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

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Via Videoconference
March 9, 2023
Commencing at 2:03 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Sheila Schuster, Chair

Steve Shannon

Valerie Mudd

Eddie Reynolds (not present)

Mary Hass

Michael Barry (not present)

T.J. Litafik

CHAIR SCHUSTER: So welcome to you all. This is the Behavioral Health TAC meeting of March 9th, and I'll call the meeting to order. I'm Sheila Schuster with the Kentucky Mental Health Coalition.

We have with us voting members of the TAC, Valerie Mudd representing consumers through NAMI Lexington and Participation Station; Mary Hass representing the Brain Injury Association of America, Kentucky Chapter; and T.J. Litafik representing NAMI Kentucky.

I know that Mike Barry could not be on. As I said, he texted me today and said that he has no power, and his phone is not working very well. So we do have a quorum, so we will go on and --

UNIDENTIFIED SPEAKER: What did you say before about -- I need to find your other one.

CHAIR SCHUSTER: I'm sorry. Is someone talking to me, or have you forgotten to mute? If you're not speaking, please mute your line. Thank you.

I distributed the draft meeting

minutes of our January 5th meeting and would entertain a motion from one of our voting members to approve those minutes.

MS. HASS: I'll so move.

CHAIR SCHUSTER: That's Mary Hass. Thank you, Mary. And a second, please?

MR. LITAFIK: Second.

CHAIR SCHUSTER: Second from T.J. Thank you very much. All those in favor of approving the minutes as distributed, say aye.

(Aye.)

CHAIR SCHUSTER: All right. And any abstentions, negatives.

Okay. We're delighted to have Commissioner Lee with us. It's been a little while since she's been able to join us, so I'm going to move right into the Medicaid data study because the folks from Data Analytics are here to present that, and I want to do it while Commissioner Lee is on.

You all who have been coming to these meetings regularly remember that this study was initially done directly with Medicaid and a little workgroup that we had

through the BH TAC. I see that Dr. Brenzel is on. He's been a member of that workgroup, Steve Shannon and me. Marc Kelly was on until he left Pathways. Kathy Dobbins from Wellspring and Natalie Harris from the Coalition For the Homeless.

And Commissioner Lee had kind of challenged -- asked the question, let's look at the data on the use of targeted case management. So the Medicaid staff could not have been more helpful in terms of working with us.

We developed a design that kind of looked at an 18-month period of six months where they might not have gotten targeted case management, six months where they got targeted case management that was part of the study, and then the six months after.

After we pulled together that data, Commissioner Lee suggested that we share that in our design study and so forth -- study design, I should say, with the folks at Data Analytics. And they have done certainly a higher-powered analysis than we were able to do, and so we're very grateful to that.

Are they on? Can we share that screen?

Oh, there's Steve Shannon. Kelli, if you might reflect in -- that Steve Shannon has joined us.

Commissioner, do you know if the folks from Data Analytics are on to make the presentation?

DR. CONNER: Yes. I'm here.

MR. DUNCAN: Dr. Schuster -- I'm sorry.

COMMISSIONER LEE: They are. Kelli, can you make Dr. Conner and Ben -- yes, thank you -- a cohost. Thank you.

DR. CONNER: All right. Can you all see my screen here?

CHAIR SCHUSTER: Yes.

DR. CONNER: Okay. Great.

So I am Dr. Kailyn Conner, and I will be walking you through the study on what the Office of Data Analytics did on targeted case management and health outcomes for individuals with serious mental illness. And we performed a cohort study, and we'll talk a little bit about what that means during this

presentation.

To go over what we'll cover today for you all, we want to review the findings from that previous work done by the Behavioral Health TAC because it was such great work and gave us a lot of guiding measures for what to do in our study.

And overview our questions for research in the context of this analysis. We want to tell you a little bit about the methods and the methodology we used for our study to give you a little bit of an insight into what exactly we did. We're also going to examine those population demographics for our population with serious mental illness, especially those that received targeted case management.

One of the main goals we wanted for this analysis was to really get to know that population and understand who those people were that were using this service. And so we thought this was a really important piece to highlight here. And then we'll examine those findings from the analytical study we conducted.

So, again, as Dr. Schuster mentioned, the TAC workgroup had an 18-month study they performed where they looked at the individuals with a serious mental illness that received TCM within that six-month window. So they examined their six months prior to the TCM use, permitted a six-month washout period, and then examined the six months after.

And in total, their population consisted of a little over 6,000 individuals, I believe around 6,200 individuals. And their population included only the individuals with serious mental illness. So we borrowed that population and that idea for our analysis. Even though there are the youth with serious emotional disturbances included in that regulation and people with substance use disorders included in that regulation, we chose to focus solely on the SMI population for the purpose of this study.

So the TAC study largely found increased cost to MCOs over the six-month period following the receipt of TCM by approximately 6.1 million. Their net

additional cost per person that they found equated to about $1,045 per person over that six-month period which equated to about $175 per person to the MCO. And they noted that that's about 52 percent of the monthly rate for targeted case management services for this population.

So what we wanted to do to expand this was to look at the health outcomes associated with targeted case management for individuals with SMI, to investigate some of those other measures established by the TAC as, like, areas of interest. And then we also wanted to further examine those costs over time to examine whether those differences in costs did persist following that six-month period in our study window.

So we'll go over some of our methodology now. We used a cohort design, which means we separated our population based on the receipt of those targeted case management services. So we compared individuals with targeted case management to individuals that did not receive targeted case management.

And we made that population consist solely of adults aged 21 to 64 that had a diagnosis of a serious mental illness. And to be considered as having an SMI in this population, we also required two outpatient visits for the same SMI diagnosis or one inpatient hospitalization for an SMI diagnosis.

So we also expanded the time period that we looked at. We looked at the time period between 2017 and 2021 and examined anyone diagnosed with an SMI that -- between this time period. So we had a five-year period compared to the six-month period that we were examining in our study.

And, again, as I mentioned, we divided our population with SMI based on that receipt of TCM and then we tried to follow those groups as long as we could within this study period to ascertain what those outcomes would be.

So compared to the -- compared to the TAC's study, how did this differ? So we believe that the TAC study population is largely contained within our population. The

TAC workgroup study really focused on the monetary value of TCM, and we chose to expand that analysis that they had already looked at to see if those differences persist over time.

And we also wanted to examine other value-added parts of TCM that the TAC study did not address but would say would be interesting areas of future research. We wanted to see how close to those we could get.

So some strengths of our design in this. We did allow that longer period of time which allowed time for more outcomes to occur. Sometimes things don't happen instantaneously. They happen -- it happens to take a while for them to appear in our data. We wanted to give enough time to allow those things to happen.

We also really wanted to do a deeper examination into some of those social determinants of health that we know are vital for this population. We also wanted to expand the time to look at those health expenses to see if it persists, and we really

wanted to understand the patient population that were using these services.

And then we also established that comparison group to compare individuals that were using targeted case management to those who weren't and see how their differences compared and how their courses of life compared based on the receipt of that service.

So some limitations. We know our MCOs are so great about having different programs in place and care management for different individuals in the population. If there are MCO programs that account for SMI in these populations, we didn't have any information on that in our claims data. And so that information may be missing from this analysis.

We also note that several of the variables we have used in our analyses may be imperfect indicators. There may be things that may be imperfectly classified. There may be things that just may have some general errors. That's always kind of a risk of these types of analyses.

And we also wanted to note that we didn't have any way to observe care that was received outside of services that were paid for by Medicaid such as through grant programs or charity care or something of that nature.

So population demographics, just to give us a little more understanding of our whole population of TCM users. On the whole, between 2017 and 2021, we found 23,863 individuals that had received targeted case management. Out of our population of people with serious mental illness, that totaled around 170,000 individuals during this time period. That means that approximately 14 percent of TCM users would receive one of these services during that time.

What we found was that the group that received targeted case management had slightly more persons who were identified as black than the group that did not receive TCM. They were also slightly more non-Hispanic than the group that did not receive TCM, and they had slightly more people who identified as female than the

group that did not receive TCM.

Interestingly, both groups were functionally of similar age to one another. I believe the mean age was around 31 years old. And the group that received TCM lived in slightly more nonmetropolitan areas than the group that did not receive TCM.

On average, TCM recipients received about ten months of TCM services, and so that's the time between first use of TCM to last use of TCM, was about ten months. And we see from our graph below showing the distribution of that, that it's heavily pushed toward the left side, showing that it's in those much lower numbers, is the most common facets of use.

Within those ten months, TCM recipients have an average of eight claims for TCM services. And, again, we see that left skew in the chart indicating that it's majority in those lower numbers of claims for this service.

To kind of quantify that a little more, around 58 percent of people who received TCM had five or fewer claims for TCM

services. Around 4,600, or 26 percent, of individuals that received TCM had between six and ten claims. And only about 5,500, or 23 percent, of TCM users had more than ten claims for TCM.

So we also wanted to look at all expenditures and look at the monetary over time and by year, and so this is a rather overwhelming chart. Overall, between 2017 and 2021, TCM users' expenses approximated 6.6 billion dollars during this time period. And the largest absorber of those expenses were WellCare, our fee-for-service population, and also Passport by Molina.

And here's a chart kind of showing those differences over time. You'll notice that absent from this chart is United. We only had one data point for United during this time period because of when United came on board. It takes more than one point to make a line, so that's why they're missing from this chart.

But we can see, again, that WellCare on top, and we can see kind of this tradeoff happening between fee for service

and Passport by Molina on the expenditures by TCM users.

Whenever we look at the expenditures for TCM overall, however, the total dropped significantly to about 65 million over this time period with, again, the vast majority being absorbed by WellCare and next by Passport by Molina. And what this means, compared to those prior numbers that we looked at, is that TCM accounts for roughly only one percent of all expenditures annually across all MCOs for users of the service.

So here it is looking at it again over time. We, again, see that WellCare had a rather large spike occur after 2019. We can see pretty steady expenditures for fee for service on TCM use. And we can see a little more growth over time for the rest of our MCOs but, again, a large spike in WellCare beyond that time period.

COMMISSIONER LEE: Kailyn, hi. This is Lisa Lee. Thank you for going through this wonderful -- we do have a question in the chat, and I want to -- I

think we -- if we address it before we move on, that way, it will be -- Marcie has asked if she heard correctly, that targeted case management is one percent of expenditures, and that's what you said. So it is one percent of overall expenditures for the population; correct, that received TCM?

DR. CONNER: Yes. Of just that received TCM, it's about one percent of the expenditures each year. I found that number by approximating each of these numbers against each of these grand totals from the previous years, and it equated to roughly one percent-ish. There may be some years where it was a little more. There may be some years where it was a little less, but it -- it centered around the one percent number.

COMMISSIONER LEE: And so that previous -- the previous expenditures included all services that individuals who received targeted case management were also receiving. So it could -- it includes hospitals, physician services, that sort of thing, and it also includes targeted case management. And the second chart is costs

for targeted case management alone so...

DR. CONNER: Yes. Yeah. That is absolutely right.

COMMISSIONER LEE: Thank you. We've answered the question.

DR. CONNER: We can get into some of the more analytical findings. So the first thing we really wanted to look at that we knew from the literature and just from speaking with people was homelessness.

We were able to identify about 9.7 percent of our TCM users as being homeless, and that was compared to about 5.8 percent among those who did not receive targeted case management. We did some statistical analysis, and we found that targeted case management users had about 1.8 times increased odds of being homeless compared to those that did not receive targeted case management.

And when we adjusted our statistical model for someone's age, how sick they happened to be, their race, their ethnicity, and their sex, the odds remained elevated at around 1.8 times the odds of a

person that did not receive TCM being homeless.

Also important to us was looking at non-emergency medical transport, and we found that about twice the frequency of users of NEMT among TCM users compared to non-TCM users. So it was about 34 percent among those who received TCM ever used NEMT compared to about 16 percent of non-TCM users that ever used NEMT.

Again, we did some statistical analysis, and we found that TCM users had about 2.7 times increased odds of using NEMT compared to those that did not receive TCM. And, again, we adjusted our statistical analysis again for age, how sick someone is, their race, their ethnicity, their sex, whether they were homeless, and their metropolitan status. And we still found those elevated odds that equated to about 2.7 times increased.

Also important to look at for us was long-acting injectable antipsychotic use because we know that these are really important measures. And we did find a

significant increase in the number of TCM users that were identified as using a long-acting injectable compared to non-TCM users. And that's about 1 percent compared to 2.7 percent.

So, again, with our statistical analysis, we found that this was a 3.1 times increased odds of someone that had used TCM using a long-acting injectable compared to those that did not receive targeted case management.

And, again, we adjusted this for age, how sick someone was, their race, their ethnicity, their sex, metropolitan status, homelessness, and whether they used NEMT. And again, we found those increased odds of about 2.6 times even accounting for all of those things in the background.

Mortality was also something that was really important for us to look at. And overall, we found that 4.3 percent of individuals with SMI were identified as having died during our study period. And this is roughly similar to what it is in our general Medicaid population.

However, whenever we stratified this out, we found that it was only 3.6 percent of individuals that had used TCM died compared to those -- compared to 4.5 percent of those who did not receive TCM. So, again, we did our statistical analysis, and we found a 20 percent decreased odds of mortality among those that used targeted case management compared to those who did not.

And, again, when we adjusted this for someone's age, how sick they were, their race, their ethnicity, and their sex, we found 18 percent decreased odds of mortality in our population of TCM users compared to those that did not receive TCM.

And we wanted to break this down and look at it a little more over the entire study period. Again, our 2021 numbers, they're a little bit of a washout number here. It's kind of like a grand accumulation from all of the other years just with how we did the analysis. But we see across all years, there is largely an increased mortality rate among our population with serious mental illness compared to the rest

of the Medicaid population in the state for mortality.

So getting into the expenditures. We wanted to look at these over time. And what we found was that on average over this five-year period, beneficiaries that received targeted case management spent approximately $2,000 more per person per year than individuals who did not receive targeted case management.

And over a five-year period, those differences did seem to decrease over time. When accounting for age, sex, and metropolitan status, those differences diminished over time even further even though they remained a little elevated over the other population for the duration of that five-year period.

What was interesting to note for both the behavioral health expenditures and the medical health expenditures, which we'll cover next, in both cases, there was a spike after five years for individuals with SMI that received TCM in those expenditures.

And what we believed that was was,

thinking about the general time period, if you made it five years into the study -- you were enrolled in 2017. You made it all the way through 2021. And at that five-year mark, it was the post-COVID period when all of the prior authorizations had been turned off, and there was pent-up demand for services.

And so we believe that's what that spike after five years was really showing, was all of that pent-up need from COVID and the removal of the prior authorizations. So that was what we believed explained that one.

As far as medical expenditures, beneficiaries receiving TCM spent approximately $3,500 more per person per year than individuals who did not receive TCM. And over a five-year period, again, those differences did seem to remain consistently increased over their non-TCM counterparts.

But whenever we account for someone's age, how sick they are, their sex, and their metropolitan status, still, it remains slightly more increased over time. And, again, we saw that five-year spike in

this analysis that we believe was attributed to the removal of those prior authorizations and pent-up demands from the pandemic after this time period.

So we really wanted to understand why, why we were seeing these increases and expenditures. And so we looked at several different outcomes of interest for this population. And we found that, actually, individuals with TCM compared to those that did not receive TCM had fewer hospitalizations, but they had more behavioral health ED visits, more medical ED visits, more outpatient primary care visits, and more preventative services compared to that other population.

So kind of wrapping this up and putting it all together and kind of understanding what it all means, the population that received TCM were more likely to use non-emergency medical transportation. They were more likely to be homeless, more likely to use long-acting injectable antipsychotics, and were less likely to die during the study period.

Like the TAC study, we also showed those increased expenditures over time for the group that received TCM, but what we found in return for that was that there seemed to be more utilization of healthcare services than the group that did not receive TCM. And so this may not necessarily be an indicator of a bad thing, to say -- it may actually be a good thing that they may be using these services because it means they have someone looking out for them during this time period.

Our data really couldn't speak to a motivation or kind of moralizing whether these services should or should not have been used but kind of taking into consideration it may not necessarily be a bad thing that they're utilizing more services.

And that is the end of our data presentation. I'm happy to take any questions.

CHAIR SCHUSTER: Thank you so much, Dr. Conner. I think there were -- I think Dr. James had a question in the chat. Tom, do you want to ask that question, about the

confidence intervals.

DR. JAMES: Yes. One of the things about confidence intervals is it helps to differentiate the kinds of treatments going on within TCM, and are there best practices that we can glean from that?

DR. CONNER: Yeah. So the confidence intervals -- admittedly from this analysis, we didn't look at a lot of those directly, admittedly. That could be something we could go back and look at.

I will tell you that our P values were generally very, very small, which usually equates to a very narrow confidence interval. Whenever you're dealing with a population of about 170,000, that's going to make your confidence intervals pretty tight out of hand if something is significant.

So yeah, one of the things that I really wanted to include in lieu of that was kind of showing those means to allow someone to kind of make a judgment call as to whether there was any clinical meaningfulness in some of those analyses. Be happy to look into that more for you, though, if there's

anything you'd specifically like to be looking at.

DR. JAMES: Maybe the baseline disease entities for the two different groups which may impact some of that health -- healthcare resource utilization. It could be not related to TCM but related to what's physiologically going on.

DR. CONNER: Definitely. I will say that one way we did try to look at that, I mentioned that we had a measure of how sick an individual was. We used a Charlson Comorbidity Index, which was a ranked score from 0 to 36 based on different physical health diagnoses found in those populations of interest.

I believe the maximum score in both of our groups was an 18 out of 36. So comparably, they looked rather the same on those Charlson Comorbidity Indices, but I definitely see your point there about the different overall disease --

DR. JAMES: Right. And Charlson has got a low R square.

DR. CONNER: Yes. Very much so.

DR. JAMES: Okay. Thank you.

CHAIR SCHUSTER: Thank you so much, Dr. Conner. I wonder if there are any other questions. I think Margaret had asked about the fee for service, and Commissioner Lee had responded that there are folks with SMI that are in waiver programs or in long-term care and receive Medicaid benefits, so they would have been included.

Is that right, Commissioner?

COMMISSIONER LEE: That's correct, Dr. Schuster. We do have our 1915C home and community-based waivers and our long-term care members who have also -- most of those are in the home and community-based waivers, but it's more -- you know, the targeted case management is a little bit more intense than the case management that those individuals might receive through their -- through their waiver program.

CHAIR SCHUSTER: Right. Could we take the screen share off, please, Kelli? Thank you. Yeah. It would be good to see people. Thank you.

Any other questions from anyone?

We will send out the PowerPoint. I'm wondering, Commissioner Lee, if you would like to opine on what you heard from this, the combination of the BH TAC study and then this.

COMMISSIONER LEE: So thank you, Dr. Schuster. I think the first thing I would like to do is just thank you all for looking into this information and looking into the data and trying to ascertain what is happening when individuals get targeted case management.

And I think what I heard is that it keeps people out of the ER and that they can navigate -- they are given assistance in navigating the healthcare services specifically for them, which, you know, I believe that's a good thing. It means that they're getting the appropriate services in the appropriate location rather than going to the emergency room.

I also heard that individuals receiving targeted case management are less likely to die, that they live a little bit longer. So I think those are some of the --

some of the things that you were hoping to see with the result and the study of targeted case management.

And yeah, I think this is just the tip of the iceberg on some of the things that we can look at. I think definitely continuing to explore, you know, policies around targeted case management and other services in the behavioral health arena are definitely going to help us drive positive policy decisions as we move forward.

And I would like to ask if Deputy Commissioner Hoffmann would like to weigh in on any of the study. And I think that OHDA has done a good job, and the teamwork in this was very valuable as we -- as we move forward with these -- with the reports.

Deputy Commissioner Hoffmann, did you have anything to add?

MS. HOFFMANN: I was just going to say what a wonderful opportunity for these groups to work together. We did -- it was just a really good collaboration from sister agencies and OHDA and the TAC and -- with a good outcome that we can utilize, something

we can utilize to drive policy. So I appreciate that.

CHAIR SCHUSTER: Well, we certainly appreciated the easy working relationship that we had with the -- particularly the DMS data people because we were really -- we started out wanting the moon, I think, would be safe to say. And they were so helpful in helping us winnow it down, and they asked such good questions that it really helped us to focus.

I wonder -- Allen Brenzel, I see that you're back on. Do you have any comments about the data as you've seen it here?

DR. BRENZEL: I do not. I think it's a complex issue and, again, I think -- you know, depending on what your overall goals are, you know, there's more that could be done. But I think one of the initial issues around overall cost and -- it's hard to know what the right answer is because when you engage people and you get them in targeted case management and they get their routine health care and they get their

colonoscopy and they get their -- you know, that's a good thing.

What we had hoped to see is a decrease in ED utilization -- right? -- in terms of getting people into appropriate services rather than emergency departments. But it's very hard to break that down. There's lack of continuity in this population. Capturing folks who got consistent amounts and months of services was challenging. Folks go in the hospital; they come out of the hospital.

But I think the -- that, overall, I think this did show that there's substantial value in the service. Granted, that it could always be improved and that we need to look at fidelity and who's getting what kind of services. But it was a Herculean effort and did -- do appreciate the collaboration with Medicaid data folks.

CHAIR SCHUSTER: And Steve Shannon or Kathy Dobbins, you were on the home team, so to speak. Steve?

MR. SHANNON: I'm going to give the message I've given throughout, that sometimes

the ER is the right place for people to be, you know. And we've never really been able to segment that out, that in a real emergency, that's where they should be. I'd just like to remind people of that, so not every ER visit's inappropriate. Some are appropriate. We just want to make sure.

But, you know, I was encouraged again that people are accessing care, you know. And that's really what needs to happen, and that's beneficial. And if you access care, you're going to be in a better place, you know, the thought process we all have.

So I'm glad that our initial little work that wasn't profound led to much more significant work and much more science than we ever added; right, Sheila?

CHAIRMAN SCHUSTER: Yes.

MS. MUDD: I mean, considering the population with mental illness like myself, the statistics say that we die 25 years younger than people who don't have mental illness, you know. Anything we can do to extend our lives is very, very helpful, you

know, so there you go.

MS. DOBBINS: Absolutely. Extending people's lives and fewer -- I believe we saw that there were fewer -- there was greater use of non-emergency medical transportation which would suggest the supportive services are helping to link people to non-emergency transportation, which is less costly.

And I think there -- I believe we saw that there were fewer hospitalizations or less cost in hospitalizations, which seems like a big -- very big plus. But definitely, you know, to see the people who are getting the service are living longer is a great thing.

MS. LANHAM: Yes, ma'am. I'm all right. I'm watching the Behavioral Health TAC.

CHAIRMAN SCHUSTER: Could you mute, please? Thank you. Go ahead, Kathy.

MS. DOBBINS: Well, no. That's all, just really kind of echoing what Val said. You know, if TCM is able to impact life expectancy in a positive way, that, to

me, is enormously important to recognize.

CHAIR SCHUSTER: Right.

MS. DOBBINS: And -- yeah. I mean, that kind of -- that says it all, really.

CHAIR SCHUSTER: Yeah. I was disappointed about the homelessness and, you know, the two things that we weren't sure that we could really get a handle on.

And I guess I would ask you, Dr. Conner -- and we may have talked about this when you first gave us the PowerPoint. How did you -- how did you find out who was homeless and who was not? Do I remember that?

DR. CONNER: I believe we did discuss this, but I'm happy to give more information on that. And whenever I start failing on my technical knowledge here, I know one of the main data analysts that helped us with this, Patrick Perry, is also on the call, so he can fill in anywhere that I have gone completely off base here.

But we used our IEES system and our Medicaid systems, our Integrated Eligibility and Enrollment System, which is the data

source that's used to track eligibility and enrollment for the Medicaid program. And that data did have an indicator or a way to identify a person as being eligible because they were homeless. So it was someone who had ever identified as having a living arrangement of HL which meant homeless and/or living in a shelter of some type.

And, again, it has some questions associated with it. It may not necessarily be the best. We may be undercounting in a lot of ways, but we wanted to really use it as an approximation for the population's outcomes. We didn't necessarily want to use it as, like, a flag to identify the persons themselves.

So kind of knowing that that statistic has a little bit of murk and mud around it. Again, it was just an approximation. We believe it is a pretty good approximation based on Medicaid's enrollment system, but it is an approximation nonetheless in that regard.

MS. DOBBINS: So, Sheila, it doesn't surprise me that we would see a

higher percentage of people who are homeless who are getting the service because those are folks who have really high needs. And if that's when they come into --

CHAIR SCHUSTER: Well, that's true. That's true. I was thinking of the end result being hopefully the targeted case management got them into some more permanent housing. So I was -- you're right. You're exactly right. So the people that are homeless are the ones with the greatest need for targeted case management.

MS. DOBBINS: And, I guess, Kailyn, based on what you were just saying, we couldn't really see if their housing status or homelessness status changed over the time they're getting TCM. Was that right? So we hope it did, but you weren't able to identify that, I don't think, but correct me if I'm wrong.

DR. CONNER: I'm going to actually defer to one of our analysts on that one. I'm not entirely certain on how that looks. Patrick, do you have a good answer for that one?

MR. PERRY: Yes, ma'am, Dr. Conner. This is Patrick Perry, statistician with ODA.

The homeless indicator from IEES was taken as documented at least one time as homeless within our study window. And that was the only way that we took it, as an indicator, so it was a dichotomous variable.

So we did not follow if individuals remained homeless, their housing status changed, or anything like that. It is if they -- during their TCM journey, during our study window had ever indicated as homeless.

CHAIR SCHUSTER: Yeah. So that -- thank you so much. That really makes sense. So that's a one-time indicator, and I think you're right, Kathy. You know, you all are identifying -- providers are identifying the people that are most in need of targeted case management, and the people that are homeless would be in that category.

I guess the other piece that we toyed with and we couldn't figure out a way to do it, we would have to go to the Administrative Office of the Courts. And that is to look at: Is there any difference

in those two populations that you have, Dr. Conner, in terms of -- with targeted case management and without in terms of their contacts with the criminal justice system.

And we really -- you know, that was not -- we couldn't figure out how to do it. That's not Medicaid data obviously, and you all didn't have that as well. But that would be the other piece of this study that would be really, really helpful to get a handle on. I think it would be the outcome in terms of homelessness and then it would also be that, you know, interface with the criminal justice system.

So anybody else have anything else? We're so grateful to the folks at Data Analytics, and Dr. Conner has been very patient with us the first time around. And the second time around, it certainly took our little study -- although our study, I think, was right in line, actually. I mean, we had the right idea in terms of a time sampling.

I love it that yours is over a longer period of time because I think it gives greater weight to those variables, and

you were able to, you know, look at more people and do that, you know, linked study with the -- with TCM and without TCM. So that's great.

And Matthew is saying Appriss is -- oh, has the incarceration criminal justice data. Yeah. That might be worth going back and looking at at some point.

So we appreciate so much your presenting, and we will send that PowerPoint out to everyone that is on our list. We'll make sure that gets out to you. And thank you so much for being with us and your colleagues as well.

DR. CONNER: Thank you all so much. It was a joy.

CHAIR SCHUSTER: Thank you.

Commissioner Lee, I know you have to leave us shortly. Any other data studies that you have in mind for us to do, now that we have figured out a little bit how to do these things?

COMMISSIONER LEE: Yeah. I was going to say, what are the next steps now with -- you know, with the study?

CHAIRMAN SCHUSTER: Yeah.

COMMISSIONER LEE: Is there anything that we can use here? And I just think it's up to the Behavioral Health TAC to try to determine what they want to look at, what data, what reports you think would be useful now that you know the system and, you know, that -- how -- what sort of data we have and how we can use it.

So anything that this committee is interested in looking further into, any sorts of specific procedure codes or services or even regional differences. I mean, that's the other thing, I think, with the targeted case management, always looking at, you know, regional differences.

Is it being promoted or utilized more often in one area than another may get back to some of those best practices, which providers seem to be delivering the services more often and who seem to be getting results. And what can we learn from them, and would we like for them to come and speak to this committee?

CHAIR SCHUSTER: Yeah. That's

excellent, and we will certainly take a look. I think people want to look at the data and, you know, have a chance to really dive into the figures and so forth. So let's put that on our agenda for our May meeting, to kind of come back and look at that.

Appreciate that invita- -- and so appreciate your making the DMS folks and then the Data Analytic folks available to us because it certainly helped us in laying out our study.

COMMISSIONER LEE: We're definitely your partners and believe that this TAC, the members of this TAC have the expertise to know what to look at to help drive those policy changes. So we -- we definitely will work side by side with you as we move forward trying to figure out what exactly we need to look at that would help us drive some policy.

And I know that we have the annual report, the 2020 -- it's a little bit dated, but this committee could look at that report. And I think you can see that some of the -- the major or the top diagnosis and procedure codes that are outlined in that annual report

do relate to behavioral health. We do hope to update those reports here in the next few months to give a 2021 and 2022 report.

And if we continue to see those same trends as behavioral health being one of those top diagnosis codes, you know, what do we -- what do we need to look at as far as workforce and maybe providers in the community or anything that we can do to promote the use of behavioral health services within our population and our provider community.

CHAIR SCHUSTER: Yes. And you presented that annual report to a number of legislative committees, so we need to get that out as well to the TAC members. So we will do that.

COMMISSIONER LEE: We plan on posting that online, too, so we'll send out a link as soon as we post that online.

CHAIR SCHUSTER: Wonderful. Thank you so much.

While you're still on, I want to bring up this next item because it has been the source of great angst among some of the

providers. And that is that the billing codes for extended length of behavioral health service sessions has been done away with, as best I can tell.

This was a recommendation made by the AMA group to CMS and really caught people by surprise. Bart Baldwin brought it to our attention under new business in our January meeting, and there's been quite an exchange of information but no real solutions.

And I'm wondering if -- and maybe, Leslie, this question to you or Commissioner Lee about what you all have looked at and where you are with this.

COMMISSIONER LEE: We have. We have been having lots of internal discussions. We have reached out to our colleagues in other states to see how they're handling this. We're getting a few little responses in, but I think Leslie and her team have been working on this topic specifically.

So, Deputy Commissioner Hoffmann, you want to weigh in on this?

MS. HOFFMANN: I was just going to mention that, Sheila, when we spoke before, I

said communication was forthcoming. And because it hasn't come out yet is actually a benefit to the providers because we decided to stop what we were doing and take the time to do the research with other states and look at the coding guidelines, and how are other states addressing the -- because it's not just Kentucky. It's everywhere. So we wanted to take that time.

We have come up with a couple of proposals, and we have a meeting on the 17th to discuss that internally. So I just wanted to let you know it's not that we didn't send out the communication. We decided to take a deeper dive into research with the other states.

CHAIR SCHUSTER: So when you say that you all are meeting, and I assume that that's an internal meeting, in terms of if there's anything that you might be able to recommend for providers?

MS. HOFFMANN: Yeah. If you can -- so our meeting is on the 17th, so let us get through that meeting. I want internally our executive leadership to take a look at a

couple of proposals that our behavioral health team has come up with, if that's okay, Sheila.

CHAIR SCHUSTER: Okay. I know that we're hearing from, you know, quite a range of providers about what difficulty this is creating particularly for people with, you know, really significant behavioral health needs. And apparently, we got a little bit of hint from some national groups that yeah, they're aware of it, but nobody's quite weighed in yet to see if something might be proposed at the national level.

Are you hearing that as well, Leslie, or --

MS. HOFFMANN: I'm hearing from other states having the same issue, so I'm guessing that the national level is hearing from the other states as well.

So I do think it's good that we tried to stop a second, though, and try to do some research about some other proposals we might be able to come up with.

CHAIR SCHUSTER: Yes. So let me ask you -- and I ask this only because, you

know, this TAC won't meet again until May -- whatever it is -- 9th maybe, if there might be some communication back to me that I might be able to share with people after -- at whatever point after you all meet on the 17th, if you have recommendations or at least some information that I might be able to share.

MS. HOFFMANN: Sure. I don't mind at all.

CHAIR SCHUSTER: Okay.

COMMISSIONER LEE: We understand the importance of this issue, Sheila, Dr. Schuster. And we will definitely get information out just as soon as we can, and we hope, you know, very shortly after our meeting on the 17th to have some sort of solution.

CHAIR SCHUSTER: All right. That would be super because, again, there really are -- I think partly what's happening is that providers are running into this. You know, it takes a while for it to kind of filter down, and maybe people haven't encountered it quite as early as it came up

in our January meeting. But more providers are coming forward and saying this is truly a problem, and it's across age groups, of course, in terms of what the needs are.

So I appreciate that, and I will be on the lookout. And as an Irish woman, since you're meeting on St. Patrick's Day, I'm going to hope you have good luck in coming up with some workaround or alternative or something like that.

Does anybody have any other additional questions about this topic?

(No response.)

CHAIR SCHUSTER: All right. Then we'll go on to the next thing. And I don't know if Justin Dearinger is on. We were looking for something that was going to be posted on the website about reporting patient no-show data. And I have not seen -- I actually have not been on the website to look. Is that up yet?

MR. DEARINGER: This is Justin Dearinger. No, unfortunately not. We are still working on that. I'm checking on it each week to make sure that it's being worked

on, and it's just not quite ready. I think it was a little more complicated than they thought it was going to be. But we are working on that and checking on it each week, so it should be up very soon.

CHAIR SCHUSTER: All right. So, Justin, you have my email address. Do you mind letting me know when it gets posted?

MR. DEARINGER: Absolutely. I will send that to you, send you the link, and we will be sending that to a lot of different providers.

CHAIR SCHUSTER: Yes. I'm sure. I'm sure you will because there's a lot of interest in it. And I think it could be a really helpful tool for our members, actually, is what I'm thinking about, particularly people with behavioral health issues who maybe are not navigating problems that come up that are really social determinants of health, transportation, child care, those kinds of things. And it just adds to their angst, and they just don't get to appointments.

So I appreciate that, Justin. I

appreciate your working on that, so we will look for that. Thank you.

MR. DEARINGER: You're welcome. Yes, ma'am.

CHAIR SCHUSTER: I understand that there's been some movement on the creation of a uniform bypass list by the MCOs for the dual eligibles on the commercial side.

MR. ELLIS: That's correct.

CHAIR SCHUSTER: Who's answering that, please?

MR. ELLIS: This is Herb with Humana.

CHAIR SCHUSTER: Herb with Humana. Great. I was going to call you out because Steve Shannon told me you were the guy or so.

MR. ELLIS: That's fine.

CHAIRMAN SCHUSTER: This is great -- this is great news. Herb Ellis. Tell me -- tell me about it.

MR. ELLIS: Sure. It's a collaboration with the Department and with the other MCOs to streamline the process on being able to process claims primary under Medicaid that we know have services that are

not typically covered by the commercial plans.

So, you know, right now, we require -- based on the Department's policy or remittance, this shows that you all did some kind of a due diligence review with the primary coverage when it's commercial before being processed as secondary under the Kentucky Medicaid program.

This bypass list has, I believe, about 82 procedure codes and three modifiers, that if the claim contains just those codes or just those modifiers, we will not require remittance. It'll just automatically pay as primary under the Medicaid program, very similar to the Medicare bypass process.

Biggest difference is that we don't take into account provider type codes. So we're not going to look at your diagnosis codes. We're not going to look at your provider type codes, your taxonomies. It's strictly based on these specific procedure codes and the three modifiers.

And we're targeting a 5/1/2023 go light. That's for all the MCOs. And as of

last Friday, we're all still on target for that. The Department did give us a green light to move forward on that -- that bypass list.

We also built into the process the ability to utilize a streamline and centralized attestation form. It's similar to one that WellCare has had in place for a while now, but all the MCOs agreed to use the same attestation form.

And that's basically there for those situations when the primary commercial carrier will not issue remittance. Then you can complete the attestation form, and it shows that you did your due diligence to try to get a coverage analysis from that primary commercial insurance company. And you can attach that to the claim when the codes on the claim are not on the bypass list. So that's what that attestation form is for.

Outside of the attestation form and the commercial bypass, everything else is standard procedure for, you know, remittances that we receive, and we'll process secondary to the remittance.

CHAIR SCHUSTER: Wow. That sounds fabulous. This is one that -- Steve Shannon and I, our typical thing is we've been working on this for 20 years. This -- this sounds great.

Let me see if anyone has any questions or -- well, let me see if I've got this, so I can put it in the minutes. So, basically, going live on May 1st of this year will be a list agreed to by all the MCOs in coordination with DMS of 82 procedure codes and three modifiers so that if those are the codes that are on the claim, they should go through without any additional paperwork or attestation or proof that you've done your due diligence and gotten a rejection by a commercial insurer if the patient is covered by both Medicaid and a commercial insurer.

MR. ELLIS: Yeah. Let me just -- it's actually 88, so I misspoke.

CHAIR SCHUSTER: Oh, 88.

MR. ELLIS: 88 procedure codes and 3 modifiers.

CHAIRMAN SCHUSTER: That's even better.

MR. ELLIS: And the 3 modifiers are TD, U5, and U6. And then there's -- like I said, there's 88 modifiers and -- sorry, 88 codes.

And, basically, we took the BH fee schedule, and it's the BH fee schedule that we then used across all the six MCOs to compare to our internal commercial plans and then looked at the utilization rate and cost tied to those codes. And anything that fell below 10 percent coverage is what we then put in as an acceptable code to bypass.

We'll still do pay and chase for the Department that might be interested, you know, for those codes that -- we did see some coverage across our commercial plans, but it was just very low. We'll still do our own pay and chase with those commercial plans. We just won't be going after the providers for it.

CHAIR SCHUSTER: Great. And then in the case where you have a code that's not on that list, you all are -- have agreed to use the same consistent attestation form that a provider can fill out and send in with

their billing.

MR. ELLIS: If you can't get a remittance.

CHAIR SCHUSTER: If you can't get a remittance.

MR. ELLIS: Yeah, yeah. That's what that -- that attestation is only for that rare scenario -- interesting. We haven't yet found one, but we've heard that there are apparently some commercial plans out there that won't even issue a remittance on certain codes if the codes are not covered. So if that ever happens, that's what the attestation form is for. But otherwise, you would expect to see a remittance.

CHAIRMAN SCHUSTER: Yeah. Okay.

MR. ELLIS: And we also have a process where any other codes outside of the 88 that we've talked about and the 3 modifiers -- if there's other codes that the providers or even the agency for the BH providers are interested in the MCOs taking a look at to see what utilization costs and rates are across the plans, we'll entertain

those as well. And so this is not like -- you know, this is a living, breathing document, if you will.

CHAIR SCHUSTER: Yeah. Wonderful. We so appreciate the MCOs coming together and working on this.

Let me see if there are any questions of anyone who's on the Zoom, any providers that have any questions for Herb. I can't see you, so you're just going to have to speak up if you have a question.

Yeah. Kathy Dobbins says: Would you make the 88 procedure codes available to this TAC group?

MR. ELLIS: Sure. I can share that. I know I shared it with Steve, and I can share that with you all.

CHAIR SCHUSTER: Okay. Great. Yes. That would be great.

MR. SHANNON: This is a big deal, really. We've talked about this for a long time, and we appreciate the leadership of Herb Ellis and his MCO partners to get us to this place. So we're excited about that.

CHAIR SCHUSTER: Well, we're really

excited, Herb, to be able to take off this agenda item for dual eligibles, which --

MR. ELLIS: Yeah.

CHAIR SCHUSTER: -- you know, we've had on there for months and months and months and months, years and years, so thank you. Thank you to you and to your counterparts and all of the other MCOs. We really appreciate that. And I will look for to you send me the list, and I will get it out to folks.

MR. ELLIS: Abso- -- we will. One question no one has asked yet. But it's for dates of service, 5/1 in 2023, just as FYI.

CHAIR SCHUSTER: It's for dates of service starting 5/1/23 and going forward?

MR. ELLIS: That's correct. That's correct.

CHAIR SCHUSTER: Yeah. Okay. All right. That makes sense. All right. Wonderful.

MS. MCFALL: This is Paula from WellCare, and I was just wanting to make sure people did try to get the attestation even if it was a code on the list so that they have their own proof if they are audited. I want

to make sure people understand that it's important to bill the primary.

MR. ELLIS: Yep. And, Steve, we talked about that -- right? -- that until such time and/or if the Department decides to change their policy, they still have that due diligence review that's required by the providers to go to the primary insurances for coverage.

I know that's an open issue or open question with the Department for review, to see if they'd be willing to, you know, accept an attestation and keep it on file for a year. But at this point, we haven't seen a decision, so right now, that's the current state's policy.

MS. MCFALL: And then another question from our operations VP, Rebecca Randall, is -- I think, is there a communication plan, that DMS is going to provide this to providers? Or how are we going to work through that? I mean, we can do it through TAC meetings, of course, and our other meetings like the CMHC meetings.

MR. ELLIS: Agreed. Yeah. And

that is also an open issue with KDMS for review as well. We -- you know, as you know, we did create the MCO version as well for the provider outreach in case the Department decided to default back to the MCOs. But we do believe it would be best interest to have just the one notice go out to the providers and hopefully from the Department versus the six that they would receive.

CHAIR SCHUSTER: Leslie or someone from DMS, can you respond to that, please?

MS. HOFFMANN: As far as sharing with other folks?

CHAIR SCHUSTER: Yeah.

MS. HOFFMANN: Yeah. We can run that through our communication. We can put it on websites, banners, or anything like that that we need to. Jonathan also covers most of the list serves.

CHAIR SCHUSTER: So I guess what we're asking is: Is DMS going to take responsibility for getting it out to the providers as opposed to each of the MCOs getting it out to their providers?

MS. HOFFMANN: I think that's fine

since it's a request of the TAC.

CHAIR SCHUSTER: Okay. Great.

MR. ELLIS: And I'm willing to share that draft -- we created a draft for the Department to use if they're interested in it.

MS. HOFFMANN: Okay. Thank you, Herb.

MR. ELLIS: I'll -- if you want, I can share that to this TAC as well. It's not --

MS. HOFFMANN: Yeah. I'm open to whatever we need to do to get the word out so --

MR. ELLIS: Perfect.

MS. HOFFMANN: Yeah. You and I can work on that outside of here and then report back to Sheila.

MR. ELLIS: Yes, ma'am.

CHAIR SCHUSTER: Yeah. That would be wonderful. Thank you so much. Wow.

So Kathy Adams is saying: How will the DMS communication be issued? And I think that's what -- that's what Herb and Leslie are going to talk about --

MS. HOFFMANN: Yeah.

CHAIRMAN SCHUSTER: -- and then they will let me know what the plan is.

MR. ELLIS: That's correct.

CHAIR SCHUSTER: Okay. Thank you. Wonderful. Our undying gratitude, Herb, and the MCOs. I'm so glad to check some things off the agenda.

Leslie, you're up on status update on the waiver for SUD services, SMI waiver, the request for extension for Team Kentucky, and all of those things.

MS. HOFFMANN: Yeah. I made some notes here because I didn't want to leave anything out, Sheila, so just bear with me.

So on the incarceration amendment, CMS reached out to -- I think there was 12 states on a call that all had some form of amendments, 1115 amendments related to incarceration, and they varied. They varied a lot.

CMS, you know, mentioned on the call that Kentucky is very unique. You know, we have a really robust relationship with sister agencies and with Department of

Corrections as well to help provide some of those services.

Our amendment was for SUD. Where California's was recently approved, it's for all populations as well as juvenile justice, and they have a 90-day post-release coverage. So it's a little bit different than ours.

So we were specific, like I said, to SUD, and then we have a 30-day post-release and then we also want to cover pretrial. Because in Kentucky, lots of folks sit for a long period of time without anything, so we want to make sure that we can catch those pretrial folks as well.

That day, we did ask for CMS to have a one-off meeting with Kentucky. We still do believe we are first in line to have those conversations even though California was approved first.

They said that there will be additional guidance that's coming out in a state Medicaid director's letter very soon and suggested that we not make any substantive changes to the amendments -- any of the 12 states make substantive changes to

what they currently have in with CMS. So I think what they were getting at is, let's try to get approved what we've got now with them. They mentioned that they had over 55 1115s to review, and they weren't going to get to all of them before the end of the year.

So they were very pleasing to work with. And I reached out again today and asked for our one-off meeting. So as soon as I get additional information on the incarceration amendment, I'll let you know.

As you're aware, too, we've got a couple of bills as well as the Omnibus Act that we're now looking at for juvenile justice, so that's forthcoming as well, too.

Our overarching Team Kentucky 1115 is still with CMS, and we're awaiting for feedback. We do still meet with them every month, but we do not have feedback on the overarching 1115 yet. And that, of course, included SUD, NEMT pieces that you're aware of, former -- there's a piece for former foster care and a piece for employee-sponsored insurance. So there's a couple of little pieces that go into that big

Team Kentucky 1115.

Our SMI 1115 amendment is expanding, so I wanted to explain that to you. We've mentioned that the SMI amendment is expected to move to public comment period sometime in spring. We did submit a draft to CMS, I think, the last week of December. But we are now having a companion waiver to that one, and they will work in conjunction together to fill in the gaps that we have here in Kentucky. So we'll have a 1915(i) as well as the 1115 amendment.

And I know that's a lot of numbers and a lot of acronyms. Basically, what we're trying to do is to encompass, Sheila, all the needs of the Kentucky members from the institutional level of care all the way up to folks who just need the pre-tenancy housing and maybe some supported employment and other community things like that.

So our 1915(i) is currently in development through -- we're doing the current research, state research, the targeting interviews, which I think, Dr. Schuster, you and Steve have participated

in maybe at least one of the interviews.

CHAIR SCHUSTER: Right.

MS. HOFFMANN: Those are going well and to align with the other existing HCBS benefits. We hope to have the analysis and the draft completed mid to late summer, conduct the town hall sessions like we normally would, post for public comment, and finalize and submit the 1915(i).

The public comment would be sometime around, again, mid to late summer, so we'll keep you involved. And you know I always try to meet with you and several of the other advocates just to let you all know where we are in our behavioral health solutions for Kentucky so...

CHAIR SCHUSTER: Right.

MS. HOFFMANN: Any questions?

CHAIR SCHUSTER: Yeah. Does anybody have any questions?

(No response.)

CHAIR SCHUSTER: So there's movement on all of those pieces. I think I see where Brenda Benson is on, and I know the question comes up all the time about the SMI

waiver for supported housing and supported employment. And I think that adding that 1915(i) piece to the 1115 amendment piece makes sense. So we were pleased to be on the -- you know, have the interview and so forth going forward. Thank you for that.

Mary Hass, update on therapy service access for individuals on the ABI waiver.

MS. HASS: Unfortunately, we're still in limbo. The latest that I had heard is that the therapies are still in the waiver. We have not gotten any indication that it has went to the extended state plan.

My biggest concern is we had a meeting back probably two, maybe three months ago that we were going to start talking about transitioning because we're losing a lot of our skilled therapists. I've got notes from two people -- because we had a 1915C waiver day yesterday at the capitol. And one of the concerns that the -- several of the providers brought to me was that they're losing their skilled therapists.

On another note, one of the

providers came to me and said that their local hospital asked them to do cognitive therapy, cognitive rehab therapy with some of their patients in the hospital. And so that was good news, but the bad news is that we're losing those skilled speech therapists who usually take the lead on the cognitive rehab, cognitive therapy, whichever way you want to say it.

So anyway, so right now, the therapies are still in the waivers, and I think we're just waiting for CMS. The latest I heard now was probably July. Leslie might be able to give a better update, but that was the latest I heard.

And then when I seen Pam Smith yesterday, she told me we now do have a waiting list for the ABI long-term care waiver. So we still don't have a waiting list on the acute. I don't know if there's something that could be worked out with someone who possibly is waiting on the long-term care, you know, so I don't know.

But right now, to answer your question, we're still in limbo.

MS. SMITH: So I can give -- I can give some updates. So yes, CMS does still have the waivers. They're within their 90-day window. We have not heard anything back from them. And we also, in addition, committed at least -- once we do get the waivers back, at least a minimum of a 60-day transition period. So we haven't even started even talking to -- talking about transitioning or doing anything with fee therapies. They are completely as they have been. We have not made any changes.

On Tuesday -- yes, ma'am, I did let you know -- I did let Mary know on Tuesday when I was over briefly that morning -- and I was thankful to be included in the 1915C waiver day -- that we do have a wait list for ABI long-term care.

The new waiver year will not begin again until July. What we are doing until that point -- it's less than ten individuals. I think we're at either five or seven. I have the staff actually evaluating them. Two, if not three, are actually still receiving services on the acute waiver.

There were a couple that were receiving services in HCB.

But what our plan is, because we have a sufficient number of acute slots, is to serve those individuals on the acute waiver until we have the slots. We, you know, turn over the waiver year in July, and we'll have slots open again and then we can transition those individuals.

They would be the first ones that would be able, then, to transition into those open slots on the long-term care. But we -- it is our intent to get them services. If they're not already receiving services through acute, to get them services in the meantime until we have the slot open in long-term care.

CHAIR SCHUSTER: So those people, Pam, are going to be served while they're waiting?

MS. SMITH: Yes, we are. We'll reach out to the individual. In most cases, it's a case manager that did the assessment for them or helped them do the -- do that application. We'll reach out to that

individual and let them know what's happening and have them help us coordinate with the individual themselves or their family member, so they, you know, don't wonder why they're all of a sudden getting assigned to the acute waiver or what's going on. So there will communication with them, but we're working on doing that -- we're working on doing that right now.

CHAIR SCHUSTER: Okay. So when you say that CMS has the waivers, I'm a little bit confused.

MS. SMITH: So we had to -- both of those waivers were due for renewal last year. They came to the end of their five-year approval period. And so right now, we are functioning on a technical extension.

So CMS has those, and they're back on the clock for them -- the 90-day clock for them to review the waivers and then to either issue us another approval, which will give us another five years, or until we have to amend them again, or they will ask us questions. They'll send us back a request for additional information. But they still are within their

review period of looking at that -- looking at those applications.

But it -- we -- I don't know how. I guess it just naturally happened that all -- all of our waivers between the end of 2021 and somewhere within 2022, every single one of them was due for a five-year renewal. So -- and it all happens right at the same time. As you know, we're working on things with rates and where we'll be amending them fairly soon, hopefully by the end of this year.

So it's been kind of the -- quite the merry-go-round process of looking at the waivers, changing what we can, submitting it to CMS.

CHAIR SCHUSTER: Right.

MS. SMITH: So -- but hopefully we will hear soon. And as soon as we hear back, then we will start -- we'll communicate again.

I don't want to go ahead and send out -- we're sending out several communications right now about unwinding and a lot of really important things, and not

that this isn't important. It is very important. But I also don't want to send out a deluge of communication and things get lost, or people get confused. So we're kind of weighing right now. We're communicating as people come to us with questions.

And, Mary, if you can, those providers or any of those people that came to you that you feel it would be beneficial for us to reach out to and talk to, if you'll send that to me, I'm more than happy to talk to them.

But we're trying to balance what the right communication level is because we don't want to scare people. But we want people to have the right information. But I also don't want it -- I want them to make sure they're able to absorb all the different communication that's coming at them at this time, too, so...

MS. HASS: Yeah. What I have communicated to them was to contact you, as just as I had said, that we're in the limbo period.

MS. SMITH: Thank you.

MS. HASS: And -- but I think the uncertainty -- the thing that's causing me heartburn and it's really concerning is that we're losing some of the skilled therapists that have been serving these folks for a long time. And I think it's that uncertainty that, you know -- because I know this is -- like you said, it's been going on for a fairly good while.

And, you know, people -- they just have to make a living. And some say, I just can't hang on anymore, that, you know, it's just the uncertainty and that if they're offered another job, a lot of them are taking it. And I think that's -- to me, that's where the concern is, is just, I think, with the providers.

And I have said, you know, just as I spoke a while ago, is that it's just -- we're in limbo. I don't know. They keep saying, well, when? And I go, I don't know. And so I have said --

MS. SMITH: I wish I could give a better answer. But, unfortunately, that's -- we're at the mercy of CMS -- of CMS right now

so...

MS. HASS: And then that's what I've explained to them, is just, you know, right now, I can't tell them. They ask me when, and I go, I don't know. I can't answer. And I have, you know, suggested that they call you, and I don't know if they have or haven't.

But that's always been -- especially even yesterday, when two or three of the providers came up to me, you know. And luckily, we do appreciate you being there yesterday because I think that was helpful. I know a couple of the bits of information you gave was very, very, very welcoming, and so anyway.

But yeah, it's just that uncertainty. And for me, you know, I've known a lot of these therapists for many years, and it's disconcerting that they're going to leave the field, and especially, you know, when our folks -- by therapies is how we get better. That's how our folks get better.

So anyway, but we'll continue. And

I look forward to continuing the process, as I said yesterday, and we'll see what we can do.

CHAIR SCHUSTER: Yeah. So both the ABI acute and ABI long-term, they came up at the same time, Pam, for a five-year renewal, and they're with CMS; right?

MS. SMITH: They -- yeah. They're staggered a few months apart, but based on just how the whole process has went -- one of them -- and I'm going to get it backwards. Acute -- so acute came back to us, has already been back to us for a response to questions, and so it's in the second part of the review. And long-term care is just in the first -- the first part of the review.

So they're kind of in different phases of the review with CMS. We haven't received any requests for additional information on long-term care yet, but the acute is in its -- they're reviewing after we responded to questions. So they've had it now for the second time.

CHAIR SCHUSTER: Okay. Well, we appreciate your being on and responding. You

all may remember that we made that recommendation to the MAC about improved communications, and I usually have -- by this time, have heard -- have gotten a response from DMS to our recommendation. But I don't believe that I have gotten that yet, so I will share that when I get that.

The provider credentialing through KHA and Verisys. And I know that Claire Arant who's usually on the TAC meeting is out of the office, but I don't know if there's any update on that. Do we know --

MS. EISNER: I haven't heard -- this is Nina Eisner. I haven't heard anything.

CHAIR SCHUSTER: You haven't heard anything?

MS. EISNER: No, I haven't. But I did just text KHA, because I knew Claire wasn't there, to see if I could get any other update. So if I do, I'll jump back on.

CHAIR SCHUSTER: Yeah. Thank you. I appreciate that because we've been waiting. I think we were hoping it might be live maybe last October or so, so hopefully soon.

We did have, in new business last meeting, questions about an RFP that's going to come out on mobile crisis services in Kentucky, and I think Kelly Gunning raised some questions about this has always been something that the CMHCs have provided and, you know, why is this coming up and so forth.

And we do appreciate DMS making available a PowerPoint that I sent out to everyone with some of that background. So, Leslie, what can you share with us at this point?

MS. HOFFMANN: So, Sheila, if it's okay, I'm just going to give you a short summary about where we are. Again, I can't talk a whole lot today, but I thought I would go ahead and give you just a little bit of the background for those who might not have been involved in the beginning. I've given mobile crisis presentations a lot over the last year, so if you haven't heard one of those presentations in other arenas.

So DMS was tasked by the Cabinet to develop an all-inclusive mobile crisis model for the state of Kentucky, and anyone would

be eligible regardless of age or gender or genetic information or anything like that. Regardless, we want them to be covered for a crisis in the community. We worked extensively with our sister agencies, and we developed some main focuses. And those were to enhance and redefine existing processes, to divert from emergency rooms when unnecessary, Steve, and to divert from psychiatric hospitals when unnecessary.

We want to divert from incarceration or from confinement, and we want to minimize unnecessary law enforcement involvement and to acquire the appropriate level of care for the person in crisis because sometimes that is not what happens. So those were our main focuses.

As you remember, DMS received a mobile crisis planning grant. It was a little over $800,000. And that was for a year, and it ended September the 30th of 2022.

One of our major accomplishments was the planning grant, which some of you took part in -- not the planning grant. I'm

sorry, the needs assessment for Kentucky. And that project took over three months, and is it was, like, 250 pages. It is on our website. If anybody wants to take a look at it, I can get that out.

We wanted to develop a unique assessment through just talking about boots on the ground, what works, what doesn't work, collaboration, communication, interviews. We did lots of research related to what we currently have and what's working and what's not working and where the gaps were in Kentucky.

So we used the needs assessment after the grant was over to drive our future plans for our implementation. We're currently looking tentatively for October of 2023 for the implementation, so that's tentative, Sheila.

We've also recently applied, for your knowledge, another HRSA grant. It's called a Rural Health Network Development to help in some of those rural areas that have limited access or limited resources available to them.

We are -- DMS behavioral health initiative is utilizing the mobile crisis as our racial and health equity model. I wanted to mention that because if you've been on other calls with me, I use mobile as my racial and health equity model. It was the first time that we really took, like, a particular project before we moved forward with it and really went that extra mile to view the project through the lens of racial and health equity and cultural humility.

And so we're kind of making that our model, so we continue to work constantly on how to expand the communication, how to reach folks who don't have access or who don't -- they don't reach out for access, how to engage those people.

So I just wanted to let you know that. And we can come later, Sheila, if that's okay, and talk again about mobile, but that's where I am right now. We're not doing this to exclude anybody. We are enhancing and refining. So, again, I can talk a little bit more about that later if it's okay.

MS. HASS: Sheila, may I ask a

question of Leslie?

CHAIR SCHUSTER: Sure.

MS. HASS: Leslie, when you say mobile and it's open to all populations, would that be someone who would be in the ABI waiver and they have a crisis situation? And the person is not wanting to go to the hospital because they actually are not a threat to themselves, but they're a threat to the other individuals in a group home. How would that work?

MS. HOFFMANN: So we're currently not -- we've been working with CMS. We're currently not allowed to go into a Medicaid-covered paid service so, like, a nursing home either. So I've got staff on, too, if I misspeak about anything.

We are taking a look at, though, if we can assist with the waiver clients. I've been asked several times about children in the waiver programs. If they're in the Michelle P., they're not necessarily receiving a residential service.

So I can let you know more about that later, Mary, but that's an excellent

question.

CHAIR SCHUSTER: So let me see if I understand your answer, Leslie. You're saying that there's a prohibition against going into any facility that's receiving Medicaid coverage?

MS. HOFFMANN: Coverage or payment. Leigh Ann, are you on? Am I stating that correctly? Sorry.

MS. FITZPATRICK: Yes. It's a federal rule through CMS that the mobile crisis cannot go into an ED or to a hospital facility or a facility that's a Medicaid-recognized and enrolled facility.

CHAIR SCHUSTER: So if somebody is in a nursing home, you can't -- mobile crisis could not go in?

MS. FITZPATRICK: Correct. CMS says that within that per diem rate within the nursing home, that those services are included so those -- you know, behavioral health services are included in that. Same as with the emergency department. Those behavioral health services should be covered and included within the coverage of the ED.

And we do know that that's not always happening, so we are -- I speak with CMS about every other day so -- with asking questions, and we are working on that. That is a CMS federal rule.

CHAIR SCHUSTER: Okay. That's interesting.

MS. HOFFMANN: We get asked a lot, Dr. Schuster, about the nursing facilities, elderly population in crisis in a nursing facility, and can we come there and assist? And so far, CMS -- that's one of the things that CMS says no. There's a federal rule around that, that they should be covering those services.

Now, that's not to say we can't figure out -- because we're trying our best to figure out -- like, think outside the box of how we can still help folks that are in bad situations because we know that that's not always happening.

MR. SHANNON: Leslie, what about staff residences? That's a Medicaid facility as well. Would that not be included?

MS. HOFFMANN: The only one that

I've specifically asked about -- and, Leigh Ann, keep me correct here -- was the children who aren't necessarily -- in the waiver who aren't receiving a residential component right now.

MS. FITZPATRICK: Uh-huh. Correct.

MR. SHANNON: Okay.

MS. HASS: Leslie, this is Mary again. The analogy that I gave you or the snippet that I gave you was actually someone who would be in an ABI staff residence.

MS. HOFFMANN: So they -- as of right now, CMS is saying that if they're in a residential setting, that those services should include the coverage for that member.

This is more about -- I better -- I better just hold off and not say anything else until Leigh Ann finishes her questions with CMS, but we're working on it.

CHAIR SCHUSTER: Yeah. I think it would be helpful, Leigh Ann, to ask that specific question about a staff residence.

MS. FITZPATRICK: Staff residence. Okay.

CHAIR SCHUSTER: Yeah. Because we

know that there are situations that come up between residents in staff residences that create crisis situations, would be one example.

MS. FITZPATRICK: Okay. I've got that down.

CHAIR SCHUSTER: Yeah. Thank you. That would be very helpful.

So I may have missed it, Leslie, and I know you can't talk much about the RFP. But what's the timeline on the RFP?

MS. HOFFMANN: So I can't talk about that.

CHAIRMAN SCHUSTER: Oh, you can't even --

MS. HOFFMANN: We're hoping to implement October of 2023.

MS. SMITH: I was going to say, I'll say the same thing that I do. She doesn't look good in orange either, and we'd like to stay out of procurement jail so...

MS. HOFFMANN: Yeah. We don't even use those three letters when we're talking about stuff. So yeah, we're hoping to implement 2023, the program.

MR. SHANNON: Can you answer this question? Has it been released?

MS. SMITH: There's a chance we'll go to procurement jail.

MS. HOFFMANN: Now, I like orange, Steve, but I better not answer that on this call.

MR. SHANNON: Okay.

MS. SMITH: And I know it sounds like I'm being very glib about it, but it truly is to protect the integrity of the process. Because the last thing we want to have happen is somebody to say, well, Pam Smith or Leslie Hoffmann said this and them say, oh, well, we need to start all over again so...

MS. HOFFMANN: Right.

CHAIR SCHUSTER: Okay. So when you say implementation, you're talking about post-award so that the program is actually rolled out in October.

MS. HOFFMANN: Through the process, right. And we plan on 90 or more days, Leigh Ann, with working with the community and getting out there and spreading the word.

MS. FITZPATRICK: Yes.

MS. HOFFMANN: Through the racial and health equity GARE tool, we've also developed communication plans. And we still are continuing to beef that piece up, like how to get into the local community. You've heard me say I know where to go in my local community here in -- I've got a little small rural community, but I don't know where to go in everybody else's communities. And that's what we want to try to figure out.

MS. FITZPATRICK: Yeah. We have a very extensive communication plan. I think people are going to get tired of hearing us by the time October comes because we are going to get -- you know, go every nook and cranny of Kentucky to get the communication out.

CHAIR SCHUSTER: So one of the questions that has come up -- and it came up at the 988 coalition -- I'm sorry that Margaret Pennington had to get off this Zoom -- was when this PowerPoint was presented there, and this is probably several months ago.

And all the 988 crisis call folks, the people that are actually answering those crisis calls, had a million questions about: How does this interface with what's going on in answering 988? Because 988 is supposed to be getting those calls and dispatching mobile crisis, if that's what's needed.

MS. HOFFMANN: Right. And, Leigh Ann, it's 988 or 911 if it's just a local call. So it can go through 911, or it'll go through all the 988s. We're not changing that; right?

MS. FITZPATRICK: Right. Correct.

CHAIR SCHUSTER: Yeah. I think the question was that those 988 calls are being answered by the community mental health center people.

MS. HOFFMANN: That's still in the diagram to continue.

MS. FITZPATRICK: Yeah.

CHAIR SCHUSTER: Okay. But the mobile crisis unit was through the CMHC, and now it's going to be through somebody else. I think that's the question.

MS. GUNNING: That's the big

question.

MS. HOFFMANN: Okay. And we can't speak about that today, but I can come back fairly soon and talk to you about it.

But the grid has not changed that we have shared. I've got a PowerPoint that I shared with you, Sheila, that procurement has allowed us to give out.

CHAIR SCHUSTER: Yes. And I got it out to everyone. You shared it right after the January meeting --

MS. HOFFMANN: Yes.

CHAIRMAN SCHUSTER: -- and then it got lost in the --

MS. FITZPATRICK: So as long as a provider can meet the criteria and the functions of the mobile crisis team, they're not going to be excluded. But they do have to meet the redefined definition of mobile crisis, which will be -- we're submitting our SPA on that to CMS this month to go effective in October.

CHAIR SCHUSTER: Okay. And I think the other thing you probably can't talk about is money. But, obviously, one of the big

questions that came up at the 988 call, because so many of the -- well, the 988 calling -- answering is being done by the CMHC, is any time you bring in anybody else to do anything, it costs you money. So where's the money -- where's the money coming from?

MS. HOFFMANN: So, Sheila, again, I can't speak about all the pieces. There's lots of pieces to this. Even outside -- we're trying to meet -- if you've heard Leigh Ann and I on the EMS TAC, we're trying to figure out ways that, in these local little areas, that maybe an EMS gets called, how they can treat, not transport, if they're the only person that's available or something like that. We're trying to figure out other transportation methods right now, too.

So I know you all hear us on a lot of TACs, so there's probably those add-on extra questions. So, again, we'll try to come back very soon and give you more than just this summary today.

CHAIR SCHUSTER: Okay. Here's somebody on from Volunteers of America

Mid-States. And what's your question, please?

MS. MCMINN: I didn't have a question, but this is my first time attending these meetings, which is fantastic. I appreciate the invite that I got from a colleague of mine. If you could just send me the invites for future meetings, I'd like to continue to attend. But this information has been really great, and I love the presentation with the data.

CHAIR SCHUSTER: If you will send your information to the email that's at the bottom of the agenda, kyadvocacy@gmail.com, I will do that.

MS. MCMINN: Okay. Great.

CHAIRMAN SCHUSTER: And that's true for anybody else. I keep a list and send everything out to everybody that's interested. Thank you.

Kathy Adams, I think you're on. And, Steve, what about number and requirements of MCO audits? Has there been any change one direction or the other?

MS. MUDD: Nina had her hand up,

guys.

CHAIR SCHUSTER: I'm sorry?

MS. MUDD: Nina had her hand up.

CHAIR SCHUSTER: Oh, Nina.

MS. EISNER: A lot of opportunities for synergy in terms of linking resources, volunteers, and so on. I sit on a CIT meeting, and New Vista had the 988 team there, as they always do. And one of the problems that they reported was not having a sufficient number of volunteers. And so we have linked our CIT to our community coalition meeting and also linked 988 to come back to our KHA behavioral health forum so that we can more broadly broadcast the need for volunteers.

So just a reminder for folks that are on CITs and/or community coalitions to connect those dots for resource development in particular. Thank you.

CHAIR SCHUSTER: Nina, if you'll drop me an email, that would be helpful, and I'll get that out to people because I may not have captured all of that.

Okay. Onto audits. Where are we

with MCO audits?

MS. ADAMS: This is Kathy with the Children's Alliance. I have not heard a whole lot from my members recently, I guess, since the holidays really. I think their biggest panic point at this time is the extended service codes that's kind of flipped their world upside down in their ability to serve their clients. So I really haven't heard much.

I did hear from one of our members. I'm aware of at least two of our members that have appealed audit findings all the way to the end of the process, you know, where you're hiring an attorney and you're having to mediate, et cetera. And both have come -- the results of the audits in their appeal processes have come out favorably on behalf of the provider, so I will share that information.

Of course, it's expensive to fight an audit finding in the appeals process. But I do know of at least two members that have been successful, one very recently.

CHAIR SCHUSTER: Yeah. Thank you

for sharing that, Kathy.

Steve, are you hearing anything from the CMHCs?

MR. SHANNON: Yeah. Neither way, more or less, you know. So I don't think there's any change from our perspective.

CHAIR SCHUSTER: Okay. All right. I put on here -- you all may have heard that there's a legislative session going on. There are a couple of mental health bills that are moving so far and some things that we've been supporting.

There's a bill on -- addressing perinatal mental health issues that has passed the senate. That's Senate Bill 135 and passed the house committee today. It would set up -- every birthing place would give more information and then the Cabinet would be pulling together a list of health and mental health providers to really do some brainstorming about how to better inform, not just moms but dads. The ratio apparently are moms -- about 1 in 5 moms are going to have some perinatal mental health issue but 1 in 10 dads, which I think is fascinating.

There also is quite a racial discrepancy, as there is in mortality and morbidity, for black and brown moms. There also is in terms of access to mental health services and so forth.

Our folks over at the homeless and housing groups are trying to make IDs, lower the cost of IDs and make them available to homeless youths -- youth and allow driver's licenses to be renewed for the homeless. And that bill has passed the house and gone to the senate.

There was a bill to exempt providers from prior authorizations, and it passed the house Health Services Committee but has been reassigned to another house committee and probably is not going to go anyplace.

House Bill 196 is Ken Fleming's bill to establish what he's calling Safe KY. It's an app for students to use that would put them in touch with a licensed mental health provider. There's a pilot program in it that would be Jefferson County and two other counties. I'm not sure how that's

going to interface with 988 eventually because I think 988 is able to be reached by text and chat at this point.

He also has a bill on workforce scholarships that would include both health and mental health providers, and it has passed the house.

Representative Webber has House Bill 148 that would require insurers to pay out-of-network providers directly and not by assignment to the policyholder, which has been a real issue for some providers, and it's passed the house and gone to the senate.

Representative Moser has House Bill 353, which is a harm reduction bill to remove fentanyl test strips as drug paraphernalia in criminal statutes, and it has passed the house. And I think there are a lot of SUD providers that are very eager to see that get passed.

And then Steve has done a lot of work on House Bill 248, which would put some licensing zoning oversight for recovery housing, and it's passed the house and is on its way to the senate.

There are a ton of bills that we really like, like banning conversion therapy and some other things that have not moved since day one. We have several bills that we are really working hard against, and they have to do with really terrible discrimination against our trans young people. One is Senate Bill 150 that has passed the senate and on to the House Education Committee, and it would absolutely negate the ability of even parents to have their students to be called by their preferred name or pronouns in the schools.

It, I think, really creates a hostile environment for students that think they may be trans or think that they need to be identified differently. I think it's going to put teachers and school personnel in a really, really difficult situation.

It also is going to open up, you know, information to parents, which I think is a good thing, but it's -- the parents' rights in this go one way but not the other way. So if I'm the parent of a trans kiddo, I'm not -- the schools don't have to follow

my request to have my son called by a different name or use different pronouns.

But the worst bill is House Bill 470 that unfortunately passed the house on Thursday. And we've been told by two national groups, Mental Health America nationally and ACLU, that it's the worst anti-trans bill in the country. It had both health and mental health providers in it. The mental health providers have been taken out, but the health providers are still in.

And they would be subject to losing their licenses and having criminal -- I think they took criminal penalties out but civil penalties for providing even information and counseling to trans youngsters, much less doing anything like puberty blockers, that kind of thing. It would make them liable for 30 years after the youngster turns 18, which is a statute of limitations longer than anybody has ever seen.

So we are extremely concerned. And I guess my response to -- yes, the mental health providers were taken out of House Bill 470, but we know that if you shut off for

trans kids and their families any access to medical advice, consultation, beginning treatment for these gender dysphoria issues, that it will have significant, significant mental health impact on an already vulnerable population.

So we encourage providers to reach out to senators in opposition to House Bill 470 and on the senate -- in the senate and on the house side to oppose Senate Bill 150.

I think I mentioned that we had a recommendation to the MAC on communication around the ABI issues, and we've not heard back yet. For our voting members of the TAC, are there any recommendations that you would like to see us make to the MAC for their March meeting?

MS. HASS: Sheila, this is Mary. I would like to continue the conversation around the mobile crisis entity that Leslie was talking about. I don't understand how a staff residence is excluded. But anyway, I would like to continue that discussion on the behavioral issues because we lost under --

when Adam Meier was secretary, we lost our behavioral -- excuse me, our neurobehavioral entity that we had at Eastern State.

So really right now, brain injury is really in a crisis. We really have nothing to reach out to if someone -- either the individual is in a crisis situation or that person, then, is causing harm to other individuals in a staff residence.

What the providers of the staff residence are saying to me is if the person who is causing the abusive behavior to the other people in the home, unless they are causing harm to theirself or voicing harm to theirself, they have nothing they can do. That's the situation I've been told.

So it's a serious situation because literally, right now, brain injury is left without any type of crisis stabilization.

CHAIR SCHUSTER: Mary, let's -- I hear your concerns. Let's put that at the top of the agenda for our May TAC meeting because I'm not sure that we have a recommendation for DMS.

MS. HASS: Okay. That's fine. I

didn't know if there was anything to continue the conversation with Leslie. If not, we can -- we can wait till May. That's more than fine.

CHAIR SCHUSTER: Well, what I'd like to do -- because I think we communicated to Leslie and Leigh Ann to have Leigh Ann ask those specific questions in her daily, it sounds like, communications with CMS. So I think we need to get some basic information.

MS. HOFFMANN: We'll reach out, Dr. Schuster. We'll reach out. Yeah. The only specific questions I've asked about so far were the children and the Michelle P. Waiver who are not in residential, so we'll follow up and let you know.

CHAIR SCHUSTER: Yeah. And let's -- Mary, you and I can talk offline about whether there are other people that we might invite to the May meeting to advise on some of these issues around the ABI folks.

MS. HASS: Okay. Thank you, Sheila.

CHAIR SCHUSTER: Okay. Yeah. Sure

thing.

So we have some repeat agenda items, as always, but we're very glad to take off the dual eligibles. It sounds like we -- the mobile crisis really needs to get elevated to a more robust discussion at our May meeting, both in terms of ABI but just generally. I'm still concerned about the interface with 988 and so forth.

Any other agenda items for our May meeting besides carryover? Anything new?

(No response.)

CHAIR SCHUSTER: We may need to be looking at -- if House Bill 470 passes, I think we need to be talking about increased awareness for behavioral health providers for what I think is going to be increased need in this population. And that's not necessarily just a Medicaid population, but I'm sure that there are children that have Medicaid services that will be affected by this as well. Anybody have any --

MS. GUNNING: Sheila.

CHAIRMAN SCHUSTER: Yeah.

MS. GUNNING: It's Kelly Gunning.

Just the thing I wanted to say as a follow-up to what you just said about 470. I think we're creating such a hostile environment, and the kids don't really have any choice but to go to school. I mean, they have to go unless, you know, their parents homeschool them. And I'm just -- like you -- really, really concerned.

There's already a lot of bullying going on, a lot of suicidal ideation and gesturing. This can't improve that whatsoever, so we need to be prepared to -- how are we going to negotiate with these people these hostile environments.

CHAIR SCHUSTER: Yeah. Well, and I think the --

MS. GUNNING: Just the message is so hateful. Just the message is so dehumanizing.

CHAIR SCHUSTER: Yeah. Yeah. And that's what I heard in Frankfort. I was there the day of the house judiciary committee meeting, and the room was filled. The overflow room was filled. The hallway was filled. And people were very quiet and

respectful. That was what the chairman asked. They didn't -- there were no, you know, interruptions and so forth.

But the outpouring of emotion when that vote was taken was really quite overwhelming. There was anger, but it's always easier for people to express the anger, I think, almost immediately. But there was so much sadness and fear.

And I talked to several parents up there. I sat next to a woman whose 19-year-old son is trans. And she said he's so -- he's happier than he's ever been in his life, and he's a student in college. And she's a teacher, public schoolteacher. And she said, I just sit here -- and she started crying.

And she said, if they had passed this bill four or five years ago when we were struggling to get mental health and medical care for our son -- our daughter at the time, she said, I don't know what we would have done. She said, it was so important for us to be able to get that consultation and that care and to have providers to go to. And she

said, I think we would have had to move out of Kentucky. I can't think of how else we could have dealt with that. So there is -- there's a real sense of attack here.

MS. GUNNING: Well, the thing that's so disconcerting is that, according to polls, 71 percent of Kentuckians oppose this legislation.

CHAIRMAN SCHUSTER: Right.

MS. GUNNING: 71 percent. So, I mean, what is this? How could this even be happening if they're listening? Oh, yeah. I'm sorry. They're not.

MS. DOBBINS: Yeah. I think, you know, that is the most disturbing thing, is how does this hurt anybody else, you know. It doesn't hurt anyone. This is a very personal attack, it feels like.

MS. GUNNING: I disagree, Kathy. I think it hurts everybody because I think it's a violation between religious and church and state, you know, just permeating through everyone's everything.

MS. DOBBINS: Well, I certainly don't disagree with that, Kelly. I just

mean: What does it hurt anybody else for someone to live their life as they choose to?

MS. GUNNING: Oh, I agree with that but, I mean, the legislation is very hurtful.

MS. DOBBINS: The legislation hurts everybody. I completely agree. I'm just talking about, you know, how does it affect anybody else. If a child feels that they're born into the wrong body and they want to make -- you know, they want to go through the process of change, I mean, that is up to them and their family. It is very deeply personal. And I do think families that have the means will leave Kentucky, and I think that's also very sad for Kentucky.

MS. GUNNING: I think (inaudible) and sad.

CHAIR SCHUSTER: Yeah. Let me wrap up here because we're about out. I don't think there's been any change in the recent -- the most recent prior authorization guidance, which I think goes back -- at this point, well back into 2022. And --

MR. BALDWIN: Yeah. This is Bart, just real quick, if I may. A couple of --

this kind of goes with the last couple agenda items maybe as far as old business but also something for the next TAC meeting. As we're ending the Public Health Emergency in May, I think there's several items. One, the prior authorization guidance, my understanding is that DMS can continue to have that in place past the Public Health Emergency, so that was just a question, I think, to see what the decision will be for Medicaid on that.

And also some of the things that were allowed under the Public Health Emergency that might be ending. I know these are -- I know these are questions that the folks at DMS are wrestling with now, so I'm not asking the question for an answer now. But I just think that that's something that, for the May TAC meeting, would be very timely since that looks like it's actually the exact same day that the Public Health Emergency ends so...

CHAIR SCHUSTER: Yeah. Excellent, Bart. We'll put that in --

MR. BALDWIN: And just on the other issue. I was in the overflow room with you

for that testimony. The testimony for the bill was very weak. The testimony against the bill was very strong. And the vote still went the wrong way but -- so it's -- it was very discouraging, so very sad.

CHAIR SCHUSTER: Well, yes. On the floor of the house, the bill sponsor, Jennifer Decker, spoke in favor of the bill, and there was one comment from one other Republican. And every Democrat, I think, in the caucus spoke against it, and three Republicans spoke against it. And yet the bill passed 75 to 22.

So people voted for it and -- but didn't want to be -- somebody said to me they didn't want to have a clip with their saying something about the bill, which I -- you know, tells you something. Anyway, yeah.

Bart, thank you for bringing up the unwinding and the end of the Public Health Emergency. We will definitely put that on the agenda for May.

The next MAC meeting is the 23rd of March from 10:00 to 12:30 and then we will meet on May 11th. And we'll go back to the

regular 1:00 to 3:00 time frame. We have been meeting from 2:00 to 4:00 during the legislative session to accommodate that so...

And I look at my clock, and it's right at 4:00. So if no one else has anything to add, I want to thank DMS for being with us for sure and DBHDID. I see Dr. David Susman who is an advisor now with DBH. Thank you for being with us, David.

And thanks to our voting TAC members and thanks to all of you who have joined us today. And I will see you in two months. And thank you, Kelli Sheets, for facilitating things today.

MS. SHEETS: Absolutely.

CHAIR SCHUSTER: Thank you all. Take care.

(Meeting adjourned at 4:01 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 27th day of March, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR