DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

Capitol Annex
702 Capital Avenue, Room 125
Frankfort, Kentucky

July 9, 2019,
commencing at 1:08 p.m.

Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter
ATTENDANCE

TAC Committee Members:
Sheila A. Schuster, PhD, Chair
Valerie Mudd
Gayle DiCesare
Mike Barry
Sarah Kidder
Steve Shannon
DR. SCHUSTER: So welcome to the Behavioral Health TAC for July 9th. And we will start, as we always do, with introductions. And I think we will start over here with Dr. Hanna.

DR. HANNA: I’m Dave Hanna with Passport.

MS. McKUNE: Liz McKune, Passport.

MR. SHANNON: Steve Shannon, KARP, member of the TAC.

MS. DiCESARE: Gayle DiCesare, BIAK and a member of the TAC.

MR. BARRY: Mike Barry, PAR and a member of the TAC.

MS. MUDD: Valerie Mudd, Participation Station NAMI Lexington, member of the TAC.

MS. GUNNING: Kelly Gunning, all things NAMI. I am not a member of the TAC.

DR. SCHUSTER: You are a prime supporter.

PARTICIPANT: Yes. It is probably because I can be tacky.

DR. SCHUSTER: And we welcome a new staff member.
MR. ALEXANDER: Yes. Davarres Alexander, NAMI Lexington as well as the Mental Health Corp.

DR. SCHUSTER: And you are going to be doing outreach?

MR. ALEXANDER: Outreach, yes, ma'am.

DR. SCHUSTER: Welcome. We're glad to have you as part of the team.

Over on this side (indicating).

MS. STEARMAN: Liz Stearman, Anthem Medicaid.

DR. SCHUSTER: Great.

MS. KIDDER: Sarah Kidder, NAMI Kentucky, part of the TAC.

MS. ADAMS: Kathy Adams, Children's Alliance.

MS. BENTLEY: Katie Bentley, Commonwealth Council on Developmental Disabilities.

MS. TIMMERMAN: Marcie Timmerman, Mental Health America of Kentucky.

MS. LOY: Beverly Loy, the Adanta Group.

MS. LENTZ: Karen Lentz, the Adanta
Group.

MR. CAIN: Micah Cain with Passport.

MS. BLEVINS: Michele Blevins with the Department for Behavioral Health and Developmental and Intellectual Disabilities.

DR. SCHUSTER: I don't know why Michele is hiding in the corner. We're very glad to have you representing DBHID, Michele. Welcome.


MR. DUNN: Jason Dunn, Kentucky Voices For Health.

MS. HAYES: Katie Hayes, WellCare.

MR. JOHNSON: Dustin Johnson with Aetna.

MS. STEPHENS: Cathy Stephens, Humana CareSource.

MS. MOWDER: Kristan Mowder, Humana CareSource.

MR. LEEDY: Brad Leedy, Bridgehaven Mental Health Services.

DR. SCHUSTER: Do you want to
introduce yourself?

MS. GORDON: Lori Gordon, WellCare.

DR. SCHUSTER: Okay. Great.

Thank you very much. And we have all six members of the TAC.

I'm Sheila Schuster with the Kentucky Mental Health Coalition and a member of the TAC. So we have all six members of the TAC here, I'm happy to say.

PARTICIPANT: Yah.

DR. SCHUSTER: Six and three-fourths, I think; Sarah is carrying the next member of the TAC and is due momentarily. I saw her yesterday in Frankfort at a meeting and I said, "You just have to hold out one more day for the TAC meeting." So...

And I think all of our MCOs are represented. We're delighted to have the behavioral health department. And the Medicaid folks said that they had conflicts and would not be able to come. I think their decision is that they are not coming as long as we meet over here at the Capitol Annex, so take that for what it is.
They asked us to actually approve minutes, which we have not done before. So I sent those out to you. And this is, essentially, the report that I give to the MAC and I just convert that same information into a set of minutes, talking about welcoming our new member, Gayle DiCesare, and various issues.

So I guess I will have to entertain a formal motion from a member of the TAC to approve the minutes.

MR. SHANNON: So moved.

DR. SCHUSTER: Steve.

MR. BARRY: Second.

DR. SCHUSTER: And a second from Mike.

Any additions, corrections, omissions?

(No response)

DR. SCHUSTER: All those in favor of approving the minutes signify by saying "Aye."

(Aye)

DR. SCHUSTER: Okay. Great.

Thank you.
So the May 25th MAC meeting was fairly unremarkable, as I recall. In fact, it was so unremarkable that I'm having a hard time coming up with any pithy comments to make about it. There were, actually, presentations by Passport and who else? Aetna?

PARTICIPANT: WellCare.

DR. SCHUSTER: WellCare, okay. So at the next meeting there will be presentations by two other MCOs who will be talking about their programs and so forth.

They did not have a quorum of the MAC, which is always a problem, although they can take our recommendations. They changed their rules to indicate that they can take our recommendations and pass them along to the Commissioner. And the next meeting of the MAC will be on Thursday, July 25th, it is at the very bottom of your agenda, at 10:00 a.m. I will not be able to attend. I will have a new hip by that time. I am getting a new hip on July 19th. But I think I am not supposed to be driving and walking around on these hard floors less than a week
after the surgery. So Steve is going to give the report for the Behavioral Health TAC at the MAC meeting.

Remember, those meetings are open for anybody who wants to attend. And sometimes there's some interesting tidbits of information that are shared there. So feel free to attend.

DMS sent its responses to our last set of recommendations. And they are on your gray paper, because they are kind of gray.

PARTICIPANT: "I know nothing."

Vague.

DR. SCHUSTER: So you will remember at the last meeting that we had quite a discussion about this rollout of the KI-HIPP program, the Kentucky Integrated Health Insurance Premium Program. And there were lots and lots of questions. And we asked that they provide in-depth education to the MAC and to any TACs that request it so that we would be in a position to answer questions. And they said, "We agree." This may be the first time in the six years we've been sending recommendations to DMS that they
started their response by saying, "We agree with your recommendation." They said they are in the process of a major communication effort around the benefits of the KI-HIPP program.

I printed off for you, and it was probably last in your pickup, a graph, a PowerPoint actually, that was presented to the consumer TAC about the KI-HIPP program. And I could send that out to you electronically --

PARTICIPANT: That would be nice.

DR. SCHUSTER: -- if you have people that want to get it.

Jason, I’m going to ask you to talk to us a little bit about some of the concerns that Kentucky Voices For Health and others have had about this program.

PARTICIPANT: Sure. We submitted a lot of questions to the Cabinet about KI-HIPP. We don’t have answers yet. We understand answers are being reviewed right now. But our main three areas of questions relate to whether it’s mandatory or voluntary, all their materials say voluntary
but the regs say mandatory that Medicaid
could be terminated for not following through
with some of the KI-HIPP requirements;
questions about the networks and payment of
out-of-pocket expenses; none of the -- they
do have a link to their page with the
materials, but there's no information in
there at all about how a KI-HIPP participant
submits bills, co-payments, co-insurance,
deductibles to get those reimbursed. It's silent on that. It is supposed to be a part
of the cost effectiveness to determine
whether KI-HIPP is the right path. But part of our concern with that is, of the
seventy-some-odd people they say who have
applied for KI-HIPP, all of them have been
found to be cost effective, which is kind of hard to believe. So we're trying to get some information about how they are determining cost effectiveness.

And then one of the other areas is
the reimbursement model. I think under the old HIPP program this was the State paying the premium directly for the individual.

This KI-HIPP requires the beneficiary to pay
their premium upfront and then submit proof of that payment through a check stub, like reporting your work. And if they want to get reimbursed for that premium that they have already paid, they have to submit all their check stubs that show where they made that payment. So we're not really sure that fits in with federal regulations. We think that may be outside of federal regulations. So we're pursuing that as well.

But largely we need some answers from the Cabinet to know whether they are really in compliance with federal rules or not. We don't really know because we don't have answers and they are administering the program right now. So it would be great to have answers on the program they are already administering.

DR. SCHUSTER: So those are some of the same questions that we talked about back in May, the main one being the cost sharing --

PARTICIPANT: Yes.

DR. SCHUSTER: -- and how that was figured and how that figured against the five
percent limit in terms of cost to Medicaid recipients.

PARTICIPANT: Right. We do have some CMS material that we found on this subject from 2015, it should still be accurate, that seemed to suggest that reimbursement was not allowable, an allowable mechanism, and that even if they see an ESI provider who's not a Medicaid provider, that Medicaid needed to find a way to reimburse that service as long as it was a Medicaid-covered service.

So those are part of the big questions we have of KI-HIPP.

DR. SCHUSTER: And is it your understanding, Jason, that they are going to rollout in August with fifty, 60,000 more letters --

PARTICIPANT: Right.

DR. SCHUSTER: -- to Medicaid recipients?

PARTICIPANT: Right. The waves are, I think, accurately listed in this presentation. The first was people that Medicaid knew had access to
employer-sponsored insurance. The next wave is people who work full-time who could have access to employer-sponsored insurance but they don't know. And then there's going to be a third wave where maybe a parent isn't covered by Medicaid but their child is covered by Medicaid or KCHIP, so if they can pay the premium of that parent to include that child, if that's cost effective. That will be the third wave.

DR. SCHUSTER: Okay.

PARTICIPANT: Maybe next year.

DR. SCHUSTER: Yeah. It says November 1st on this, but I don't know when they will get it done.

PARTICIPANT: Okay, okay.

DR. SCHUSTER: Because somewhere I had heard that that second phase, that August phase, was going to be fifty, 60,000 letters going out.

PARTICIPANT: Right. That's the big one.

DR. SCHUSTER: Yeah, that's the big one.

PARTICIPANT: So we're anxiously
awaiting the FAQs of the questions we have
asked. And it will probably generate a whole
other round of questions, like FAQs normally
do.

PARTICIPANT: Jason, do you think
that there are fifty to 60,000 people that
are really eligible?

PARTICIPANT: No. I mean, the way
the program is written and the way cost
effectiveness is supposed to be determined,
based on the State regulation it doesn't seem
to us like very many people would be eligible
for it. Because there's probably not a lot
of employer-sponsored commercial insurance
plans that end up being cheaper than Medicaid
coverage.

PARTICIPANT: Right, right.

DR. SCHUSTER: With equal coverage.

PARTICIPANT: With equal coverage,

yes. Yes. All things considered, yeah.

DR. SCHUSTER: We've been
particularly concerned about most commercial
plans that report behavioral health coverage
compared to Medicaid.

PARTICIPANT: Right. Yeah, right.
And Medicaid can cover that. But then you are piling more of the cost on Medicaid under a fee-for-service.

DR. SCHUSTER: Right.

PARTICIPANT: So that is where the cost effectiveness really starts to drop off.

DR. SCHUSTER: So on the non-Medicaid providers, if somebody is covered in this KI-HIPP program and they go to a non-Medicaid provider.

PARTICIPANT: That's a big question. That's a big open question for us.

DR. SCHUSTER: Okay.

PARTICIPANT: Because at the last community forum, where they presented this information, they said if they choose to go to a provider that is under their employer's plan but not a Medicaid provider, that they would be liable for the out-of-pocket expenses.

PARTICIPANT: Wow.

PARTICIPANT: Which doesn't seem to comport with what we find on the CMS website.

DR. SCHUSTER: Well, and that implies a degree of specification that is
difficult for all of us --

PARTICIPANT: Yes. Right.

DR. SCHUSTER: -- to determine.

You know, you can have an entity that looks like it is in network, as we know from surprise billing, and then you can have providers within that entity that are not.

PARTICIPANT: Right, right.

DR. SCHUSTER: And so you go in thinking you are going into a Medicaid agency or a Medicaid hospital or a Medicaid whatever.

PARTICIPANT: Right. I had to diagram it for myself, like a Venn diagram. There's Medicaid providers and DSM providers and people in the middle can take both. We think we know what happens with Medicaid and the providers who take both. But what happens with that solely employer-sponsored.

DR. SCHUSTER: With the solely non-Medicaid employer-sponsored.

PARTICIPANT: According to that CMS material, the State has to find a mechanism to pay those providers up to the negotiated rate of the ESI provider. So there's a lot
of questions.

PARTICIPANT: Yes.

PARTICIPANT: Has anyone seen the letter that is going to be sent out? Because my concern is, normally they give a letter about this.

PARTICIPANT: I got it through an open records request this week. So I can send it to you, Sheila.

DR. SCHUSTER: Yeah, send it to me, if you would; yeah, that would be helpful.

PARTICIPANT: I mean, it is scant on details, so just know that. But you won't find information about cost sharing reimbursement.

DR. SCHUSTER: Well, I guess the other thing is, is the tone written in a way, Jason, that people are going to read this and say, "Oh, this is something I have to do"?

PARTICIPANT: Well, that was one of my questions. Some of the wording in there seems to imply it's voluntary. The word "voluntary" is not used. The word "mandatory" is not used. But it does talk about once you decide to look into it that
there are required documents to send in.
So it could be misconstrued, yes.

DR. SCHUSTER: Because that was one of our concerns from the very beginning, is that. And someplace like Participation Station is going to be inundated with people getting these letters and coming in and saying, "What do I do with this? What do I need to do?"

PARTICIPANT: It just triggers panic.

PARTICIPANT: I think right now tell them no, don't do it. There is just not enough information for us to recommend anybody do it for sure.

DR. SCHUSTER: Okay. All right.

PARTICIPANT: This is on the agenda for Thursday, right, the forum?

PARTICIPANT: Yes. Yes.

PARTICIPANT: In Northern Kentucky?

PARTICIPANT: Hopefully they will have their answers created before then, but we will see.

DR. SCHUSTER: There was, you know, one of their webinar in-person stakeholder
forums this Thursday, two days from now, at 1 o'clock up in Northern Kentucky. And you can follow it on Facebook Live and get the documents and, you know, see it in action, if it doesn't freeze, which it seems to do a lot on Facebook Live, but if you can't go to Northern Kentucky.

But they are supposed to be talking about two topics that we have talked about that are of concern. One is the substance use disorder rollout, of which there are still lots of questions, and the other is this KI-HIPP. So I would really recommend. And I will send out that notice and the link to the Facebook --

PARTICIPANT: Okay.

DR. SCHUSTER: -- for the forum.

And, again, that's this coming Thursday at 1 o'clock.

It seems to me that one of the things that the Commissioner is offering, if any MAC or TAC has any questions, please feel free to send these questions to Sharley Hughes. Why don't we piggyback off the questions that you have sent. Jason and I
will send those questions or some re-worded variations of them --

PARTICIPANT: Okay.

DR. SCHUSTER: -- on behalf of the Behavioral Health TAC to Sharley so that they are getting those questions asked.

PARTICIPANT: All right.

DR. SCHUSTER: So if any of you have any specific questions that you want asked, please e-mail those to me and I will put those together with Jason's questions. But I think, basically, we're -- the voluntary versus mandatory, how does the cost sharing really work, how does this paying first to get reimbursed work. Because that's going to be a huge problem for our folks. And we think when the program was originally in existence the State was paying directly those premiums. So why the change?

PARTICIPANT: Right, right.

DR. SCHUSTER: And then what's the deal with the non-Medicaid providers, that people are going to non-Medicaid providers. Because they really need to have -- they need to know what the liability is going to be.
PARTICIPANT: Right.

DR. SCHUSTER: Okay. Thank you very much, Jason. I appreciate that.

PARTICIPANT: No problem.

DR. SCHUSTER: And I will send out this PowerPoint electronically. It will be a little bit easier to read. I couldn't afford to print each slide on a page, so I had to cheat. So you have to use your magnifying glass.

We've had a few people come in and join us. So back row, would you introduce yourselves, please, behind the door.

MS. CULL: Marie Cull, Cull & Hayden.

MS. DEMPSEY: Patty Dempsey.

DR. SCHUSTER: We are so glad to see you, Marie and Patty. And over here in the front row.

DR. RAYAPATI: Abner Rayapati. I'm a psychiatrist at UK HealthCare.

DR. SCHUSTER: Great.

MS. McFARR: Amy McFarr. I am a case manager at Oliver Winston.

DR. SCHUSTER: Okay.
MS. CARMINE: And I'm Kate Carmine. I work at Oliver Winston.

DR. SCHUSTER: Okay. And there are handouts up here and a sign-in sheet, so come up at any time.

Oh. Hello.

PARTICIPANT: Hello. My name is Kelley Gannon, and I'm with Aetna Better Health.

DR. SCHUSTER: Well, wearing a different hat from the last time we saw you.

PARTICIPANT: Congratulations.

PARTICIPANT: Thank you.

DR. SCHUSTER: All right. Welcome. Please sign in at some point so I have your e-mail addresses. Because then I will be sure that you all get the materials from this the next time around.

We recommended that more information be provided about the change in calculating units of service for nonclinical behavioral health services provided by peer support personnel. And DMS responds, "The fee schedule for the new behavioral health services can be found on the website."
A webinar was conducted on June 17th and June 20th, and that webinar has been posted."

Now, Kathy, correct me if I'm wrong, was that webinar offered just to the BHSOs?

PARTICIPANT: They said it was offered to everybody.

PARTICIPANT: But nobody knew about it.

DR. SCHUSTER: But a lot of people did not know that the webinar was being offered?

PARTICIPANT: No, no.

DR. SCHUSTER: Okay. Because that's what I was afraid of.

PARTICIPANT: No.

DR. SCHUSTER: Because we had tried to go back and find out.

DR. GUNNING: No. We had Davarres monitoring that, and we didn't get any alerts.

PARTICIPANT: Not at all.

DR. SCHUSTER: Yeah. So I think at this point, the thing to do, again the forum on Thursday is supposed to be touching on
some more of these SUD rollout questions, so be sure that you sign up if you go to Northern Kentucky and get on the Facebook. But those are the links to get the webinar. Because I wasn't even aware of the webinar until actually Michele called me and said, "You know, what was the deal with this webinar?" And I said, "What webinar?"

PARTICIPANT: Yes. They did it in secret.

PARTICIPANT: Actually, the members -- our members that seemed to know about it, the few that did, were behavioral health MSGs rather than BHSO.

DR. SCHUSTER: MSGs being...

PARTICIPANT: Multi-Specialty Groups.

DR. SCHUSTER: Oh. Multi-specialty groups.

PARTICIPANT: So they are not licensed by the State, where the BHSO is licensed.

PARTICIPANT: Imagine that.

DR. SCHUSTER: That's interesting.

Okay.
PARTICIPANT: And the BHSOs are the ones that had to be in compliance and register by the 1st.

PARTICIPANT: Yeah.

DR. SCHUSTER: Right. Yeah.

Because, Brad, you all over at Bridgehaven had some questions, too, I think about this.

PARTICIPANT: Yeah.

DR. SCHUSTER: Okay. So I have not been very successful at getting answers to you except getting you these resources, the webinar material.

PARTICIPANT: When you say SUDs, is this associated with methadone being covered or something broader than that?

DR. SCHUSTER: It is all the changes being made as of July 1, so it is methadone.

PARTICIPANT: Methadone, increased meds.

DR. SCHUSTER: Increased meds.

PARTICIPANT: And changed the peer support.

DR. SCHUSTER: And changed the peer support reimbursement, right, which is really
the thing that has been the most problematic. We're trying to figure out how those units are being calculated and so forth. Yeah.

PARTICIPANT: It is a three-tier system now.

DR. SCHUSTER: Say that again.

PARTICIPANT: For tiering the BHSOs according to ASAM.

PARTICIPANT: Yeah.

DR. SCHUSTER: So the behavioral health service organizations, the BHSOs, now are being tiered, right? So there is mental health only, substance use only, and then mental health and --

PARTICIPANT: And then residential. And that's new.

DR. SCHUSTER: And residential. And that's new, right?

PARTICIPANT: Yeah. From the 17th, right?

PARTICIPANT: From the webinar.

PARTICIPANT: So that came out on the webinar on the 17th and we had two weeks to know that.

DR. SCHUSTER: Did we know that
PARTICIPANT: No, no.

PARTICIPANT: I don't think we knew that the core stuff was going to be implemented that quickly.

PARTICIPANT: They changed Chapter 15 of 907. Yeah.

DR. SCHUSTER: Okay.

PARTICIPANT: There is also a requirement where you have to go in and -- where the providers have to I guess, like, register. So it changes how they look on the MPL, based on those tiers.

PARTICIPANT: Yep.

DR. SCHUSTER: Okay.

PARTICIPANT: What is an MPL?

DR. SCHUSTER: That's a Master Provider List.

PARTICIPANT: Davarres had already gone through all of this in North Carolina, so he is being our watch dog on all of that and he was on the webinar.

DR. SCHUSTER: So once again --

PARTICIPANT: Yeah. No, none.

DR. SCHUSTER: -- we're supposed to
be advisory to Medicaid as they are thinking
about doing these things.

PARTICIPANT: Right.

DR. SCHUSTER: But we never find
out anything until after they have done them.

Welcome, Diane. Diane Schirmer,
Brain Injury. Not that you are brain
injured. I'm sorry. I didn't mean to imply
that. Welcome. Sign in. And handouts are
up here, too. Thank you for coming.

PARTICIPANT: Yes.

DR. SCHUSTER: So I think, again,
in our recommendations we need to make that
recommendation even more strongly, that once
again there is no forewarning and no
notification to the Behavioral Health TAC
about any of these changes that are being
contemplated so that we can get the word out,
we can get some feedback to them. There is
no sense of us being listed as an advisory
group if that's not the case.

PARTICIPANT: They don't want that.

DR. SCHUSTER: All right. So at
this point all I can do is to recommend that
you go to these links, look up the webinar,
which I guess would give you some
information, and then be on Facebook on
Thursday at 1.

PARTICIPANT: Okay.

DR. SCHUSTER: We had quite a
discussion last time about co-pays and their
effect and the fact that primary care and
pharmacy in particular were not checking to
see if people were below 100 percent of
federal poverty level and so people were
being denied medications and other services.
And I brought that up.

And their response was that they
provide messaging back to the pharmacies
regarding co-pays at the time the pharmacy
submits the prescription for payment at the
point of sale. All providers have been
notified to access the KentuckyHealth-Net
website to determine who they can and cannot
refuse service to. Any beneficiaries having
issues with co-pays or providers refusing
services should contact their MCO or DMS and
we will investigate.

PARTICIPANT: It is a non-answer.

DR. SCHUSTER: Well, yeah, it is.
I will again encourage you to use that Kentucky Voices For Health co-pay collector. Because that's the one central place. And I will send it out to you again and I will do it again after this meeting, where we've had 156 responses to that with some good quotes and so forth. And I will include those in my report to the MAC.

But the other thing is, if you have a consumer who really is willing to step forward and say this is what happened to me at this pharmacy when I was denied medication and shouldn't have been, we actually need to get those bodies. And we're going to have to take those individual cases with their name and serial number and rank and all of that stuff and go to DMS with it.

So those of you who are in a position, Brad may be it at Bridgehaven, you have got some people at Participation Station, some of the Comp Cares may see these people come in and complain about what's happened, not at the Comp Care but someplace else, and let's see if we can't get people and get some names and faces and, you know,
Social Security numbers. I mean, that is really what it is going to take.

PARTICIPANT: A lot of times my people don't know all of the facts. I mean, they don't even know what question to ask when they go to the pharmacy. Like one lady that I am thinking of in particular, yeah, she said that she was told she had to pay $50 at the pharmacy. Well, come to find out, that was not actually the case. Because she doesn't understand.

PARTICIPANT: Either way she walked away.

PARTICIPANT: Yeah.

DR. SCHUSTER: She didn't get her medication.

PARTICIPANT: Yes. Because she doesn't want to appear stupid. That's what she said. She said, "I didn't want to ask any more because they were getting irritated." And so, you know, there's just that whole intimidation factor.

PARTICIPANT: And, you know, I brought that up when Ms. Sharley was here and she was like, or the Commissioner, "Oh, no,
that's not happening." Well, that's probably the truth, but my person thought it was.

DR. SCHUSTER: Yeah.

PARTICIPANT: Do you know what I am saying?

DR. SCHUSTER: Right, right.

PARTICIPANT: The result was not good either way.

DR. SCHUSTER: Right.

PARTICIPANT: She didn't understand the information.

PARTICIPANT: So, I mean, bringing her to talk about that, if she was able, she is not, but she wouldn't even, you know, know how to talk about it.

DR. SCHUSTER: So are there peer supports or other folks that can sometimes go with somebody to the pharmacy?

PARTICIPANT: Yes. And we have told them to ask for that. And we also would like to have -- Steve's offered before to come over and do some explaining. And Valerie and I were talking about trying to get that scheduled with him while the legislature is not in session. But I know
you are busy anyway. But we thought that
would be helpful. So we could have a thing
where we have families and peer support
specialists there that could go with people
and understand it better.

DR. SCHUSTER: Yeah. Because I
think that's a really good situation for
either a peer support specialist or a family
member, to go to the pharmacy or to the
primary care and make sure that they -- and
if they know that they are below 100 percent
federal poverty level, to know that that's
the law and they cannot be denied services,
they cannot be denied their prescriptions.

PARTICIPANT: Yes.

DR. SCHUSTER: And that's what we
need to be doing. So...

PARTICIPANT: It is just like these
fifty to 60,000 letters that you are afraid
that are going to go out. Unfortunately,
what we mostly get are just reactions,
you know, this just means something bad, I
just know it's not good, so, therefore, I'm
probably not going to go to the doctor
anymore. And people just don't understand
the way they apply this so broadly to that.

DR. SCHUSTER: Right, right.

PARTICIPANT: And, I mean, even if you get it in the mail you are like, "Oh my God, that is coming from here." I mean, that is the way I feel when I look at the mailbox everyday thinking that I am going to get a review for my SSDI; you know, you see that letter and you are like, you know, I'm in trouble. Do you know what I mean?

DR. SCHUSTER: Yeah, yeah. Trouble, yeah. I think if Steve can go over and talk to somebody, that would be good.

PARTICIPANT: It triggers a panic reaction. And then I don't think they are even hearing the other piece of the conversation we're trying to have with them sometimes.

DR. SCHUSTER: Yeah, yeah.

PARTICIPANT: But we're working on it.

DR. SCHUSTER: I know you are. And I appreciate that.

We continue to bring up the reviving the classification of medically
frail. And that's, obviously, not going to happen.

PARTICIPANT: Until the court.

DR. SCHUSTER: It is part of the Kentucky Health 1115 waiver held up by the court. There will be no implementation. You know, we kept trying to push the co-pays should be lifted for those that have the status and we still believe it still makes sense. But, you know, this is about the third time that we've made that recommendation and they keep coming back.

Sarah, you and I have talked about that as being a really important thing to push. But I don't know how else to push it except that we're making a recommendation and they are making a statement that it is just not going to be a viable --

PARTICIPANT: Yeah.

DR. SCHUSTER: -- classification.

This next one was on the basis of what Mary and Diane told us about, serving on the 1915 waiver advisory --

PARTICIPANT: The secret service.

DR. SCHUSTER: -- advisory panel
were being kept secret. And apparently other groups, I think P&A, raised that question about these can't be closed meetings and we can't keep secret of the people on the work groups and they are working with their attorneys.

So they are saying if any beneficiary or advocate wants to provide input on various aspects of the waiver redesign, they may do so through the comment mailbox or contact the department.

PARTICIPANT: But that's not the same as being in the room. You are not responding to a conversation. You are initiating something that goes nowhere, you know. So...

DR. SCHUSTER: Yeah.

PARTICIPANT: It is not really a good answer to the real issue that was raised for more participation.

PARTICIPANT: Or input.

DR. SCHUSTER: Yeah. So have you had any more meetings, Diane, of your group?

PARTICIPANT: I missed the last meeting. I was on a KARP field day. I also
know that a few people have resigned from committees and that they have hired a representative and that they feel that they won’t -- they signed letters saying they are only to rubber stamp things.

PARTICIPANT: A token.

PARTICIPANT: It is a token. And I'm probably going to do the same thing.

DR. SCHUSTER: And what about Mary, do you know?

PARTICIPANT: Mary is not feeling confident about her role, either.

DR. SCHUSTER: Yeah. And she is what we call the Big Kahuna, the advisory board, right?

PARTICIPANT: Yeah.

DR. SCHUSTER: So people have been resigning?

PARTICIPANT: Yeah. I know at least three people have.

PARTICIPANT: Well, maybe that will garner some attention.

PARTICIPANT: But they are just looking to replace them, because they are looking for other people. At the IDD TAC,
they were telling us that they were looking
for some other folks, people who receive
services to replace. And they are looking
for people because people dropped off.

PARTICIPANT: Well, warn them it is
a token committee.

PARTICIPANT: Everybody is jumping
at the chance to do it. So...

PARTICIPANT: We all need to let
our legislators know why we're dropping off.

PARTICIPANT: Tokenism.

DR. SCHUSTER: Yeah. If people are
going to resign, they really need to let
their legislators know.

PARTICIPANT: Yep.

DR. SCHUSTER: Okay. And then we
raised the question that we've discussed
about the EMS services not taking mental
health clients to a hospital that didn't have
psych services to one that did. And I am not
sure what additional information they need in
order to investigate this.

PARTICIPANT: Name, rank, and
serial number.

PARTICIPANT: Which is what she
said she didn't want from us, so I'm very confused from that answer.

DR. SCHUSTER: That's right.

PARTICIPANT: So you may ask that question.

PARTICIPANT: Yeah.

PARTICIPANT: We don't understand.

You said you didn't want specific identifying information, but it seems like we can't get the question answered in a broader way.

DR. SCHUSTER: All right. So that was a very satisfactory kind of exercise to go through.

And then the Commissioner, because they were not coming, thought she would comment on our agenda, which I thought was super helpful. "It appears your agenda for the July meeting is the same as the May meeting." Well, that's because we never get any response from you that's helpful that we can close an item.

PARTICIPANT: Are you going to say that?

DR. SCHUSTER: Yeah. I think I probably will.
PARTICIPANT: I think you should.

PARTICIPANT: We will back you.

PARTICIPANT: Yeah.

DR. SCHUSTER: So the update on Kentucky Health, as we know, is that it still is on hold due to court proceedings. I do think that the hearing is supposed to be maybe in September, they are thinking, at the appeal court level. We asked the questions about KI-HIPP. KI-HIPP (pronouncing), I guess it is called. And we have Sharley's e-mail address.

Now, on the implementation of changes to the SUD services, they do say that they would be glad to arrange a briefing on the details of this waiver to the TAC if we desire. I don't know if that means they will come here or whether we will have to go there.

PARTICIPANT: Medicaid staff is in 149 right now.

DR. SCHUSTER: Right now, right.

PARTICIPANT: Oh, really?

That's...

DR. SCHUSTER: Yeah.
PARTICIPANT: Geez.

PARTICIPANT: So we know they know their way to the Capitol Annex.

PARTICIPANT: And we're in Room 125.

PARTICIPANT: We have been on the schedule for how long now. So...

DR. SCHUSTER: So they come here for the MAC meetings.

PARTICIPANT: Stephanie was here this morning.

PARTICIPANT: They had meetings today.

PARTICIPANT: She was there.

DR. SCHUSTER: So the others are on track, on track, medical frail will not be operational, and the redesign we've already talked about.

PARTICIPANT: Sheila, did you see the 1915(c) stuff they sent out yesterday?

DR. SCHUSTER: No, I didn't.

PARTICIPANT: I will send it to you.

PARTICIPANT: What was it?

PARTICIPANT: It is the Medicaid
newsletter, nothing earth shattering. I just
didn't know if you got that or not. So...
I skimmed it, but I didn't see
anything in there.

DR. SCHUSTER: So it feels like the
changes to the SUD services and the
reimbursement and billing for peer support
services, which are six and eight on our
agenda, are possibly going to be more
information forthcoming on Thursday, although
one should not hold one's breath.

Why don't we do this. Why don't we
-- after you all have downloaded the webinar
information and heard the Facebook
presentation on Thursday, e-mail me what
questions you have that you think are still
unanswered. I think that's the way that
makes the most sense. Yeah.

PARTICIPANT: I have one question
about it that was a little bit of lack of
clarity. I know that they plan for the
changes that they propose to the State
amendment, you know, State plan amendment,
and they said that those changes were going
to go into effect July 1. However, I know
that they are still seeking approval from CMS and the federal government on the changes that they are attempting to make.

And I'm wondering if we're still going to be currently under the old regulations until they actually get that official approval. Because they have not sent out any information to say that CMS actually approved what they are wanting amendments to.

PARTICIPANT: I thought the substance abuse stuff has been approved. The remainder of the 1115, I think they submitted two pieces, the substance abuse changes have been approved, the rest, the big 1115 changes, have not and that's on hold.

PARTICIPANT: I got it.

PARTICIPANT: But that's still, now know --

PARTICIPANT: That's still a large chunk.

PARTICIPANT: That is a lot.

PARTICIPANT: But that is still a problem of the July 1st date. They released the regs.
PARTICIPANT: Right. Really, I mean, what I got recently on the regs, they are not signed and have not been filed yet.

PARTICIPANT: Well, that's what they are saying.

PARTICIPANT: That is the question. And you know --

PARTICIPANT: I don't think July 1st is agreeable.

PARTICIPANT: That's -- yeah, is July 1st the actual real implementation that it is in fact, you know, going into effect.

PARTICIPANT: Those regs have not been sent out officially by Medicaid. They have not been filed here, so I don't think they should be in effect yet.

PARTICIPANT: If it is not July 1, it would be January 1, right?

PARTICIPANT: No.

PARTICIPANT: Whenever they say.

PARTICIPANT: It could be tomorrow.

DR. SCHUSTER: It would be whenever they file the regs.

PARTICIPANT: Which ones are you talking about?
PARTICIPANT: The BHSO stuff.

PARTICIPANT: They have been filed.

PARTICIPANT: Have they?

PARTICIPANT: Yes. It was filed on June 27th with a delay, implementation date of July 1st, and then licensure filed an eReg the same day.

PARTICIPANT: So they are in effect right now?

PARTICIPANT: They released them already.

PARTICIPANT: Well, see, who knew that?

PARTICIPANT: It is on the website.

PARTICIPANT: Except brilliant people that are watching it everyday, I guess.

PARTICIPANT: If you are on the list serve.

PARTICIPANT: Right, if you are on the list serve. So it was eReg.

PARTICIPANT: I got you.

DR. SCHUSTER: So are there any -- Kathy, are there any outstanding issues that still need to be addressed and raised?
You feel like the regs are in place?

PARTICIPANT: Well, I think the biggest issue is the fact that they filed regs on June 27th, which is a Friday, with an implementation date on Monday, including licensure. How can you comply with new licensure requirements?

PARTICIPANT: Right. No, I mean, you get the webinar on the 17th and providers are like scrambling, yeah.

PARTICIPANT: I mean, even on the 17th, when you find out, that's not enough time until the 1st.

PARTICIPANT: Right.

PARTICIPANT: The review of the regs on the 17th from that webinar were -- they were very clear they were a draft and they could change.

PARTICIPANT: Right. So you didn't know.

PARTICIPANT: Right.

PARTICIPANT: But, now then, so then we have from the 27th until the 1st.

DR. SCHUSTER: So you have over the weekend.
PARTICIPANT: That's over the weekend and on a holiday. No, it was before the holiday.

PARTICIPANT: They didn't send them out until the 1st.

PARTICIPANT: Yeah.

PARTICIPANT: Yeah. Yeah, it was on the 1st.

PARTICIPANT: So new residents and new students and new regulations. That's great. I can't imagine.

PARTICIPANT: This is just wrong.

DR. SCHUSTER: Well, yeah. I think that's --

PARTICIPANT: If they want to become a provider, especially if they don't have a psychiatrist now.

DR. SCHUSTER: So --

PARTICIPANT: How many rural BHSOs are going to be able to have a psychiatrist, I wonder.

PARTICIPANT: Not many.

PARTICIPANT: How many, Steve?

PARTICIPANT: Not many.

PARTICIPANT: Amen. That will
probably cut the BHSOs by a lot, because they
won't be in compliance now. But it was such
a good idea to open the network.

DR. SCHUSTER: So do we want to --
PARTICIPANT: Start a revolution?
Yes.

DR. SCHUSTER: I don't know what
forum. You know, they won't let us ask
questions. So we have to make a
recommendation.

PARTICIPANT: We recommend more
time.

DR. SCHUSTER: Proper notice?
PARTICIPANT: Yes.

DR. SCHUSTER: And --
PARTICIPANT: And transparency.

DR. SCHUSTER: -- transparency?
PARTICIPANT: Why haven't they
worked with the TAC?

PARTICIPANT: Yeah.

DR. SCHUSTER: Yeah.

PARTICIPANT: Or at least send it
to TAC members.

PARTICIPANT: Yeah. Even if it is
just you six.
PARTICIPANT: Yeah. Even if it was just you guys. You can tell everyone else.

PARTICIPANT: I don't know. We might have to be secret.

DR. SCHUSTE: Yeah.

PARTICIPANT: It might be top secret. We might have to kill you.

PARTICIPANT: It is bizarre, in theory. Because if someone shows up and they have an addiction and the person doesn't have a co-occurring, what is the BHSO going to do when they have a mental illness. Sorry.

PARTICIPANT: Well, I'm going to tell you, that's my topic of conversation for the day, the whole reason I got up this morning.

PARTICIPANT: Well, they all know you increase complexity, you increase access to care.

PARTICIPANT: Absolutely.

PARTICIPANT: Well, that can be in the minutes.

PARTICIPANT: Yes, please.

DR. SCHUSTER: What was it?

PARTICIPANT: You increase
complexity, you decrease access to care.

PARTICIPANT: Because it is easier.

DR. SCHUSTER: All right. So we want to set the stage that --

PARTICIPANT: It is really overwhelming, isn't it, what they do?

DR. SCHUSTER: Yeah.

PARTICIPANT: What we have is a failure to communicate.

DR. SCHUSTER: So if the BHSOs did not know this was coming and they have to figure out now over a weekend what their category is, what their tier is and whether they meet that criteria, and they had three days over the weekend. Actually, if they were notified on July 1st they had zero days.

PARTICIPANT: Zero days, right.

PARTICIPANT: Well, what they said was, if you didn't have a psychiatrist you're basically -- all of the available services are done. If you have already a BHSO license and you have a psychiatrist, then you automatically become tier one; you automatically just become that. If you are dealing with folks that have co-occurring
and you don't have an APRN with a psychiatric
specialty or, you know, a physician's
assistant with SUD under the consultation of
a psychiatrist, then you cannot serve
coccurring disorders.

And it's going to definitely limit
the number of providers that can do
coccurring. And we know that often many
mental health patients also have
coccurring. I mean, it's a high likelihood
of seeing that together. So...

PARTICIPANT: But the other problem
is, if SMI is their primary diagnosis, it
doesn't work anyway.

PARTICIPANT: Right.

PARTICIPANT: Are you saying that
the psychiatrist needs to even be in place
for BHSOs --

PARTICIPANT: Yes.

PARTICIPANT: -- for tier one's?

PARTICIPANT: Yes.

PARTICIPANT: I don't know if
that's true.

PARTICIPANT: Absolutely. The
webinar --
PARTICIPANT: I heard for tier two and tier three there has to be a psychiatrist in place. But...

PARTICIPANT: We heard for co-occurring.

PARTICIPANT: Well, for co-occurring, yes. But the BHSO is just providing mental health services only.

PARTICIPANT: That's tier one.

PARTICIPANT: You still need to have a psychiatrist in place.

PARTICIPANT: I don't know that that's accurate.

PARTICIPANT: We will have to watch and learn.

PARTICIPANT: Well, there was a change on the MSG regs, too, that said you have to have an AODE if you are going to do co-occurring, which is also a very big change.

DR. SCHUSTER: You have to have an AODE licensure as well.

PARTICIPANT: Which is a very big change. It is particularly --

PARTICIPANT: What is AODE?
DR. SCHUSTER: Alcohol and other drugs.

PARTICIPANT: It is particularly problematic just because of the co-occurring piece. Because a lot of the MSGs only serve mental health, and that's fine, but how many of their patients have co-occurring. When does it come up in therapy and do they need to refer out immediately. So that is an issue we're trying to figure out as well.

PARTICIPANT: And what we're running into is it is all denied in the meantime.

PARTICIPANT: Yeah. In the meantime it is --

PARTICIPANT: In the meantime we can't get people anywhere, can we?

PARTICIPANT: No, no.

PARTICIPANT: And then you worry about if an MSG has a relationship with someone and they are serving mental health issues and then all of a sudden a substance abuse issue comes up, they have to discharge them, do the workers follow through?

PARTICIPANT: And, besides, if they
have SMI as primary, they can be denied treatment because they can't work in their program. How many of those have we had just in the last month? Fifteen?

PARTICIPANT: We have had a lot, yes.

DR. SCHUSTER: They are saying if you have an SMI you can't be working on SUD issues?

PARTICIPANT: Not in their program.

PARTICIPANT: No. Because if you don't have both the BHSO and the AODE licensures and the psychiatrist, that's the level of complexity that they are asking for, then you can't serve them.

PARTICIPANT: Not only that, it is also a discrimination and non-parity. Because if you have the SMI diagnosis, they are rejecting them just based on that, that we can't serve the SMI.

PARTICIPANT: Yes.

PARTICIPANT: So I've talked to everybody I know about this at the department and everywhere else about it. So there's all of this substance use treatment money out
there for the opioid crisis, but we can't have someone that has SMI and the opioid or other drug addiction getting served. We're being -- all of our people are being denied.

PARTICIPANT: Yes.

PARTICIPANT: What happened to treating the whole person?

PARTICIPANT: And, so, do you know what they told me? They said, "Well, unfortunately there is no money for SMI."

DR. SCHUSTER: Is Michele still back there? Are you hearing this, Michele?

PARTICIPANT: Did you hear that Michele? Am I telling it right?

PARTICIPANT: The story changes from day to day sometimes. But yes. That federal funding is very restrictive to --

PARTICIPANT: And that's what I am told over and over.

PARTICIPANT: -- not just substance use but opioid use.

PARTICIPANT: I wanted to apply for some of the money to treat our co-occurring people and they said we can't qualify, even though we're doing DTR and RAP and all of
this addiction treatment is being put in our
lap because of our SMI people. We can't get
any of the money because they are SMI also.

PARTICIPANT: Yeah. And that's a
problem nationwide with that.

PARTICIPANT: I know.

PARTICIPANT: That's a federal
problem.

PARTICIPANT: But, still, it is our
people.

PARTICIPANT: We talked about it at
length at our national convention and that
was a big issue. Because even if they come
in with cancer, they can't be treated;
you know, it is any other illness.

PARTICIPANT: That's the only way
that I am into that.

PARTICIPANT: Exactly. NAMI is
going to focus on SMI. We were looking at a
larger co-occurring population and we are
like if they have PCOS and happen to have an
opioid addiction, they are also getting
dismissed nationally, not just in Kentucky.
So...

PARTICIPANT: Yeah.
PARTICIPANT: We have tried to have conversations with the federal project officers about some of those types of things and just being able to work -- you know, comprehensively address the whole issue, because it is touching on lots of other things.

PARTICIPANT: Because, you know, our percentages are 85 percent co-occurring.

PARTICIPANT: But nationally, if you look at what they are doing even medically, they are siloing things again instead of looking at a broad perspective to treat people. We're not looking at person-centered.

PARTICIPANT: No. I talked to Dr. Brendville [ph] about it. But he said, "Sorry, there is no SMI money."

PARTICIPANT: I think they are frustrated, too.

PARTICIPANT: They are. I know they are. But, I mean, what are we supposed to do for people in the meantime? Everybody is frustrated.

PARTICIPANT: It is awful what is
PARTICIPANT: But it is definitely a parity issue at the very least.

PARTICIPANT: Just of note, Mental Health U.S. has a national group that has formed to piggyback on one of the Kennedy Center's projects, which NAMI are a part of it. And brain injury focus is getting on board because it addresses the issue. It is one of their many platform issues. But their goal is to change the federal funding dollars so our department can do stuff.

PARTICIPANT: Well, it is ridiculous. Yeah.

PARTICIPANT: And it is not just SMI. But SMI figures prominently in there because 85 percent of our people that we serve are co-occurring. And we can't get them into any treatment. And even -- we're doing the treatment uncompensated now, so we're eating it. I mean, we're just continually doing more and more and more and getting cut, cut, cut. The mental health court was just cut 30,000 from LFUCG, who is
our funder. But we're seeing more. I mean, we can't take them fast enough.

DR. SCHUSTER: Yeah, yeah.

PARTICIPANT: And this may not make sense to all segues. Because if you look at what is happening with CMS, Medicare, they are collapsing the CMGs, which are the case mix codes, for all post-acute care, like rehab and SNF and home health and outpatients, so that stroke won't be recognized anymore. And they are doing away with therapy.

So if you have got the person who has a stroke as a result of opioid misuse, they won't be entitled to rehab. They will be funneled to SNF, but they are no longer allowed to get therapy. So those people are going to not get anything and they are going to be some of the worst cases that we have to deal with.

PARTICIPANT: And these are people that have been seized and Narcaned. I mean, we actually know some of these people and they go nowhere.

PARTICIPANT: Yeah. So there is a
whole -- I mean --

PARTICIPANT: Where we used to go
to Cardinal Hill for rehab, they can't take
them anymore.

PARTICIPANT: That's correct.

So at a national level, agencies are trying
to ban together to deliver messages because
this is not person-centered.

DR. SCHUSTER: So they are
collapsing the categories and, therefore,
shutting off avenues to --

PARTICIPANT: They are, they are.

DR. SCHUSTER: -- post-trauma
relapse?

PARTICIPANT: Yeah. And Medicare
decided that, you know, on the acute side
they don't need STEM, which is how you
measure progress in rehab. They did their
own tool. And instead of 15 scores for
motor, they have two. And they decided you
didn't need to measure cognition, you know.

DR. SCHUSTER: That sounds like the
medically frail forum, right?

PARTICIPANT: Yes, exactly.

PARTICIPANT: It doesn't measure
cognition or ADLs or any of that.

PARTICIPANT: Right. Exactly.
So it is just nonsensical, what they are doing. Yeah.

DR. SCHUSTER: Kelly.

PARTICIPANT: We have another big problem. And that is, our community mental health provider doesn't have any Medicare therapist, Medicare billable. And so if they want to keep their doctor, they can't see another therapist outside of that unit. But there are no therapists. So they either can go mid only and no therapist or if they seek a therapist outside; they lose their doctor, who many have had for 15 plus years.

PARTICIPANT: Yeah, yeah.

DR. SCHUSTER: So the CMHC doesn't have any LPSW?

PARTICIPANT: No. No Medicare billable therapist. And they are a med only patient, but they can't see a therapist in a network that has a Medicare billable therapist.

DR. SCHUSTER: Because...

PARTICIPANT: Because they will
lose their doctor.

DR. SCHUSTER: Wow.

PARTICIPANT: And we were just told, "Sorry. There is a shortage of Medicare billable therapists."

PARTICIPANT: Yep.

DR. SCHUSTER: Which are all LCSWs and doctor level psychiatrists.

PARTICIPANT: Yeah. Uh-huh. So we had two people just in the last month that had to make the choice of whether to see their doctor that they've had for 15 years plus and are very stable with and go without therapy.

DR. SCHUSTER: Wow.

PARTICIPANT: Yeah.

PARTICIPANT: How is that fair?

PARTICIPANT: It's not. It's not.

PARTICIPANT: And how can we have an open network and not have an open network? And now all of this tiering of the BHSOs, the addition of the psychiatrists and the AODEs. And then the multi-speciality groups are a whole other can of stuff. I mean, I don't know what we're supposed to do anymore.
But the bottom line, Sheila, is, if you are SMI and co-occurring or God for bid you have IBD and post-traumatic stress and all of these other things, you are screwed. They are not getting help.

PARTICIPANT: I mean, honest to God, I mean, raise your hand if you know this to be true. I mean, I can't believe it. Because we have people in the mental health court that have five diagnoses. They have five.

DR. SCHUSTER: Yeah.

PARTICIPANT: And they have cancer. We have one that had colon cancer, IDD, serious mental illness, opioid use disorder, and PTSD --

PARTICIPANT: Yep.

PARTICIPANT: -- severe PTSD, which is SMI but, still, it is a whole other thing to treat.

DR. SCHUSTER: Right, right.

PARTICIPANT: Five diagnoses.

Can't get any help because of all of it not meshing.

PARTICIPANT: Yeah.
DR. SCHUSTER: Wow.

PARTICIPANT: Yeah. We staff that every Monday and run into those same obstacles. And, you know, we just try as a team to hold them together to reduce the recidivism. But where can we put them? Where can we place them? So we just -- we continue to try to allocate resources, the limited resources that we have to work with.

PARTICIPANT: So we're not eligible for any drug money that's here in oceans.

PARTICIPANT: We might have better luck with the cartel. I would sell my soul for treatment for people.

DR. SCHUSTER: Right, right.

PARTICIPANT: I've already been accused of that in the past.

PARTICIPANT: I remember that.

PARTICIPANT: Anyway, as far as recommendations.

DR. SCHUSTER: Yeah. What do we recommend?

PARTICIPANT: A revolution.

PARTICIPANT: Yeah, almost.

PARTICIPANT: We need to get these
stories to the legislators. I don't know.

PARTICIPANT: I talked to Carla Carter about this. You need to call her, seriously. Because my comments already confused her. So I think she needs to hear it from you.

PARTICIPANT: Okay.

DR. SCHUSTER: Okay. Do you have anything else on ABI services and supports, Diane?

PARTICIPANT: That's pretty much where we are with things. I mean...

DR. SCHUSTER: Mary sent me a notice about there was some discussion about the case managers.

PARTICIPANT: At the State level they are looking at abolishing case managers. They are really slicing and dicing.

PARTICIPANT: It is the lifeline --

PARTICIPANT: It is.

PARTICIPANT: -- for the people, to do away with that case management.

PARTICIPANT: Right. Yeah. They would be -- they keep chopping them off at the knees.
PARTICIPANT: We have a couple of brain injury people in court.

PARTICIPANT: Yeah.

DR. SCHUSTER: So has that been an open discussion at some of the redesign things or is that just behind the scenes?

PARTICIPANT: That's behind the scenes.

DR. SCHUSTER: Yeah. Have you heard that, Steve?

PARTICIPANT: I've heard many things. Like the State wants a new case manager. That always comes up. So that would be -- they will appoint a new case manager.

DR. SCHUSTER: Yeah.

PARTICIPANT: Everyone can do it better.

PARTICIPANT: And do you guys know, are the CSAs being included in this peer support stuff, community support --

PARTICIPANT: No.

PARTICIPANT: -- people?

PARTICIPANT: There was a change in the policy.
PARTICIPANT: Yeah. That's what I thought. But what was it?

PARTICIPANT: MSGs have never been allowed to provide medical home services or bill for that. And they are now, those regs.

PARTICIPANT: So like navigators and support?

PARTICIPANT: Yes. The CCSA code.

PARTICIPANT: Yeah, okay.

PARTICIPANT: That has only taken three years to change.

DR. SCHUSTER: What was that?

PARTICIPANT: The community support associates. The -- say it, Sarah. You said it much better.

PARTICIPANT: MSGs have never been allowed to bill for that, only BHSOs, and they just finally, in the recent batch of regs, the three-day ones, the MSGs can now bill for that CCSA level of service.

PARTICIPANT: Certified community support associates.

PARTICIPANT: And if you are going to go that route, they will be able to work more hours than a peer support. Peer support
can't work no more than 30 hours now, period. The new regs say that, yes.

PARTICIPANT: As of July 1. But we just found out.

PARTICIPANT: It is just direct clinical hours.

PARTICIPANT: Are they working more than 30? Are you billing more than 30 now?

PARTICIPANT: We don't bill.

PARTICIPANT: You could before.

But...

PARTICIPANT: I don't know anyone that was.

PARTICIPANT: Yeah.

PARTICIPANT: No, we don't bill.

So...

PARTICIPANT: Even some peers that do groups, it still -- it doesn't add up that way. So peer leads a group for half an hour, it is still 30, two units, not multiplied by each person.

PARTICIPANT: Well, there was confusion about units versus events and all of that stuff, too.

PARTICIPANT: I think 30 hours, a
lot of peers don't go over that anyway.

PARTICIPANT: No. We don't, either. And we don't bill. So...

And it is blowing my mind that as much as two weeks ago they are still encouraging me to become a BHSO. Why the hell would I want to do that?

DR. SCHUSTER: So the limit is on billable hours, right --

PARTICIPANT: Yes, yes.

DR. SCHUSTER: -- at 30? Yeah. So I'm feeling kind of overwhelmed here.

PARTICIPANT: I'm sorry. But it is true. It is all true.

DR. SCHUSTER: No. I'm sure it is all true and I know that.

PARTICIPANT: And we're so frustrated.

DR. SCHUSTER: So what recommendations do we make?

PARTICIPANT: Change the system, change the world.

PARTICIPANT: I think what we are all saying is they need to give us more notice. They need to -- more transparency.
They need to consult the BH, at least the TAC members.

DR. SCHUSTER: They have to give people time.

PARTICIPANT: Yes.

PARTICIPANT: Administration time, yes.

PARTICIPANT: Administration of all of this stuff.

PARTICIPANT: Administration of all of these places, time, and a heads up.

PARTICIPANT: Can you imagine in three days?

PARTICIPANT: No. None of my peers would do that.

PARTICIPANT: It was a weekend. It wasn't even a work -- three work days.

PARTICIPANT: And it didn't arrive until the 1st. So I can't tell you how many times we did that at UK. So we would open a piece of mail and be like, What? So...

DR. SCHUSTER: Well, we don't think all of the people that should have been notified of that webinar were notified, right?


PARTICIPANT: Absolutely. No. Only BHSOs, right? Only BHSOs, Sheila.

PARTICIPANT: Not even all of them.

PARTICIPANT: Not even all of them.

DR. SCHUSTER: Yeah.

PARTICIPANT: Yeah. A good number of them were not on it.

PARTICIPANT: How about improve your communication skills?

DR. SCHUSTER: What else do we want to tell them?

PARTICIPANT: Is there a way we could subtly threaten them with going to the legislature?

DR. SCHUSTER: Well, we can do that anyway. We don't have to threaten them.

PARTICIPANT: Well, that that's part of our plan. Part of our plan would be if this doesn't change we need to seek other solutions. I don't know. You know me, I'm always out there. Somebody with some sense talk. I like what we said. Steve said it very succinctly. "Increase in complexity equals decrease to access." And if we don't know things, that increases the complexity of
the system --

DR. SCHUSTER: Right.

PARTICIPANT: -- which results in decreased access.

PARTICIPANT: And poor outcomes.

PARTICIPANT: And poor outcomes.

PARTICIPANT: That's where we're headed.

PARTICIPANT: And increased cost.

PARTICIPANT: Oh, yeah. Do have cost in there.

PARTICIPANT: Be sure you get cost.

PARTICIPANT: We thought we were 49. We're now --

PARTICIPANT: 53.

PARTICIPANT: Uh-huh. That's right.

PARTICIPANT: Kelly, just to ask for clarity, when you talk about access, are we talking because of tiering of the BHSO it limits access to BHSOs or are we talking about --

PARTICIPANT: Providers.

PARTICIPANT: Any increase in complexity will increase difficulty for our
clients to access providers, period, whether it is a BHSO. Or look at what's happening with the community mental health centers if you don't have a Medicare provider.

PARTICIPANT: Right.

PARTICIPANT: I mean, it is just in general.

PARTICIPANT: But for different reasons across different entities?

PARTICIPANT: Yes.

PARTICIPANT: Okay. What about the multi-specialty group? What is the concern there?

PARTICIPANT: Well, it is just what -- you said it, Sarah. If you are a BH client and you have co-occurring substance use disorder, you might have to be discontinued from the specialty group which is treating your behavioral health to go to the co-occurring.

PARTICIPANT: Unless they get an AODE license.

PARTICIPANT: I think a lot of these changes are -- I think those substantive changes are when they are
increasing standards across the State. So the intent is really good. And the Department, the Cabinet wants to move toward higher quality standards and more oversight of substance use providers. That makes sense. That is resulting in siloing the substance use and behavior health into the specialty of mental health again.

PARTICIPANT: She said it very well.

PARTICIPANT: I didn't hear her.

PARTICIPANT: It is re-siloing.

PARTICIPANT: The intent is to increase, you know, standards for substance use, which came from legislation and from the 1115 waiver approval. But, so, the department is headed into a really good direction to increase standards or increase oversight of substance use providers. But it is kind of resulting in --

PARTICIPANT: Unintended consequences.

PARTICIPANT: Right, unintended consequences, re-siloing behavioral health and separating it out.
PARTICIPANT: See, they went to behavioral health so it would include SMI and substance use disorder. But, in fact, what they are doing is they are segregating it more.

PARTICIPANT: And you threw out a number of 85 percent. Conservatively, you know that co-existing mental illness or substance use is over 70 percent. And the literature plays that out over and over.

PARTICIPANT: I'm talking about our actual data shows 85 percent of people in our treatment realm.

PARTICIPANT: Which is because of the extremely high co-morbidity.

PARTICIPANT: I'm like you, I don't think they understand the unintended consequences of creating more silos.

PARTICIPANT: Yeah. And I think it was an effort to -- you know, rising of water, right, all those, whatever. But it is having --

PARTICIPANT: It is having a --

PARTICIPANT: You don't raise the bar overnight.
PARTICIPANT: No. Exactly.

PARTICIPANT: You give them a target and say, "Six months, in a year this is where you need to be."

PARTICIPANT: The rollout, sure.

PARTICIPANT: But not in three days.

PARTICIPANT: There was no discussion with providers.

PARTICIPANT: And, also, in medication-assisted treatment, I think that is where a lot of this came from, was oversight for the medication-assisted treatment programs, the Suboxone and methadone and all of those things. I think that's why the psychiatrist component got added or the APRN with the substance, you know, specialty. That's probably just so there would be appropriate professional oversight.

PARTICIPANT: Right.

PARTICIPANT: Which there is no problem with that. But you can't do it within three days or on a weekend or if nobody knows about it. Did you know about
it?

PARTICIPANT: I did, but not that long ago.

PARTICIPANT: Yeah.

PARTICIPANT: And I had to pay for that information.

PARTICIPANT: They didn't give a lot of time, yeah.

DR. SCHUSTER: I had to pay for the information, yeah.

All right. So we're going to communicate this long list of things --

PARTICIPANT: And you are going to make it sound beautiful.

DR. SCHUSTER: -- in our recommendations to Medicaid about how they should shape up and give us more notice, show more transparency, and consult at least with the TAC members, get people to respond particularly to changes in licensure and the administration, make sure that all of the affected parties are invited to the information sharing to start with, improve their communication skills. I think that is worth saying.
PARTICIPANT: And going back to this siloing is really --

DR. SCHUSTER: Yeah. Yeah, I think that really is an important point.

PARTICIPANT: I think so, too.

Because they wanted it to all to be behavioral health for a reason. They were supposed to be moving toward integrated health.

DR. SCHUSTER: Right, right.

PARTICIPANT: But this is not having that result.

DR. SCHUSTER: Yeah, yeah.

All right. So do the TAC members trust me to come up with some recommended language out of all of that?

PARTICIPANT: Most certainly.

PARTICIPANT: Yep.

PARTICIPANT: I think you will do fine.

PARTICIPANT: I can't wait to see the response.

PARTICIPANT: Me, neither.

DR. SCHUSTER: So do we have a motion to communicate to Medicaid these
various messages? Yeah, Kathy.

PARTICIPANT: One question I have. It is probably a process question.

But how do you take our issues that we, the Behavioral Health TAC, submits at the MAC meeting, how do you make an issue separate from that and get it on the MAC agenda? You know, is this something that the MAC needs to be having a discussion about rather than us just submitting our suggestion?

PARTICIPANT: I think it is a bigger systemic issue.

PARTICIPANT: How would we get something like this on the MAC agenda?

DR. SCHUSTER: Well, we can probably -- we can't do it for the next meeting because they already submitted their agenda. But I'm good friends with the Chair of the MAC, so that helps.

PARTICIPANT: It really does.

PARTICIPANT: Maybe it can be new business.

DR. SCHUSTER: We could -- see, I am not -- I think only MAC members can bring
up new business. So we would have to plant that idea with the Chair or with somebody. And I think they are having their elections in July. So she may not remain as the Chair, but she will be on the MAC.

PARTICIPANT: Maybe new business would be a start, like Sarah said.

DR. SCHUSTER: But new business would be, you know, the whole process. Because they talked about it in terms of the bylaws and the Commissioner wanting to micromanage the TAC process. And the MAC, obviously, pushed back on that.

But the truth is, that if Medicaid continues to make all of these secret decisions without ever letting the TACs know so they could give some feedback on it, there really is no purpose in our meeting.

PARTICIPANT: We're a token.

DR. SCHUSTER: Yeah. We're not even a token. We're an after thought.

PARTICIPANT: These are unofficial coalition meetings.

DR. SCHUSTER: We are a -- yeah.

We are a bookmark afterwards.
So, yeah, I think that's a good idea. And I will talk to Beth about whether she can bring that up under new business. And I am not going to be there. Steve is going to give the report. So remind him to wait until the next meeting.

PARTICIPANT: And then we could get people there.

DR. SCHUSTER: Yeah.

PARTICIPANT: But we can't talk anyway.

DR. SCHUSTER: So can I get a motion from one of the TAC members --

MS. MUDD: Sure.

MR. BARRY: So moved on all of that stuff.

DR. SCHUSTER: -- to draft these recommendations. So Mike and Val. Any additions? Suggestions?

PARTICIPANT: Good luck.

DR. SCHUSTER: All in favor signify by saying "Aye."

(Aye)

DR. SCHUSTER: All right. We do need to have a change in the next two TAC
meetings, and the agenda I sent out had the wrong date on it, so these are actually the right dates. We're moving the meeting that had been scheduled for Tuesday, the 10th of September, to Tuesday the 3rd, which is the day after Labor Day. Because the week of September the -- I can't remember the reason.

Oh. There is a big school health meeting on the 10th. And then the meeting in November is on election day. And we thought there were probably other things we needed to be doing on election day. And I think State workers have four hours off or something like that.

PARTICIPANT: So you made it the 4th, then? It is a Monday, I think.

DR. SCHUSTER: Yeah. We made it Monday, the 4th. And we will continue to be in Room 125. So you all, I know Monday is a bad day for you.

PARTICIPANT: But we might be able to make it.

DR. SCHUSTER: Okay. And then the next MAC meeting is July the 25th.

PARTICIPANT: And we will be at the
Kentucky --

DR. SCHUSTER: Yeah.

PARTICIPANT: -- forum.

DR. SCHUSTER: Are there any other issues or updates that anybody has?

PARTICIPANT: I have a question.

DR. SCHUSTER: Yeah.

PARTICIPANT: I don't know if this is too early. But it might be a good thing to think about this before.

But this is from CMS. The ET3, where emergency services can have or maybe a QMHP have on-site evaluations and transport to nonemergency rooms for evaluations. The reason I ask is, Oliver Winston is well-suited for that type of work in transitional care. And if there is any movement in how that was -- if we were looking at that as a group or if there were any updates from the Medicaid folks.

DR. SCHUSTER: Tell me a little bit more about it. I am not sure I understand exactly what you are...

PARTICIPANT: It is called an ET3, which is -- let me look here -- Emergency
Triage, Treat, and Transport, which is in meeting -- this is my assumption -- the HEDIS score of excess recidivism in emergency departments, nonemergent care in behavioral health, that that can be done through evaluation. And working with EMS services, they are exhausted because of repeated calls and the time it takes to -- I guess paperwork related to frequent calls from the crisis calls. And then how those individuals can engage with community partners in care and bypass the emergency room, which is a cost to us all. So it is something that's supposed to rollout early 2020, January or February.

And so, like, thinking about our previous discussion and not being behind it or, you know, to think about that now or maybe add it to the agenda for those in the know to help educate us on what to look for.

DR. SCHUSTER: Okay. And this is a Medicare rule that's being rolled out, a CMS --

PARTICIPANT: Uh-huh.

DR. SCHUSTER: -- Medicare rule?

Huh. Well, thank you for alerting us to
that. It may fit in with that -- you know, the flip of that is the problem we're having with EMS not responding to calls to transport people.

PARTICIPANT: It is a huge problem.
DR. SCHUSTER: Yeah, yeah.
PARTICIPANT: Well, and it could also be with these new paramedicine teams that are cropping up, you know, allowing them to do some more things.
DR. SCHUSTER: Right. Okay.
PARTICIPANT: But they have to have a QMHP.
DR. SCHUSTER: Do they have to have a QMHP?
PARTICIPANT: Yeah.
PARTICIPANT: Well, I was hoping somebody would educate me more on that.
DR. SCHUSTER: Oh, okay.
PARTICIPANT: I just have a brief blurb on it being rolled out.
PARTICIPANT: We will hook up with you --
PARTICIPANT: Okay.
PARTICIPANT: -- and look into it
together.

PARTICIPANT: Sure. Absolutely.

DR. SCHUSTER: Yeah. Okay. Well, anything else?

(No response)

DR. SCHUSTER: All right. For those of you who did not sign in, if you would sign in so I have your e-mail address. And get your handout. I would appreciate it. Thank you all very much. Have a safe trip home.

(Proceedings concluded at 2:30 p.m.)
CERTIFICATE

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professor Reporter, hereby certify that the foregoing record represents the original record of the proceedings of the Behavioral Health Technical Advisory Committee; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 19th day of July, 2019.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR