

1 DEPARTMENT OF MEDICAID SERVICES
2 BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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8 Capitol Annex
9 702 Capital Avenue, Room 125
10 Frankfort, Kentucky
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14 November 4, 2019,
15 commencing at 1:13 p.m.
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21 Lisa Colston, FCRR, RPR
22 Federal Certified Realtime Reporter
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A T T E N D A N C E

TAC Committee Members:

- Sheila Schuster, PhD, Chair
- Sarah Kidder
- Steve Shannon
- Valerie Mudd
- Gayle DiCesare

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DR. SCHUSTER: Happy Election Eve,
post Halloween. Maybe the two are related.

Okay. Welcome to the Behavioral
Health TAC meeting. And let's have
introductions. And we will start over in the
Passport corner.

MS. MCKUNE: I am Liz McKune,
Passport Health Plan.

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

MR. CAIN: Micah Cain with
Passport.

MR. BLACKBURN: Shane Blackburn
from Pathways.

MR. KELLY: Marc Kelly, Pathways.

MS. SHUFFELT: Christy Shuffelt,
New Beginnings.

MR. ROGERS: Don Rogers, New Vista.

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

MS. GUNNING: Kelly Gunning, NAMI
Lex.

MS. SCHIRMER: Diane Schirmer with
Modern Care and Brain Injury Association of

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Kentucky.

MS. HASS: Mary Hass, Brain Injury Association of Kentucky, advocate.

MS. MUDD: She almost beat me.

DR. SCHUSTER: She just has a long name. Marie.

MS. CULL: Marie Cull, Cull & Hayden.

MS. LENZ: Karen Lenz, representing Adanta.

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

MS. KIDDER: Sarah Kidder, representing NAMI of Kentucky.

MR. BALDWIN: Bart Baldwin, representing Kentucky Resource Alliance, ABA Advocates.

DR. SCHUSTER: Do you want to add any more?

MR. BALDWIN: No.

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

MS. STEARMAN: Liz Stearman, Humana.

MS. MOWDER: Kristan Mowder, Humana

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Caresource.

MR. SHANNON: Steve Shannon, KARP.

MS. GORDON: Lori Gordon, WellCare.

MR. CROWLEY: David Crowley,
Anthem.

MS. MESKA: Vicki Meska, Anthem.

MS. ARANT: Claire Arant, KHA.

MS. ABBOTT: Susan Abbott, PNA.

MS. PAXTON: Julie Paxton, Mountain
Comprehensive Care Center. I'm standing
because, you know, I want to be seen, right?

MR. JOHNSON: Dustin Johnson with
Aetna.

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

DR. SCHUSTER: Great. So we have a
quorum. We have five of our TAC members
here.

Those of you who don't know it,
Mike Berry had a massive heart attack. And
fortunately he was presenting, I think in
Lexington, I know he was outside of
Louisville someplace, right across the street
from a hospital. And, so, he is fine, he
says. He's back home recuperating. And I

1 really did mean to bring a card, and I forgot
2 to do that. But if you have his e-mail
3 address, it is
4 mike@peopleadvocatingrecovery.org, I'm sure
5 he would love to hear from you. But he says
6 he is doing fine and thanks everybody for
7 their good wishes. But, you know, he has had
8 some health scares with throat cancer. So
9 this really came out of the blue, and I think
10 really....

11 MS. GUNNING: Those treatments
12 weaken your heart.

13 DR. SCHUSTER: Yeah. Yes. I just
14 read about that. So, anyway, a little prayer
15 in his direction I'm sure would be much
16 appreciated.

17 You have the minutes of the
18 September 3rd Behavioral TAC meeting. And I
19 sent those out in advance. If you are not
20 getting these things in advance, let me know
21 and I will be sure that I have your e-mail
22 address correct. So this is an adaptation of
23 the report that I give at the MAC meeting,
24 which you all have that.

25 So do we have a motion from someone

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on the TAC to approve the minutes?

MS. MUDD: I will move.

MR. SHANNON: I will move.

DR. SCHUSTER: Valerie. Steve,
that was a second I think.

MR. SHANNON: Yes.

DR. SCHUSTER: Okay. All in favor
signify by saying aye.

(Aye)

DR. SCHUSTER: Okay. Very good.

The September 26th MAC meeting was
pretty unremarkable. It is so unremarkable
that I can't remember it very well. So I
guess it was really unremarkable. There were
a number of questions that were asked of the
Commissioner about one thing or another.

One was the credentialing agency.
And that RFP has gone out for that. So a lot
of her answers were, "I can't talk about that
because the procurement thing is underway."
And I guess, Kathy, that's been true for ages
now from the credentialing organization.

MS. ADAMS: I mean, I understand
that they can't talk about the RFP. But they
can still give us a tentative timeline for

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implementation.

DR. SCHUSTER: Right. Yeah. Which is what we asked them in our recommendations.

MS. ADAMS: Yeah. So I don't get it.

DR. SCHUSTER: Yeah, yeah.

MS. GUNNING: Shame on you, Kathy.

MS. ADAMS: Oh, Kelly, don't get mad at me.

MR. BALDWIN: You don't like what she is saying.

DR. SCHUSTER: So on the blue paper, I would have printed it on black but you wouldn't have been able to read it, were the responses from DMS. They really don't like our recommendations. What can I say?

MS. MUDD: No. They make it very clear that they don't.

DR. SCHUSTER: They make it very clear that they don't like it, and they take a lot of time and effort to tell us that. I wish they were spending their time and effort on more productive things than to be fighting with us, but that seems to be the case.

So we go round and round about this

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business of why don't they let us know what they are thinking about so that we could give them input ahead of time. And that doesn't happen. And they tell us it's because if they were going to talk to us it would have to be in an open meeting. We would certainly invite them --

MS. MUDD: This is an open meeting.

DR. SCHUSTER: -- to our open meeting to discuss with us things that they are thinking about.

It is interesting, when we get to the statement of consideration from the reg, the BHS0 reg, lots of people also raise that issue with Medicaid. And they took that same kind of response of, you know, we let everybody know we were going to do this, which was, I think, not the case. But anyway.

MS. GUNNING: It wasn't the case.

DR. SCHUSTER: So, you know, we have all of these statutory ways that we can respond to regs. Now, when we get to that part in the agenda, which will come next, we actually got some things changed in those

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regs that we were unhappy about. But...

We ask that they withdraw the emergency regs, which we knew they wouldn't do, and they said they wouldn't do it and they didn't do it. We also actually wanted the MAC to ask them some questions that day at the meeting. But the MAC's not really set up to do that. I think if we hadn't gotten some positive response to the regs we probably could come back and say to the MAC, you know, we still want these questions answered. And I still would be curious about some of these, but I don't know that it's worthwhile to just keep going after them, because they keep hiding behind 13A and all of that stuff.

So in case you didn't know, the reg process, this is it. And that will notify you of what's in the statute about the reg process. And, you know, again, the question about the timeline. And I agree with you, Kathy, I don't know why procurement doesn't give you some -- even if they said, "Once we make an award, here's the timeline that we have put into the RFP or that we're

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envisioning" --

MS. ADAMS: Exactly.

DR. SCHUSTER: -- would be helpful. You know, we think this whole process could be completed by whatever.

You know, the central credentialing was a big issue for KHA as well. So I'm wondering if the Hospital TAC has asked any questions about it. Do you know, Claire?

MS. ARANT: No, we haven't. Not to my knowledge.

DR. SCHUSTER: Not to your knowledge?

MS. ARANT: Uh-uh.

DR. SCHUSTER: At the Hospital TAC?

MS. ARANT: I have not attended the Hospital TAC. I attended the Hospital Reimbursement TAC.

DR. SCHUSTER: Okay. We maybe made a little bit of progress on some of the stuff we raised about the formulary. You know, we keep having this problem, and we talked about it the last time when the MCOs told us about changes they made in the formulary, and we keep saying this is really unhelpful that we

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get this kind of after the fact and our people are so affected by that and so forth and so on. And at least we got a "We will take it under advisement," which I think is a baby step forward as opposed to "no" and "hell no," which is what we get to most of our stuff. So...

I don't know if there's a better way for us to be putting our recommendations out there, quite frankly, that's going to get any kind of different response. But...

I did hear from someone that Commissioner Steckel was complaining about how much time she was spending dealing with the TACs.

MS. GUNNING: I thought she wanted to come to every meeting.

MS. MUDD: Every one, yeah.

DR. SCHUSTER: Well, and I guess she is still -- if you meet over at the Cabinet, maybe you do get more attention. But I'm still kind of amazed and befuddled by why the TACs are taking up any of her time, quite frankly. I mean, she's made it clear that we are advisory, advisory-advisory,

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advisory actually to the MAC, which is advisory to DMS. So we're so far down the pecking order that I am not sure that -- why it makes any sense for her to deal with us at all, in terms of rules and regulations.

MS. MUDD: She is the one who decided she wanted to go to all of these meetings, right?

DR. SCHUSTER: Yeah, yeah.
Yeah, Kathy.

MS. ADAMS: One of the things I noticed at the last MAC meeting, again trying to remember back that far, but it was obvious, I thought, at the MAC meeting that there are some TACs that have direct communication with Medicaid, they are not going through the MAC, like they told us we have to do, I thought it was very obvious that some of the TACs have a direct line of communication with Medicaid. And maybe that's because they meet at the Cabinet and Medicaid reps come to their meeting. But it was very obvious at the MAC that some of the TACs have that kind of a relationship with Medicaid staff, and clearly we don't.

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DR. SCHUSTER: Yeah.

MR. BALDWIN: Sheila, I attend the similar client behavioral TAC whenever I can do that, and there used to be regular Medicaid employees that attended that, and now I don't think there have been any at all.

DR. SCHUSTER: That's what I have heard from Emily, they don't have many, right, representatives at DMS.

MR. SHANNON: The IDD TAC had a Medicaid staff person.

DR. SCHUSTER: But did they take an active role?

MR. SHANNON: They answered questions.

DR. SCHUSTER: They answered questions?

MR. SHANNON: Yeah, asked of them or agenda items.

DR. SCHUSTER: Which is what they used to do when they came to our meetings.

MR. SHANNON: Yeah. They are not bringing things to the TAC, necessarily.

DR. SCHUSTER: Well, there clearly are things that the Commissioner has talked

1 about at the MAC meetings and it has been
2 reinforced by Chris Carl, who is on the MAC
3 as the Vice Chair and as a hospital guy, that
4 there is a lot of conversation between
5 Medicaid and KHA. Now, whether they call
6 that the Hospital TAC or not I think may be a
7 difference.

8 MS. GUNNING: Yeah.

9 DR. SCHUSTER: Because it sounds
10 like they are working out some things.
11 Obviously, the Hospital TAC has got to be
12 synonymous with KHA. I mean...

13 MR. SHANNON: Yeah.

14 DR. SCHUSTER: You know, they are
15 the only hospitals, right, in the state.
16 So...

17 I don't know. You know, we could
18 give in and move back over to the -- maybe we
19 will wait and see what the results will be
20 like.

21 MR. SCHIRMER: Yeah.

22 MR. SHANNON: I also think it would
23 be a good conversation that TACs have members
24 on the MAC, because some TACs are represented
25 by MAC members, because the MAC member gives

1 the report for that TAC. That's not the case
2 here.

3 MS. GUNNING: Right.

4 MR. SHANNON: You know, where there
5 may be a consumer on the TAC that has a
6 mental illness but that's not a member of the
7 Behavioral Health TAC.

8 DR. SCHUSTER: Right. And you are
9 right, Steve. But many of the MAC members
10 are on their TACs or lead their TACs.

11 MR. SHANNON: Yeah.

12 DR. SCHUSTER: Well...

13 MR. BALDWIN: Can you get on the
14 MAC, Sheila?

15 MS. GUNNING: Yeah, can you get on
16 the MAC?

17 MR. BALDWIN: Do you want to get on
18 the MAC?

19 MS. ADAMS: We will talk about that
20 after the election.

21 MR. BALDWIN: Yeah.

22 DR. SCHUSTER: Yeah. We might have
23 a better chance. I mean, the other way to do
24 it is to change the legislation that set up
25 the MAC.

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MR. SHANNON: Yeah.

DR. SCHUSTER: I mean, the MAC is -- the MAC part of that legislation has not been changed, I don't think, Steve, since the 1990s when it was first put into place.

MR. SHANNON: I don't think so.

DR. SCHUSTER: So if you think about there is no representation of behavioral health, there is no representation of the therapies, speech, PT and OT.

MS. GUNNING: I think it should be updated.

DR. SCHUSTER: There is no representation of the IDD.

MS. MUDD: You would think there would be representation from each TAC.

MS. ADAMS: You have to be careful. Because if we go and -- if a bill is put forth to mess with the statute, things we might not want to happen might.

DR. SCHUSTER: Might happen, too.

MS. ADAMS: Yeah. Might happen, too. I could see it all going away.

DR. SCHUSTER: It also would make the MAC be much larger than it is.

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MS. GUNNING: It is hard for them to get a quorum.

DR. SCHUSTER: Yeah. Hmm. Well, I do send an invitation to this meeting to DMS staff, just so you all know. I mean, it is the same staff, Stephanie Bates and others, Ann Holland and others, that have come traditionally, you know. At one point Sharley Hughes told me I couldn't do that. And I said, "Try to stop me." I mean, you know, I'm a free citizen. I can send e-mails to -- they're public officials, you know. And then she sent me an e-mail and said, "Well, no, it's okay." So I, you know...

Obviously, I'm touch tone in one form or another. Anyway...

Okay. Moving on. You have a pretty dense four pages. And I took these literally out of the response, the statement of consideration and the response, the amended reg from the Cabinet.

Brad, I should have let you know I was going to put you on the spot, but can you kind of summarize for us. Because

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Bridgehaven kind of led the charge here on some of these changes.

MR. LEEDY: Well, I think probably the largest one, the largest change that we advocated for was the way that the emergency regs delineated between the BHSO's, tiers 1, 2 and 3, and it seemingly siloed those mental health services into 1 and the substance abuse into 2 and 3. And we advocated for change back to the original language, that BHSO 1's could still provide those co-occurring treatments or treatments for people who have both mental illness and substance abuse as long as the primary diagnosis remains mental health-related.

And, so, they went back through and changed those regulations that kept us from doing that.

DR. SCHUSTER: So that's a huge victory.

MS. GUNNING: That's huge.

DR. SCHUSTER: I mean, one of the things that we talked about was that our folks were getting siphoned off into really AODE kinds of BHSO's, where nobody knew how

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to deal with their mental illness, which was really their primary diagnosis. And I think we all weighed in on continuity of care and appropriate services being available and stuff. So I think that is a huge victory.

MS. KIDDER: For MSGs, too.

DR. SCHUSTER: Yeah, yeah.

MR. LEEDY: I think one of the big differences and the impetus for the tiering was primarily the opioid illness -- or opioid epidemic there. And I think Ramona was here the last time when we discussed the primary drugs of choice for people who are use -- who have mental illness, are alcohol and marijuana, which help to quiet some of the more positive symptoms of those illnesses.

DR. SCHUSTER: Right.

MR. LEEDY: So we're really dealing with different types of substance use and, you know, treatment.

The other areas that we addressed were both the cap on peer hours as well as the number of people who are in a group. The cap was not necessarily removed, but they better defined it to 30 hours per week of

1 direct service that peers could provide to a
2 Medicaid beneficiary.

3 DR. SCHUSTER: Which, again, makes
4 it a full-time --

5 MR. LEEDY: Position, yes.

6 DR. SCHUSTER: Possible for
7 full-time employment.

8 MR. LEEDY: Yeah.

9 DR. SCHUSTER: Right?

10 MR. LEEDY: Yeah, yeah.

11 MR. SHANNON: It is work, not
12 billable units is the real distinction.

13 MR. LEEDY: Yes. Exactly.

14 DR. SCHUSTER: Yeah.

15 MR. SHANNON: And 30 hours or unit
16 is okay.

17 MR. LEEDY: Thirty units, yeah.
18 And then the other one was that we -- there
19 was the cap placed at eight people in a peer
20 led group or eight clients or however you
21 refer to them. And they said that would
22 stand, they would not change that.

23 DR. SCHUSTER: And it had been 12
24 before?

25 MR. LEEDY: It had been 12 before.

1 They also said that none of these -- they
2 couldn't find anywhere in their existing
3 regulations that they had ever given
4 permission for peers to lead groups. And
5 they had said that they wanted feedback on
6 that, because they always said it was an
7 individual service. But it was clearly
8 established in the 2014 BHS0 regs, the
9 original ones, that they said it was
10 individual or group.

11 MR. SHANNON: And they never said
12 they couldn't do it.

13 MR. GUNNING: No. Right.

14 MR. LEEDY: Yeah. Exactly.

15 So those were the primary issues that we
16 addressed. And we're very pleased with the
17 outcome overall.

18 DR. SCHUSTER: Great. Because I
19 had gotten an e-mail from Fareesh Kanga on
20 behalf of NAMI Lexington and also her
21 psychiatric practice about the importance of
22 peer support specialists and, you know, being
23 really concerned about them not being able to
24 have full-time work and not -- you know,
25 being constricted and so forth.

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MR. LEEDY: Yeah.

DR. SCHUSTER: But I think the redefinition of that BHSO 1 back to where it had been is really huge.

MS. GUNNING: Yeah.

DR. SCHUSTER: So the voice of the people was heard.

MS. GUNNING: Yah. Go people.

DR. SCHUSTER: Yes. Go people. So you can go through. You can tell -- and this is all on-line. If you want to see the whole thing, it runs about 90 pages because they go through the reg and make all the changes and then they have the statement of consideration.

But you can tell there's lots of stuff about the ABA folks. And, Bart, I'm sure you were commenting on some of that, where they were concerned about not having been consulted or who they consulted about some of these things and so forth, right?

MR. BALDWIN: Yes. And, because, they put in some new CPT codes just back in January and they were adding. The biggest change with the emergency regulations was a

1 good thing, it allowed a non-BHSO, a
2 multi-specialty group or a provider group, to
3 be able to provide the full range to protect
4 for the RBT position within the ABA model.
5 Before that, you had to be a licensed PRTF
6 for BHSO, which requires you to be licensed
7 and accredited. For small practices that was
8 cost prohibitive. So they had to stifle the
9 number of providers that were -- wanted to
10 become Medicaid providers.

11 DR. SCHUSTER: Okay.

12 MR. BALDWIN: So they changed that.
13 But there were other issues in terms of
14 requiring that it had to be an RBT. And we
15 were working on trying to get a grace period
16 in there so that they could hire them and you
17 didn't have to wait, because it takes 90 days
18 to 6 months. There are not enough RBTs out
19 there to just go hire them. So you have to
20 really pretty much bring folks in and train
21 them. So we're working on a grace period.
22 It didn't make it in here, but I'm optimistic
23 we are going to get movement on that.

24 DR. SCHUSTER: On that grace period
25 issue?

1 MR. BALDWIN: On the grace period
2 issue, yeah, after -- amended after comments.
3 So we're still in communication with them on
4 that. It didn't make it into the --
5 DR. SCHUSTER: Into this version?
6 MR. BALDWIN: -- into this version.
7 DR. SCHUSTER: So are you --
8 MR. BALDWIN: How did they address
9 it?
10 DR. SCHUSTER: No. They said they
11 were not going to do it.
12 MS. KIDDER: That they are not?
13 MR. BALDWIN: Yeah. They weren't.
14 But we're still working on it, so it is
15 looking likely they will.
16 DR. SCHUSTER: So you will pursue
17 it when it goes over to ARIS?
18 MR. BALDWIN: Yes. Amend the
19 comments and present it at the ARIS.
20 DR. SCHUSTER: Okay.
21 MR. BALDWIN: Anything else on the
22 ABA side? There is a co-occurring.
23 DR. SCHUSTER: Oh. There was the
24 use of the lesser-trained --
25 MS. KIDDER: That's the TAC.

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DR. SCHUSTER: -- ABA person.

But they have allowed that. That is one of the few bachelor's level people that get reimbursed by Medicaid, right, for therapy services?

MR. BALDWIN: No. That's the -- that will be ABA.

DR. SCHUSTER: The ABA, okay.

MR. BALDWIN: Yeah. Which there are two in the state, so it is kind of a moot point.

DR. SCHUSTER: Oh. Is that right?

MR. BALDWIN: Yeah. So it is an issue in terms of comparability to other disciplines. But there is not any there, so it is the RBT, the behavior tech. They did require that you had to be a registered behavior technician.

DR. SCHUSTER: Okay.

MR. BALDWIN: That is not a licensed person. It is just their true type position. The RBT requirement is only about five years old, so it is just now working its way. But they did require it in order to bill. And, so, that's why we needed a grace

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period in order to get folks trained to get that.

DR. SCHUSTER: Okay.

MR. BALDWIN: Is that making sense?

DR. SCHUSTER: Yeah. It really -- and I read it quickly. I was like, because they have more levels than psychology does. So...

MR. BALDWIN: So some progress.

DR. SCHUSTER: Yeah. But, again, I think the big ones are the peer support specialists and employability and the way they are counting those hours.

MR. BALDWIN: So we're trying to get more access to ABA services for Medicaid recipients, is the ultimate goal.

DR. SCHUSTER: Right.

MR. BALDWIN: Even though it has been allowed for five years, since 2014, they were all seeing a Medicaid provider because of some of these barriers. And still rates, rates is an issue as well.

DR. SCHUSTER: Right. Right.

MS. GUNNING: So have they operationalized this group code now? It says

1 they will be. Right here (indicating).

2 MR. BALDWIN: Okay.

3 DR. SCHUSTER: Where are you
4 looking?

5 MS. GUNNING: On page 60 at the
6 last paragraph.

7 MR. BALDWIN: Oh. You are talking
8 about the peer group, peer support.

9 MS. GUNNING: Yeah. Have they
10 operationalized that code that will allow?
11 It says, "DMS is operational for peer
12 support. The code is new to Medicaid and it
13 is the first time a peer support specialist
14 and their employers have received in writing
15 authority to conduct peer support authority."

16 DR. SCHUSTER: Are they ignoring
17 the 2013 reg?

18 MS. GUNNING: That's what I am
19 asking.

20 MR. BALDWIN: No. They are not
21 ignoring it. But they are saying that they
22 never gave permission for it to begin with,
23 is their rationale.

24 MS. GUNNING: But they never
25 prevented it.

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MR. BALDWIN: But they never prevented it.

MS. GUNNING: Right.

MR. BALDWIN: But it clearly says individual or group services in the 2014 regs.

MS. GUNNING: I know. But now they are saying they are operationalizing it.

MR. BALDWIN: Yeah. They do have a new code for group as opposed to individual, yes.

MS. GUNNING: Do we know that code?

MR. BALDWIN: Yes. It was in the webinar materials that were sent out back in June.

MS. GUNNING: Okay.

MR. BALDWIN: I can't remember what it is off the top of my head. But...

MS. GUNNING: Can you send it to me? And I will also get on the webinar.

MR. BALDWIN: Yeah, yeah.

DR. SCHUSTER: All right. Any other questions? So if you don't have anything else to celebrate tonight, you should celebrate the voice of the people were

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heard.

MS. GUNNING: Yah. Go people.

DR. SCHUSTER: So I put on here the MCO formulary changes and the relationship to DMS. And I'm only putting that on there because it is such a huge issue for us. And I cannot figure out how to get DMS to do more than take it under advisement. I mean, we have been over this and over this, and I don't think there is anything in the new RFP for the MCOs that says that they can't have their formularies and do things the way that they have always done them, right? Liz, I'm asking you. Was there anything in the RFP that changed the way that MCOs have their own formulary or their own BMT committees?

MS. McKUNE: Not that I am aware of.

DR. SCHUSTER: Are any of you all from the other? No, I didn't think so.

MS. GUNNING: After our last meeting, when it was Aetna that provided that list of fifty-some changes to their formulary, I was able to communicate with Kelly Gannon. And she didn't mention

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anything like that.

DR. SCHUSTER: Yeah. So I guess I'm -- you know, I yearn for the old days where we had one formulary, it was run by Medicaid, and we had a Medicaid P&T committee that we actually had some influence on and we actually passed legislation to put a second psychiatrist on, who had to be a CAMC psychiatrist and the other one had to be from either UK or U of L. And we used to storm the Bastille, you know, from my testimony and all of this stuff, and we had some influence about these changes and we had a whole lot more notice about them. And I guess it's just a done deal. But I just -- I put it on there because I'm like, it just is maddening to me that we can't get a better handle on it. And we get no help from the Medicaid pharmacy person. You know, we've tried to, over the past couple of years, engage the Medicaid pharmacy person. We, you know, worked on that.

MS. GUNNING: Has the MAC done anything more on this?

DR. SCHUSTER: And they very seldom

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have --

MS. GUNNING: Even taken it up.

DR. SCHUSTER: -- pharmacy issues. You know, they have a couple of things. But we're the ones -- we're the one TAC that probably has more issues around the availability of medications for our people, the right time at the right dose and the right meds.

MS. GUNNING: Well, that's because our medicines are atypical.

DR. SCHUSTER: Yeah, yeah. And the need is so great.

MS. GUNNING: There's not 500 kinds of high blood pressure medication you need to choose from.

DR. SCHUSTER: So I don't know. And there may be nothing that we can do. But is it just -- I keep trying to rack my brain. So, anyway, we will leave it on there, if anybody has any great ideas of ways that we can -- you know, we've been trying to get -- require at least the MCOs to notify the Medicaid P&T committee of these changes, so it would all be centralized someplace,

1 which is what we recommended the last time
2 and they said, you know, essentially there is
3 no relationships between the Medicaid
4 formulary and the MCO formularies. And so...

5 MR. SHANNON: Therefore, the
6 recommendation to create one.

7 DR. SCHUSTER: Well, yeah.

8 MR. SHANNON: I mean, that was
9 really what our recommendation was.

10 DR. SCHUSTER: Which was really
11 what our recommendation was, yeah.

12 So I guess we'll see if there is
13 any change in personnel and then we will come
14 back at it. I just -- it is such an
15 important issue for our folks, that I just
16 really --

17 MS. MUDD: We should have had this
18 meeting on, like, Wednesday.

19 DR. SCHUSTER: Wednesday. We might
20 have all been hungover for one reason or
21 another, I don't know.

22 So, Kathy, there is no timeline
23 apparently; or if there is one, it is only in
24 the mind of the powers that be.

25 MS. ADAMS: It is a secret.

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DR. SCHUSTER: It is a secret,
yeah.

The update on Kentucky Health.
Did you all see that Indiana has suspended
its work program?

(Yes)

DR. SCHUSTER: I'm beginning to
feel like we're having, you know, influence.
And some other state dropped their work
waiver.

MS. GUNNING: Arkansas.

DR. SCHUSTER: No, no. Arkansas
had a bad experience. But somebody was
getting ready to file a waiver with a work
requirement and they backed off.

MS. HASS: And you are correct.
And I can't remember.

DR. SCHUSTER: I can't think of who
it is. But, anyway, so the report --

MS. HASS: Was it New Hampshire?

DR. SCHUSTER: I don't know, Mary.

MS. HASS: Anyway, but you're
thinking is correct. But I can't remember,
either.

DR. SCHUSTER: Okay. It is not a

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bunch of age that I can't remember.

MS. GUNNING: No. It is TMI.

DR. SCHUSTER: So the attorney that was in the room at the hearing, and then Deb Yetter wrote quite a, you know, from the courthouse kind of piece. Apparently all of the questioning by the federal appeals court, a panel of three judges, was directed at the government attorneys and really hammering them on, you know, what's the data, cite one study that says that work is good for your health, which they were unable to cite.

MS. MUDD: That's because of all of that fraud out there.

DR. SCHUSTER: And, you know, one thing after another about, you know, where does it say that Medicaid should be a work program and so forth. So we're hoping that, you know, based on that that the rulings are going to come down again to hold up the waiver.

And, you know, obviously, if Governor Bevin is re-elected he will take it to the Supreme Court. He's threatened that if the final ruling, which would be the

1 Supreme Court or if the Supreme Court decides
2 not to hear it, which is possible, then the
3 final ruling would be the federal Court of
4 Appeals, and he will just disband the
5 Medicaid expansion program.

6 Now, he cannot do that by executive
7 order. So we will have to see how that would
8 take place. I think it's safe to say that if
9 Beshear is elected, that the waiver will not
10 exist.

11 MS. GUNNING: He said it would be
12 done the first week.

13 DR. SCHUSTER: If he is in office,
14 yeah.

15 MS. KIDDER: Not only if -- I mean,
16 if Bevin does win, I think statutorily he
17 would need an HP3 to put some of the remarks
18 coming forth. So it would be a big help.

19 DR. SCHUSTER: Yeah. Right. So
20 that's one of the reasons that we have been
21 monitoring the Public Assistance Reform Task
22 Force so heavily, you know, KBH and the
23 Equal Justice Center and the Center for
24 Economic Policy and the Council of Churches
25 and the KFTC. And who else is in there? The

1 ACLU has been there. Because we're so afraid
2 that they will do something statutorily that
3 will give the Governor the ability to disband
4 Medicaid expansion, either in that
5 legislation or in some other legislation.

6 MS. KIDDER: And it is to worker
7 requirements for the others.

8 DR. SCHUSTER: And what?

9 MS. KIDDER: And it is to worker
10 requirements for the others.

11 DR. SCHUSTER: And the new work
12 requirements for the others, yeah.

13 The Cabinet, the DCBS actually
14 testified against substance use screenings,
15 which I thought was wonderful. They had on
16 their PowerPoint, you know, this is money
17 spent with no return on investment.
18 Bill Wagner, who is one of the few
19 non-legislators on that task force, really
20 came out with a strong statement. He said --
21 he runs the FQHC, the Family Health Center in
22 Louisville. And he said, you know, we run
23 both physical health and behavioral health
24 and, you know, I cannot sit on a panel that
25 is going to recommend this, essentially is

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what he said.

So we're waiting to see. Their last meeting is November 18th. They are supposed to be coming out with whatever recommendations. There has been no public discussion of recommendations, which is an interesting process. Apparently there will be some circulated by e-mail to the task force members, and then there will be a public discussion on November 18th.

So we're thinking that we're better off with either no recommendations or recommendations that would be helpful, like let's ease the, you know, the benefits cliff and give people a softer landing or a slide down or something, let's really do some quality job support or work support programs. There has been a little bit of discussion about affordable housing, which has been good. And we all know that there's not nearly enough affordable housing, defined as being at 30 percent of your income and including utilities. So if you use that as your benchmark, there is really not much affordable housing. So we will see what

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happens, but November 18th could be interesting.

MR. BALDWIN: Yeah. I think there are strategies to help people who are on public assistance, and drug screening is not necessarily one of them.

DR. SCHUSTER: Right.

MR. BALDWIN: You know, taking away benefits for a job work requirement, there are other things that we can do.

MS. GUNNING: That work, that really work and they are backed by empirical evidence.

DR. SCHUSTER: Yeah. And there have been a couple of pilot programs that have been successful. And, so, people are wanting to go back to those.

One of the things the Cabinet said was, "We really are afraid that if you put in the drug testing, that people will not sign up for benefits if they think that that's a requirement." And you penalize them, but you really penalize their family members, including their kids. And, obviously, then if they do get screened, then, you know,

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whatever, and lose their benefits, then obviously you have hurt everybody in the family, not just the person that loses the benefits.

MR. SHANNON: It has been ruled unconstitutional in other states.

MS. GUNNING: Yes.

MR. SHANNON: In Florida.

DR. SCHUSTER: Yeah. I think they are trying to get around that by saying that they have to have had a serious drug conviction or something and nobody is quite sure what that means. But, yeah, Bart.

MR. BALDWIN: Two things. There was two things that the TAC has met, two of those public assistance.

DR. SCHUSTER: Yeah.

MR. BALDWIN: And the most recent one was on the drug screening, which I missed. The one before was a lot -- it was presented on shifting money from TANF over -- what was it? Basically, it was making TANF and these other programs more of a work focus program. Which in Kentucky, we use a lot of TANF dollars for child welfare services.

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DR. SCHUSTER: For child welfare services, yeah.

MR. BALDWIN: And the Department is very vocal. It made comments about the significant detrimental impact that could have on those programs. And Chairman Moser made comments, who is not on the task force, around this issue of program -- of folks that lose their benefits, especially those that are dealing with substance use disorders, at the time when they need it the most were taken away.

DR. SCHUSTER: He was very vocal, yeah.

MR. BALDWIN: And, so, I thought her comments were completely contra -- you know, on the opposite end of what most of us did.

DR. SCHUSTER: Right.

MR. BALDWIN: At least from the House majority. So I thought that was really interesting, that meeting with both of those two groups.

DR. SCHUSTER: Well, the guy that they brought in from the American Enterprise

1 Institute rattled off all of this stuff about
2 shifting the money around. And we were out
3 of whack with other states because we were
4 putting so much into child welfare. And I
5 think Chairman Humphries said, "Well, how
6 would you redistribute it?" And he said,
7 "Well, I would just give it evenly to
8 everything else, like two percent to
9 everything else." I mean, it was so -- it
10 was such a dumb answer. And then there was
11 some pushback. And he was still on the --
12 you know, he was still at the table when
13 Moser made her comment. And he got up and he
14 just left right after his testimony. So I
15 don't know whether that was planned. I mean,
16 he did not hang around. I think he decided
17 that maybe this wasn't the most positive,
18 you know, audience.

19 MS. GUNNING: It doesn't sound like
20 he had a real answer.

21 DR. SCHUSTER: No. He didn't have
22 a real answer.

23 MR. BALDWIN: I will give him one
24 piece of credit. He did say that -- he did
25 acknowledge the shift would have a big impact

1 on how Kentucky uses the TANF. And that
2 would be a decision for the state, for
3 Kentucky to make, which we used to get lauded
4 for that, that we used TANF dollars. It used
5 to be a good thing, right?

6 DR. SCHUSTER: Yeah. We have been
7 hearing the positive side for that. And I
8 think you have got, you know, Representative
9 Meade, who is all about child welfare. And
10 it is real hard for me to see him being a
11 party to, you know, some major redistribution
12 of funds that's going to hurt foster kids and
13 child welfare and, you know, that kind of
14 thing.

15 MR. BALDWIN: I talked to a couple
16 of task force members afterwards. And they
17 focused on benefit claim, was the thing that
18 they seemed to be most focused on in trying
19 to address, which I think, you know,
20 depending on what they do, I think that makes
21 a lot of sense.

22 DR. SCHUSTER: Right, right.

23 MR. SHANNON: But that's where that
24 recommendation comes out, somewhere to ease
25 -- less of a cliff and more of a transition.

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That could be good.

DR. SCHUSTER: Yeah. That could be very positive.

MR. BALDWIN: Although it would be an expansion of benefits to do that.

MS. KIDDER: Yeah. I have a hard time seeing the Assembly, even though they seem to recognize that the problem of benefits, they seem to be interested in fixing that, but any fixing it would be technically an increase in funding, and it is really hard to see in this budget session, tax reform, pension, all of that, them doing that.

DR. SCHUSTER: Well, somebody said to me, "You have got to be careful when you talk about fixing the benefits cliff that they don't decide the way to fix that is to cut benefits across the board, so you have fewer people going over the cliff, I mean literally." So I'm like, yeah, I hadn't thought about it that way.

There was an excellent -- you know, I'm always pleased to see consumers of services there. And there was a young woman

1 who works now for the ACLU who testified at
2 that most recent one and really did a nice
3 job talking about being a felon and being in
4 recovery and how difficult it was to get a
5 job, to get housing, stay in recovery, take
6 care of her little girl, you know, these
7 kinds of things. They really did a nice job
8 of, you know, putting -- painting that
9 picture. They also have Cathe Dykstra there
10 from the Family Scholar House, and she had a
11 mom with her who has been through that
12 program and graduated, now has her bachelor's
13 in social work, is getting her master's, and
14 is back as an employee helping others. And
15 she had, you know, lots of impressive numbers
16 about people that have come through that
17 program and so forth.

18 Sometimes I worry that when you
19 have such a -- what seems like a very
20 successful program, that the legislator are
21 like, oh, well we're already doing enough,
22 then, you know, we have got all of these
23 numbers out here and they think it is real
24 easy and there's, you know, lots of hiccups.
25 In fact, they were trying to do some

1 expansion and couldn't get, you know, the HUD
2 funding and all of that worked out for all of
3 their people because a lot of them are felons
4 and so forth. So, anyway...

5 MR. BALDWIN: So you said that
6 Bevin can't pull back Medicaid expansion by
7 executive order?

8 DR. SCHUSTER: Right.

9 MR. BALDWIN: But it was expanded
10 by executive order.

11 DR. SCHUSTER: Right.

12 MR. BALDWIN: But he can't undo it
13 by executive order because...

14 DR. SCHUSTER: Well, he can do it
15 by executive order because there is
16 legislation, I think this is right, that you
17 have to take advantage of availability of
18 federal funding.

19 MR. BALDWIN: Oh, okay.

20 MS. GUNNING: The match.

21 MR. BALDWIN: Yeah. Okay.

22 DR. SCHUSTER: You know, if it is
23 out there, you know.

24 MR. KIDDER: That's what they tried
25 with that amendment.

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DR. SCHUSTER: Right, right.

MR. BALDWIN: Okay. I got you.

DR. SCHUSTER: So I can tell you that Kara Stewart, when she was at KHSC and now is lead counsel, you know, for the House Democrats, has researched this thing up one side and down the other. And, you know, you cannot -- he cannot do it by executive order.

MR. BALDWIN: Well, he can do it.

DR. SCHUSTER: So there either has to be an amendment to that statute or some other, you know, language that would enable him to do it.

MR. BALDWIN: Oh, okay.

DR. SCHUSTER: Which is scary when you think about the super majorities of both the House and the Senate.

MR. SHANNON: Yes.

MR. BALDWIN: I think I remember when that statute was put in. Was that, like, in the late 90s?

DR. SCHUSTER: That sounds right, but I don't know.

I don't know anything further about the KI-HIPP rollout. Have you all heard

1 anything from Medicaid members? Are they
2 getting letters, more letters?

3 MS. ADAMS: Did you go to any of
4 the Medicaid forums?

5 DR. SCHUSTER: Forums, I did not.

6 MS. ADAMS: Because they talked --
7 they had a great presentation and a nice talk
8 about the program at the forum. I attended
9 the one in Frankfort.

10 DR. SCHUSTER: Okay.

11 MS. ADAMS: But, again, it is just
12 the push to get people enrolled. They still
13 don't have that many enrolled in it at all.
14 And...

15 DR. SCHUSTER: You know, I think
16 the worry that I hear from my KBH friends is
17 they could make it mandatory and not
18 voluntary, which would be -- and they still
19 are raising the issue that they don't think
20 that the state actually has the authority to
21 do it as a reimbursement. You know, the way
22 the program is set up is --

23 MS. ADAMS: Right.

24 DR. SCHUSTER: -- that the person
25 has to pay the premium and then get

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reimbursed. And the research, the legal research that they have done and they are trying to get -- of course trying to get something from CMS that is contrary to what Kentucky is doing, is pretty hard to get these days. But...

Some of the other groups in D.C. also agree with them, that they really don't have the authority to do that. So I think there is some real concern, there is no doubt. There is a guy who is a MAC member. And it is made for him. He has a child who is on a waiver program, so is Medicaid. They're middle class or upper middle class. He is a U of L professor. And, so, that kind of program is really ideal for them. But that's a fairly narrow niche, if you think about all of the Medicaid recipients. And I just think, my concern again is, our Medicaid folks are going to get these letters and think that they have to do something or, you know, do something and not -- and particularly the ones with behavioral health needs.

MS. ADAMS: The clarification that

1 helped me the most was the fact that if the
2 Medicaid person in the family, you know there
3 only has to be one family member that is the
4 Medicaid recipient, they don't lose their
5 Medicaid. Even though they pay their
6 premium, they get their -- the insurance.
7 So then they have a primary insurance and
8 then Medicaid becomes secondary for that
9 individual. So that made me feel better,
10 because I couldn't imagine anybody giving up
11 the dental and vision benefits that come with
12 Medicaid --

13 DR. SCHUSTER: Which are not
14 covered on most.

15 MS. ADAMS: -- which, you know,
16 where could you get that from your primary
17 insurance.

18 DR. SCHUSTER: And I still think
19 the behavioral health is stronger on Medicaid
20 than it is in most employer insurance.

21 MR. SHANNON: And case management
22 doesn't exist in private insurance.

23 MS. ADAMS: Yeah. That's right.

24 DR. SCHUSTER: Right, right.
25 So what you are hearing, Kathy, is that the

1 Medicaid recipient still has access to that
2 full range of Medicaid benefits?

3 MS. ADAMS: Yes.

4 MR. SHANNON: Yeah. I think it is
5 the cost. How do you pay the premium, just
6 barely making it.

7 MS. GUNNING: And they get
8 reimbursed later.

9 MR. SHANNON: Yeah. But that is
10 going to lag.

11 MS. GUNNING: I know. That's what
12 I mean. That's the problem.

13 MR. SHANNON: A couple of months or
14 something, I don't know.

15 DR. SCHUSTER: But they are liable
16 for the cost sharing on the employer's plan
17 also.

18 MS. GUNNING: Yeah, yeah. And that
19 could be a lot.

20 DR. SCHUSTER: So the deductible
21 and the co-insurance and so forth.

22 MS. GUNNING: That's not going to
23 help, is it?

24 MR. SHANNON: No, no.

25 DR. SCHUSTER: No? You don't think

1 they are?

2 MR. BALDWIN: They go with the
3 Medicaid.

4 MS. KIDDER: If the provider is a
5 Medicaid provider and accepts their
6 insurance, then Medicaid should pay their
7 cost sharing.

8 DR. SCHUSTER: But if they are
9 not...

10 MS. KIDDER: But Medicaid co-pays
11 are still --

12 MS. GUNNING: But it is still
13 retroactive, right, still reimbursement.

14 MR. BALDWIN: But if you go to a
15 provider that is in-network with the
16 commercial but not with Medicaid, then you
17 get stuck.

18 MS. GUNNING: Yeah. People can't
19 afford it.

20 DR. SCHUSTER: So it can get
21 complicated. People are already confused
22 about who is in-network and who is not and
23 that kind of thing. So that can get --

24 MS. GUNNING: And then when you
25 find out they are really not when they say

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they are.

MS. SCHIRMER: Yeah.

DR. SCHUSTER: Yeah, yeah.

MS. SCHIRMER: Shew. Wow.

MS. GUNNING: It is a mess.

MS. SCHIRMER: It's a hot mess.

MR. BALDWIN: And the providers take on that risk, on the flip side, it shows up that they are Medicaid eligible but they are not, that kind of stuff, and if you get dinged, which is bad enough. But it is different than a family getting stuck with that when you thought it was a Medicaid provider on the flip side and it turns out it is not, so now you have co-insurance, so an 80/20 commercial plan.

DR. SCHUSTER: So it is a form of a surprise billing problem, which is what they are talking about on the commercial side; you know, if you go to an in-network hospital, you use an in-network surgeon and you get a huge bill from an anesthesiologist who you had no choice in choosing and they are out of network. Yeah.

Again, I think if people are used

1 to dealing with commercial insurance, they
2 can probably wing their way and it is going
3 to be helpful. For the straight, what we
4 think of as our kind of more typical Medicaid
5 recipient, it would be hard for them to
6 remember that.

7 What are you all hearing on
8 co-pays? You are still collecting them,
9 I'm sure.

10 MS. GUNNING: I haven't -- it has
11 died down on our end.

12 DR. SCHUSTER: Has it?

13 MS. GUNNING: I don't know if they
14 are understanding it or they are getting it
15 waived or what happened.

16 MS. MUDD: Or they are just not
17 paying it.

18 MS. GUNNING: I don't think...

19 DR. SCHUSTER: You don't think they
20 are paying them?

21 MS. GUNNING: Do you? Don, what is
22 going on on your end?

23 MR. ROGERS: I don't think a lot of
24 folks are paying them.

25 MS. GUNNING: That's what I think.

1 MR. SHANNON: We're trying to
2 collect. But, yeah. You know, you are
3 better off providing service.

4 MS. GUNNING: If they don't have
5 it, you still aren't turning them away.

6 MR. ROGERS: Well, right, we're not
7 going to drain a bunch of resources in trying
8 to collect --

9 MS. GUNNING: That's what I mean.

10 MR. ROGERS: -- because the
11 resources would be greater than what we
12 collect.

13 MR. SHANNON: Yeah. It is a cut to
14 the provider.

15 MS. GUNNING: It is a cut to
16 providers. But that's what we think. I
17 mean, we just --

18 DR. SCHUSTER: But are you hearing
19 any more pharmacy problem stories?

20 MS. GUNNING: Not lately.

21 DR. SCHUSTER: Because the two
22 areas that we were concerned about was
23 pharmacy and primary care.

24 MS. MUDD: (Moved head up and
25 down).

1 MS. GUNNING: But we have also
2 raised those issues, you know, here and with
3 the MAC you have.

4 DR. SCHUSTER: Right, right.

5 MS. GUNNING: And I'm wondering
6 if --

7 DR. SCHUSTER: Well, they did some
8 -- they have told me they did some education
9 with the Primary Care TAC and with the
10 Pharmacy TAC. So maybe, you know, one of the
11 things was people that were below 100 percent
12 of the federal poverty level.

13 MS. GUNNING: And we've also had
14 navigators go with people --

15 DR. SCHUSTER: Good. Okay.

16 MS. GUNNING: -- that didn't report
17 any issues. So that's -- that's why I'm
18 wondering.

19 And the same with people going to
20 appointments, you know, it didn't stop them
21 from getting what they needed. But it is a
22 cost to you all.

23 DR. SCHUSTER: Yeah. You are
24 eating that cost. You are eating that cost,
25 right, Mike?

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MR. CAIN: Yes.

DR. SCHUSTER: Julie, you all are eating that cost at Mountain?

MS. PAXTON: I'm sure we are.

DR. SCHUSTER: Yeah.

MS. PAXTON: I don't know, but I'm sure we are.

DR. SCHUSTER: Yeah. I mean, it's just...

MS. GUNNING: Well, because they can't afford to go after it.

DR. SCHUSTER: And you are not going to turn people away.

MS. PAXTON: No.

MR. CAIN: Right.

MR. BALDWIN: So you are just stuck.

DR. SCHUSTER: You are the safety net.

MS. GUNNING: Right. You are the safety net, man.

MR. CAIN: We're not going to turn people away, no, absolutely not.

MR. SHANNON: Financially you are better off getting some rather than zero.

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MS. GUNNING: Exactly.

DR. SCHUSTER: Yeah.

MS. GUNNING: Which that's why it was such a stupid thing to begin with. Well, I mean, come on. Well, it was stupid. I hope you are writing that down.

MR. CAIN: You can't take a private practice model and put it on the CMHC's.

MS. GUNNING: No, you cannot, on the public health service.

MR. CAIN: You just can't. I mean...

MS. GUNNING: Or FQMAC.

MR. CAIN: It is defeating the purpose of why CMHC's are there to begin with.

MS. GUNNING: Exactly. That's why they were created the way they were.

MR. CAIN: To serve regardless of payer.

MS. GUNNING: Right, right.

DR. SCHUSTER: Kind of like the Statute of Liberty.

MR. BALDWIN: But you get all of that money from the state as the safety net,

1 right?

2 MS. GUNNING: From the general
3 fund.

4 MR. CAIN: Yeah, from the state
5 general fund.

6 MS. KIDDER: Do you know any idea
7 how hard Senator Meredith is going to push
8 this bill?

9 DR. SCHUSTER: I don't know.
10 Senator Meredith has pre-filed again his
11 co-pay bill and will put it on the Kentucky
12 Mental Health Coalition advocacy flag for
13 sure. I don't know. You know, he -- he is
14 -- he is so interesting. You know, he was on
15 the panel of the Kentucky Voices for Health
16 meeting. And he has a vision about the way
17 he thinks the world should work, and he is
18 pretty stubborn about it, and one of them is
19 to protect people in rural areas and rural
20 providers. I mean, he is just all over that.
21 And, so, any of these things, you know, he
22 still would like to, no offense folks, but
23 have at the most two MCOs, you know, I think
24 his bill has gone up to three now but he is
25 still going to file that again. You know,

1 it will be interesting to see if Bevin and
2 Alvarado get elected. He's likely to be
3 Chair of Senate Health & Welfare.

4 MS. KIDDER: Yeah.

5 DR. SCHUSTER: And, you know, he
6 could wield a whole lot more power in that
7 position than he could before. And,
8 you know, I think he is with us on a whole
9 lot of things.

10 MS. SCHIRMER: He is.

11 MS. KIDDER: It is another one of
12 those things that tomorrow will really
13 determine.

14 DR. SCHUSTER: Yes. Tomorrow could
15 be really -- yeah, Valerie is right, maybe we
16 should have met on Thursday.

17 MS. KIDDER: I mean, even if he is
18 Chair, he does push his bill because it was a
19 Bevin, I could see it being vetoed. It would
20 be a veto override question. It could get
21 pretty tricky pretty quick or interesting.

22 DR. SCHUSTER: Yeah. But if any of
23 you know him, I think we, you know, we sure
24 ought to encourage him. And there was a
25 positive response in the KBH meeting,

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obviously, all over that. So...

MS. ADAMS: You know he took a nasty fall a couple of days ago.

DR. SCHUSTER: No. He did?

MS. ADAMS: Senator Meredith, uh-huh. He was in the emergency room, I know. But he did -- my information is Facebook. But they had a picture, it had the picture, and he had a bandage around his head. But it was quite obvious that his face was quite bruised and that. So...

MS. GUNNING: I wonder if he had a TBI.

MS. SCHIRMER: Or a concussion.

MS. ADAMS: But he says he took a nasty fall.

DR. SCHUSTER: Wow. I'm sorry to hear that.

Well, we better hope he is okay, right, with no TBI.

MS. ADAMS: Right. Exactly.

MS. HASS: That was my first thought.

DR. SCHUSTER: Steve, what is the status of the redesign of the waivers these

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days?

MR. SHANNON: The public comment period starts Friday. They are going to submit their recommendation to CMS, that is going to consolidate language, have rates listed for different services and rates consistent for us, all six waivers. But the public comment was going to start last Friday and now it is moved up to this Friday.

DR. SCHUSTER: Yes.

MR. SHANNON: All six waivers. And the main three waivers are financially the big losers.

MS. HASS: Yeah. The ABI waivers took the serious cuts. They even say in their slides that Navigant said that this was at the expense of the ABI waiver. Now, they have called a meeting. It just came across my little thing. It says for the 6th and 14th they are calling ABI providers, because they've heard some concerns about the methodology on the rate study, which probably may have come from me. But, anyway. Perhaps.

MR. SHANNON: They were told before

1 that they will get calls from the losers, not
2 the winners. So...

3 MS. HASS: Right. Yeah. And the
4 things that are most concerning to me, there
5 are three areas that are most concerning.
6 One is the speech therapy. And they still
7 really do not get cognitive therapy. They
8 really do not understand what is the
9 difference between the individual therapies
10 with a brain injury than maintenance type
11 issues that we see in some of the other
12 waivers. But speech therapy, for instance,
13 got a 32 percent cut.

14 MS. SCHIRMER: Right, right.

15 MS. HASS: And case management was
16 cut from 434 to 346.

17 MR. SHANNON: Yeah.

18 MS. HASS: And again, especially on
19 the acute side, when you are looking at three
20 R's of therapy per day, the things that an
21 ABI case manager has to do is much more
22 intense than some of the other waivers.

23 The other thing that is very
24 concerning is on adult day training they took
25 from 403 to 243 a unit. And, again, we have

1 a ratio of no more than 1:5. So I am
2 somewhat concerned that they will take the
3 ratio off and just say, "Okay. Well, there
4 will be 243 a unit." So then we're --

5 MR. SHANNON: So it is 10 or 12
6 instead of 5.

7 MS. HASS: Right.

8 MR. SHANNON: It can't be as good,
9 right?

10 MS. HASS: So, again, how are we
11 going to be able to do training and do
12 one-on-one with our individuals? So those
13 are my concerns. My biggest concern on that
14 243 rate is that you are going to be
15 competing with the, no offense to anybody
16 that works at McDonald's, but you are going
17 to be competing for the McDonald's flippers.

18 And, you know, so it just truly
19 hurts the integrity and the intent of what
20 the two waivers were supposed to be doing.
21 And I have met with them on numerous
22 occasions, Diane has been with me on many of
23 the occasions, to talk to them about
24 cognitive rehab. And it's just --

25 MS. SCHIRMER: It really shows

1 their lack of understanding of brain injury
2 and how it differs from other categories.
3 They are just not getting it.

4 DR. SCHUSTER: Do they have anybody
5 anymore?

6 MS. HASS: No.

7 DR. SCHUSTER: Is there a brain
8 injury, supposed, head anybody any place?

9 MS. HASS: No.

10 DR. SCHUSTER: Not at DBHDID?

11 MS. SCHIRMER: No.

12 DR. SCHUSTER: Or at DMS?

13 MS. HASS: Well, under Dale you
14 have the TBI Trust Fund and our case managers
15 that we use with the Trust Fund. And then
16 Tonia Wells, who is staff to the TBI Trust
17 Fund under Dale, does have experience with
18 brain injury. Other than that, there is no
19 experience, at least that I am aware of, and
20 somebody can correct me if I'm wrong, but no
21 one else that I am aware of has any type of
22 brain injury. Under the Trust Fund, which I
23 sit as Chair, all of our case managers have
24 to have the behavioral -- help me out Diane.
25 The behavioral specialist certification.

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MS. SCHIRMER: Oh. Behavior --
certified behavior analyst.

MS. HASS: Right. All of the case
managers under the Trust Fund have to have
that credentialing.

MS. SCHIRMER: It is actually --
you are talking about the active, the
certified brain injury specialist.

MS. HASS: Right.

MS. SCHIRMER: Yeah. So...

DR. SCHUSTER: So you've got
meetings set up...

MS. HASS: The 6th and the 14th.

MS. SCHIRMER: Yeah, yeah.

DR. SCHUSTER: Good. And you are
going to be submitting comments, I'm sure.

MS. HASS: Yeah.

MS. SCHIRMER: And we sent out
action alerts to notify people.

MS. HASS: That was the thing.
Because I was keeping track, because the last
time they said they did not get comments in.
But we were keeping track. And I had over
300 comments go in that I could account for.
And they said that they only had one or two

1 comments on speech therapy, which I find
2 very, very hard to believe. Because, again,
3 we were tracking the numbers, and that's what
4 they said that they didn't --

5 DR. SCHUSTER: That's why KBH has
6 collected all of those comments and sent them
7 in, because that's what you get.

8 MS. SCHIRMER: It is insulting what
9 they are offering to speech therapists, it
10 really is. It is acting like they don't have
11 any expertise at all.

12 DR. SCHUSTER: Expertise at all,
13 right.

14 MS. HASS: Because they will pay a
15 CODA, which a two-year degree, versus a --
16 with a master's degree, they are paying more
17 to the CODAs and the PTAs than they are to
18 the speech therapists.

19 MS. SCHIRMER: Yep.

20 MS. HASS: I know. Go figure.

21 DR. SCHUSTER: What else do you see
22 in the impact on the ABI waivers?

23 MS. HASS: I think the biggest
24 impacts are the three that I mentioned.

25 DR. SCHUSTER: Okay.

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MS. HASS: They did raise
supportive employment. But again if we --

MS. GUNNING: If you don't have the
others.

MS. SCHIRMER: Yeah. It is putting
the cart before the horse.

MR. SHANNON: Smaller units.

MS. GUNNING: If you haven't been
habbed, you can't be rehabbed.

MS. SCHIRMER: Right. Exactly. It
is the cart before the horse.

MS. GUNNING: Yes. That's my
thing. I mean, you know, if you haven't been
habbed, you can't be rehabbed.

MS. HASS: Right. I think they
really, to me, and this is just my opinion
and I can be, you know, debated on this, I
really think this is a way when they brought
in to do the super waiver, make everybody --
like some things they have done well,
you know, calling certain things the same
thing and some of the things they have done
have been good.

DR. SCHUSTER: Some of the
consistency across waivers.

1 MS. HASS: Right. I am not saying
2 it has all been bad. But when you look at
3 the dollars they paid Navigant in their
4 contract and you look at what they propose
5 are going to be savings.

6 MS. SCHIRMER: And this is the same
7 group that on looking at incidents said that
8 people with brain injuries never have falls.
9 We had to debate that in the meeting.

10 DR. SCHUSTER: People with brain
11 injuries never have falls?

12 MS. SCHIRMER: Never have falls,
13 right.

14 MS. GUNNING: Never?

15 MS. HASS: Never.

16 MS. SCHIRMER: Never.

17 DR. SCHUSTER: They must have a
18 unique population of people with brain
19 injuries, right?

20 MS. HASS: Again, all I can say is
21 when we go through and we delve through it,
22 their methodology is totally flawed.

23 MS. GUNNING: Just think if they
24 would have given you the money they gave
25 Navigant.

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MS. HASS: Thank you.

DR. SCHUSTER: Which is up in the millions of dollars.

MS. GUNNING: That is what drives me crazy. We will spend all of these dollars studying, studying, getting opinions and we won't ask the people with lived experience, who could tell you what works and what doesn't for nothing. Just give us the money and we will provide the services.

MS. SCHIRMER: They didn't even try to look at what happens regionally or nationally, either. The data is there.

MS. GUNNING: And we are way behind nationally; there's no secret there.

DR. SCHUSTER: Yeah, yeah. You had mentioned, Diane, waiver audit.

MS. SCHIRMER: Yeah.

DR. SCHUSTER: What is that issue?

MS. SCHIRMER: We've gotten feedback that there is a lot of inconsistency between provider to provider. And, so, I think we would -- and we have been advocating to the state that they should have a consistent set of tools that would perhaps be

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qualitative, to look at how a program is doing and not treat each provider differently.

MS. GUNNING: Standardization.

MS. SCHIRMER: That's correct.

There needs to be standardization across the board.

MS. HASS: Because we had one provider being -- it is all the inconsistencies of policy. But one provider was recouped because she had a water temperature at 121, one degree higher than whatever. But all of us could go turn our hot water on and in the morning it could be different than it is at night. But they were dinged for one degree, instead of having a range. And then one of them said that their sheets didn't smell fresh.

MS. SCHIRMER: Yeah. And they didn't have snacks in adult treatment. But the other thing is, somebody was cited for their ADT notes, yet they did the notes the same way in 2014 and they were never cited then. So there's just a lot of inconsistency.

1 DR. SCHUSTER: And who is doing the
2 inspection and so forth? Is that the state?
3 MS. SCHIRMER: It's the state that
4 does them. They come out of that department,
5 the brain injury department.
6 MS. HASS: The acquired brain
7 injury branch.
8 MS. SCHIRMER: Yeah, yeah.
9 DR. SCHUSTER: So if they're -- if
10 you go up a level, everybody wants more
11 consistency across waivers. What you are
12 talking about is consistency within the
13 waiver.
14 MS. SCHIRMER: Yeah.
15 DR. SCHUSTER: Are they talking
16 about that at all?
17 MS. HASS: No.
18 MS. SCHIRMER: Well, not really.
19 I mean, I brought it up twice. But there
20 needs to be discussion. Because it is not
21 fair to providers, especially the small ones.
22 They are getting dinged for things that
23 really can make or break them, yet some of
24 the larger providers never -- they never have
25 that issue come up. So...

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DR. SCHUSTER: What is the end game for the whole Navigant and the reorg of the waivers?

MS. GUNNING: Navigant makes lots of money.

DR. SCHUSTER: Is there an end point to this?

MS. SCHIRMER: And they retire.

MS. GUNNING: And we don't get shit.

MS. SCHIRMER: Right.

MS. HASS: I mean, that's a good question. I might ask that question in the next meeting we have that is coming up, is, again, it seems like their contract was for one amount, then they re-upped the contract. So it just seems like a perpetual process.

MS. GUNNING: It is crazy.

DR. SCHUSTER: Well, and at some point, I mean, I guess the Administration or somebody has got to say, "Okay. We have done it. Now it is over and we're moving on to the next thing."

MR. SHANNON: And phase two, that starts I think in 2020.

1 MS. SCHIRMER: Yeah. You're right.

2 MR. SHANNON: They are building up
3 more work. This is just the first step.

4 DR. SCHUSTER: What is the phase
5 two?

6 MS. GUNNING: Repeat phase one.

7 MR. SHANNON: I think it is more --
8 it is associated with planning and maybe
9 service provision as opposed to definition
10 and rates.

11 MR. BALDWIN: Yeah. It is supposed
12 to be more in detail as to waivers, right?

13 MS. KIDDER: It takes it beyond
14 standardization.

15 MR. BALDWIN: Yeah. Okay.

16 MS. GUNNING: But they need to do
17 standardization.

18 MR. SHANNON: Managed care.

19 MS. HASS: Well, shouldn't we have
20 done that before you did the study? I'm just
21 asking.

22 MS. KIDDER: Yeah.

23 MS. HASS: I'm just asking,
24 you know. I sell real estate in my real
25 life. So...

1 DR. SCHUSTER: Wow. Do we have any
2 recommendations for the MAC at its next
3 meeting?

4 MS. GUNNING: None we can say here.

5 MS. MUDD: I think we need to have
6 an emergency meeting on Wednesday.

7 DR. SCHUSTER: Or not.

8 MS. MUDD: Or not.

9 DR. SCHUSTER: Maybe we will give
10 them a break.

11 MR. SHANNON: Yeah.

12 DR. SCHUSTER: I think that we have
13 all -- you know, they would be appreciative.

14 MR. SHANNON: I would make a
15 recommendation to provide DMS response to
16 speed up the process.

17 DR. SCHUSTER: Steve, you had an
18 issue that you wanted to put on the agenda
19 for our January meeting.

20 MR. SHANNON: Yeah. Let's talk
21 about targeted case management, the
22 experience people have with that.

23 DR. SCHUSTER: In January?

24 MR. SHANNON: In January.

25 DR. SCHUSTER: So that would be a

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discussion for -- to involve the MCOs as well. We're talking about definitions. And...

MR. SHANNON: Yeah. Access to services, things like that.

DR. SCHUSTER: Access to services, okay.

On the back of your goldenrod paper, this follows the same schedule that we've had, which is that I look at where the MAC meeting is and then I go up two weeks and go over to the Tuesday before that, unless there is a problem with the Tuesday. So January and November would be on Wednesdays, because the first Tuesday of January is when the Legislature opens and that is always a day that we like to be up here and around and we're not sure what the schedule is going to be and so forth. And then the November date would be, again, the election. And this time I think I moved it to the Wednesday. So it would be post-election, so we will know. We won't have a Governor's election but we will have lots of legislators and President and a bunch of other things.

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So I guess I will ask the TAC members mostly. Does this kind of schedule work for you all? I mean, it is pretty much what we've had before. And we will continue to meet here in the Annex unless we --

MS. SCHIRMER: Oh, good. We love meeting here.

DR. SCHUSTER: -- unless we get so desperate to have some input from DMS. Maybe I will propose to them that if they would like to meet with us and discuss something that they are thinking about doing before they do it, that we would meet with them over at the Cabinet. We will never get a response to that offer, I don't think. But...

MS. ADAMS: I can't remember. Does AARS meet on Tuesdays or Monday?

MR. SHANNON: It is a moving target.

DR. SCHUSTER: Yeah, they are not nearly as predictable.

MR. SHANNON: Sometimes there has been a conflict with this one and I bounce between the two.

MS. ADAMS: Right. That is my only

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issue.

MR. SHANNON: But it has to be before the 15th.

DR. SCHUSTER: Yeah.

MR. BALDWIN: That used to happen like clock work, but it is all over the place.

DR. SCHUSTER: It has really been all over the place lately.

MS. ADAMS: There is a new committee chair.

DR. SCHUSTER: Yeah. But you are right, that would be the only conflict that we've had. We could, I guess, move to Wednesday all the way down the line. Do you want to do that?

MS. MUDD: That's fine.

DR. SCHUSTER: Is there a regular schedule for when your psych and CD forum meets?

MS. ARANT: Yes. We meet quarterly. We have not come up with 2020 dates yet, but our next meeting is December 17th.

DR. SCHUSTER: Is...

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MS. ARANT: December 17th.

DR. SCHUSTER: Okay. Because we conflict with you all on that sometimes and we try to avoid that.

MS. ARANT: Okay.

DR. SCHUSTER: So that is a Tuesday. I think that's why I was thinking that.

MS. ARANT: I'm the KHA staff member in charge of it. So when making the 2020 dates I can be mindful of the Behavioral TAC.

DR. SCHUSTER: Yeah. Because Ninah and I go back and forth and I send out these meetings and then she's like, "Oh. That's when we're meeting."

MS. ARANT: Yes.

DR. SCHUSTER: What do we think about Wednesdays? Do you all have a preference one way or the other?

MS. ADAMS: If they are in the afternoon, it's good.

MS. HASS: Yeah, afternoon is good.

MS. GUNNING: Yeah.

DR. SCHUSTER: So that would be

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March 11th and May 13th. And July 8th.

MS. GUNNING: And September 9th.

DR. SCHUSTER: And September 9th.

MS. GUNNING: We've already had
that one.

MS. MUDD: Yeah. It says '19.

DR. SCHUSTER: Oh. I'm sorry. And
that other one should say '20 also.

MS. SCHIRMER: And the one in
January stays the same.

DR. SCHUSTER: Yeah, because it was
already on a Wednesday.

MS. GUNNING: Yeah, 7/8. And
9/9/20 and 11/5/20.

DR. SCHUSTER: No. 11/4, I already
moved that one.

MS. MUDD: And the one in
January is the 9th?

DR. SCHUSTER: No. The 8th,
because that was already.

All right. Let's go over these
dates one more time, folks. And then I will
send it out.

So the one in January is
January 8th. The one in March is March 11th.

1 The one in May is May 13th. The one in July
2 is July 8th. The one in September is
3 September 9th, and that should say '20, not
4 '19. And then the one in November is
5 November 4th; that was already on a Wednesday
6 but it should say '20 and not '19.

7 MS. SCHIRMER: I got it.

8 DR. SCHUSTER: All right.

9 Everybody got it?

10 ("Got it")

11 DR. SCHUSTER: So they are now all
12 on Wednesday. So that way, Kathy, AARS is
13 either on a Monday or a Tuesday all the way
14 along.

15 MS. ADAMS: Yeah. Sometimes
16 morning and sometimes afternoon.

17 DR. SCHUSTER: Right, right. And
18 then the MAC meeting is November 21st. So
19 it's the week before Thanksgiving at 10 a.m.
20 in the Capitol Annex.

21 Any other business to come before
22 the TAC? How TAC-less do you feel?

23 MS. MUDD: TAC-full.

24 DR. SCHUSTER: All right. Thank
25 you all very much. We appreciate you being

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here.

("Thank you")

(Meeting concluded at 3:29 p.m.)

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C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Hospital Technical Advisory Committee meeting; 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 11th day of November, 2019.

 /s/ Lisa Colston

Lisa Colston, FCRR, RPR