CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
BEHAVIORAL HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 11, 2023
Commencing at 1:06 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, Chair

Steve Shannon

Valerie Mudd (not present)

Eddie Reynolds

Mary Hass

Michael Barry (not present)

T.J. Litafik

CHAIR SCHUSTER: So we will go on and call the meeting to order just a couple of minutes late. Thank you all for your patience. This is the Behavioral Health Technical Advisory Committee meeting of May 11th, 2023. And I'm Sheila Schuster, the chair of the TAC.

Steve, would you introduce yourself, please?

MR. SHANNON: Yeah. Steve Shannon with KARP Association with 12 of 14 mental health centers.

CHAIR SCHUSTER: And T.J.?

MR. LITAFIK: Good morning. T.J. Litafik representing NAMI Kentucky.

CHAIR SCHUSTER: Thank you. And --

MR. LITAFIK: Good afternoon.

CHAIR SCHUSTER: I'm sorry?

MR. LITAFIK: I said good afternoon, rather.

CHAIR SCHUSTER: Oh, good afternoon. Yeah. I wondered what time zone you were in, but we're all in kind of the Ethernet here.

And Eddie, please?

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

CHAIR SCHUSTER: Great. Thank you so much. So those are our voting members, and when Mary gets on, we will have her identify herself after --

MS. HASS: Sheila, I should be -- I should be on.

CHAIR SCHUSTER: Oh, okay. There you are. Yes. I see you. Great, Mary. That's great. So we have five of our seven members. Thank you so much.

So I sent out the draft minutes of our March 9th Behavioral Health TAC meeting and would entertain a motion from one of our voting members for approval of the minutes.

MR. SHANNON: So moved. Steve Shannon.

CHAIR SCHUSTER: And a second, please?

MS. HASS: Mary Hass will second.

CHAIR SCHUSTER: All right. Are there any questions, corrections, omissions, revisions?

(No response.)

CHAIR SCHUSTER: If not, I'll call for a vote of the -- to approve the minutes as distributed. All in favor, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed, like sign, and abstentions?

(No response.)

CHAIR SCHUSTER: Great. Thank you very much. We'll have that out of the way.

We are anxious to get an update from the Kentucky Hospital Association about the provider credentialing, and I'm very pleased to have Mr. Jon Copley, an old friend of ours -- I should say a longstanding friend of ours -- I won't call you old, Jon -- to make that report. So the floor is yours.

MR. COPLEY: Thank you, Sheila, or Dr. Schuster. I don't want to say the wrong --

CHAIR SCHUSTER: Yeah, Sheila. That's fine. I answer to almost anything.

MR. COPLEY: I -- can you hear me?

CHAIR SCHUSTER: Yes.

MR. COPLEY: Okay. I thought so.

No. I appreciate the warm introduction. I was flipping through all the names. It's great to see so many familiar faces from at least four -- four former employers and two or three different boards. And it's always good to see my friend Steve Shannon and you, so thank you for the warm introduction.

Good afternoon, Behavioral Health TAC members, other invited guests. My name is Jon Copley. I'm the Senior Vice President of Strategy and Operations at the Kentucky Hospital Association. I appreciate the opportunity to provide you an update today on the credentialing alliance.

Right now, we're finalizing the modernization of the current setup. It is live, but it's not -- it's not where we want it to be in Kentucky just yet. So we're finishing a modernization of that, so it truly is the CBO as intended in the legislation that KHA and the MCOs previously worked on with Representative Fleming.

There's a lot of nuances around how this is implemented in other states that we've worked through. To that end, I do want to

thank our partner, Verisys, and Justin Gilfert and Laura Malloy in particular with them. They have been excellent in working with us to customize this to what we need for Kentucky.

We expect at some point in July, August at the latest, to be fully functioning with the three largest MCOs: WellCare of Kentucky, Passport Health Plan by Molina Healthcare, and Aetna Better Health of Kentucky who also administers the SKY program.

This will include something this group has requested in the past, a universal, one-stop form for the process. We'll also be rolling out electronic options in lieu of paper, for folks that want those, and a clear appeals process.

I also want to thank DMS Senior Deputy Commissioner Veronica Judy-Cecil. She has been a great support as we've worked through customizing this process along with the three largest MCO CEOs, Corey Ewing at WellCare, Ryan Sadler at Molina Passport, and Paige Franklin Mankovich with Aetna. Those three

CEOs, KHA President Nancy Galvagni -- who this is her baby -- and myself have all worked together, the five of us, to move this where we're right here on the verge of realizing the best-case scenario for providers and MCOs and what we've wanted for a long time. So just be patient with us another 60 days, 90 days here, and we'll be what the legislation intent was.

Now, there was legislation in this past session, Senate Bill 209, a late amendment from the speaker that came from conversations, I think, with us and others. We appreciate the importance of all six MCOs, all MCOs being included in the credentialing alliance being spelled out more definitively.

To that end, I'm pleased to announce another name that I think will be familiar to many of you, that Rosmond Dolen joined the KHA team just this week as Associate Vice President of Payor Relations and Health Finance Policy.

Rosmond has an extensive payor-related legal compliance and operations background. She's a former executive director of the

Kentucky Association of Health Plans, is very familiar with credentialing alliances, and has a close professional relationship with Verisys.

So we'll be looking at her to work with Humana, Anthem, and United to join KHA, WellCare, Molina, and Aetna, so we can fully implement the new provisions from Senate Bill 209 by the end of the calendar year as prescribed, which was the intent of the legislation and the only practical outcome.

So like I said, hang in there another 60, 90 days. We will be fully up and running with the three largest MCOs with adding the other three by the end of the calendar year.

And, Sheila, that's my update. I'm happy to take any questions at this time.

CHAIR SCHUSTER: Great. That's very encouraging. We have, as you know, been eagerly awaiting this, Jon, and, you know, each step of the process.

Let me open it up both to voting members of the TAC and any of our participants if anyone wants to ask a question. And, I

guess, raise your hand, although I'll have to ask Erin to call on you as I can't see everybody. Is that workable, Erin, for you to do that?

MS. BICKERS: Absolutely.

CHAIR SCHUSTER: Okay. So if anybody has a question for Jon?

While we're waiting to see, Jon, I'm trying to recall -- because we had some pretty in-depth questions about this when it was first presented several months ago to the BH TAC.

And I think one of the questions was: If a provider wants to be credentialed by, let's say, all three -- WellCare, Passport, and Aetna -- there still is an individual process with each one; is that right?

MR. COPLEY: For contracting.

CHAIR SCHUSTER: For contracting. Okay.

MR. COPLEY: So one of the things we've run into when I'm mentioning modernizing and how is it rolled out in other states is, as you just described, it's really been functioning as both the central CBO but

then also individual, and it really is supposed to be centralized for the credentialing part. And then the MCO makes the decision around a network contract.

So when this is up and running right, the credentialing will be centralized as one and then the network contracting decision will be up to each MCO and the provider.

CHAIR SCHUSTER: Okay. So if a brand-new provider, let's say, comes into Kentucky and somebody says you need to get credentialed and here's the way to do it with at least three, go to however -- wherever this is housed, to KHA or wherever, and they fill out that credentialing form, does it go to all three of your contracted MCOs at that point?

MR. COPLEY: So when the process is fully up and running, what we'll do -- it will go to the -- Verisys will then credential or make a credentialing decision, if you will, the file and then they will notify the three MCOs relative -- or the six MCOs for a decision, which is why it's extremely important that all six MCOs be on

the speaker and others realize that, that for this to truly work as the original legislation intended, all MCOs need to be in.

So -- but yes, that is the intent, that there's one decision. It's communicated to those MCOs and then they know that that provider is available to be in their network or not be in their network, if you will.

CHAIR SCHUSTER: Okay. So yes, I would certainly encourage it. I encourage those other MCOs that are not currently in, we will certainly applaud you getting involved and getting in. Because I think this is supposed to be a one-stop shop, Jon; right?

MR. COPLEY: Yes, ma'am. Yep.

CHAIR SCHUSTER: Y'all don't have to duplicate that credentialing process over and over again --

MR. COPLEY: Yes, ma'am.

CHAIR SCHUSTER: -- four or five or six times. Yeah. Are there any other questions, then? Any other questions from anyone?

MS. BICKERS: I don't see any hands

raised.

CHAIR SCHUSTER: All right. Thank you, Erin. I guess, Jon, my last question -- we always ask this. How will we know when it's completely modernized and is ready to go? Will you send me a -- send over a white celebratory flag, and I'll let everybody know or -- I'm sure that the MCOs will let people know but...

MR. COPLEY: I think -- is there a commercial out there right now with that pigeon flying or whatever? I still haven't figured out what that's about. But no, we'll shout it from the rooftops, over-communicate, make sure everyone understands what's going on.

Like I said, and then you have people with, you know, my background and now Rosmond Dolen's background here. So we'll definitely be in touch with all the right people. And Rosmond and I both will be back at your next meeting, and it look like it's July 13th there on the agenda.

CHAIR SCHUSTER: Right.

MR. COPLEY: So I'll make sure to

note that.

CHAIR SCHUSTER: Oh, that would be great. If you could give us kind of a, you know, here's where we are now, and we're thinking it's going to be July 13th or sometime, that would be great.

All right. Seeing no further questions, I sure appreciate it. It's great to see you, and you certainly are invited to stay for the rest of the meeting if you would like to do so.

MR. COPLEY: Before I go, can I do a quick commercial on the Kentucky Hospital Association convention next week? Do you allow me that?

CHAIR SCHUSTER: Yes. We'll allow you that.

MR. COPLEY: Thank you. All right. So the Kentucky Hospital Association convention is in Lexington next Tuesday and Wednesday at the Central Bank Center. Key topics include worker safety, quality, workforce development, leadership. There are tracks around nursing, finance, legal.

And on Wednesday, the day after the

primary election, we're going to have KSR's Matt Jones and RunSwitch's Scott Jennings on -- for a lunch and to do a friendly debate over the upcoming elections this fall and I'm sure presidential things and those kind of things as well.

I believe many of you all know Claire Arant on our team. She's --

CHAIR SCHUSTER: Yeah.

MR. COPLEY: -- worked with a lot of folks. She's in charge of the convention this year, has done a fabulous job. We have a record number of registrants. Both the Hyatt and the Hilton are sold out.

So if you'd like to attend Tuesday or Wednesday or both as a late registrant at a commuter rate, if you send me an email at jcopley, j-c-o-p-l-e-y, @kyha.com, I'll get you taken care of, get you a reduced rate if you want to come on in next Monday or Tuesday.

And then finally -- I know you'll appreciate this, Sheila. So speaking of the election, Kentucky has an early, no excuse voting law in effect. So I voted this

morning. I got the sticker here to prove it.

So vote early this week. Come to the KHA convention next week; all right? So thank you all again. I appreciate it. Always a pleasure to see you.

CHAIR SCHUSTER: Yeah. And, Jon, is the convention Tuesday/Wednesday or Monday and Tuesday?

MR. COPLEY: It's a soft start on Monday with some ACHE, but the -- the guts of it is Tuesday and Wednesday.

CHAIR SCHUSTER: Tuesday and Wednesday.

MR. COPLEY: Yes, ma'am.

CHAIR SCHUSTER: Okay. Wonderful. Thank you.

I think Medicaid chatted if you'll send a flyer, they'll also send that out.

MR. COPLEY: All right. That's awesome.

CHAIR SCHUSTER: If you'll do that. Okay. Thank you so much. I appreciate it.

MR. COPLEY: Thank you.

CHAIR SCHUSTER: There's the address, Jon, erin.bickers@ky.gov for a

flyer and your email address.

We have a couple of new business items that I'm not sure if anybody -- who's on from Medicaid. But there was a request made at our March meeting, and it's in the minutes, that we have a presentation on the Medicaid unwinding, on what the process is with the recertifications, and any other changes related to the end of the federal Public Health Emergency period.

So I don't know who we might have on from Medicaid. I think Deputy Commissioner Veronica Judy-Cecil has been giving those presentations, but I don't know.

MS. HOFFMANN: Sheila, I'm not sure if she's on today. This is Leslie, and I apologize. I'm in my car at a conference. But we can definitely get that done. It's the same presentation we've been giving at the MCO forums. So we can definitely get that presentation out to you and then we can do something special if you want to. We can have a special meeting or come back to the next one.

But you might want us to go ahead and

get that information out since, you know, there's some folks who might be affected in the next couple of months.

CHAIR SCHUSTER: Yeah. Absolutely, Leslie. That would be great, if you could send out the presentation.

MS. HOFFMANN: Yeah.

CHAIR SCHUSTER: And then I can ask people to let me know if they want to have a special meeting where Veronica or somebody else from Medicaid --

MS. HOFFMANN: Yeah.

CHAIR SCHUSTER: I know people have been very positive about the presentation that she has given to several groups and --

MS. HOFFMANN: There's one or two -- yes. It's a huge undertaking, and she's tried every way in the world -- the team has -- to ensure that nobody gets left behind, for lack of better words.

So there's one or two pages that are very specific about things that you need to do, like, right now. Like get on, establish -- you know, check your addresses, establish your -- an account. That way,

you'll get all the information that you'll need and get reminders and things like that.

So we can flag those particular pages in her PowerPoint, but the PowerPoint is complete. We've just got to pull it out of our MCO forums that she's been doing.

CHAIR SCHUSTER: Okay. That would be great. Thank you.

The other one was in reference to a comment that Commissioner Lee made at our last meeting about the 2020 annual report. And I wasn't sure, Leslie, where that's posted. She had encouraged everyone on the TACs -- not just our TAC but I think all the TACs -- to look at that. And I think you all are already working on your 2021 annual report. So can you tell me where that report is listed?

MS. HOFFMANN: Erin, would you mind --

MS. SPARROW: Sorry. This is Angela.

MS. HOFFMANN: I'm sorry. Would you mind to follow up?

MS. SPARROW: Real quick, before we

move on to the next one, Beth Fisher -- this is Angela with DMS. Beth Fisher put some good information in the chat regarding the unwinding. So, again, it looks like there are already some additional meetings scheduled, again, to keep that information in the public and ongoing.

And so she dropped some information there that might be helpful to make sure everybody sees that and that you, again, can go ahead and register for those forums as --

MS. HOFFMANN: Thank you, Angela. Thank you.

MS. SPARROW: You're welcome, before we move on.

MS. HOFFMANN: I couldn't see that on my phone.

MS. SPARROW: That's okay.

CHAIR SCHUSTER: Yeah. Thank you. And --

MS. BICKERS: And I also have a copy of the presentation that Veronica gave to the Primary Care TAC that I can also send out right after the meeting, Dr. Schuster.

CHAIR SCHUSTER: Oh, okay.

MS. BICKERS: And I will also send the email -- or the website address that Beth put in the chat, so you guys have that as well.

CHAIR SCHUSTER: All right. Great. If you'll get that to me right after the meeting, Erin, that would be wonderful, and then I can send that out to everyone that I have on my list anyway.

And let me remind anyone who's on this who doesn't get regular agendas and reminders of this meeting to -- if you'll simply email me at kyadvocacy@gmail.com, I'm happy to add you to my list. Erin does a great job of getting it out to DMS and DBH and the MCOs, but I keep a list of anyone who's participated in the past and is interested in staying attuned to that. So that's great.

Since we're on new business, I know that we have a pressing issue. And, Angela, I know that you're on. I think David Susman from DBH is on. Is Tracie Horton on?

MS. HORTON: Yes.

CHAIR SCHUSTER: Okay. Tracie, do you want to describe this issue under new

business that we talked about, and we've alerted DMS and DBH that this issue is coming up?

MS. HORTON: Okay. We have received an audit from one of the managed care companies. And in that audit, they're specifically looking at case management and have determined that, based on the regulation, that case management requires a separate care plan.

And unfortunately, what we have determined, based on how the guidance came from DBHDID several years ago, this is in direct conflict with how our system is configured. Our system is configured to have an integrated care plan.

And so my concern is, is that, you know, this has been in place -- the current system has been in place many years and that the new interpretation of separate care plan and what the MCOs -- or what this particular MCO is saying is leading to a significant recoupment from our standing.

And just to have some concerns that, you know, if the guidance from the department was

one thing, that we're not all on the same page and that, you know, if this guidance is changing based on the interpretation from this MCO, there needs to be some communication from the department. And there needs to be some point in the future that this is corrected and allowed, you know, to move forward.

You can't go in and arbitrarily determine that a regulation is being interpreted differently and start recouping based on that in conflict with how the state has provided guidance since 2016.

CHAIR SCHUSTER: All right. And my understanding also, Tracie, is that particularly for CMHCs such as yourself that have an electronic health records system, that it's extremely difficult or impossible actually to have multiple care plans in there.

MS. HORTON: I've been told that that is -- it complicates the process. I won't say that it's not doable, but it might necessitate costly changes with our software vendor to ensure that we have that

capability.

CHAIR SCHUSTER: Yeah.

MS. HORTON: But I think, you know, my concern is just that, you know, we're talking about a significant recoupment without any prior notification that, you know, their interpretation had changed and that it potentially could open the door for this -- you know, other interpretations and, you know, massive paybacks from our agency when we actually have care plans. We have everything that we need. It just doesn't meet the format that they've determined now is, you know, their new interpretation.

CHAIR SCHUSTER: Okay. Thank you.

MR. SHANNON: I know people have their hands up. I'm going to weigh in, Sheila. One, I've heard repeatedly that the electronic health record, two plans, if not -- it's not prohibited, but it's just -- you know, you have two sets of data searches. You've got to get different information. You've got to pay people to do that. It's just not feasible.

And, secondarily, and I think more

significantly so, is the regulation language is "the development and periodic revision of a specific care plan for the recipient." Now, it's a TCM, but it says specific care plan. It does not differentiate overall plan, targeted case management plan.

I think the "specific," that word, applies to the recipient and not the care plan. And why would we not want to have specific care plans for recipients as opposed to a specific care plan for case management?

The regulation also references medical, social, educational, and other services. Is the expectation a care plan for medical, for social, for educational, or other services? I don't think that's the case.

I think, clearly, an integrated care plan is the approach that we want to move forward on. And this is an interpretation, and it's a regulation. It's open to interpretation. But I don't think anyone can take action on a recoupment based on their interpretation.

And I will continue to report CMS issued guidance on reentry from correctional

facilities. I am on that TAC. Their case management language doesn't specify a distinct plan. It's a comprehensive plan.

I don't think CMS' intent is to have a specific targeted case management plan. I think the plan is we want to have a specific care plan for the recipient, not a specific care plan for the service.

And I think the distinction is if you have a targeted case management plan specific to that, does a plan that says we shall have four contacts per month meet that standard of a specific care plan for targeted case management? That's not a good care plan. It's for the individual.

I'm really frustrated this has come up. I really think -- we talked last month about targeted case management, and the cost benefit analysis was clear. And now we have this issue.

I think this is just an overreach of the interpretation, and I know DBH and DMS is going to look at it. But I don't believe the regulation -- you can hang your hat on a distinct plan for case management. I just

don't see it. And at best, it's -- you could argue it's neutral to it. You can't recoup on neutral.

CHAIR SCHUSTER: And, Steve, this reg has been in effect -- remind me -- 2015?

MR. SHANNON: 2015. So it would be eight years --

CHAIR SCHUSTER: Yeah.

MR. SHANNON: -- of targeted case management based on this interpretation. And those are dollars going back, both state match and federal match. Un- -- just -- it's almost a random action opinion.

MS. BICKERS: Kathy has her hand raised.

CHAIR SCHUSTER: Yeah. Kathy Adams from the Children's Alliance has her hand raised. Kathy?

MS. ADAMS: Thanks, Sheila. This is a huge issue for our members as well, and we have actually reached out to the secretary and commissioner and raised our concerns. I echo exactly what Tracie has said and Steve has said. We are in complete agreement that we support an integrated care plan. We

disagree with the new interpretation from the regulation and believe that specific care plan does not indicate a separate case plan, that those are not the same thing.

And we are very concerned. We feel like this is something that needs a response soon because we're very concerned. Our members are very concerned. The other managed care companies will take the same interpretation and that members will be facing even more take-backs than the one MCO that is taking this interpretation now. And we also have at least one member that is facing take-backs from the one MCO for this very reason.

So, again, we represent multiple behavioral health service organizations and behavioral health multispecialty groups and wanted to weigh in that this is a huge issue for us as well.

CHAIR SCHUSTER: Did you get any response back from communication with Secretary Friedlander or Commissioner Lee?

MS. ADAMS: Yes. I do know that Commissioner Lee and our president, Michelle Sanborn, are -- have had some dialogue. And

I do believe Michelle is on the meeting, if she wants to chime in and add anything.

MS. SANBORN: Commissioner Lee just said that their interpretation hadn't changed and that she was looking into that. I sent another reminder about this this week to her. It was several weeks ago when we had that exchange. I sent in a reminder saying that we would be talking about it today.

So I really don't have anything, but I don't know -- when they say it hasn't changed, we got feedback from DMS -- yeah. DMS had indicated that it was separate, is what specific meant.

And so we, of course, again, are advocating that we -- we only have one integrated care plan. But if the interpretation is separate, that we change the reg to say separate, and we allow providers to have months -- six months at least, while the reg is being changed, to get their systems in order to do separate.

But we don't know of any other state that requires a separate plan even though we know this specific language is actually

federal language. And so we know we're -- you know, we're following federal laws with specific. But there are several agencies who provide care in many other states, and none of them have a separate care plan for this.

CHAIR SCHUSTER: Okay. That's very helpful, Michelle. Thank you. And Bart Baldwin has his hand up.

MR. BALDWIN: Yeah. Thank you, Sheila. Just as someone who represents different provider groups, just want to say ditto to all this. You know, I think that this type of change could just wreak havoc, to say the least, on the TCM services provided to the Medicaid members across the state, you know.

So I just want to reenforce what my colleagues are saying, that this is something that -- if it hasn't changed, then we need to stop this. But if we're going to change this interpretation, then it needs to be through the formal regulatory process.

CHAIR SCHUSTER: Okay. Thank you. And, Dr. David Susman, special advisor to DBHDID.

DR. SUSMAN: Thank you. Yeah. I just -- I want to add, I guess, more of a process comment, which is, you know, over a number of years, the migration to an integrated, comprehensive, person-centered recovery plan is our best practices.

And so, you know, that plan includes all aspects of an individual's care, and that train has left the station a long time ago. And we're not going back to having nine separate plans for people's care. So just, you know, thinking about what our best practices are.

CHAIR SCHUSTER: And I think that's what I'm hearing from the providers that are being represented here, David, is that everybody is talking in terms of an integrated care plan for the individual, not specific to even the kind of service that's being rendered but that all of it is geared toward helping that individual in all aspects that are appropriate for the provider to focus on. So that's -- that's very helpful.

MR. SHANNON: And if the interpretation is it is a specific care plan,

that ought to have been shared prior to eight years; right? I mean, that's the real message. And the regulation was -- it was effective -- I just lost my -- April 3rd, 2015. So eight years and one month ago, this was in effect, went through the process.

And now we're hearing the last 45, 60 days, Tracie, that we need -- you know. And what's going to happen is -- and I will tell folks you need to have a targeted case management plan that says four contacts per month. But it doesn't say what the plan has to be if it has to be specific.

And that's not good service, is it, Dr. Susman? We're just going to play a game to placate an issue that's been raised. I think it doesn't meet people's needs.

In a past life, I spent a lot of time in Somerset. And the Department of Justice, United States Department of Justice wanted an integrated care plan. And if you didn't do it, they were going to sue you. That's what they want.

And now we're going to say, no, we're going to have this stand-alone plan, and

we'll go back to a recreation plan or a -- and they're all separate. And the poor individual will talk to six other people and be more confused, less access.

It's not better services. It's not better. And I think, if nothing else, this group wants better services, not more plans. So my recommendation would be better services.

CHAIR SCHUSTER: Yeah.

MS. HORTON: If I may, I can read you -- it says, "While targeted case management services should be identified in a recipient's overall treatment plan along with all other services being provided to the member, there must be a care plan specific to targeted case management services to meet regulatory requirements."

MR. SHANNON: Where is that?

MS. HORTON: That was in our letter, our recoupment letter.

MR. SHANNON: Okay. But I say look at the regulation.

MS. HORTON: Yeah.

MR. SHANNON: "Develop a periodic

revision of a specific care plan for the recipient." If there's a conflict within the regulation, that needs to be resolved.

CHAIR SCHUSTER: Angela, are you on to represent DMS on this issue?

MS. HOFFMANN: Sheila, I'm still on, if I could just take this one.

CHAIR SCHUSTER: Oh, yes. Absolutely, Leslie. Thank you.

MS. HOFFMANN: Commissioner Craycraft and I have already met more than once about this, and she's here with me today at this conference. So we want to take this back. As you're aware, we were just made known of the situation recently.

I know Tracie is in a little bit different situation than the fear of others but just know that we're going to take a look at it. We've been on this tour, and we just haven't had a chance to have two seconds in the office to address it. So I know -- and I don't take Tracie's situation lightly, and I understand that. So just let us take this back and let us work through it.

We have not made any changes. We have

not made any changes. So if it's DMS language, then we need to take a look at it, at the guidance or -- and/or the language to make guidance, if that makes any sense.

So just give us a little bit of time. Again, I know Tracie's situation is different, but we need to all get back into the office and be able to talk about it just a few minutes; okay?

CHAIR SCHUSTER: Yeah. Let me ask you two questions, Leslie. And, of course, we're happy that DBH and DMS are going to talk about this because I think there had been some training, as Tracie relayed to me, by DBH originally about how care plans should be constructed and so forth. And Adanta as well as other providers, I think, were following that guidance, as I recall.

Can you give us any kind of time frame, and what would be the process of your at least letting me know, so we can let people know? That's No. 1.

And No. 2, for someone like Tracie who has this recoupment letter, is there some way -- and I don't know enough about

recoupment, so I may be asking a question that doesn't make any sense. But is there any way to stop the clock on this if there's some kind of penalty or whatever until it's resolved?

MS. HOFFMANN: I think that we could probably, Dr. Schuster, find time to get together next week. We've been on the road with the MCO tours and then today was the Children's Mental Health Acceptance Day. So we're all here today. So I would hope I can get together sometime next week and have a discussion.

And that's -- again, I don't want to sound just so flighty to you, but I was hoping that we could not talk about this today until we could get some answers for you because I like to try to resolve your situations.

CHAIR SCHUSTER: Well, I think since we were having the meeting and there were so many people affected, I think one of the things we've tried to do is to create a forum at the BH TAC for people to bring up these kinds of situations and to use it as a

way to let DMS or DBH or the formulary people or whoever -- wherever the problems are kind of know what's being experienced on the ground.

So we're not -- you know, don't hear us as being negative towards you at all, but we're just concerned, for sure. And I think individuals coming to you all, you know, has been helpful, but this brings the collective voices together. So that's why I took advantage of the fact that we were having a meeting today to go on and put it --

MS. HOFFMANN: It's okay. It's okay.

MR. SHANNON: I think --

MS. HOFFMANN: So like I said, give us -- go ahead, Steve. I'm sorry.

MR. SHANNON: I think it's fair for the recoupment be held in abeyance until this is resolved.

MS. HOFFMANN: Again, I'm going to have to take a look at it.

MS. HORTON: I've asked them for a pending status. I've asked them to pend it because, you know, at this point, they've

indicated we can appeal it again, and we've taken those steps to appeal it. But I've also asked, in light of the second appeal and the ongoing communication that we're having with the state, that, you know, it be put in a pended status moving forward.

MR. SHANNON: Yeah.

MS. HORTON: Because, otherwise, by -- if they don't have a response by May 19th, they're going to recoup thousands of dollars.

MS. ADAMS: This is Kathy Adams. I just wanted to add that our member that is facing recoupments, they have appealed this with the MCO, so hopefully that will give them a little bit more time. But, again, it is a little bit urgent, so we appreciate DMS' prompt attention to this. Thank you so much.

MS. SANBORN: And I believe it's my understanding that Aetna sent something out to their -- to their network talking about this and asking their providers to do a separate one.

MS. ADAMS: That's correct, Michelle, and I have a copy of that

correspondence if Sheila needs it.

CHAIR SCHUSTER: Yeah. That would be helpful because I have not seen that, and I don't know if DMS has seen it. Are you aware of that, Leslie?

MS. HOFFMANN: I don't think I've seen a letter. I've seen the emails that have been going back and forth related to the recoupment and then I think Stephanie Craycraft sent out an email just that we were going to go back and work on this together.

CHAIR SCHUSTER: Well, I'm concerned that Aetna has gone on and sent out a letter to their providers saying this is what needs to happen when we're not at all sure that that's what needs to happen.

Kathy, why don't you -- if you would, send it to me.

MS. HOFFMANN: I was going to say somebody forward that, yeah.

CHAIR SCHUSTER: Send it to Leslie as well. You're on mute, Kathy.

MS. ADAMS: I will send it to you and then Angie -- Angela Sparrow and --

CHAIR SCHUSTER: Leslie Hoffman.

MS. HOFFMANN: Leslie.

MS. ADAMS: Yeah, Leslie. Okay. I sure will.

CHAIR SCHUSTER: And send it -- you could send it to David Susman as well, so DBH is in the loop.

MS. ADAMS: All right.

CHAIR SCHUSTER: That would be very helpful because I am concerned about it going out and providers who don't know the background saying, oh, my gosh, now we've got to do this completely differently.

And as Dr. Susman pointed out, this is really a huge step backwards in terms of quality of care. We're dealing with very complex folks who need case management. We already have talked about that, and we have the data from multiple studies now about the importance of it. And I am concerned about this going out to providers.

Nina Eisner has her hand up.

MS. EISNER: Which MCO are we -- hold on. Let me get off -- which MCO are we talking about?

CHAIR SCHUSTER: It's Aetna.

MS. EISNER: Aetna. Okay. Thank you.

CHAIR SCHUSTER: And so far, Nina, as far as we know, that's the only one that has made this interpretation.

MS. EISNER: Thank you.

CHAIR SCHUSTER: Yeah. Since we're talking about targeted case management, there's a little side issue that has come up under new business. Bart Baldwin, do you want to bring that up, please?

MR. BALDWIN: Sure. Thanks, Sheila. Just one of the pieces. As part of the unwinding of the Public Health Emergency, TCM has been allowed to utilize telehealth for some of those visits throughout this time period.

It's our understanding that, obviously, the use of telehealth in lieu of in-person has been extended as part of the legislation and Medicaid decisions moving forward. But we just want to be sure that that is -- but, again, I think it's a regulatory piece. The TCM regulation itself hasn't been updated to say that can be done.

And so I just -- I keep hearing from providers that there's concern that -- on one hand, they continue to use telehealth because we still have some folks that -- you know, either it's remote to get to and beneficial to access them remotely, or some of the individuals --

You know, I know today is the day the Public Health Emergency ends, but we all know that COVID is still real and still out there, and people still have safety concerns. And so there's some clients that would prefer to continue to do these things virtually.

And so I just keep hearing from providers that they're concerned after today that they will be -- get recoupments for that reason or claims denied for that reason so just seeking clarification on that.

My -- when I've asked that, it's just been stated that yes, telehealth has been extended, which is great. I just want to be sure that that's clear.

MR. SHANNON: What does that mean?

MR. BALDWIN: Yeah. Yeah. So does that make sense, what I'm asking,

Dr. Schuster? Yeah, Steve. Thanks.

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: So, Dr. Schuster, currently, right now, there's no thoughts about changing anything related to telehealth. CMS, the Federal Government, will make some changes possibly related to the platform that we use. The platform has been extended, I think, through August.

And then there was also some conversations in the federal world related to audio only. They accept audio only, but in the future, they may ask for audio and visual. So that's all I can think of right now.

MS. SPARROW: And, Leslie, this is Angela again. With the passage of House Bill 140 and DMS telehealth regulation, again, the services that allowed the flexibilities under the Public Health Emergency to continue once the Public Health Emergency ends.

So I think that was part of the discussion on the agenda, Item No. 10. TCM falls in with all of the other behavioral

health services mentioned there. Like Leslie stated, with the passage of that, there are no changes.

Once the Public Health Emergency ends, that bill and that regulation allows those services to still be carried out as long as they meet the allowance under that telehealth regulation, being that there's no restrictions in an individual -- the licensure boards or, again, any of the coding. There's no restrictions on any of those services under the national coding procedures or anything like that. So, again, those are -- continue to be carried out.

CHAIR SCHUSTER: Okay. I'm sorry. I had to step away for a minute. Bart, does that answer your question? Does that give you what you need?

MR. SHANNON: I think so.

MR. BALDWIN: Yeah. Yeah. I think it sounds like carry on as we've been doing things for the last three years, so that's -- that was what I heard, yeah.

CHAIR SCHUSTER: It depends on what your definition of carrying on is. No. I

was --

MS. SPARROW: And we will -- (audio glitch) -- that over time, we will need to update the regulations to align with the telehealth regulation, the language around face-to-face and in-person. But, again, the telehealth reg supersedes those other -- the behavioral health regs in terms of that language at this time.

MR. BALDWIN: Okay. That helps. Thank you, Angela.

MS. SPARROW: You're welcome.

MS. HOFFMANN: This is Leslie. I was going to mention, too -- sorry. I lost service just for, like, two seconds, so you may have already said this, Angela.

Commissioner Lee had also mentioned that there's a lot of conversations in the federal world related to the current platforms that may not be considered HIPAA-compliant right now might be able to get HIPAA-compliant by the time that the platform rules come out from CMS.

So currently, right now, you know, Facebook or something -- not Facebook, but

FaceTime might not be allowed. But if FaceTime is able to get into compliance -- I'm just saying FaceTime or, you know, Teams or Zoom or whatever the platform is that CMS ends up approving federally, we've heard that those larger companies are trying to get into compliance.

CHAIR SCHUSTER: Oh, okay. That would be good news, I think, as well. That's very helpful.

And we have one other item of new -- well, let me make sure. Any other questions about, you know, the interface between telehealth and the TCM issue?

MS. SPARROW: Sheila, this is Angela again. I'm just going to put a reminder on the telehealth regulation. Again, that's 907 KAR 3:170. And so, again, the services need to meet the telehealth regulation.

CHAIR SCHUSTER: Yeah. Thank you. And we have sent those out in the past. If somebody wants them again, you can email me. We had a -- actually, I think it was Jonathan Scott presented to our BH TAC, I want to say,

Angela, maybe back in November. I've kind of lost track of time. But this -- when they were issued and went through them in great detail, and that was very helpful.

I think, actually, don't you all have an FAQ about the telehealth reg? Yeah. And you've just put the reg in there, 907 KAR 3:170. There's also an FAQ document that was created that I think is very helpful to go along with the reg because the regs are not always easy to read and understand and so forth. So thank you very much for that.

Kathy Adams, I think you had a question about the BH, behavioral health --

MS. ADAMS: Fee schedule.

CHAIR SCHUSTER: Fee schedule, yeah.

MS. ADAMS: Right. Thanks, Sheila.

So I believe at the last MAC meeting, the commissioner brought up the Behavioral Health TAC -- the possibility of the Behavioral Health TAC looking at some of the most-used codes or the most important codes when it comes to behavioral health services simply because DMS doesn't have the money to

provide across-the-board rate increases for everybody but that they might have some money to increase specific codes ser- -- or slash services.

And so the children's alliance has been working with some of our members on that, but I guess it was day before yesterday at the Administrative Regulation Review Subcommittee, Commissioner Lee spoke, was addressing some of the legislators' concerns about three regulations. And she indicated that they are -- that Medicaid is doing a behavioral health rate study, and this was news to me and -- as well as when I reached out to Sheila.

So we were just wondering if there's any update or any information that can be shared on the behavioral health rate study that Medicaid is doing. And Commissioner Lee also indicated that there was a special focus on children's behavioral health services as well.

MS. HOFFMANN: This is Leslie. I'll have to ask if Angela knows anything specific, too. I know we've been taking a

look at just about all the rates. We can't do across the board, but we are trying to look at specific things that we might can make a change to or maybe state specific codes as well. I do know that that's in the mix. Ann Hollen has actually been working on that.

Angela, do you have any more information?

MS. SPARROW: I don't. I'm sorry. But we can definitely take it back and ask.

CHAIR SCHUSTER: Yeah. I think it would be helpful because I really heard the commissioner at the last MAC meeting, which would have been at the end of March, kind of making that blanket request of all of the TACs to look at their -- at their codes and look at the ones that perhaps are the most useful or the most frequently used or, you know, whatever criteria to point out some that would really be helpful if they were increased.

And if DMS is undertaking some kind of behavioral health study, we'd sure like to know about that before we spend a lot of time

looking at codes and so forth. So any information that you all can get back to us to let us know, I would tentatively put that topic on our July BH TAC meeting agenda just to get a discussion going.

But I think the other thing that she, you know, suggested -- and I don't know how this would work with our provider groups but to do something similar to what the hospitals have done --

MR. SHANNON: Right.

CHAIR SCHUSTER: -- in terms of putting up their share of the match to get increased rates. And, you know, I see a big difference between what the hospitals have to offer in that regard and what most behavioral health providers have, but maybe there's some room to look and be creative there as well.

Obviously, if the state is not responsible for the state match but it's coming from someplace else, then you've got some money to work with to get the match on increased rates and maybe additional services and so forth. And, Steve, I know that you've looked at that over the years.

MR. SHANNON: Yeah. She said at the MAC meeting, Commissioner Lee, look at codes to increase reimbursement as a more strategic approach.

CHAIR SCHUSTER: Yeah. Yeah. So if -- Leslie and Angela, if you could give us some feedback about where DMS is in that, that would be helpful. And I think Jonathan Scott has shared some information in the chat as well on those issues, but we will certainly look at that.

So lots of new business. The next item I have on here is a very specific and very loud thank you to DMS for the recent and quick recommendations on billing for extended services -- extended length of behavioral health services.

We had a lot of providers who were seeing some high-need patients who were really suffering when those extended length sessions were not available. And we are certainly very grateful for the quick work around that in proposing a kind of workaround with an additional code and also posting the BHSO reimbursement rates.

I also would like to especially thank Leslie. And Kelly Gunning couldn't be on the meeting today because of their activities today and tomorrow around peer support and so forth. But she wanted me to share that we had a Medicaid member who was a long-time, long-time substance use user, also had co-occurring mental health issues, I think came to the attention of their mental health court. And they were working with him, and he had really turned the corner in his recovery process.

And then there was a glitch, and he lost his Medicaid coverage and couldn't get his medications. And Kelly reached out to me, and I reached out to Leslie. And Leslie worked whatever magic that is that she and those of you at DMS are able to do sometimes. And we got this guy back on his medications before he relapsed and had some other physical health and behavioral health issues.

