding, if you're billing straight Medicaid which probably happens but not nearly as much as commercial and MCO.

MS. GUICE: Have you considered asking the MCOs if they would follow that same process?

MS. PARKER: This is Angie. I actually provided that form to the MCOs back in July after our last Behavioral Health TAC.

MS. ADAMS; This is Kathy Adams. Our members used that form. It was April probably two years ago that they were using that form. And, then, all of a sudden, MCOs stopped accepting it and we could not find out why. And, then, the pandemic hit. So, yes. It's the TPL form, third-party liability.

DR. SCHUSTER: Well, this is obviously not going to get solved today and I want to move on to the medical respite.

Let's put two parts of this on the agenda for November. One is to get a briefing from DMS on the file or chart and the comparisons. And, then, I'm going to request through DMS that the

MCOs come and report how they are handling these billing issues. Okay? I know everybody will be thrilled about that.

Let's move on to a new topic that I think is super interesting and something that we need to pay attention to, and I'm going to turn it over to Andrienne Bush from the Homeless and Housing Coalition of Kentucky to introduce our speakers - a father and son team.

MS. BUSH: Thank you so much, Sheila, and thank you to the Behavioral Health TAC for having us.

We got started really working on medical respite - and by medical respite, we're talking about care for people experiencing homelessness once they are discharged from the hospital.

We don't want to discharge them back into homelessness, whether it's on the street or in a shelter, and sometimes people need, like, mid-level but they're well enough to be discharged, they're not well enough to be living on their own.

And, so, a couple of years ago, pre-pandemic - I guess it probably feels like ten years ago - we got in touch or they got in touch with

us. Tom Walton, who wears a couple of different hats but is with the University of Louisville as an Executive in Residence but also is part of the Louisville Health Advisory Board - Community Coordination of Care Committee.

And, so, he has gotten in touch with us and we're like, hey, there's something here. The Kentucky InterAgency Council on Homelessness which HHCK facilitates, we had had a number of providers report that medical respite was something that they wanted to work on that they saw a need for.

So, with that, I'm going to turn it over to Tom and Matthew and whoever is here. That's the thing with Zoom meetings. I'm never quite sure who is here and who isn't. But, anyway, we're really glad to have you on board, Tom, and anybody else you want to introduce or if you just want to go through the slides, that's great, too.

MR. WALTON: Sure. I'm going to run through these slides really quickly so we have a little bit of time for discussion.

When we started, we actually have some people on the Community Coordination of Care who do street outreach, and she took these pictures and these are places where people are

actually recovering after hospitalizations.

When we talk about medical respite, another term that's used is recuperative care. We use the term respite but know in this situation they're pretty much interchangeable.

As Adrienne mentioned, this is part of the Louisville Health Advisory Board which the whole Advisory Board is about eighty organizations. The Community Coordination of Care is about thirty organizations and we have three work streams.

One is to screen for unmet basic human needs. We were really instrumental in thinking about screening for health systems, food banks, etcetera for these more commonly called the social determinants of health.

We also do a lot of work with navigation. We did a lot of the thinking behind the United Community which is the community-wide navigation systems that's run by Metro United Way.

And, then, we realized you can screen and you can navigate, but unless you have capacity, you really have not served the needs of individuals. So, we're working to increase capacity and coordination in the areas of food, housing and

transportation.

Our larger initiative is called Housing As Health because on our committee, we have Norton Healthcare, New Directions Housing Corporation, people from all over the spectrum of Health and Human Services.

So, again, we're very interested in affordable housing, very interested in addiction prevention, but this specific project I'm going to talk to you about today is about respite care.

And, then, as Adrienne mentioned, we were talking about this in the Louisville I'll call it the LHAB, the Louisville Health Advisory Board, and they said, hey, you guys need to go to Frankfort and talk to the Housing and Homeless Coalition. So, we've been working together since then.

DR. SCHUSTER: Can I interrupt for just a second? I have a question in the Chat. Are you willing to share your slides afterwards?

MR. WALTON: I am.

DR. SCHUSTER: Okay. Great. So, I can send them out to everyone on my list. Thank you very much.

MR. WALTON: A lot of the research we are doing, we are involved with the National Institute for Medical Respite Care of the National Health Care for the Homeless. They have a lot of research on quality standards, outcomes, implementation manuals, etcetera.

We look at a lot of academic and industry publications and we're very interested and we've actually applied for a Robert Wood Johnson Systems for Action grant to address the wrong pocket problem.

A good example of that in the housing sector is if a child lives in a home with a lot of rotting carpet and mold and keeps going to the ER with asthma, well, it really is the MCO that's paying for that. However, it's the housing sector that is generating the cost.

So, again, we're looking at that, and part of our reason for being so focused on that is we're very interested in sustainability.

This is about some of the conversations that we've had. We had three we call them design calls. One of the calls we had the voice of the client, people that do street outreach, health systems, MCOs, etcetera, as Adrienne mentioned, the

Kentucky Council on Homelessness. We've talked with Commissioner Lee, Leslie and Angela. And we also report about this work bimonthly to the full LHAB and also monthly Community Coordination of Care meetings, with the Homeless Task Forces.

And, then, it's highly possible that I've talked with you about this before if you work for health systems, an MCO, the Kentucky Hospital Association, etcetera. In other words, we're trying to get as broad a representation of stakeholders as possible.

What I'm going to ask of you today is we really need the expertise of Medicaid and all of you who are on this committee, and particularly your lived-experience experts.

Those are the people who are experiencing homelessness or who have experienced because what we believe is that they need to be hard-wired into the decision-making process for us if we're willing to be successful and can meet their needs.

This is the why. We have some data from the Health Services and Facilities Data, and you can see that there's over 11,000 people experiencing homelessness - again, this is statewide

data - and a re-admission rate of 3,700 which is about 33%, again, coming out of the hospital sector.

So, again, if we had this number of re-admissions, we have been extremely (inaudible).

The reason we're talking with you all today is we also are looking at DRG's. Again, there's over almost 11,000 cases where the discharge diagnosis was documented, the DRG was documented. Sixty percent of those had a psychiatric diagnosis and by far the most common diagnosis was psychosis.

So, we believe that a respite program really will serve the populations with which you all are concerned.

When we want you to be involved, this is sort of the how. We're setting up these three workgroups to develop a strategic framework.

One, we're going to set up the unifying goals and shared measures, and, again, I'll talk about each of these in a little more detail. The second is practice models and the third is payment models.

So, again, I have written some

possible goals here. I want you to know that we're very interested in co-creating this framework with you all and with other stakeholders around the state, but I thought it would be helpful to tell you some of the indicators that are in the literature.

The number one which impressed me was the improved quality of life. We tend to jump into like reduced costs and all that kind of stuff, but the literature very, very strongly suggests that you will have a lower mortality rate, fewer unsheltered days, less disease burden, etcetera.

Again, I'm not going to read through all of these but I do want to talk about appropriate utilization, and the number one thing that people look for in a respite setting is the connection to primary care, so, they, in fact, can break the cycle of using the emergency rooms as their primary care site.

People also look at stable housing and better value. And, again, when you are coming out of the hospital, I'm always looking at re-admission rates and length of stay and things like that, but, again, we're looking for a very holistic set of measures.

The second area are these

practice models. Again, I can talk a lot about these and this is my let's start now, that we don't have to wait for a dedicated respite facility. Each community around the state can start thinking like how can we better coordinate services.

In Louisville, we actually started back in 2012. We had these community-wide case management conferences where we looked at people who were familiar faces to multiple ER's and hospitals, etcetera and started to develop sort of community-wide care plans. It was really, really successful.

Again, the technology is much, much better now. In the Louisville market, I think Aetna Better Health uses across the state the Unite Us platform. So, it's much easier to do these kind of navigation services.

Some people, again, in Lexington and around the country uses a temporary setting, a hotel, shelters, etcetera.

There's also models where they have dedicated facilities. Some of them are staffed with providers and registered nurses 24/7. Some are more non-medical which means that the providers come in to provide services but they don't necessarily

have 24-hour staffing.

We also know from looking at the data that recovery is a really significant issue.

And, then, the model which I'm actually quite fascinated with now based on this study from UC Davis is this integrated, co-located, patient-centered model and that's where you have a campus very similar to these continuing-care campus for older adults where you have assisted living, independent living, permanent supportive housing, etcetera, and, again, constantly thinking about efficiency and how do we pull services there.

And, again, I'm going to go back to this idea of having the clients themselves participate in the design of the services.

The last area is the payment models. So, we can thank our friends at the National Institute for Medical Respite Care and United Healthcare for funding a paper on different payment models. So, I've referenced that here, but, again, there's all sorts of payment models.

The reason that this is really important right now, I will just tell you, in Louisville, the Family Health Centers, the Phoenix Health Care Centers for the Homeless are using part

of their Health Resources and Service Administration, their HRSA funding to stand up a new respite location at Hotel Louisville.

We will be looking at the data in that very, very closely, and the reason for that is we want to document the fact that this is a sustainable business model. And, again, this goes back to the wrong pocket problem.

We could ask a health system to invest really hundreds of thousands of dollars in adding new case management, but unless that benefits them, we just know it will not be a sustainable model.

And, then, I think - and I don't have a slide on it - but it's the ability to talk about the technology to link all of this together.

Again, the Epic Systems has care everywhere that can do things. We have United Community, but, again, to be very intentional about how these different systems of care can be linked using technology.

And the last is these are sort of the, in addition to participating on these workgroups to design the strategic framework, we're

really interested in each organization going back and looking at your engagement with people experiencing homelessness because we do know that we all have balance sheets we have to pay attention to and profit and loss statements, but, again, to go back and look at what makes sense for your organization, you know, to talk about your North Star.

Also, our next virtual planning conference is on September 30th at 10:00, and, again, this will be in the slide. So, you're all welcome to attend.

You can email me at tom.walton@louisville.edu, and I will be glad to send you an invitation.

The Phoenix Health Care Center for the Homeless is going to be talking about their model for respite care. And, again, they looked at their data and the data that we're supplying and they are (inaudible) hard-wired mental health services into their program because we know that's a really critical phase.

And, then, you're always welcome to join the Louisville Health Advisory Board - Community Coordination of Care and hear us how do we flush out all of this work.

Any questions? I think we have a couple of minutes left, or, Sheila, I'll yield the agenda to you.

DR. SCHUSTER: Thank you very much, Tom, and I appreciate having had a chance to talk with you and your son Matthew and Adrienne.

I guess from a behavioral health standpoint because obviously we have problems with people getting discharged from the hospitals purely on the behavioral health side and not getting back to what we call warm hand-off or the connection back into the community which is a problem, but you all are focusing, I assume, mostly on people that are being discharged from the hospital for a physical health reason?

MR. WALTON: No, not at all. In fact, if you go back and look at the data, it is the large psychiatric hospitals that have the highest re-admission rates.

And what we would be really interested in, and, again, I might use these little lingely terms from the health care world of systems of care. We're very interested in designing systems of care with the idea of no wrong door. So, you can enter any way and navigate out to the most

appropriate resources.

I think the thing that we are going to pay a lot of attention to, though, is the medical discharges where we have pretty much ignored the behavioral health components, and I think that's the big add here.

DR. SCHUSTER: I think that's interesting. One of the things that we're - we've only been asking for it for fifteen years or so is a Medicaid waiver to address our folks with severe mental illness and it would have a housing component, a supported housing component.

And I wonder, Tom, if medical respite couldn't be a part of that. I mean, it makes sense because it's our SMI folks that are in that revolving door in and out and we know that they also have significant, significant physical health problems because they die twenty-five years sooner than their same-age peers who do not have an SMI.

So, that could really be a place for at least some of this is land.

MR. WALTON: Sheila, I'll send you a link to that UC Davis paper. It's 100 pages and usually I just, quite frankly, just blow through those things. I'm reading it in great detail and it

outlines models from around the country and different approaches that they have taken.

And, again, this is where I think we really have to hard-wire the voice of the client into it so that they have some decision-making process to some - you know, they are involved in the decision-making process to choose the services and the system of care that most benefits them.

DR. SCHUSTER: Diane, you had your hand up. This is Diane Schirmer, Tom, who is with the Brain Injury Alliance.

MS. SCHIRMER: I just wanted to say that we would like to get more information simply because we serve the military and we have a grant and there's a high percentage of military individuals who are homeless both with hospitalization and without, but we have to address those issues. And, so, I'd love to get more information and somehow get us involved.

MR. WALTON: That's wonderful. Thank you.

MS. SCHIRMER: So, I need to make sure I get your email.

MR. WALTON: Sure.

DR. SCHUSTER: Tom, if you want

to, type your email in the Chat there so people can - we used it earlier. Are you using your tom.walton@louisville.edu or another one?

MR. WALTON: That's the best one, yes.

DR. SCHUSTER: Okay. Why don't you go on and put it in the Chat.

So, you met with some folks at Medicaid. How do you see this being implemented through Medicaid, I guess? They would have to put it in the contracts.

MR. WALTON: That would certainly be one way to do it. I would think they also need some technical advice on like how to bill it, like, do you bill, like, a room and board charge? I think (inaudible) would be okay with billing for the medical services.

We would also be really interested in some demonstration projects about the use of telehealth. And, again, I'm going to put on my world health care hat here and think, like, could you, in fact, have somebody discharged from Lexington and returned to Somerset and, then, link back in to the specialist in Lexington so that they can get respite care in their respective communities and to

see how that sort of would work.

Again, we just know that transportation from our general Community Coordination of Care is a very, very significant issue. When we go back and look at the United Community data, transportation is probably one of the top three services that are needed.

DR. SCHUSTER: Yes. And we certainly have learned to rely on telehealth during this pandemic. It works for the majority of the people. It doesn't certainly work quite as well for some.

Any other questions? If I can't see you, just jump in because I can only see a few people.

MS. MUDD: It's Val. I have a question. I mean, I know it's different for everybody, but I think specifically about our population of folks who are in the revolving door aspects.

How long does respite last? If they go back in the hospital, do they get respite again when they come out? I need a little clarification on that, if you can.

MR. WALTON: So, again, I'll

refer you to this paper, but in the research for that, there's a chart in there that gives the lengths of respite time.

Like, some have an average length of stay of twenty days. Some have an average length of stay of ninety-one days, but, again, I think the idea of this integrated campus is really attractive because people can move amongst that campus and see the same providers.

We also believe that nursing homes will be more willing to accept people with medical needs if they know that they're not going to get "stuck" with them, that they could be transferred to a respite setting after their nursing home time, but it really does vary.

And, again, part of the - I'm going to put on my work stream hat - is the ability to assess people's housing status.

We looked at one study in Philadelphia where they had a very high re-admission rate in the first seven days and they went back and they did not assess housing status while the person was in the hospital. So, they just were not thinking in terms of the, you know, they weren't considering the context of the patient.

MS. BUSH: The other thing, too, is we want to be careful with respite programs and designing respite programs that are not just another place to warehouse the homeless and the mentally ill, that this is just a point of contact, a place for people to go to get the care that they need post hospital but also get them connected to permanent housing and prioritized for permanent supportive housing or rapid re-housing, whatever the appropriate housing intervention is.

MR. WALTON: Thank you, Adrienne. I had in my notes to talk about why the title Respite to Residence. It is very intentional that there's a point of intent care coordination that occurs while in respite.

And, then, the idea is to move them - to spend at least a year with them post respite and to navigate into permanent supportive housing are the most appropriate housing situation for them. So, thank you. Whoops. I forgot that.

MS. BUSH: No. You're fine. Tom brings the health care piece and I bring the housing piece. That's why we work well together.

DR. SCHUSTER: That's great. Any other questions?

MS. SCHIRMER: Well, I was just going to say that when you talk about something like that, in brain injury, there have been projects across the country called resource facilitation which are those wraparound services that you're talking about that really are in communities to help link the people with the resources to give them the ability to be successful in the community, whether it's housing or vocational opportunities and other things to get them successful.

And, so, I'd love to dialogue more about this because I have a pretty good working knowledge of how resource facilitation works and building those small communities, and I'm linked up in Kentucky with others that have that interest.

MR. WALTON: That's wonderful. Thank you.

DR. SCHUSTER: Thank you so much, Adrienne, for bringing this to our attention and, Tom, for putting together the slides and it's delightful to get to meet your son also who is a data geek for the State which is great.

You are welcome to attend our BH TAC meetings anytime. Obviously, housing has been high on our priority list. I'm looking at Sarah

Kidder here. That's one of the things that NAMI has been on for years and years and years.

Steve Shannon and I have been advocating around a Medicaid waiver for supported housing and this obviously is a piece of it that needs to happen as well.

So, we thank you very much. And with your permission, then, I will share the slides back out to people that are on today.

MR. WALTON: Thank you.

DR. SCHUSTER: All right. Thank you. Appreciate it. Thanks, Adrienne.

We are revisiting an old topic but one that has been interesting and is still unresolved and that's the issue of ambulance or EMS transportation of individuals with behavioral health issues.

And some of you may remember, we used to have probably, well, it was in the previous Administration, so, it was two years ago, we used to have these discussions about people would show up at an ER at a hospital that didn't have a psych unit and want to be admitted, and the folks at the hospital felt like they ought to be transported safely, even though it was a voluntary commitment,

and EMS would either not show up or say they don't have to take people with mental health issues or something like that.

So, the Kentucky Hospital Association is working on this issue very hard because they're having so many problems in getting hospital-to-hospital transfers and so forth.

So, I just wondered if anybody on the call had any examples or anecdotes that you could share briefly?

MS. DANSLOW (sic): I have one with my teenage daughter.

DR. SCHUSTER: Okay. What's that?

MS. DANSLOW: (Inaudible) she has been in and out of psychosis. So, we had to call the CIT team and CIT wasn't allowed to talk to her. And, then, the ambulance and Fire Department showed up. This wasn't even at the hospital. This was at our house.

MS. DANSLOW: They didn't touch her. They were just standing there watching me guide her and chase her down the road and she ran in front of multiple cars because they wouldn't touch her.

DR. SCHUSTER: Huh.

MS. DANSLOW: So, there's a little bit of misguidedness on whether they should touch or not touch as well as transport. They ended up transporting her because she was clearly in a state that was not safe but (inaudible) they wouldn't do anything.

DR. SCHUSTER: Are you in urban, rural?

MS. DANSLOW: Louisville, Kentucky.

DR. SCHUSTER: Louisville.

MS. DANSLOW: And even with a CIT officer there, they still wouldn't touch her and (inaudible). I was able to get in the ambulance with her and transport her but (inaudible). And I don't know if this is just a teenager rule or if this is an adult as well rule but it has happened twice.

DR. SCHUSTER: Okay. I'm sorry it's happened. That's a great example. Jeff, do you have something to add?

DR. SCHUSTER: And, Jeff, do you have something to add?

MS. DANSLOW: Oh, whoops. That was my dad's name. I forgot to change it. My name is Carrie (sic) Danslow. I just got this computer

from him because mine died yesterday. My apologies.

My name is Carrie Denslow and I am from Mental Health America of Northern Kentucky and we currently are offering free mental health first aid. I will leave the person's contact email in the Chat if anybody would like to send it out to your first responders or they themselves would like to take mental health first aid. We are offering it virtually.

So, yeah, I just thought this would be another resource that folks can utilize. And thanks for letting me share and I will change my name.

DR. SCHUSTER: And Tom Walton just put his email address in the Chat. Somebody was looking for it - tom.walton@louisville.edu.

Any other EMS stories? Thank you for sharing that.

All right. If you hear of any or become aware, just send me an email - kyadvocacy@email.com and let me know about it. Thank you, Marcie. You just put it in the Chat for me.

Lee, I think this is you, the update on the no-show data-gathering panel and how the data will be used.

MS. GUICE: Yes, ma'am. What I have are a couple of reports that I received.

What I can't tell you is how it's going to be used other than to tell you we're going to be sending reports to MCOs on this.

I think the testing on this has been completed, but I don't know if they're done sending the reports live right now.

What I can tell you is this, and I can share a listing with you on my screen if you would like for me to.

DR. SCHUSTER: Yes, why don't we do that, Lee. That would be great.

MS. GUICE: Okay. Sharley, can you give me the ability?

MS. HUGHES: You already are, Lee.

MS. GUICE: Okay, great. Thank you. I have too many things open on my computer. Let me see if I can make it a little bit clearer - or, too much bigger. I don't know how to zoom in here but I can make it a little - there you go - just a little bit bigger. Can you see that at all?

DR. SCHUSTER: Yeah. That helps.

MS. GUICE: Okay.

MS. HUGHES: Lee, click on Enable Editing. There you go.

MS. GUICE: That worked. I think you can see everything. What I have here is, right here on the left-hand side is the name of the provider type, okay, not the actual provider but the name of the provider type.

These are the providers that have been using the system and have reported missed or cancelled appointments and the number is how many times they have used it.

DR. SCHUSTER: And can you only enter one data point each time you use the system, Lee? In other words, if you had three clients in one day that missed their appointment, does that come up as three on your list or does that come up as one?

MS. GUICE: It will come up as three is what I'm trying to say because this means that a licensed clinical social worker has used the system six times.

DR. SCHUSTER: Okay.

MS. LEE: Okay? And you can see that individual dentists at 34 and physicians' group and optometrists individually have used it the most.

The total there is 248 different providers.

What this is telling me actually, Sheila - I'm sorry - is that only one adult day center has used the system. This tells me that one hospital has used it. Wait a second. I have the other information that you're looking for, however.

DR. BRENZEL: It looks like from this, only one community mental health center has reported.

MS. GUICE: Yes. I'm going to stop sharing for just a second until I can open this new and just to make sure that it opens to the - there we go. Let me go back and share again. Can you all see that? It's got the list of the - I know - probably not very well.

DR. SCHUSTER: Okay. It's the list of the MCOs.

MS. GUICE: Yes, ma'am.

DR. SCHUSTER: Okay.

MS. GUICE: I'll make that a little bit bigger.

DR. SCHUSTER: Oh, that helps. Yeah. Oh, good.

DR. BRENZEL: And that's just the raw number of individuals reporting. So, it's a

little hard to not know their total membership to know what that means but it just shows you there were 12,000 missed appointments.

MS. GUICE: Okay. So, I can tell you that WellCare has the most members at a little over 400,000, and Molina has probably the next, with United Healthcare has the least. Humana, Anthem and Aetna, Aetna is probably the fourth and then Anthem. I thought about letting some different numbers on here but not knowing exactly what you wanted to see, it was hard to make the decision.

So, this Count of Member ID's, these are individual, unduplicated members that were reported and these members belong to WellCare, okay, and this is how many times an appointment was missed.

DR. SCHUSTER: So, roughly 9,500 individuals unduplicated missed 12,500 appointments.

MS. GUICE: Yes, ma'am.

DR. SCHUSTER: Okay. All right. So, some missed more than one appointment obviously.

MS. GUICE: Yes.

DR. SCHUSTER: Okay. All right. So, that is helpful, I guess, to the MCOs.

So, the other data would tell us by provider type who is using the system and

reporting.

MS. GUICE: Right. Exactly.

DR. SCHUSTER: Okay.

MS. GAINES: This is Nikki from Kentucky River, one of the community mental health centers. I know for us, if I could just speak about our experience, I think this is pretty new, having this form available for tracking purposes, and I think the data is wonderful to have.

I don't think it's really been integrated into our folks' work flow yet in terms of the reporting because it's fairly new. Because our staff are spread out and because we're doing telehealth, etcetera, things take time to get integrated into the work flow to probably have some really good data through the system.

Now, if I go pull a report out of my system to show me about how many missed appointments we have, we usually run close to 30% but that's integrated into my system, whereas this is another system where somebody has to go put in data.

So, I think that extra step could be part of the reason for the slow reporting.

MS. GUICE: Sure.

MR. BALDWIN: This is Bart. A

similar type question. If there was a way to, like Nikki said, to batch and send a report without manually coding in every single missed appointment into the system, I think you would get a lot greater compliance.

If we give you, like you said, 30%, I mean, we're talking about - I mean, that's----

MS. GAINES: Very significant.

MR. BALDWIN: ----that's thousands a month just right there and that's a lot of manual entry and a lot of staff time that's probably already in a system to begin with.

MS. GAINES: Exactly, yes.

MR. SHANNON: We track that. I don't know the number offhand like Nikki does but I suspect we all know what that number is.

And I still think and I think this is one point Sheila was making, I have been asked how is this information used, and I think people's concern is will the individual get contacted by somebody. You know, you've missed appointments. How come? That's a concern that has been expressed to me as well.

And it may not be. It may not happen at all. It could be a completely rational

concern but I've heard that from other folks.

DR. BRENZEL: I don't how the information will be used, but one way it could be used is for managed care companies to offer care coordination and do outreach and find out. Is that an invasion of privacy or is that----

MR. SHANNON: No.

DR. BRENZEL: ----(inaudible) and I'm trying to find out why they haven't been in to see me.

MR. SHANNON: And we don't think it's a privacy issue. We just think is there some negative consequence for the individual?

DR. BRENZEL: But I do know some providers fire people who miss two appointments which is also inappropriate in my opinion.

DR. SCHUSTER: I think that was my concern, Allen, was people being labeled in some way if they show up as a chronic no show or something like that. I mean, we have enough problems with stigmatizing and stereotyping.

So, Lee, obviously, there are member names in here, right?

MS. GUICE: Yes.

DR. SCHUSTER: I guess my

question is, are the members' names then turned over to the MCOs?

MS. GUICE: Well, it makes it a little bit difficult to do any coordination without sending their membership back to them that shows that they have - I mean, they would have to have that information to do anything with it.

I don't know what they do with it. You would need to ask the MCOs that question.

MS. CECIL; This is Veronica Cecil with Medicaid. I think it is the intent for this information to be utilized by the MCOs to do just as Dr. Brenzel indicated, some type of outreach.

Now, especially if we're identifying a member that has missed several, there could be something going on. And having the MCOs reach out and check in with that member and see if there's other supports they need, is it transportation, there's a whole host of things that could be causing the missed appointment.

It absolutely is not to stigmatize, and I think we all - and by we, I mean the Department to the providers to the MCOs - are just trying to do what's in the best interest of the member and support them.

There is nothing that can be done to the member. So, again, this is all about being supportive and being helpful and just trying to identify are there other supports that could be provided to the member to assist that they're getting access to the care.

MS. MUDD: With my care personally - I go to The Ridge for outpatient services - and if I miss an appointment, they try to contact us three times. And on that fourth time, if I'm not mistaken - whoever is on here from The Ridge possibly can clarify that - but I believe that fourth time, they do a welfare check and they send someone to the home.

DR. SCHUSTER: So, that's a service that you get, Val, as a regular patient in their outpatient services?

MS. MUDD: Yes.

DR. SCHUSTER: The welfare check part of that, I think, is one thing.

MS. HUGHES: Sheila, I know at one meeting that I heard Commissioner Lee talk about this, they wanted to be able to do some outreach. And if we find, say, for instance, transportation is an issue, then, to make sure they're hooked up to the

transportation benefit of Medicaid to help them get to these appointments.

So, it's stuff like that that I think is what the Commissioner's goal was is just to really and truly to help these folks, like Deputy Commissioner Cecil said.

DR. SCHUSTER: Yeah. And please don't hear me as saying that I think anybody on this call or anybody in the Department or any of the MCOs are stigmatizing or treating people badly.

I think it's just the danger is there of people getting labeled.

MR. SHANNON: And, Sheila, it's relatively new. I think we meed to look at that piece as well.

DR. SCHUSTER: I think what I'll do is to ask - maybe November is too early - but maybe in January, the MCOs would have enough time to have a little bit of a sense where they could give a report about we followed up on "x" number and these are the things that we found were keeping people from their appointments kind of thing because I do think that that's kind of a reverse needs assessment in some ways.

And I wouldn't be surprised,

Sharley, if it was transportation because transportation is always at the top of the list in terms of issues.

I think somebody just asked here in the Chat, Lee, when will these reports be going to the MCOs?

MS. GUICE: Let me check and see if I can run that down before the meeting ends.

DR. SCHUSTER: Okay. And was there another comment in the Chat that I need to look at?

MR. SHANNON: I think they were both kind of the same.

DR. SCHUSTER: Yeah, same thing about timing. And who are you sending the reports to I guess might be helpful to know because obviously there's lots and lots of staff at the MCOs and lots of people who would be----

MS. GUICE: I'm pretty sure it's not just like going out in an email. So, I'm sure that it is transmitted over the secure site the same way we transmit everything else.

MS. PARKER: Lee, I believe it's going to be on SharePoint where the MCOs have access to pull the report.

MS. GUICE: Perfect. Thank you, Angie. And I'm going to stop sharing the screen now. Is that okay?

DR. SCHUSTER: Yeah, that's fine. Thank you very much for bringing that data, Lee. That's helpful.

MS. GUICE: Certainly. Thank you.

DR. SCHUSTER: And, Angie, that SharePoint, it's called SharePoint? What is it called?

MS. PARKER: Yes, it's SharePoint. It's a, for lack of a better word, a system that is able to share information with the MCOs without having to - it's a secured site, I guess is the word I was looking for.

DR. SCHUSTER: Okay. And another MCO rep is asking what's the name of the report? Do we know that?

MS. PARKER: We'll get hopefully that answer before the end of the meeting.

DR. SCHUSTER: Okay. Thank you very much, Lee.

I reached out to Abner Rayapati to see if there was any further need to talk about

lock-ins for pharmacies and providers. Are you on the call by chance, Dr. Rayapati? I did not hear back from him.

You remember he had an issue and Dr. Ali was on last time and gave him some people to check in with.

MS. HUGHES: Unless he is calling in, Sheila, I don't see him on the list of participants.

DR. SCHUSTER: Okay. And is Dr. Ali on?

DR. ALI: Yes.

DR. SCHUSTER: Wonderful. Thank you so much, Dr. Ali. I have not gotten a lot of eruptions from the community about anything having to do with the pharmacy. So, it's been nice. Do you have any updates for us, Dr. Ali?

DR. ALI: Well, that's certainly good news. No news is good news.

In terms of lock-in, I don't have much except that we removed Sublocade from the lock-in list. So, we shouldn't be seeing any issues with Sublocade. Any other non-Sublocade-related lock-in issues can be triaged over to the respective MCO and they should be able to help with those

concerns.

I don't have any updates on changes to the single PDL. I did want to note that our P&T meeting is coming up on September 16th at 1:00 p.m. Keep in mind these are public meetings. So, anyone can attend those as a regular attendee, and the link to that meeting is on the Magellan provider portal. I'm happy to place it in the Chat here as well.

In terms of changes to non-PDL drugs, I did want to remind everyone that the non-PDL grandfathering will end on September 29th. So, beginning September 30th, those products will no longer be grandfathered and just another reminder as to which products fall into that list.

If the MCO was covering a specific product without a prior authorization prior to 7/1 and now requires a prior authorization, those products are being grandfathered through September 29th.

So, in other words, these products will show up at the pharmacy with a point-of-sale messaging informing them that the product is being grandfathered. So, prescribers are more than welcome to submit a proactive prior authorization and

we encourage prescribers to do so.

We have been hearing that some prior authorizations are not being honored as a proactive prior authorization. So, we are working with MedImpact to see what the underlying issues are there.

If you see anything and you get a denial that says that it doesn't require a prior authorization but your understanding is that it does, please feel free to reach out and we'll address those issues in a timely manner.

I don't have any other prior authorization issues. We get specific member cases from time to time and we're able to resolve them. So, if anyone has questions, I'm happy to take those.

DR. SCHUSTER: Thank you so much, Dr. Ali. Let me just make sure I understand.

So, this grandparenting I like to call it - so, it's non-sexist - grandparenting period will end on September 29th. So, any of those drugs that would have required a PA will now require a PA.

DR. ALI: Right. So, if an MCO was not PA'ing the product and it is now being PA'd as part of the new formulary, it is being

grandfathered currently. And after September 29th, it will require a prior authorization; but, again, we encourage prescribers to submit proactive prior authorizations so the member can continue therapy with the drug without any interruptions in care.

DR. SCHUSTER: Okay. So, the prescribers know that the deadline is looming and you're asking them to be proactive so people don't get left without their medications essentially.

DR. ALI: And we've been communicating via lettering. We sent out a communication very recently at the thirty-day mark. We've also sent it out at the sixty-day mark as well.

DR. SCHUSTER; Okay. Thank you. Any questions for Dr. Ali? It's wonderful to have you on the call, Dr. Ali. Medications are so important to our people, we want to be sure they have access. Does anybody have any questions for Dr. Ali on anything pharmacy-related, access to medications?

MS. MUDD: Let me see if I can ask this question smartly.

So, if the grandfathering stops on the 29th and it has to be preauthed on the 30th, I assume that will be flagged and folks will see that list. When they need that prior auth, will it go

through pretty quickly because there's already that list? Do you know what I'm saying?

DR. ALI: Yes. And, you know, that's where we encourage pharmacies, members and prescribers alike to be proactive. The members can certainly take charge of their health and call their doctor and ensure that the prior authorization has been submitted.

We've been communicating with members, prescribers and pharmacies alike to make sure that the word is out there.

Pharmacies can also help by calling the prescriber and ensuring that they're aware that certain products need a prior authorization, and there are certain medications where pharmacies can initiate prior authorizations as well. So, it's a collaborative effort at the end of the day.

DR. SCHUSTER: So, I think, Val, from the consumer perspective, the issue is to be watching those meds and checking with your prescriber to make sure that he or she is sending a prior auth because we're in the month now.

So, if you get a thirty-day prescription, you've got to be ready for the next

month, right? Good question. Thank you very much.

Any other questions for Dr. Ali? All right. You get off easy today, Dr. Ali. Thank you so much for being with us. We really do appreciate that.

And, Leslie, this is our age-old question of you - status update on the waiver for SUD services for incarcerated persons.

MS. HOFFMANN: Hello, Sheila. It's me again.

I met with CMS week before last again. I actually talked to Felisha (sic) at CMS who is my lead person for this incarceration amendment, and she again said please reiterate to our executive staff, our leadership and our advocacy because I reiterated everything she said and I said, this is what I'm telling people.

She said do not feel bad. It's not negative. There's no bad decisions being made. It's just being visited at a much higher level because so many states are involved now, and they want to make sure that they've got it right before they roll anything out.

So, I'm just reiterating what she said to me the other day. It's all still

positive. I meet with them on a regular basis every month and I keep it on the agenda and I'll keep you guys posted.

DR. SCHUSTER: That's what I've been telling people. It comes up at our various meetings because people are really anxious, and I said one of the down sides of being a trailblazer, which is what Kentucky is in this regard, is that we kind of caught CMS without some of the guidance that they needed, as I understand it, Leslie, right? They had not prepared some of the guidance documents and so forth that they would need to have ready for other states.

MS. HOFFMANN: Yes, that is correct, such things as metrics, policy. There's a lot of things that go into an 1115 that a state is held accountable to and what that would look like, especially the metrics and the monitoring piece.

DR. SCHUSTER: Okay. So, the message is that the guts of the thing, the target population and the interventions and so forth are a go. We just aren't going yet. Is that accurate?

MS. HOFFMANN: That's accurate as far as I know. They've not given me any indication that they would not allow this in some

form. Now, they might decide to have me to modify it in some way, but they've not even provided guidance from the federal public comment period, those questions. They've not provided me anything even from that yet.

DR. SCHUSTER: Okay. All right. Well, we will, of course, keep it on our agenda. I think it's permanently in my computer at that spot. So, thank you for that.

I don't think - Sharley, can you look and see if Dr. John Sullivan is with us?

MS. HUGHES: Let me look here real quick.

DR. SCHUSTER: Okay. Thank you.

MS. HUGHES: No, I don't see him.

DR. SCHUSTER: So, this is his issue around 99214 and 99215. So, we will try again next time.

The 2021 General Assembly Interim Session Task Forces. Leslie, the last time, you gave us kind of an update. Are you doing that again this time or am I?

MS. HOFFMANN: Sheila, I didn't have any particular things to give you for an update

this time. Jonathan might be on the call. I'm not trying to put him on the spot; but if not, I can check on those task forces and give you any updates that I'm aware of or that I can find out.

DR. SCHUSTER: Thank you. We had some excellent presentations in August really around recovery services and housing. So, we had Bridgehaven Mental Health Services in Louisville. We had Wellspring. We had New Beqinnings in Lexington. We had a program from Mountain Comp Care, and we had Pathways CMHC also presenting.

So, we've covered a lot of ground so far on that SMI Task Force. And the next meeting - I meant to look it up - I'll have to look and see when it is because they keep changing the dates of these things but I'll post it when I see it.

So, they will meet in September, October and probably try to wrap it up in November in terms of - September 21st. Yeah, you're right, Sarah. Thank you. September 21st at 3:00 p.m.

DR. BRENZEL: Commissioner Morris is going to ask to speak as well as I've been asked to present on state hospitals.

DR. SCHUSTER: Great.

DR. BRENZEL: So, we'll be on the agenda for that September 21st meeting.

DR. SCHUSTER: Okay. What is Commissioner Morris going to speak about, Allen?

DR. BRENZEL: I'm not 100% sure but I think there was a specific request from the committee regarding Tim's Law and the Louisville pilot.

MS. HOFFMANN: Sheila, this is Leslie. I'll be presenting on our initiatives towards an SMI/SED waiver.

DR. BRENZEL: Excellent.

DR. SCHUSTER: Great. And, Allen, you're going to talk about the psych hospitals, the state psych hospitals and that system?

DR. BRENZEL: I think so. We had some very specific questions about average lengths of stay, number of people, how we're coordinating discharge, follow-ups and things like that. I think a specific member had some specific questions.

DR. SCHUSTER: Great. Thank you. For those of you who are not following that, it's available to watch live on the Legislative Research Commission's YouTube channel, and I

typically have sent out that link, but if you go to the LRC website which is www.legislature.ky.gov - oh, Marcie put the link in there for you. Thank you, Marcie. You get good coverage.

I mean, you can't speak, so, it's not like signing up and being able to speak but we've had some excellent consumer stories which is always helpful and we appreciate that.

Is there any updated prior authorization guidance? I haven't seen anything come out for probably two months, I guess. Any change?

MS. GUICE: Nothing has changed as far as behavioral health goes.

DR. SCHUSTER: Okay. Thank you. New recommendations to the MAC?

I would like to propose that we recommend to the MAC that prior authorizations continue to be suspended for all behavioral health services through the end of this fiscal year which is June 30th of 2022.

So, I will make that motion. Is there a second from a voting member of the TAC?

MR. SHANNON: Second. Steve Shannon.

DR. SCHUSTER: Okay. My

reasoning for taking it into June 30th of 2022 is that I think we're still going to be dealing with the behavioral health sequelae of COVID and Delta. We thought we were coming up on the other side and I'm not so sure that we are.

So, that's my recommendation and I'd like to hear any discussion from any of the voting members.

MR. SHANNON: I agree, Sheila.

MS. SCHIRMER: I agree. I agree.

MS. MUDD: Me, too.

MR. SHANNON: This Delta surge, I think has caused a lot more anxiety for many people going forward and Lambda is coming. So, I think it's a concern.

MS. MUDD: We actually closed Participation Station last Friday again going back to virtual programming.

DR. SCHUSTER: Yeah, and we're still seeing increased calls to the suicide line and the overdose rates are still up and so forth.

MS. MUDD: We can't keep up on our warm line at all.

DR. SCHUSTER: Right. So, the

motion has been made and seconded. All those in favor of making that recommendation to the MAC, signify by saying aye. Thank you.

Any other recommendations to take to the MAC at their September 23rd meeting?

MR. SHANNON: This is Steve Shannon. I think just let the MAC know about an SMI waiver, that we support that. We've talked about it a lot here, in a variety of settings. The SMI Task Force, the last time, there was some testimony, but P&A is supporting the SMI waiver. Other folks have. So, I just think make that recommendation so we go on record as supporting an SMI waiver, SMI/SED waiver.

MS. SCHIRMER: That's a great idea.

DR. SCHUSTER: Is that a second, Diane?

MS. SCHIRMER: Yes, I'll second it.

MS. BLANDFORD: The only thing I would add to that conversation is that I'm not seeing a lot of focus in any of the policy committee meetings that I've been in on pediatric mental illness and it's surging as well.

DR. SCHUSTER: Yeah. Who is

that that just made that comment?

MS. BLANDFORD: Rhonda Blandford, NAMI Louisville.

DR. SCHUSTER: Aren't you talking, Steve, about SMI/SED?

MR. SHANNON: Yes. That's what Leslie Hoffmann said.

DR. SCHUSTER: So, that would be the severe emotional disturbance in kids, but, yes, you're right, Rhonda, there is certainly much more of that.

Any other comments on that motion? So, we have a motion and a second to recommend to the MAC that we support the development of an SMI/SED waiver. All in favor, signify by saying aye. And opposed and abstaining?

Any other recommendations for the MAC? Okay.

We have several items that we're going to carry over from this meeting. So, we seem to have an ongoing thing.

And if we get some good data back from Medicaid, we may be able to put that on the November meeting date to see what the Medicaid data looks like as far as the targeted case management

goes. So, that's pretty exciting to think we could get our hands on some pretty targeted data.

The next MAC meeting will be by Zoom September 23rd. It's a Thursday. It starts at 10:00. We've been ending early but it is scheduled to go until 12:30.

And, then, our next BH TAC meeting is November 3rd at 1:00 p.m. Eastern via Zoom.

MS. HUGHES: Sheila, you all had last time, if I recall correctly, had voted that you would basically follow as far as Zoom or in person, that you would follow what the MAC was doing.

DR. SCHUSTER: Yes.

MS. HUGHES: Okay, because I was just going to say - and you do have the November. I didn't realize that November would be your last meeting until I just started talking, but I was going to ask that I had hoped that maybe we would just stay Zoom for the rest of the year with this Delta variant and so forth.

DR. SCHUSTER: I'm waiting to see, Sharley, what's going to happen with the Session opening on January 4th. I think we all thought that we would be back up in Frankfort like we used to be.

You all remember those days, and I'm not at all sure that we're going to be back up there in any kind of numbers or anything else.

So, yes, this will take us via Zoom all the way through 2021, and, then, we'll kind of see at that point when we meet in November. We probably will start off via Zoom.

We've had tremendous participation. I think at one point, we had seventy-three people on the Zoom call and, of course, it's so much easier without having to drive and so forth. It's not as much fun and not as much networking and it's hard to keep track of everything, but we certainly appreciate everyone participating and being on it.

We'll be in touch with Tom Walton. I think he presented some very interesting and thoughtful data. We'll get that Powerpoint out to you and let's see what we can do.

I think folding it in in some way in an SMI/SED waiver around housing would really make some sense. Good stuff.

Any other questions or anything else that anybody wants to bring? I'm letting you all go early.

Sharley, thanks as always and thanks to all the DMS and DBHDID folks that are on, our voting members and the MCOs and all of you good behavioral health folks. Stay safe and healthy. Have a good Labor Day weekend and we'll see you soon.

MEETING ADJOURNED