

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A T T E N D A N C E

TAC Committee Members:

- Sheila A. Schuster, PhD, Chair
- Valerie Mudd
- Gayle DiCesare
- Mike Barry
- Sarah Kidder
- Steve Shannon

1 DR. SCHUSTER: So welcome to the
2 Behavioral Health TAC for July 9th. And we
3 will start, as we always do, with
4 introductions. And I think we will start
5 over here with Dr. Hanna.

6 DR. HANNA: I'm Dave Hanna with
7 Passport.

8 MS. MCKUNE: Liz McKune, Passport.

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

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

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

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

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

20 DR. SCHUSTER: You are a prime
21 supporter.

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

24 DR. SCHUSTER: And we welcome a new
25 staff member.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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 DBHDID,
Michele. Welcome.

MS. SLOAN: Miranda Sloan, Kentucky
Society of Addiction Medicine and the
Kentucky Psychiatric Medical Association.

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 started their response by saying, "We agree
2 with your recommendation." They said they
3 are in the process of a major communication
4 effort around the benefits of the KI-HIPP
5 program.

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

12 PARTICIPANT: That would be nice.

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

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

19 PARTICIPANT: Sure. We submitted a
20 lot of questions to the Cabinet about
21 KI-HIPP. We don't have answers yet. We
22 understand answers are being reviewed right
23 now. But our main three areas of questions
24 relate to whether it's mandatory or
25 voluntary, all their materials say voluntary

1 but the regs say mandatory that Medicaid
2 could be terminated for not following through
3 with some of the KI-HIPP requirements;
4 questions about the networks and payment of
5 out-of-pocket expenses; none of the -- they
6 do have a link to their page with the
7 materials, but there's no information in
8 there at all about how a KI-HIPP participant
9 submits bills, co-payments, co-insurance,
10 deductibles to get those reimbursed. It's
11 silent on that. It is supposed to be a part
12 of the cost effectiveness to determine
13 whether KI-HIPP is the right path. But part
14 of our concern with that is, of the
15 seventy-some-odd people they say who have
16 applied for KI-HIPP, all of them have been
17 found to be cost effective, which is kind of
18 hard to believe. So we're trying to get some
19 information about how they are determining
20 cost effectiveness.

21 And then one of the other areas is
22 the reimbursement model. I think under the
23 old HIPP program this was the State paying
24 the premium directly for the individual.
25 This KI-HIPP requires the beneficiary to pay

1 their premium upfront and then submit proof
2 of that payment through a check stub, like
3 reporting your work. And if they want to get
4 reimbursed for that premium that they have
5 already paid, they have to submit all their
6 check stubs that show where they made that
7 payment. So we're not really sure that fits
8 in with federal regulations. We think that
9 may be outside of federal regulations. So
10 we're pursuing that as well.

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

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

23 PARTICIPANT: Yes.

24 DR. SCHUSTER: -- and how that was
25 figured and how that figured against the five

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 employer-sponsored insurance. The next wave
2 is people who work full-time who could have
3 access to employer-sponsored insurance but
4 they don't know. And then there's going to
5 be a third wave where maybe a parent isn't
6 covered by Medicaid but their child is
7 covered by Medicaid or KCHIP, so if they can
8 pay the premium of that parent to include
9 that child, if that's cost effective. That
10 will be the third wave.

11 DR. SCHUSTER: Okay.

12 PARTICIPANT: Maybe next year.

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

16 PARTICIPANT: Okay, okay.

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

21 PARTICIPANT: Right. That's the
22 big one.

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

25 PARTICIPANT: So we're anxiously

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 there are required documents to send in.

2 So it could be misconstrued, yes.

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

10 PARTICIPANT: It just triggers
11 panic.

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

16 DR. SCHUSTER: Okay. All right.

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

19 PARTICIPANT: Yes. Yes.

20 PARTICIPANT: In Northern Kentucky?

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

24 DR. SCHUSTER: There was, you know,
25 one of their webinar in-person stakeholder

1 forums this Thursday, two days from now, at
2 1 o'clock up in Northern Kentucky. And you
3 can follow it on Facebook Live and get the
4 documents and, you know, see it in action, if
5 it doesn't freeze, which it seems to do a lot
6 on Facebook Live, but if you can't go to
7 Northern Kentucky.

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

16 PARTICIPANT: Okay.

17 DR. SCHUSTER: -- for the forum.
18 And, again, that's this coming Thursday at
19 1 o'clock.

20 It seems to me that one of the
21 things that the Commissioner is offering, if
22 any MAC or TAC has any questions, please feel
23 free to send these questions to Sharley
24 Hughes. Why don't we piggyback off the
25 questions that you have sent. Jason and I

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1 PARTICIPANT: Right.

2 DR. SCHUSTER: Okay. Thank you

3 very much, Jason. I appreciate that.

4 PARTICIPANT: No problem.

5 DR. SCHUSTER: And I will send out

6 this PowerPoint electronically. It will be a

7 little bit easier to read. I couldn't afford

8 to print each slide on a page, so I had to

9 cheat. So you have to use your magnifying

10 glass.

11 We've had a few people come in and

12 join us. So back row, would you introduce

13 yourselves, please, behind the door.

14 MS. CULL: Marie Cull, Cull &

15 Hayden.

16 MS. DEMPSEY: Patty Dempsey.

17 DR. SCHUSTER: We are so glad to

18 see you, Marie and Patty. And over here in

19 the front row.

20 DR. RAYAPATI: Abner Rayapati. I'm

21 a psychiatrist at UK HealthCare.

22 DR. SCHUSTER: Great.

23 MS. McFARR: Amy McFarr. I am a

24 case manager at Oliver Winston.

25 DR. SCHUSTER: Okay.

1 MS. CARMINE: And I'm Kate Carmine.
2 I work at Oliver Winston.

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

6 Oh. Hello.

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

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

12 PARTICIPANT: Congratulations.

13 PARTICIPANT: Thank you.

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

19 We recommended that more
20 information be provided about the change in
21 calculating units of service for nonclinical
22 behavioral health services provided by
23 peer support personnel. And DMS responds,
24 "The fee schedule for the new behavioral
25 health services can be found on the website.

1 A webinar was conducted on June 17th and
2 June 20th, and that webinar has been posted."

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

6 PARTICIPANT: They said it was
7 offered to everybody.

8 PARTICIPANT: But nobody knew about
9 it.

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

13 PARTICIPANT: No, no.

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

16 PARTICIPANT: No.

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

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

22 PARTICIPANT: Not at all.

23 DR. SCHUSTER: Yeah. So I think at
24 this point, the thing to do, again the forum
25 on Thursday is supposed to be touching on

1 some more of these SUD rollout questions,
2 so be sure that you sign up if you go to
3 Northern Kentucky and get on the Facebook.
4 But those are the links to get the webinar.

5 Because I wasn't even aware of the
6 webinar until actually Michele called me and
7 said, "You know, what was the deal with this
8 webinar?" And I said, "What webinar?"

9 PARTICIPANT: Yes. They did it in
10 secret.

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

15 DR. SCHUSTER: MSGs being...

16 PARTICIPANT: Multi-Specialty
17 Groups.

18 DR. SCHUSTER: Oh. Multi-specialty
19 groups.

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

23 PARTICIPANT: Imagine that.

24 DR. SCHUSTER: That's interesting.
25 Okay.

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

4 PARTICIPANT: Yeah.

5 DR. SCHUSTER: Right. Yeah.
6 Because, Brad, you all over at Bridgehaven
7 had some questions, too, I think about this.

8 PARTICIPANT: Yeah.

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

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

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

19 PARTICIPANT: Methadone, increased
20 meds.

21 DR. SCHUSTER: Increased meds.

22 PARTICIPANT: And changed the peer
23 support.

24 DR. SCHUSTER: And changed the peer
25 support reimbursement, right, which is really

1 the thing that has been the most problematic.
2 We're trying to figure out how those units
3 are being calculated and so forth. Yeah.

4 PARTICIPANT: It is a three-tier
5 system now.

6 DR. SCHUSTER: Say that again.

7 PARTICIPANT: For tiering the BHSOs
8 according to ASAM.

9 PARTICIPANT: Yeah.

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

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

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

19 PARTICIPANT: Yeah. From the 17th,
20 right?

21 PARTICIPANT: From the webinar.

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

25 DR. SCHUSTER: Did we know that

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

that was coming?

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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,

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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,

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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,

1 that's not happening." Well, that's probably
2 the truth, but my person thought it was.

3 DR. SCHUSTER: Yeah.

4 PARTICIPANT: Do you know what I am
5 saying?

6 DR. SCHUSTER: Right, right.

7 PARTICIPANT: The result was not
8 good either way.

9 DR. SCHUSTER: Right.

10 PARTICIPANT: She didn't understand
11 the information.

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

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

19 PARTICIPANT: Yes. And we have
20 told them to ask for that. And we also would
21 like to have -- Steve's offered before to
22 come over and do some explaining. And
23 Valerie and I were talking about trying to
24 get that scheduled with him while the
25 legislature is not in session. But I know

1 you are busy anyway. But we thought that
2 would be helpful. So we could have a thing
3 where we have families and peer support
4 specialists there that could go with people
5 and understand it better.

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

15 PARTICIPANT: Yes.

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

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

1 the way they apply this so broadly to that.

2 DR. SCHUSTER: Right, right.

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

11 DR. SCHUSTER: Yeah, yeah.

12 Trouble, yeah. I think if Steve can go over
13 and talk to somebody, that would be good.

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

19 DR. SCHUSTER: Yeah, yeah.

20 PARTICIPANT: But we're working on
21 it.

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

24 We continue to bring up the
25 reviving the classification of medically

1 frail. And that's, obviously, not going to
2 happen.

3 PARTICIPANT: Until the court.

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

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

19 PARTICIPANT: Yeah.

20 DR. SCHUSTER: -- classification.

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

24 PARTICIPANT: The secret service.

25 DR. SCHUSTER: -- advisory panel

1 were being kept secret. And apparently other
2 groups, I think P&A, raised that question
3 about these can't be closed meetings and we
4 can't keep secret of the people on the work
5 groups and they are working with their
6 attorneys.

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

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

17 DR. SCHUSTER: Yeah.

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

21 PARTICIPANT: Or input.

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

24 PARTICIPANT: I missed the last
25 meeting. I was on a KARP field day. I also

1 know that a few people have resigned from
2 committees and that they have hired a
3 representative and that they feel that they
4 won't -- they signed letters saying they are
5 only to rubber stamp things.

6 PARTICIPANT: A token.

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

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

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

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

16 PARTICIPANT: Yeah.

17 DR. SCHUSTER: So people have been
18 resigning?

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

21 PARTICIPANT: Well, maybe that will
22 garner some attention.

23 PARTICIPANT: But they are just
24 looking to replace them, because they are
25 looking for other people. At the IDD TAC,

1 they were telling us that they were looking
2 for some other folks, people who receive
3 services to replace. And they are looking
4 for people because people dropped off.

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

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

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

11 PARTICIPANT: Tokenism.

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

15 PARTICIPANT: Yep.

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

23 PARTICIPANT: Name, rank, and
24 serial number.

25 PARTICIPANT: Which is what she

1 said she didn't want from us, so I'm very
2 confused from that answer.

3 DR. SCHUSTER: That's right.

4 PARTICIPANT: So you may ask that
5 question.

6 PARTICIPANT: Yeah.

7 PARTICIPANT: We don't understand.
8 You said you didn't want specific identifying
9 information, but it seems like we can't get
10 the question answered in a broader way.

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

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

22 PARTICIPANT: Are you going to say
23 that?

24 DR. SCHUSTER: Yeah. I think I
25 probably will.

1 PARTICIPANT: I think you should.

2 PARTICIPANT: We will back you.

3 PARTICIPANT: Yeah.

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

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

20 PARTICIPANT: Medicaid staff is in
21 149 right now.

22 DR. SCHUSTER: Right now, right.

23 PARTICIPANT: Oh, really?

24 That's...

25 DR. SCHUSTER: Yeah.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 that they are still seeking approval from CMS
2 and the federal government on the changes
3 that they are attempting to make.

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

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

17 PARTICIPANT: I got it.

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

20 PARTICIPANT: That's still a large
21 chunk.

22 PARTICIPANT: That is a lot.

23 PARTICIPANT: But that is still a
24 problem of the July 1st date. They released
25 the regs.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 probably cut the BHSOs by a lot, because they
2 won't be in compliance now. But it was such
3 a good idea to open the network.

4 DR. SCHUSTER: So do we want to --

5 PARTICIPANT: Start a revolution?
6 Yes.

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

11 PARTICIPANT: We recommend more
12 time.

13 DR. SCHUSTER: Proper notice?

14 PARTICIPANT: Yes.

15 DR. SCHUSTER: And --

16 PARTICIPANT: And transparency.

17 DR. SCHUSTER: -- transparency?

18 PARTICIPANT: Why haven't they
19 worked with the TAC?

20 PARTICIPANT: Yeah.

21 DR. SCHUSTER: Yeah.

22 PARTICIPANT: Or at least send it
23 to TAC members.

24 PARTICIPANT: Yeah. Even if it is
25 just you six.

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

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

5 DR. SCHUSTER: Yeah.

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

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

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

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

20 PARTICIPANT: Absolutely.

21 PARTICIPANT: Well, that can be in
22 the minutes.

23 PARTICIPANT: Yes, please.

24 DR. SCHUSTER: What was it?

25 PARTICIPANT: You increase

1 complexity, you decrease access to care.

2 PARTICIPANT: Because it is easier.

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

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

7 DR. SCHUSTER: Yeah.

8 PARTICIPANT: What we have is a
9 failure to communicate.

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

17 PARTICIPANT: Zero days, right.

18 PARTICIPANT: Well, what they said
19 was, if you didn't have a psychiatrist you're
20 basically -- all of the available services
21 are done. If you have already a BHSO license
22 and you have a psychiatrist, then you
23 automatically become tier one;
24 you automatically just become that. If you
25 are dealing with folks that have co-occurring

1 and you don't have an APRN with a psychiatric
2 specialty or, you know, a physician's
3 assistant with SUD under the consultation of
4 a psychiatrist, then you cannot serve
5 co-occurring disorders.

6 And it's going to definitely limit
7 the number of providers that can do
8 co-occurring. And we know that often many
9 mental health patients also have
10 co-occurring. I mean, it's a high likelihood
11 of seeing that together. So...

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

15 PARTICIPANT: Right.

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

19 PARTICIPANT: Yes.

20 PARTICIPANT: -- for tier one's?

21 PARTICIPANT: Yes.

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

24 PARTICIPANT: Absolutely. The
25 webinar --

1 PARTICIPANT: I heard for tier two
2 and tier three there has to be a psychiatrist
3 in place. But...

4 PARTICIPANT: We heard for
5 co-occurring.

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

9 PARTICIPANT: That's tier one.

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

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

14 PARTICIPANT: We will have to watch
15 and learn.

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

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

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

25 PARTICIPANT: What is AODE?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 have SMI as primary, they can be denied
2 treatment because they can't work in their
3 program. How many of those have we had just
4 in the last month? Fifteen?

5 PARTICIPANT: We have had a lot,
6 yes.

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

10 PARTICIPANT: Not in their program.

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

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

21 PARTICIPANT: Yes.

22 PARTICIPANT: So I've talked to
23 everybody I know about this at the department
24 and everywhere else about it. So there's all
25 of this substance use treatment money out

1 there for the opioid crisis, but we can't
2 have someone that has SMI and the opioid or
3 other drug addiction getting served. We're
4 being -- all of our people are being denied.

5 PARTICIPANT: Yes.

6 PARTICIPANT: What happened to
7 treating the whole person?

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

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

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

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

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

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

22 PARTICIPANT: I wanted to apply for
23 some of the money to treat our co-occurring
24 people and they said we can't qualify, even
25 though we're doing DTR and RAP and all of

1 this addiction treatment is being put in our
2 lap because of our SMI people. We can't get
3 any of the money because they are SMI also.

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

6 PARTICIPANT: I know.

7 PARTICIPANT: That's a federal
8 problem.

9 PARTICIPANT: But, still, it is our
10 people.

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

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

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

25 PARTICIPANT: Yeah.

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

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

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

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

19 PARTICIPANT: I think they are
20 frustrated, too.

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

25 PARTICIPANT: It is awful what is

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

happening.

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

1 our funder. But we're seeing more. I mean,
2 we can't take them fast enough.

3 DR. SCHUSTER: Yeah, yeah.

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

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

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

25 PARTICIPANT: Yeah. So there is a

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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 med 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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1 But the bottom line, Sheila, is,
2 if you are SMI and co-occurring or God for
3 bid you have IBD and post-traumatic stress
4 and all of these other things, you are
5 screwed. They are not getting help.

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

12 DR. SCHUSTER: Yeah.

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

17 PARTICIPANT: Yep.

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

21 DR. SCHUSTER: Right, right.

22 PARTICIPANT: Five diagnoses.
23 Can't get any help because of all of it not
24 meshing.

25 PARTICIPANT: Yeah.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 stories to the legislators. I don't know.

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

7 PARTICIPANT: Okay.

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

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

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

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

19 PARTICIPANT: It is the lifeline --

20 PARTICIPANT: It is.

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

23 PARTICIPANT: Right. Yeah. They
24 would be -- they keep chopping them off at
25 the knees.

1 PARTICIPANT: We have a couple of
2 brain injury people in court.

3 PARTICIPANT: Yeah.

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

7 PARTICIPANT: That's behind the
8 scenes.

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

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

16 DR. SCHUSTER: Yeah.

17 PARTICIPANT: Everyone can do it
18 better.

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

22 PARTICIPANT: No.

23 PARTICIPANT: -- people?

24 PARTICIPANT: There was a change in
25 the policy.

1 PARTICIPANT: Yeah. That's what I
2 thought. But what was it?

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

6 PARTICIPANT: So like navigators
7 and support?

8 PARTICIPANT: Yes. The CCSA code.

9 PARTICIPANT: Yeah, okay.

10 PARTICIPANT: That has only taken
11 three years to change.

12 DR. SCHUSTER: What was that?

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

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

21 PARTICIPANT: Certified community
22 support associates.

23 PARTICIPANT: And if you are going
24 to go that route, they will be able to work
25 more hours than a peer support. Peer support

1 can't work no more than 30 hours now, period.
2 The new regs say that, yes.

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

5 PARTICIPANT: It is just direct
6 clinical hours.

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

9 PARTICIPANT: We don't bill.

10 PARTICIPANT: You could before.
11 But...

12 PARTICIPANT: I don't know anyone
13 that was.

14 PARTICIPANT: Yeah.

15 PARTICIPANT: No, we don't bill.

16 So...

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

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

25 PARTICIPANT: I think 30 hours, a

1 lot of peers don't go over that anyway.

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

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

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

10 PARTICIPANT: Yes, yes.

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

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

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

17 PARTICIPANT: And we're so
18 frustrated.

19 DR. SCHUSTER: So what
20 recommendations do we make?

21 PARTICIPANT: Change the system,
22 change the world.

23 PARTICIPANT: I think what we are
24 all saying is they need to give us more
25 notice. They need to -- more transparency.

1 They need to consult the BH, at least the TAC
2 members.
3 DR. SCHUSTER: They have to give
4 people time.
5 PARTICIPANT: Yes.
6 PARTICIPANT: Administration time,
7 yes.
8 PARTICIPANT: Administration of all
9 of this stuff.
10 PARTICIPANT: Administration of all
11 of these places, time, and a heads up.
12 PARTICIPANT: Can you imagine in
13 three days?
14 PARTICIPANT: No. None of my peers
15 would do that.
16 PARTICIPANT: It was a weekend. It
17 wasn't even a work -- three work days.
18 PARTICIPANT: And it didn't arrive
19 until the 1st. So I can't tell you how many
20 times we did that at UK. So we would open a
21 piece of mail and be like, What? So...
22 DR. SCHUSTER: Well, we don't think
23 all of the people that should have been
24 notified of that webinar were notified,
25 right?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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 BHS0 it limits access to BHS0s or are we talking about --

PARTICIPANT: Providers.

PARTICIPANT: Any increase in complexity will increase difficulty for our

1 clients to access providers, period, whether
2 it is a BHSO. Or look at what's happening
3 with the community mental health centers if
4 you don't have a Medicare provider.

5 PARTICIPANT: Right.

6 PARTICIPANT: I mean, it is just in
7 general.

8 PARTICIPANT: But for different
9 reasons across different entities?

10 PARTICIPANT: Yes.

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

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

21 PARTICIPANT: Unless they get an
22 AODE license.

23 PARTICIPANT: I think a lot of
24 these changes are -- I think those
25 substantive changes are when they are

1 increasing standards across the State. So
2 the intent is really good. And the
3 Department, the Cabinet wants to move toward
4 higher quality standards and more oversight
5 of substance use providers. That makes
6 sense. That is resulting in siloing the
7 substance use and behavior health into the
8 specialty of mental health again.

9 PARTICIPANT: She said it very
10 well.

11 PARTICIPANT: I didn't hear her.

12 PARTICIPANT: It is re-siloing.

13 PARTICIPANT: The intent is to
14 increase, you know, standards for substance
15 use, which came from legislation and from the
16 1115 waiver approval. But, so, the
17 department is headed into a really good
18 direction to increase standards or increase
19 oversight of substance use providers. But it
20 is kind of resulting in --

21 PARTICIPANT: Unintended
22 consequences.

23 PARTICIPANT: Right, unintended
24 consequences, re-siloing behavioral health
25 and separating it out.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.

1 PARTICIPANT: And going back to
2 this siloing is really --

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

5 PARTICIPANT: I think so, too.
6 Because they wanted it to all to be
7 behavioral health for a reason. They were
8 supposed to be moving toward integrated
9 health.

10 DR. SCHUSTER: Right, right.

11 PARTICIPANT: But this is not
12 having that result.

13 DR. SCHUSTER: Yeah, yeah.

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

17 PARTICIPANT: Most certainly.

18 PARTICIPANT: Yep.

19 PARTICIPANT: I think you will do
20 fine.

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

23 PARTICIPANT: Me, neither.

24 DR. SCHUSTER: So do we have a
25 motion to communicate to Medicaid these

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 up new business. So we would have to plant
2 that idea with the Chair or with somebody.
3 And I think they are having their elections
4 in July. So she may not remain as the Chair,
5 but she will be on the MAC.

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

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

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

19 PARTICIPANT: We're a token.

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

22 PARTICIPANT: These are unofficial
23 coalition meetings.

24 DR. SCHUSTER: We are a -- yeah.
25 We are a bookmark afterwards.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 meetings, and the agenda I sent out had the
2 wrong date on it, so these are actually the
3 right dates. We're moving the meeting that
4 had been scheduled for Tuesday, the 10th of
5 September, to Tuesday the 3rd, which is the
6 day after Labor Day. Because the week of
7 September the -- I can't remember the reason.
8 Oh. There is a big school health meeting on
9 the 10th. And then the meeting in November
10 is on election day. And we thought there
11 were probably other things we needed to be
12 doing on election day. And I think State
13 workers have four hours off or something like
14 that.

15 PARTICIPANT: So you made it the
16 4th, then? It is a Monday, I think.

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

21 PARTICIPANT: But we might be able
22 to make it.

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

25 PARTICIPANT: And we will be at the

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

1 Triage, Treat, and Transport, which is in
2 meeting -- this is my assumption -- the HEDIS
3 score of excess recidivism in emergency
4 departments, nonemergent care in behavioral
5 health, that that can be done through
6 evaluation. And working with EMS services,
7 they are exhausted because of repeated calls
8 and the time it takes to -- I guess paperwork
9 related to frequent calls from the crisis
10 calls. And then how those individuals can
11 engage with community partners in care and
12 bypass the emergency room, which is a cost to
13 us all. So it is something that's supposed
14 to rollout early 2020, January or February.

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

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

23 PARTICIPANT: Uh-huh.

24 DR. SCHUSTER: -- Medicare rule?
25 Huh. Well, thank you for alerting us to

1 that. It may fit in with that -- you know,
2 the flip of that is the problem we're having
3 with EMS not responding to calls to transport
4 people.

5 PARTICIPANT: It is a huge problem.

6 DR. SCHUSTER: Yeah, yeah.

7 PARTICIPANT: Well, and it could
8 also be with these new paramedicine teams
9 that are cropping up, you know, allowing them
10 to do some more things.

11 DR. SCHUSTER: Right. Okay.

12 PARTICIPANT: But they have to have
13 a QMHP.

14 DR. SCHUSTER: Do they have to have
15 a QMHP?

16 PARTICIPANT: Yeah.

17 PARTICIPANT: Well, I was hoping
18 somebody would educate me more on that.

19 DR. SCHUSTER: Oh, okay.

20 PARTICIPANT: I just have a brief
21 blurb on it being rolled out.

22 PARTICIPANT: We will hook up with
23 you --

24 PARTICIPANT: Okay.

25 PARTICIPANT: -- and look into it

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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.)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

* * * * *

C E R T I F I C A T E

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