So -- in fact, Leslie reached out and asked, you know, for kind of an update, and the update was so positive. I just wanted to share with you all that this guy had

apparently a long-time girlfriend who had stuck with him through thick and thin, through some very tough times, and had said to him if he ever got, you know, into recovery and was really making progress, that she would marry him.

And so they got married. And he's happy as can be, and she's happy. And he's in recovery, and -- you know, so it takes a team. Like they say, it takes a village to raise a kid. It certainly takes a team of people.

But I think it's a good example. And I do particularly want to thank you, Leslie, and others from DMS and DBH who, you know, are able to work your magic and fix some of these things.

But I think it's that teamwork of those of us who are at the ground level and know what's going on and, you know, can get the information out to people that can do something about it. So I thank you very much for that.

I don't know if Justin Dearinger is on. I wondered about the status of the website

dashboard.

MR. DEARINGER: Yes, ma'am. Thank you.

CHAIR SCHUSTER: Great. It's nice to see you, Justin. What's our status?

MR. DEARINGER: Well, so we had originally had November -- I'm sorry, not November. It probably seems like it's going to be November. We had originally had an April release date scheduled.

We received notification that that had been bumped due to the unwinding, and some IT -- some of our IT staff that were working on finalizing that dashboard got pulled into the unwinding update. So we're hoping for June. That's the goal. But I keep pushing. And as soon as that's done and complete, you all will be the first ones to know.

And in addition to that, I had -- I wanted to let you know in particular because I know this is a topic that we've discussed before. There were some providers at the MCO forums who had talked about creating -- using that -- you know, the no-show reports that they were going to have access to but also

putting together some suggestions to send in to their respective TACs as providers on ways to assist in decreasing the no-show issue.

And I know, as I had discussed at one point in time, that dashboard will be a benefit for us in DMS because it will help providers -- show the providers the importance to reach out to members and try to get a -- you know, some type of reasoning.

And, you know, even if it's 10 percent of people, if there's an issue with transportation or there's an issue with understanding --

CHAIR SCHUSTER: Right.

MR. DEARINGER: -- something like that, even if it's a small percentage, if we can get that, at least that's something that we've accomplished so...

But just kind of wanted to let you know where we're at with that. I, at least once a week, touch base with our IT staff about where that's at, where their progress is, and try to get that completed as soon as possible.

So as soon as it's done, I will make

sure to do a presentation on it and about it and show it to you all. And I'll be very glad and happy so...

CHAIR SCHUSTER: Yes. We will be very glad and happy as well, Justin. Thank you. And thanks for hanging in there and pushing it forward. We would definitely -- particularly if it might go live in June, I'll keep this on the agenda for our July meeting. And we would give you some time to walk us through that and how it's being used.

I do like the idea of once it's out there and it's more public and more usable and we have more numbers, trying to identify at least for the behavioral health clients, what are those social determinants of health, or what are those barriers that we can identify.

I know there's some changes being made in non-emergency medical transportation. And I suspect as we go -- I'm with the group that goes around to different communities and does kind of a road show on services. And NEMT is always a hot topic at these groups, I tell you, with people struggling to get

transportation and so forth. But child care may be another one, and even using telehealth still may be one.

So I like your idea of using it to give some feedback to the MCOs and to others about addressing those issues. So appreciate it very much, Justin.

Does anybody have any other questions for Justin?

(No response.)

CHAIR SCHUSTER: Okay. Thank you very much.

Is Leslie still on? Because the next item is the newly-released CMS guidance on waivers.

MS. HOFFMANN: Sheila, I asked Angela to take this one since I'm in the car on the phone.

CHAIR SCHUSTER: Oh, okay.

MS. HOFFMANN: Angela, can you take that one? It's a little lengthy.

CHAIR SCHUSTER: All right. That's fine. I asked -- I linked together about six questions, I think, in this agenda item. So, basically, we're looking at this

newly-released CMS guidance on SUD services and how it might impact our -- Kentucky's waiver application, the end of the public comment period on the 1115 SMI waiver. Where are we with the 1915(i) waiver for supported housing and supported employment, and then where are we with the request for extension of the Team Kentucky 1115 waivers?

So, Angela, take it away, please.

MS. SPARROW: Hi. Again, Angela Sparrow with DMS. And so if we can, I'm actually going to start with the pending extension request since that's kind of the overall 1115 authority.

And just to -- again, probably the quickest update there. We continue to have our monthly calls and conversations with CMS around the ongoing 1115. We have asked them if there's any questions for Kentucky, any additional information they need from us regarding that pending extension application. And they have not provided us with any additional information at this time. So they know the importance and how pressing it is but, really, we just don't have any updates

from them, but we continue to ask.

So, again, they know the time frame that we're under, and it does look like there are other states that are getting their extension requests approved, again, I know that were in queue prior to us. So that's promising. But, again, it continues to be on the agenda.

Regarding the recent guidance from CMS around the reentry demonstration opportunity, you know, again, the disclaimer I keep telling everybody is we still don't have all of the answers. So, again, it's very much still an ongoing conversation with CMS as well as the other states that have pending demonstrations. So, again, still working closely with them as well.

Just kind of a highlight, an overview of the guidance that they released recently. Going through that, Kentucky is going to need to make some changes to our pending application. Our pending application is not going to be approved as is, and that's okay. I think that that was anticipated knowing that it's -- there has been, you know, quite some time that's lapsed since we initially

submitted that.

But with that being said, we continue to work with them to determine what is the scope of changes that we would need to make in order to get that approved. And really, that's because CMS has definitely given states some flexibilities in that guidance that they issued around covered settings, reentry settings; again, covered services and how to deliver those services.

So, again, just some conversations to still be had around moving forward with what was originally submitted or again, you know, how in-depth the changes we might want to or need to make as we kind of work through if we're already making changes so really just trying to determine what that might be.

But, again, in the guidance, CMS has mandated -- for any of the states that do receive the 1115 opportunity for a reentry, there are three minimal required services that the states must provide.

No. 1 being case management. If you have seen the guidance or read through the guidance, it is very significant. Again, it

is beyond, you know, our current targeted case management requirements. And so that's -- there's definitely a lot of guidance around that.

But, again, the goal of that demonstration is really the importance of improving those care transitions for those individuals, and so all of the tasks under the demonstration really have to tie back to that.

The other -- another service is medication-assisted treatment is required to be offered, and that does include the accompanying therapies for those individuals. And then, again, states are required to provide a 30-day supply of all medications, not just related to MAT, at the time that the individual is released.

And so those are the three required. Again, states have the opportunities and flexibilities to request additional services. They have been up front with states that may request full state plan coverage, that they are not going to initially approve that. It doesn't mean that a state can't request that.

But, again, that's not going to be approved upfront.

Another thing, again, that they have been very clear about is the pre-release time frame. So, again, states can -- they can approve 30 days under the SUPPORT Act. Through the demonstration, states can request additional coverage prerelease up to 90 days.

Again, any state that requests beyond 30 days up to 90 days has to be able to provide justification why that time frame is needed, again, to help improve those care transitions, which I think we all agree, it can be done. And so -- but, again, with that being said, they are very clear that the states would not receive any federal match funding prior to -- or greater than 90 days prerelease.

So, again, we continue to work with them. Our state agencies, again, will be convening some stakeholder -- definitely some engagement. They really, through the guidance, put an emphasis on working with individuals with lived experience as the state looks at planning and implementation of

these programs.

And then again, there's lots of health IT integration requirements, which will be large system changes that we'll have to work very closely with our state agencies and partners to develop, to really ensure -- CMS wants to know that the state has a clear path and plan that those services, again, are really coordinated and available immediately upon release.

There is some guidance around eligibility of the member for those that might have a short-time prerelease date versus those who, again, maybe had a longer incarceration date, but there are -- definitely would have to be some eligibility changes.

But, again, all promising things. We are excited that states finally have the framework and the guidance to work through. But, again, we -- it's great to see and also work with the other states that have pending amendments. But I think every state also is aware that every state is different in their ask and in their makeup, so really just

working through that.

So I'll pause -- I'll touch, I guess, briefly on the reinvestment plan that's also required under the demonstration. And, again, there's lots of discussion to still be had around the plan and the requirements.

So, essentially, any service that the carceral setting is already receiving state funding to provide services for or, again, any of those existing services that might be expanded or enhanced under the demonstration, the state Medicaid agency is required to reinvest the full federal match funding that they receive for those services to new services or -- again, there's a wide array of how states can reinvest that funding.

States can even include their state dollars for those services as part of their reinvestment plan. It can go towards, again, enhancing and expanding the IT systems and, again -- so there's -- it doesn't have to be necessarily around new services but, again, how to ensure that those services are delivered.

So there's lots of, again, opportunity,

flexibilities for states. But, again, there's still questions and things to be addressed with CMS as well.

So any questions around the incarceration?

MR. SHANNON: Yeah. Not so much a question, Angela. You know, we had the Persons Returning to Society From Incarceration TAC, the world's longest-named TAC, and we discussed this.

And clearly, the impression I got there, you know, the guidance requires Kentucky to comply with that is not necessarily what was already submitted. It helps, I guess, that there's guidance. And they're hoping that -- this morning, it was reported at our meeting -- fall to December maybe, you know, get the work in place and go from there. But, you know, that TAC has been paying attention to this 1115 for a very long time and hoping -- every month, Leslie says we hope to hear soon, or every other month that we meet. So we're glad to have guidance, you know, but I think we really are eager to get this started.

And part of the thing that we did not include initially was a big emphasis on physical health as well in there. And I asked -- you know, there was the 1115 SMI piece that was submitted on IMD and the medical respite. Would these folks be eligible for medical respite?

And I think that's a question that's being discussed. And they may be -- if they don't have a place, they're at risk of homelessness, they may be eligible as well for medical respite, kind of tying those things together.

MS. SPARROW: Right. Yes. I think that that's a good point, Steve. And I think that that, again, goes back to it's exciting but, again, kind of the -- still trying to navigate the scope of changes that the state needs to make and the scope of changes that maybe need to occur up front versus to get approval and then amend the demonstration at a later time to grow additional populations, to include additional populations or services or conditions and so forth.

And so, again, that's because -- like

you stated, I think, you know, we have been waiting for quite some time for those opportunities --

MR. SHANNON: Isn't it three years?

MS. SPARROW: I think November will be three years. So, you know, we do want to act as soon as we can. And, again, we will have to make some changes, but CMS has been upfront. It's not like the state has to withdraw what we have submitted. We can amend what we have already submitted.

And, again, we would still go through another public comment period to make sure stakeholders are aware of what those changes would be. So we're, by no means, starting over, definitely not. But yes, there are some still some changes that have to occur.

MR. SHANNON: And Kentucky submitted it first; right?

MS. SPARROW: Correct.

MR. SHANNON: So we were first and then California --

MS. HOFFMANN: Angela, if I may. So, Steve, I think what we're probably going to do is -- we don't want to pull back what

we have. We want to amend it, and so we can get that approved and start moving forward very quickly.

And so we've already talked about this. We want to develop kind of a time frame to roll -- maybe do some phases or rollouts, and we need a time frame to keep ourselves on track with the times that we want to submit these things.

So like Angela talked about, there's a lot of pieces to this. And in the three years, there's a lot more opportunities that are out there now that weren't out there and some requirements that we didn't know about.

California had been working through a pilot that they had internally for almost five years. If you remember, we had a bill that had us to address this to get it out very quickly in about a 90-day time frame. So they had worked for a very, very long time on that reinvestment and to justify the 90 days.

We're not going to get 90 days just because we want it, but we do feel like we can get more than 30. So I think that's

something that we'll take a look at.

And don't forget we have two bills out there right now with Moser and Carroll. There's two bills and then the Omnibus Act to take a look at the DJJ, individuals who are confined, the youth.

So I think we'll probably do some kind of timeline to do a rollout plan.

MR. SHANNON: Because this includes youth as well, doesn't it, the guidance.

MS. SPARROW: It can.

MS. HOFFMANN: Yes. I think California did, didn't they, Angela? So that's something that's come out since we've submitted that. So those are things that we've got to -- we're going to take a look at.

And I think our best bet, to start getting something approved now and then build on it. I don't want to develop something for five years. I want to get something in that we can get approved and then start on the development and the next phases.

MR. SHANNON: All right. Thank you all. Good work.

CHAIR SCHUSTER: Yeah. I was going to ask about the public comment period, and it sounds like that would be a part of the amendment process as well. So very thorough. Thank you.

And the final thing would be the 1115 SMI waiver piece and then the 1915(i) waiver piece.

MS. SPARROW: So for updates on the SMI waiver. Again, thank you to everyone who submitted public comments on the draft that had been posted and everybody that attended the forums to review the draft.

The public comment period did end last Friday on the May 5th, so we are currently reviewing all of the public -- the comments that we did receive. I think there were a couple handfuls of those or more, which is great, so we're taking a look at those. We will provide response to all of those prior to and, with that being said, based on the public comments, ensure that we make any amendments to the application that is needed prior to submission.

So, again, still hoping and planning to

be able to submit that to CMS by the end of the month. But, again, really taking a look at those comments at this time.

So everyone who submitted comments should receive a notification, and the responses will be certainly posted to the website for review and, again, before the actual submission to CMS. And so that's where we are on the SMI amendment.

For the 1915(i), I'm going to pause. I'm not sure that Pam Smith was able to join us or not. And if she's not, I'll give an update real quick on that.

And so, again, just kind of a reminder. I believe this has been mentioned. But regarding the 1915(i) SPA submission, DMS, again, is still considering levels of supported housing in the SPA package; tendency (sic) reports or, again, supportive housing; supported education, supported employment, planned respite, case management, medication management, services in the 1915(i) SPA package.

I know the team was very grateful, again, of everyone who participated in those

stakeholder meetings. The group is currently reviewing that feedback that was collected through those meetings and, again, are working on conducting some strategic design sessions to really narrow the scope of the services and those that target populations and definition of those services as they work towards drafting an application, which I believe, again, that they're still hoping to do early to midsummer. And, again, with a public comment period of mid to late summer with the anticipated submission to CMS hopefully to follow that.

And so that's the update on 1915(i). And, again, Leslie, if you have anything else to add on that.

MS. HOFFMANN: And, Angela, did you mention -- sorry. I'm going back and forth. Did you mention that we hope to have the public comment out summer, maybe late summer for CMS? Okay. Sorry.

MS. SPARROW: Yep. No. That's all right. I think mid to late summer is the anticipated time frame.

CHAIR SCHUSTER: All right. That

sounds very good.

Does anybody have any questions? So I guess I'm a little bit confused. The medical respite was in the 1115 waiver amendment. Is it also going to be in the 1915(i)?

MS. SPARROW: Sorry, Sheila. So the medical respite, again, is in the 1115 amendment. The planned respite that we spoke about under the 1915(i) is the behavioral health respite.

So, again, the behavioral health respite and medical respite are two different services. They target two different populations. The medical respite, again, is really for those individuals that are --

CHAIR SCHUSTER: Discharged from the hospital; right?

MS. SPARROW: Yeah, the homeless correct. The homeless population, right.

CHAIR SCHUSTER: Yeah. All right. So the behavioral health respite is what?

MS. SPARROW: It's more of the caregiver, the planned caregiver respite.

CHAIR SCHUSTER: Okay. I didn't

remember that was part of that.

MS. HOFFMANN: Sheila, the recuperative care or the medical respite can only be approved in an 1115. That's why it's there.

CHAIR SCHUSTER: Okay.

MS. HOFFMANN: It's the only place that CMS has approved it so far. So we did the best we could in trying to connect on that.

CHAIR SCHUSTER: Yeah. That's fine. I mean, I think we're all happy to have that service. I didn't remember that there had been a behavioral health respite that would be for caregivers. I mean, I think of that with kids.

MS. SPARROW: Well --

MS. STALEY: Hi. This is Sherri from --

MS. SPARROW: Sorry. Go ahead, Sherri.

MS. STALEY: Oh, sorry, Angela. I was just going to jump in. And I think you're exactly right, Dr. Schuster. It would give the opportunity for behavioral health

respite for non-DCBS and non-1915C waiver, children primarily. And it might be to stabilize a home placement to prevent further out-of-home services or other possibilities.

It does give the caregiver a break, just as any of those other situations would. But it's more for behavioral health type things to stabilize kids in the community in their own homes.

CHAIR SCHUSTER: Okay. So now I'm really confused because -- and we keep having this discussion. I thought the 1915(i) was devoted to adults with SMI.

MS. ALLEN: Dr. Schuster, this is Jodi Allen. I'm here with Leslie traveling.

CHAIR SCHUSTER: Okay.

MS. ALLEN: So -- all right. I would love to answer this question.

CHAIR SCHUSTER: Good.

MS. ALLEN: Okay. So for the 1915(i), when we're talking about behavioral health respite, we are talking about individuals with SMI that are adults, and it's the planned caregiver respite for individuals with SMI.

MS. HOFFMANN: And then our SED will address --

MS. ALLEN: And the SED is going to be -- we are planning on approaching that through SPA.

MS. HOFFMANN: What Sherry was --

MS. ALLEN: Yes, what Sherry was talking about.

CHAIR SCHUSTER: Okay. All right.

MS. ALLEN: Does that make sense?

CHAIR SCHUSTER: Yeah. I just got really confused there because --

MS. ALLEN: Well, it is confusing.

MS. HOFFMANN: It is confusing.

MS. ALLEN: It is, yes. It's very confusing.

CHAIR SCHUSTER: I was pretty sure it was just me. Okay.

MS. ALLEN: Well, no. I think it's the term "respite." That's why we're calling it recuperative care because respite, in all of our minds in Kentucky, is a whole different service. So the recuperative care is in the 1115 proposed and then the 1915(i) will cover the behavioral health respite,

which is planned respite for adults with SMI.

At the same time, there are a lot of discussions about the multiple different services that we can include in the 1915(i). So there are some other services that could be somewhat overlapping, and we're still in the conversation stage on that; okay? As far as, like, what exactly in the 1915(i) will be included. But definitely supportive housing and supportive employment as was discussed and as we know has been directed by SJR 72.

CHAIR SCHUSTER: Okay. Great. And Kathy Dobbins from Wellspring has her hand up. Kathy?

MS. DOBBINS: No. This is great information. But could you define -- two questions really. One is: Could you define planned respite in just a few sentences? And then, secondly, when the 1915(i) is posted for public comment, could you let Sheila know that so that she could send that out to all the BH TAC and those who are -- those of us who participate regularly?

MS. ALLEN: Yes. Thank you, Kathy. Of course. We will make sure that

notifications are sent to all of the TACs, and so that will -- that will happen for the 1915(i). I'm on the planned workgroup, and so I'll make sure to communicate that.

And then the other thing, as far as what is planned respite, really, we're looking for respite of the caregiver who provides the care for the individual who has SMI. So it will be planned in advance.

MS. DOBBINS: So they'll be providers offering a new level of care to give the family or whoever the caregiver is a break?

MS. ALLEN: That's what we are looking at. We are looking at how other states are able to provide that. At the same time, anyone who is in residential would not be eligible for that care, for that service.

MS. DOBBINS: Right. Understood.

MS. ALLEN: Yes, yes.

MS. DOBBINS: Okay. All right. Thank you.

MS. ALLEN: Does that answer your questions?

CHAIR SCHUSTER: Yeah. That's a

new service that would be available for people that -- for instance, parents with whom an adult with SMI is living or other caregivers like that, and it would be provided by the providers, by the Medicaid providers.

MS. ALLEN: Yes.

CHAIR SCHUSTER: Okay. All right. That's very helpful. And you all have always been very good about letting me know about public comment and so forth, and we will depend on that again because I think there's so much interest, as you know, in this issue. And a lot of people have been -- a lot of our BH TAC attendees and so forth will want to carefully look at this 1915(i) and give you their feedback. So thank you very much for that.

So that's progress and kind of a time frame. That's very exciting. We appreciate that. Appreciate that, Jodi and Sherri and Leslie and Angela.

MS. ALLEN: We are excited, too. It's a great opportunity for us to provide so much more. And even though it's kind of

looking different than I think we all originally thought but still going to be able to expand services in a comprehensive way, which is great.

CHAIR SCHUSTER: Yeah. Exactly. All right. Very grateful for that.

I don't know if anybody is on -- Dr. Ali or anybody from the Medicaid formulary? We have an issue that has come up where -- let me get my paperwork. This came after we were in Bowling Green talking about services. And a woman there sent me some information that there are a number of pharmacies in the Greenville area, Beechmont, who are now saying that they are no longer going to fill prescriptions for stimulant medications.

And at first, I thought it was connected only with an MAT clinic there called New Start, and they were the ones that were given this information. But it also is a primary care clinic there that's called CareNow.

These are Walmart, Walgreens in Greenville and Madisonville, Hometown Pharmacy in Madisonville, Rice Drugs in Beaver Dam, Midtown Pharmacy in Beaver Dam,

Yates Pharmacy in Russellville, Cayce's Pharmacy in Hopkinsville, Tom's Pharmacy in Hopkinsville, and Main Street Pharmacy in Cadiz.

And I guess my question is: How is it that these pharmacies can just decide that they're not going to fill prescriptions for a certain whole class of medications? I don't get it.

MS. BICKERS: I don't see anyone on from pharmacy, so I'll take that back and see if I can get that answer to you -- for you.

CHAIR SCHUSTER: All right. I will also follow up, Erin, with a direct email to Dr. Ali. And I'll copy you, so you have that information.

MS. BICKERS: Okay. Thank you.

CHAIR SCHUSTER: Yeah. She typically -- or somebody from formulary had typically been kind of monitoring our agenda, so I didn't think to send it to her ahead of time. But I will follow up with an email and copy you and probably Commissioner Lee and Deputy Commissioner Judy-Cecil.

MS. BICKERS: Okay. Thank you.

And I do send out the agenda to them. It's just probably with all the forums and all the events going on --

CHAIR SCHUSTER: Yeah. But this is of great concern, and it's particularly a concern to me as a psychologist. Because when I was in practice, I was doing those evaluations for, in my case, kids. But it's also adults who need psychostimulants for treatment of ADHD, and I just am very concerned about people not having access to appropriately-prescribed medications that they need.

And it sounds like it's -- you know, it's seven or eight pharmacies here that are affected and two clinics at least, one MAT clinic and one primary care clinic. So I'll gather that together and send that along. Thank you, Erin.

We also had a question about changes in telehealth rules for IOP, partial hospitalization, and outpatient behavioral health with the end of the federal emergency. And then I got a follow-up email from this person from Peace Hospital who said, oh, it's

apparently only for Medicare beneficiaries that there were changes in telehealth rules.

But it made him wonder and wanted me to ask: Are there any changes anticipated for Medicaid members? So I can't remember whether he sent me exact wording. Has anybody from Medicaid heard anything about this, about changes in those particular services with regard to telehealth?

MS. HOFFMANN: This is Leslie. I have not. If you want to forward that information to us, I can reach out. There hasn't been anything, like, specific to specific services. It's just been that there are no changes at this time other than there might be some platform changes in August and audio versus audio and visual coming at the end of the year.

CHAIR SCHUSTER: Okay. I will forward it to you. It came from, as I said, one of the leadership staff over at Peace Hospital who was obviously concerned coming from a psych hospital with IOP and PHP and outpatient all being affected by this, relieved that it was only Medicare, but it

made him wonder if there were any implications for Medicaid. So I will send that to you, Leslie. Thank you.

And Nina has asked: What were the changes for Medicare? And I actually -- I don't remember, Nina. When I find the email, I'll also share it with you.

MS. EISNER: Thank you, Sheila.

CHAIR SCHUSTER: Yeah. So I'm hoping that we have nothing but good news about the bypass list for people that are dual-eligible, Medicaid and commercial insurance, and I hope that the bypass list has been made available. Do we have anyone that can report on that?

MR. ELLIS: This is Herb with Humana. I can talk about that.

CHAIR SCHUSTER: Great. Thank you, Herb.

MR. ELLIS: Yeah. So we -- the department actually did share the bypass list along with the communication and the attestation form, I believe, at the last BH TAC meeting, and so everybody should have it who attended that TAC. I also shared it with

Steve and a few other BH providers. But -- so it is out there. All six MCOs are following the same bypass list.

CHAIR SCHUSTER: Wonderful.

MR. ELLIS: We haven't been able to post it yet on our website because it has to get approved by the department until we can -- so all of the MCOs are waiting for approval from the department on those documents, so we can actually post them to our website.

CHAIR SCHUSTER: Okay.

MR. ELLIS: But the department did share the same bypass list that we're going to post along with the attestation form and the general communication to the providers about how to use that bypass list.

And it's a very general list. It's specific codes and three specific modifiers. So it's not based on provider types. It's not based on diagnosis codes. It's not based on blood type or anything. You submit the claim and it has that code on there, or one of those three modifiers, then that claim line will bypass the need for commercial

insurance EOB.

CHAIR SCHUSTER: Okay. Leslie or somebody from DMS, could somebody send that to me?

MS. HOFFMANN: Yeah. I believe I did, but I'll take a look at that --

CHAIR SCHUSTER: Yeah. And I apologize.

MS. HOFFMANN: -- and get it out again, Sheila. And I think we shared -- I don't have the list in front of me, but I'm pretty sure we shared on some list serves as well. It seems like Jonathan Scott may have sent out on several of the list serves and then I think Erin or -- I think Kelli was here during that time. Kelli may have sent to all the TACs as well.

CHAIR SCHUSTER: Yes. And I apologize if I didn't -- I may have gotten it, but I -- it's not ringing a bell with me. And I sometimes get direct, you know, emails from people saying do you have this whatever, and it's helpful for me to have it. So I appreciate that.

MS. SHEETS: Dr. Schuster, this is

Kelli. I can go back and dig that out and send it back to you.

CHAIR SCHUSTER: Okay. That would be great. Thank you.

MS. SHEETS: No problem.

CHAIR SCHUSTER: Leslie, I don't think Leigh Ann Fitzpatrick maybe is on. We have this follow-up --

MR. SHANNON: Now, hold on, Sheila. I just want to thank Herb Ellis for heading that up on the bypass list.

CHAIR SCHUSTER: Yes.

MR. SHANNON: We've been talking about it for a long time, and it really got busy in the last six to nine months maybe. And we have a product, you know, so we're going to see how it works out and what happens. So we're -- appreciate that, Herb.

MR. ELLIS: No problem. Thank you for the patience.

CHAIR SCHUSTER: Yes. We do appreciate that, and we appreciate all of the MCOs cooperating with it and being a part of the process. Because, obviously, like the credentialing, the more that everybody is on

the same page, the easier it is for providers and payors and certainly easier for our clients to get the services they need. So thank you very much.

MR. ELLIS: You're welcome.

CHAIR SCHUSTER: Thank you, Steve, for reminding me.

Leslie, you may remember that Mary Hass brought up this issue at the last BH TAC meeting about her relative that was in a waiver -- ABI waiver setting.

MS. HOFFMANN: Yes.

CHAIR SCHUSTER: And we had raised the question about whether anybody could intervene in that situation. And Leigh Ann had volunteered that she was in touch with CMS around some of these, and there was some federal rule that said that there couldn't be an emergency intervention in a federally-funded -- I'm doing this from memory, so I may be way off base. But there was some glitch about that.

And we asked her to pursue that because I know Mary would like to have an answer. Because this -- I'm sure her relative is not

the only one that has encountered this problem.

MS. HOFFMANN: So, Sheila, what CMS had said is that they wouldn't come to a facility that's currently being paid like a Medicaid facility. They actually consider waivers as a community residential. Like, that's their home.

So we're going to double-check, but if the last -- the last information I remember getting from CMS, it's going to allow us to cover the waiver members that are in residential, which would be the two ABI waivers and the SCL waiver. As far as I know, those should be covered.

But I will go back and double-check because we've not looked at this language for a little while. It's been a couple of months. But that's what I remember. So as long as they consider the waiver client in a community type of setting, which is considered their home, we should be able to do that.

Now, I will tell you we'll have to develop some rules around providers --

residential providers about -- I don't want everybody to call a crisis line when some things could be handled by the provider, and we do expect some things to be taken care of.

Now, I think Mary had mentioned things like hurting themselves or others or a fight that might have occurred between two members in a home. So we just need to take a look at those scenarios. But I believe CMS is going to allow us to cover the waiver members in community residential care.

CHAIR SCHUSTER: All right. And let me ask Mary if she has any follow-up questions, then.

MS. HASS: Well, I think -- I think this is good. I mean, these crises happen. It's not just someone I care about but, you know, I care about all the participants in the waivers. And I think if we can get some regulations or however way you think would be best, Leslie.

But this will not just happen this one time. It's happened in the past and, you know, I also think we need to look more around neurobehavioral crisis stabilization.

You know, so it's a pretty big topic and -- you know, so I appreciate your work on it so far. But I think it's multifaceted. Let me put it that way.

So I think it's going to take some work to hopefully get some type of stabilization, you know, even -- you know, as far as the person who's -- the perpetrator and also the person who's the victim of the aggressive behavior and everything.

So it's a lot because the person who suffered the abuse is now undergoing counseling twice a week just trying to deal with the victimization that she experienced. So, anyway, I think it's multifaceted.

So I appreciate you looking at it, but I think it's going to -- you know, I think providers don't know what to do in this situation and, you know, like I said -- and no one wants someone to be kicked out of their home. But then in the other sense, the person needs to be kept safe. That's, you know, being the victim so...

CHAIR SCHUSTER: Yeah. I think that's well said, Mary, because I think

there's rights on both sides. But I think our first and basic is to make sure that everyone is safe.

MS. HASS: Right. And, you know, I have sympathy for the person who, you know, is exhibiting the unwanted behaviors. And then also, like I said, the person that's a victim now, that person is undergoing, you know, twice-a-week counseling just trying to deal with -- and she keeps saying I didn't do anything wrong. And she's right, you know. So it's multifaceted. Let me put it that way.

CHAIR SCHUSTER: Yeah. Okay. Yeah. Thank you, Leslie. I just remembered that Leigh Ann had been on that discussion and had been in touch with DMS --

MS. HOFFMANN: Yeah. It's not a problem, and I'll continue to work on that. Because we do need to know -- that comes up often, so we do need to know. Of course, I'm well familiar with the brain injury world, so I do want to try to figure this out that we can serve the most people we can.

You've heard me say, you know, anyone

anytime, and we want to make sure that we really can stand by that, no wrong doors. So we're working on it. But we'll probably have to have a few rules around it. If it's a residential provider that's getting paid, we'll have to have a few rules around it.

CHAIR SCHUSTER: Yeah. Yeah. Thank you.

Next item is a wrap-up of the 2023 session, and I'm going to mention just a couple of things and then I will follow up with a list in writing that you all can look at.

We did a maternal mental health bill that I think will hopefully help address what we've always called postpartum depression. It's now actually called perinatal mood and anxiety disorders, or PMADs. And that was Senate Bill 135.

It requires anyone who is attending the birth of a baby in whatever setting to provide information not only to the mom but also to family members. Interestingly, not only are women prone to these disorders, but the fathers are as well. And there's a

correlation. If there's already some mental health issues in the family or if the mom is significantly impacted, the dad is likely to be as well, so we need to educate the entire family.

There also is going to be a stakeholder group convened by the cabinet to look at training of more mental health professionals to treat perinatal mood and anxiety disorders -- there really are not very many mental health providers -- as well as the providers on the healthcare side looking at support services. There are a number of services available in other states and in other countries, actually, for women to be able to identify symptoms.

Most of the screening is actually done by pediatricians because, as those of us who have had babies remember, you go see your OB maybe one time after a birth and then probably not for another year. Whereas, you're seeing your pediatrician on a very regular basis during that postpartum period, which is when the symptoms are likely to appear.

And, obviously, the bill that was passed the previous session to extend postpartum Medicaid coverage for 12 months is a huge step in the right direction.

Senate Bill 47 authorizes medical cannabis for limited conditions. I think there are more questions than answers in this legislation. It's not effective for another year, January of 2025. And I think there will be further legislation in the 2024 session.

But I think physicians, nurse practitioners, physician assistants who would be making these recommendations probably have lots and lots of questions about how this is going to happen and what the parameters are going to be.

Senate Bill 94 will allow APRNs, advanced practice registered nurses, to continue prescribing controlled substances without having to have an agreement with the physician if they've had one for four years.

We think that this will open up more APRN practices all over the state. They tend to stay in their local home communities, and

we think there will be more access to health care and mental health care. There's a growing number of APRNs that are going back to school to get certified in psych mental health nursing, which I think is going to be a real plus.

House Bill 21 arranges for the homeless to get access to IDs and particularly allows homeless youth, 16 and 17-year-olds. We know how important it is to be able to have a picture ID for various things, and this bill is going to allow that. It also establishes a rural housing trust fund.

House Bill 148 should be of interest to all behavioral health providers. It requires insurers to pay behavioral health out-of-network providers directly as opposed to sending the payment to the policyholder which had been the practice of many of them. So we think this will be a significant improvement for behavioral health providers.

House Bill 200 is attempting to look at the healthcare workforce by providing more scholarships. There's opportunities to partner with this fund, particularly if you

have a particular kind of provider that you want to see more of or you're in a particularly underserved area. That's Representative Ken Fleming's bill.

House Bill 248 attempts to regulate recovery housing for the protection of residents. Thanks to Steve for his work on this with Representative Heavrin and others.

This has been kind of a wild, wild west with recovery housing, and we think there are situations where people have been taken advantage of. So this is at least a small step in the direction of putting some regulations in there.

An important piece on the SUD side was House Bill 353 which allows fentanyl test strips to be used. They had previously been determined to be drug paraphernalia, and so they were not available. And now they can be made available, and they will save lives. I don't think there's any doubt about that.

House Bill 551. I'm not suggesting that we had a position on whether we wanted sports betting or not, but the significance of this is that, after about 20 years of work, this

is the first piece of legislation that actually puts funding in place for the prevention, education, and treatment of problem gambling.

And this is a group on the Council For Problem Gambling that has been working literally for 20 years on this. Mike Stone and Dennis Boyd, many of you will remember as a former commissioner, had worked on this tirelessly. So there's funding in that.

And then House Joint Resolution 39 requires the cabinet to address the benefits cliff issue. And this is what happens when people make one dollar over the Medicaid limit and then lose that coverage. There's no slide down, if you will. They just fall over the cliff.

And there's been talk in the last two to three sessions about creating some kind of slide-down or some kind of handoff or some kind of other way to make sure that people get coverage without just abruptly ending their coverage.

And then I was not aware, but Jon Copley mentioned SB 209 which really encourages that

provider certification to be across all of the MCOs.

We have a number of bills that were supported that didn't go anyplace, bills to establish an all payers' claims database, which I think would give us much-needed information on where our healthcare dollars are being spent, a bill to provide insurance coverage for chronic pain treatments, bill to exempt providers from prior authorizations if they have a good record with the insurer, a bill that's been there for several years to use the Mental Health Protection Act that would ban conversion -- they call it therapy. It's actually -- Senator Kerr says conversion torture, done by unscrupulous mental health professionals actually to try to convince kids through very negative means that they are not gay or whatever the situation is.

There was also a bill to put an app on the phone of all Kentucky students where they could immediately text mental health help. That was, again, a Representative Fleming bill. It passed the house but didn't pass the senate.

On the ugly side -- so that's kind of the good, the bad, and then the ugly. I think there are a lot of concerns about House Bill 3, which was the Juvenile Justice Reform Act. It's going to allow youths to be detained for 48 hours before they're ever evaluated, which is dangerous, I think, for kids when we don't know what their status is with regard to suicide and some other things.

It also keeps them housed in an old building in Louisville that's not set up for mental health treatment, and it doesn't provide any additional funding for mental health needs.

Senate Bill 65 ended a new program that the cabinet had begun for adults on Medicaid who would receive enhanced dental, vision, and hearing benefits.

And I guess the worst from my standpoint is Senate Bill 150, which cuts off access to gender transition medical services for trans kids and puts -- makes the schools much less a safe place for our trans students. And I'm very concerned that we're going to see an uptick in suicides among our trans youth.

So I will send that out to you separately, and you will have that information.

Are there any recommendations for the MAC meeting in May from any of our voting members?

(No response.)

CHAIR SCHUSTER: All right.

MR. SHANNON: Sheila, do we need one on targeted case management? I don't know if we need one, but it was a big topic of discussion today.

CHAIR SCHUSTER: Yes. Let's do one just to put it on the record. Steve, what would you recommend? A clear policy statement from DMS?

MR. SHANNON: Yes. A clear policy statement on targeted case management as it relates to comprehensive plans of care or integrated plans of care.

CHAIR SCHUSTER: Okay. So that's your motion, that we recommend that DMS issue a clear policy statement on targeted case management as it relates to integrated plans of care?

MR. SHANNON: Correct.

CHAIR SCHUSTER: All right. Do we have a second from any of the voting members?

MR. REYNOLDS: This is Eddie. I will second.

CHAIR SCHUSTER: Eddie, thank you very much. So we have a motion and a second. All of those in favor of the motion, signify by saying aye.

(Aye.)

CHAIR SCHUSTER: And opposed and abstain?

(No response.)

CHAIR SCHUSTER: All right. We will make that recommendation. Thank you very much.

MR. SHANNON: For me, it's to go on record with the MAC.

CHAIR SCHUSTER: Yeah.

MR. SHANNON: It doesn't necessarily -- I know Leslie is going to work on it. Commissioner Craycraft is going to work on it. I just think we, as the TAC, need to go on record.

CHAIR SCHUSTER: I think that's

right, Steve. Thank you. We have a number of carryover items, some of which we hope will get resolved before our July 13th meeting.

I don't believe there's been any updated prior authorization guidance. I don't think there's any change in that.

Has there been any change with regard to the MCO audits? Steve is shaking his head no. Okay.

All right. Our next MAC meeting -- or the next MAC meeting is coming up in two weeks. That's May 25th at 10:00 a.m., and the Zoom link is on the DMS website. But I'll also send it out to everyone that I have email addresses for. And remember to email me at kyadvocacy@gmail.com if you want to get those updates from me.

The next BH TAC meeting is July 13th, and we're back, as we were today, at the 1:00 to 3:00 time frame.

Is there any other business to come before the TAC?

(No response.)

CHAIR SCHUSTER: Let the record

show that we're ending at the stroke of 3:00 at the appointed time. So I thank you all. I thank the voting members of the TAC for your participation and for all of you who have participated and certainly thank the DMS and DBH staff for all of your help.

And, Erin, you and I can touch base on some follow-up items after the meeting. We welcome you back.

MS. BICKERS: Thank you. It's great to be back.

CHAIR SCHUSTER: All right. Thank you all very much. Enjoy the rest of the day, and we'll see you in two months. Thanks for being on.

(Meeting concluded at 3:01 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 19th day of May, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR