INTERIM JOINT COMMITTEE ON HEALTH, WELFARE, AND FAMILY SERVICES

Minutes of the 7th Meeting of the 2020 Interim

December 15, 2020

Call to Order and Roll Call

The 7th meeting of the Interim Joint Committee on Health, Welfare, and Family Services was held on Tuesday, December 15, 2020, at 1:00 PM, in Room 149 of the Capitol Annex. Representative Kimberly Poore Moser, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Ralph Alvarado, Co-Chair; Representative Kimberly Poore Moser, Co-Chair; Senators Julie Raque Adams, Tom Buford, Danny Carroll, Denise Harper Angel, Alice Forgy Kerr, Morgan McGarvey, and Stephen Meredith; Representatives Danny Bentley, Tina Bojanowski, Adam Bowling, George Brown Jr, Tom Burch, Daniel Elliott, Deanna Frazier, Robert Goforth, Mary Lou Marzian, Melinda Gibbons Prunty, Josie Raymond, Steve Riley, Steve Sheldon, Cherlynn Stevenson, Nancy Tate, Russell Webber, and Lisa Willner.

Guests: Jason Dunn, Division Director, Division of Family Support, Department for Community Based Services, Cabinet for Health and Family Services; Terry Brooks, Executive Director, Mahak Kalra, Chief Policy and Advocacy Director, Kentucky Youth Advocates; Marta Miranda-Straub, Commissioner, Department for Community Based Services, Cabinet for Health and Family Services; Melanie Taylor, Assistant Director, Division of Protection and Permanency, Department for Community Based Services, Cabinet for Health and Family Services; Van Ingram, Executive Director, Kentucky Office of Drug Control Policy, Justice and Public Safety Cabinet; Bonnie Hackbarth, Vice President, External Affairs, Foundation for a Healthy Kentucky; Mayor Les Stapleton, Prestonsburg, Kentucky; Representative Kim Banta; Vanessa Ashley; Jon Inman, Chief Policy and External Affairs Officer, Teresa Cooper, Director of Government Affairs, Kentucky Primary Care Association; and Kimi Banta.

LRC Staff: DeeAnn Wenk, CSA, Ben Payne, Chris Joffrion, Samir Nasir, Becky Lancaster, Hillary Abbott, and Shyan Stivers.

Approval of Minutes

A motion to approve the minutes of the November 19, 2020, meeting was made by Representative Bowling, seconded by Representative Webber, and approved by voice vote.

Consideration of Referred Administrative Regulations

The following referred administrative regulation with amendments were placed on the agenda for consideration: **201 KAR 020:085 Proposed** - Licensure periods and miscellaneous requirements; **201 KAR 020:161 Proposed** - Investigation and disposition of complaints; **201 KAR 035:040 Proposed** - Continuing education requirements; **902 KAR 002:020 Emergency** - Reportable disease surveillance; **902 KAR 002:020 Proposed** - Reportable disease surveillance; **902 KAR 004:030 Proposed** - Newborn screening program; **902 KAR 045:110 Proposed** - Permits and fees for retail food establishments, vending machine companies, and restricted food concessions; **902 KAR 050:050 Proposed** - Manufacturing plant requirements; **902 KAR 050:071 Proposed** - Repeal of 902 KAR 050:070; **902 KAR 050:080 Proposed** - Standards of identity and labeling requirements; **902 KAR 050:090 Proposed** - Milk adulteration; and **902 KAR 050:120 Proposed** - Unpasteurized goat milk.

Pandemic Electronic Benefits Transfer (PEBT)

Terry Brooks, Executive Director Kentucky Youth Advocates (KYA), stated that food security was an issue before the pandemic but also expanded due to the pandemic. The 2020 KIDS COUNT Data Book noted that 16 percent of Kentucky's children are suffering from food insecurity. By national estimates, there was a 70 percent increase in food insecurity. For Kentucky to meet the food needs of families there must be a flexible, multiple pronged approach. He stated there must be private and public efforts. The private efforts are already happening in Kentucky. The Free Store and Dare to Care are working with Kroger in a nonprofit effort. The rollout of the Pandemic Electronic Benefits Transfer (PEBT) cards was a strong and vigorous effort. He stated that the Cabinet for Health and Family Services (CHFS) leadership was extremely responsive when KYA brought up a problem.

Jason Dunn, Division Director, Division of Family Support, Department for Community Based Services (DCBS), Cabinet for Health and Family Services, stated that PEBT cards were made available to states through the bipartisan Families First Coronavirus Response Act passed by Congress on March 18, 2020. PEBT cards are a 100 percent federally funded program. PEBT cards are designed to provide a reimbursement equivalent to the value of free meals that students would have received in the school setting if not for the measures put in place to control the spread of COVID-19. PEBT cards are a different type of benefit than the better-known Supplemental Nutrition Assistance Program (SNAP). He discussed the eligibility requirements for free or reduced priced meals. He stated that 81 percent of Kentucky school children meet the Community Eligibility Provision (CEP) under federal law.

Mr. Dunn stated that all students are eligible for PEBT cards if they are: eligible for free or reduced-price meals, including all students attending CEP schools; and unable to attend school in-person due to efforts to control the spread of COVID-19. PEBT cards can

only serve students served by the National School Lunch Program, which includes almost all public schools, Kentucky's military base schools, and some private schools. PEBT cards are 100 percent federally funded; benefits do not flow through the state or to any individual, but are paid to grocers, farmers' markets, and other United States Department of Agriculture (USDA) approved businesses only when the card is used to purchase eligible food items. DCBS, working closely with the Kentucky Department of Education (KDE), was able to: provide PEBT benefits to all students who were current SNAP beneficiaries directly to existing SNAP EBT cards; and establish an application process for all other non-SNAP students who were eligible for PEBT cards. He explained that the second phase of PEBT cards, in the fall of 2020, had issues due to delays in guidance, short deadlines, and eligibility complications. He stated that with such a short deadline, implementing an application process was not practical. DCBS provided PEBT cards to all potentially-eligible children using the best data available at the time.

Mr. Dunn stated that any child attending a school covered by the Community Eligibility Standard and in a non-traditional instruction (NTI) program was eligible to receive PEBT benefits. This could include those that would not normally receive these kinds of benefits. There was no mandate to use the benefits, those that did not require the support could simply destroy the card as instructed in the accompanying letter. He stated that amount per student varied based on in-person school schedule. DCBS identified the schools that were inadvertently omitted from the dataset for August and September PEBT cards. DCBS issued PEBT cards to those students last week. PEBT cards have been re-authorized from October 2020 through September 2021, if needed, by the Continuing Appropriations Act and the Other Extensions Act. Eligibility is similar to past phases, except that states can use "simplifying assumptions" to average and standardize benefit amounts. He stated that some children in childcare centers were added to the list of eligible PEBT card recipients. DCBS will continue to learn and make improvements along with the federal partners.

Mahak Kalra, Chief Policy and Advocacy Director, Kentucky Youth Advocates, stated that organizations must work together with stakeholders, the business community, educators, health professionals, churches, and others to ensure that families have access to food. Kentucky needs to build on the capacity of local and state efforts to work and learn together to change the course for children. The PEBT program can be strengthened by educating the general public on how the PEBT program is administered, what to expect from the PEBT program, and how to get questions answered. KYA received calls from families wanting to know what the program is, how to access the PEBT program, and the amount of money on the card.

Ms. Kalra stated that another idea is to create a plan to engage stakeholders who are actively connecting with families including KDE. She stated that Kentucky needs to do a better job of engaging leaders of immigrant communities when developing outreach plans. Schools are a trusted source of information in a community, schools sending information

to families could improve communication. Kentucky needs to consider increasing capacity to answer calls and emails regarding the PEBT program. The PEBT card needs to be simple and easy to use for families. She stated that adding a phone and email option could streamline communication. Kentucky can achieve food stability by strengthening the PEBT program to ensure all families that are eligible have access to the financial support.

In response to questions and comments from Representative Moser, Mr. Dunn stated that the first round of PEBT card distribution had an application process. If a parent was not a SNAP recipient, they had to actively apply in order to receive the PEBT card. In the second round of PEBT card distribution did not include enough time to set up the application process. DCBS made the decision to issue the cards to all children who were potentially eligible for the benefit or in a CEP school. DCBS plans on setting up a more structured plan for the next rounds of PEBT card distribution. Mr. Dunn stated that he believes a high percentage of people have used the PEBT cards. He stated that DCBS will consider making a plan to ensure eligible families are applying for the PEBT benefits. DCBS has not finalized a plan how the application process will work for the October and beyond benefits.

In response to questions and comments from Representative Bojanowski, Mr. Brooks stated that 16 percent of Kentucky's children are suffering from food insecurity.

In response to questions and comments from Representative Sheldon, Mr. Dunn stated that the benefit amount is based on the cost of delivering meals in schools which is averaged over the state. The spring average was $5.70 per student per day. In the fall average was $5.86 per student per day.

In response to questions and comments from Representative Gibbons Prunty, Mr. Dunn stated that it is routine in public schools that all students qualify for the PEBT benefit if the amount of students eligible for free or reduced-price meals in the school equals 81 percent or higher. Mr. Brooks stated that it was not that long ago that schools had ways to identify individual children with numbers or colors to not stigmatize them for free or reduced-price meals. He stated that the federal law for all students in a school to receive free or reduced-price meals in a school if the total qualifying amount is high. That law has been in place long before the pandemic.

In response to questions and comments from Senator Danny Carroll, Mr. Dunn stated that if a Head Start program was affiliated with a school and fall under the national school lunch program, it would be eligible for the PEBT benefit. Other Head Start programs were served by the Child and Adult Care Food Program (CACFP) that did not meet eligibility for the PEBT program. He believes that all Head Start programs will be eligible for October and beyond benefits but DCBS is waiting for further instructions from the USDA.

Update on Training and Child Welfare

Marta Miranda-Straub, Commissioner, Department for Community Based Services, Cabinet for Health and Family Services, stated that meetings have been set with the families that testified at the Child Welfare Oversight and Advisory Committee meeting on November 16, 2020. She met with one of the families and is in process of reviewing the family's situation with DCBS. The number of children in the custody of or committed to CHFS hovered between 9,000 and 10,000 children. She reviewed the DCBS priorities for youth in out-of-home care. DCBS' focus is on placement stability and ensuring that children in care achieve permanency timely. DCBS continues to focus on recruitment and retention of qualified staff to maintain manageable caseloads. She stated that quality services to children and families is dependent on valued, experienced staff. She shared a graph that displayed the average child protective services (CPS) caseloads from calendar year (CY) 2017 to CY 2020.

Commissioner Miranda-Straub stated that when she joined DCBS, surveys were conducted of both staff and stakeholders. There was a positive response by both staff and stakeholders regarding the use of virtual platforms and electronic means for all types of needs. DCBS found that there was reduced time spent on travel and the inclusion of those who otherwise might not be able to participate. She stated there was an increased efficiency reported among staff working remotely. DCBS has opportunities to decrease the brick and mortar footprint and improve efficiency with the use of virtual platforms. She stated that the 21st century DCBS is designed within a culture of safety through the infusion of primary and secondary prevention initiatives. The triple pandemics of COVID-19, racial inequity, and the opioid crisis have created opportunity for meaningful, systemic, and structural agency change. DCBS finalized Phase I, the stabilization phase, within six months. The stabilization plan was been designed by 25 various members of DCBS staff. DCBS is preparing to move into Phase II, the innovation phase, an 18-month plan where DCBS will be assessing all DCBS programs, reviewing for disportionality and disparity, along with the outcomes and deliverables. DCBS will innovate new business models for programs for ones not performing well. Phase III, the thriving phase, is a three year plan. Everything learned in Phase I and II will be implemented and infused in Phase III.

Commissioner Miranda-Straub stated that the five pillars for DCBS work are: social and economic equity; trauma, resilience and engaged healing; families, youth, and children; health and wellness; and operations implementation and evaluation. She discussed the challenges of working at DCBS such as exposure to multiple traumatic events, burn out, vicarious trauma, and compassion fatigue, which cause a high turnover rate of employees. Front line staff may deal with secondary post-traumatic stress disorder, where the worker may experience the same trauma symptoms as the clients. She stated that the quality of services, work capacity, and staff retention are diminished. She listed some of the symptoms of secondary post-traumatic stress disorder along with potential solutions. DCBS does not have administrative leave for anyone who is traumatized at work. Solutions

include comprehensive self-care, individual and organizational policy process, and strong resilience building.

Commissioner Miranda-Straub stated that DCBS partnered with universities to create The Academy and its curriculum is used for all DCBS staff. Moving forward DCBS is changing The Academy training to DCBS certification with competency-based training focused on skill development. The certification will be a support for new and existing workers to ensure they know how to apply the policy. She stated there will be a certification program for supervisors and leadership. DCBS is partnering with the University of Kentucky Center to create the child welfare trauma training toolkit and will offer new staff trainings in 2021. There will be a new field training specialists program to pair new workers with Field Training Specialists to evaluate and coach the new worker on a daily basis. DCBS is implementing a safety model which is a practice used in child welfare to assists workers and supervisors with making decisions regarding safety and risk throughout multiple points in a case.

In response to questions and comments from Representative Moser, Melanie Taylor, Assistant Director, Division of Protection and Permanency, Department for Community Based Services, Cabinet for Health and Family Services, stated that there is a statewide, 24-hour hotline phone number to report child or adult abuse and neglect. Kentucky is a mandatory reporting state so every citizen is mandated to report abuse or neglect if suspected. There is also a web-based reporting system.

In response to questions and comments from Representative Frazier, Commissioner Miranda-Straub stated that DCBS sent out surveys to community partners, youth who were at the end of their foster care placement, foster families, and adoptive families. DCBS received approximately 180 responses. DCBS has approximately 75 people who work with DCBS in workgroups to review the five pillars to make recommendations to DCBS.

Substance Use Disorders During COVID-19 Update

Van Ingram, Executive Director, Kentucky Office of Drug Control Policy, Justice and Public Safety Cabinet, stated that the drug epidemic and overdose deaths were an issue before the pandemic, however the problems have worsened. He shared a graph that shows the number of Kentucky resident drug overdose deaths from January 2017 to September 2020. In May 2020, the highest monthly number of drug overdose deaths was recorded at 243 deaths. In 2019, there were 1,336 overdose deaths in Kentucky. In 2020, there have already been 1,439 overdose deaths in Kentucky. There has been a rise in the number of drug overdose deaths nationally. Mr. Ingram shared a graph that displays the number of emergency medical services (EMS) opioid overdose related encounters in Kentucky. He stated that Kentucky is trending back to 2019 numbers. He presented a graph that displays the numbers of Kentucky hospital opioid overdose related encounters which also saw a spike in May 2020.

Mr. Ingram stated that one strategy in the fight against drug overdose deaths is Narcan distribution. The Kentucky Department for Public Health (DPH) held nine public events in 2020. The Kentucky Office of Drug Control Policy used the syringe service programs to also distribute Narcan to individuals who may benefit from its use. Early on in the pandemic, there was a radio campaign to remind people to call the Kentucky Help Call Center for screening and referral services. The Kentucky Office of Drug Control Policy is working to try to expand the service's evening and weekend hours. He described several major treatment projects where the Kentucky Office of Drug Control Policy partnered with other agencies to maintain.

Mr. Ingram stated that Kentucky Office of Drug Control Policy worked to support recovery housing with different programs and grants. He stated that the Kentucky Opioid Response Effort (KORE) is a prevention program in over 200 Kentucky schools with an evidence-based curriculum called, "I am too good for drugs." He stated that during the pandemic Kentucky Medicaid was quick to drop the prior authorization requirement for substance use disorder treatment so that people who need help could get help to recover. Kentucky Medicaid changed regulations regarding virtual individual and group counseling and the payment structure to allow such treatment.

In response to questions and comments from Representative Moser, Mr. Ingram stated that some of the bridge clinics are exceeding expectations and others are struggling. He stated that the bridge clinics are improving and he is pleased with the progress. He stated that the Kentucky Office of Drug Control Policy is working hard to address the overdose epidemic by focusing on helping people in recovery to stay in recovery.

In response to questions and comments from Representative Frazier, Mr. Ingram stated that he does not have data that ties to the increase in overdoses in May 2020 to the distribution of the stimulus checks. He stated that Kentucky struggled with the amount of fentanyl that is on the streets and many other types of drugs. He stated that the Kentucky Office of Drug Control Policy needs to look more into the details to know what caused the spike in overdose deaths in May 2020.

In response to questions and comments from Representative Gibbons Prunty, Mr. Ingram stated that the Celebrate Recovery Program is run on its own resources and to his knowledge do not receive assistance from the state.

Discussion of Regular Session 2021 Proposed Legislation

Bill Request (BR) 410, AN ACT relating to the regulation of tobacco products and vapor products, sponsored by Representative Kimberly Poore Moser. Representative Moser stated that BR 410 relates to the local control of the marketing and sales of tobacco products in Kentucky. She stated BR 410 is a cost-free step for Kentucky to reduce tobacco related illnesses and associated health care expenses. BR 410 would permit cities and counties, if they so choose, to adopt regulations to govern the marketing and sales in the

community. BR 410 is not a local mandate but it gives local government a tool to use to improve the health of their community. Kentucky has the highest rate of cancer and cancer deaths in the nation. More than one-third of the cancers are caused by smoking and could be prevented. Smoking also leads to heart disease, strokes, and chronic obstructive pulmonary disease (COPD).

Representative Moser stated that in Kentucky, the annual health care costs directly caused by smoking are approximately $1.92 billion per year. Approximately $589.8 million of those costs are covered by Kentucky Medicaid. Kentucky residents' state and federal tax burden from smoking-caused government expenditures is $1,074 per household each year. The National Youth Tobacco Survey indicated that in 2020, there are about 1.8 million fewer youth in the United States that are e-cigarette users compared to 2019. However, approximately 3.6 million youth in the United States still currently use e-cigarettes. She stated that on average, private employers pay approximately $5,826 in extra costs for a smoking employee over a nonsmoking employee. Tobacco use is also related to the increased risk of injury and property damage.

Bonnie Hackbarth, Vice President, External Affairs, Foundation for a Healthy Kentucky, stated that tobacco rates differ across counties and cities in Kentucky. She stated that per the provided graphs that smokeless tobacco use is much higher in the eastern and southern parts of Kentucky than the greater Louisville and western regions of the state. There are significant differences in tobacco use rates depending on social and other factors. Tobacco use is much higher among Native Americans, persons with lower education levels, lower household incomes, or persons with a disability or limitation. There is only one measure that cities and counties can adopt to reduce the health risks and costs associated with tobacco use, which are smoke-free laws.

Ms. Hackbarth stated that as of August 1, 2020, 36.2 percent of Kentuckians are protected by smoke-free laws covering all indoor workplaces and public places. She stated that local communities should have the right to adopt measures that the constituents want and the communities are ready to implement. Local measures are preempted by a 1996 law that bars local tobacco control. BR 410 would allow cities and counties to: require health warnings on retail tobacco displays; limit tobacco product advertising in stores near schools and playgrounds; and to create buffer zones between schools and tobacco retailers. BR 410 would not allow cities and counties to raise local excise taxes.

Mayor Les Stapleton, Prestonsburg, stated that the Kentucky constitution allows local government to control local issues. As mayor he hears about local issues such as smoking bans or tobacco marketing issues and knows what his constituents want in his area. The local government also hears issues in public forums to get input from the community. He stated that there are also local council meetings where the community is invited to speak. There are 30 cities and 11 counties that have adopted some type of public smoking ordinance. He stated that local government can govern the local constituents

easier and more effective than big government. The Kentucky League of Cities board will be discussing legislation to support. The board supported legislation similar legislation to BR 410. He stated that he is confident that the board will also support BR 410.

Discussion of Regular Session 2021 Prefiled Legislation

2021 Regular Session (RS) BR 35, AN ACT relating to out-of-network billing, sponsored by Senator Ralph Alvarado. Senator Alvarado stated that BR 35 is a surprise billing bill. He stated that the federal government may resolve the issue for the states. The federal government has proposed solutions that will come with an end of the year bill. He stated there may be a formal agreement posted online. BR 35 is unique to Kentucky and a product of a 2020 workgroup with insurance companies, medical providers, and the hospital association. BR 35 hold patients harmless, if someone does receive a surprise bill it would require insurance to cover a payment to the provider based off of the current median in-network rate or the median in-network rate for 2019, whichever is higher. The insurance company would make the payment and provide a dispute process for the provider with the insurance company. If the amount is above $675 there is an appeal process and arbitration process if necessary.

2021 RS BR 86, AN ACT relating to Medicaid eligibility for individuals diagnosed with metastatic breast cancer, sponsored by Representative Kim Banta. Representative Banta stated that BR 86 will eliminate the pay down for metastatic breast cancer patients. She stated that over 270,000 people suffer from breast cancer that also bankrupts families. Vanessa Ashley stated she is a social worker with DCBS and enjoys her job however her income is modest. She borrowed money to finish her degree while raising two children. She has stage four breast cancer, she was initially diagnosed in 2017 with the possibilities of treatment. She had surgery and thought the cancer was removed. She had a double mastectomy and hormone suppression drug treatment. With the help of other medical staff, a biopsy, and a medical scan, it was discovered that the cancer had spread and mutated into triple negative metastatic breast cancer which migrated to her bones. Her triple negative metastatic breast cancer is incurable and the most difficult type to treat. Radiation and chemotherapy are her only options for treatment. The weekly treatments take a lot of out of her.

Due to COVID-19, Ms. Ashley is allowed to work from home. However, she is only 55 and must continue to work to keep her health care benefits. She has been on treatment for almost a year and her body is responding to the treatment but due to the debilitating effects of the treatment she will need to stop working at some point in time. She will then have to begin social security disability benefits. She stated there is a three to five month processing time period with an additional two year waiting period before she can access Medicaid. She needs help with the cure gap because Medicaid is not the best option. She does not have a spouse with medical benefits as a backup plan and is too young for Medicare. Disability is her best option but must bridge the gap for care somehow. Many face her similar problem.

Ms. Ashley stated that she learned of an attempt to pass the Medicare Access to Care Act in the United States Congress. The law would allow breast cancer patients like herself with outside supports to get immediate access to Medicare and to continue treatment without waiting for disability. The waiver of disability waiting period is extended to terminal renal patients and amyotrophic lateral sclerosis (ALS) patients. Congress would add breast cancer to the list to allow continuity of care. The bill did not advance this year. She stated that she needs Medicaid for two years until Medicare eligibility coverage begins. As a tax paying Kentucky citizen, she requests support to waive the spend down provisions and have sponsored waivers to secure her final years.

In response to questions and comments from Representative Moser, Representative Banta stated that the Department for Medicaid Services (DMS) would have to apply for a waiver.

2021 RS BR 163, AN ACT relating to telehealth, sponsored by Representative Deanna Frazier. Representative Frazier stated that BR 163 would extend the temporary emergency orders regarding telehealth delivery during the pandemic. BR 63 would align insurance and Medicaid statutes by requiring CHFS to establish minimum standards. BR 63 would require reimbursement rates to be equivalent to same rates as in-person visits. BR 63 would allow for audio or telephone only visits due to the lack of broadband. She stated that the expansion of telehealth services has been extremely valuable for patients.

Jon Inman, Chief Policy and External Affairs Officer, Kentucky Primary Care Association (KPCA), stated that KPCA represents federally qualified health centers and rural health clinics in Kentucky. He stated that KPCA supports BR 63 because telehealth has been vital to the KPCA members during the pandemic. He stated that DMS has been very flexible and offered a lot of guidance regarding telehealth to KPCA. He stated that the audio only aspect of the bill is helpful to patients in rural areas and to patients that do not have access to the internet or technology. BR 63 addresses the payment parity issues to the providers because the providers' overhead costs do not go down with telehealth.

Teresa Cooper, Director of Government Affairs, Kentucky Primary Care Association, stated that BR 63 states that the patient should have an annual visit with the practitioner. KPCA would like to see that requirement extended to the practice or network in which the practitioner practices medicine for the sake of on-call or after-hour telehealth visits. The requirement could assist in decreasing patient visits to the emergency room and the coordination with specialists. Representative Moser stated that provision was put under the jurisdiction of the licensure boards so it is not explicitly outlined in BR 63 that the in-person annual visit be a requirement.

2021 RS BR 966, AN ACT relating to addiction treatment, sponsored by Representative Kimberly Poore Moser. Representative Moser stated that BR 966 lifts prior

authorizations for medication for addiction treatment. Prior authorizations are used to approve or deny treatment prescribed by a health provider. Prior authorizations force the healthcare provider to contact the insurance company or pharmacy benefit manager to get approval before starting certain treatments. The treatment could be delayed from several hours to a few weeks as insurers review the request. BR 966 seeks to lift the prior authorization requirements by managed care organizations (MCOs) and private insurers to specifically allow medication for addiction treatment to be available for patients when the patient is ready for treatment and the health care provider prescribes the lifesaving medication. She stated that medication for addiction treatment works and helps to keep people out of jail, in jobs, with their families, and saves lives. She stated that there should be no delay in patients getting this life saving treatment from their treating physician.

Kimi Banta, a Kentucky citizen, stated that she is in long-term substance use disorder recovery. She has been on medically assisted therapy (MAT) for three years. She tried MAT after years of failed attempts to stop her drug use. Her counselors thought that MAT would be a good fit for her because while she was doing everything else suggested for treatment she could not stop the drug use. She stated that she could never stay sober long enough to move through the steps of a 12-step recovery program. Often times she used drugs within six months of her recovery journey. She stated there is a stigma and misinformation regarding MAT but with recovery the fear and shame of using MAT went away. Many abstinence only recovery facilities state abstinence is the only way to recover. Abstinence based programs have worked for many people but there are outliers.

Ms. Banta stated that there is evidence that with the disease of addiction there are neurological changes in the minds of people with substance use disorder. Not every person who struggles with a substance use disorder can recover in the same manner. Patients should be provided MAT as a tool for recovery. She is married, works fulltime, cares for her pets, and pays her bills with help from MAT. She has reintegrated herself into society to which others thought she would never be able to accomplish. MAT is vital to her life and other Kentuckians who have struggled with a drug use disorder. Removing the barrier of prior authorization for MAT would give more people the opportunity to recover and live a fuller life. She stated that with overdose deaths rising in the state, removing prior authorization is more important than ever.

Adjournment

There being no further business, the meeting was adjourned at 3:21 PM.