INTERIM JOINT COMMITTEE ON HEALTH, WELFARE, AND FAMILY SERVICES

Minutes of the 6th Meeting of the 2020 Interim

November 19, 2020

Call to Order and Roll Call

The 6th meeting of the Interim Joint Committee on Health, Welfare, and Family Services was held on Thursday, November 19, 2020, at 1:00 PM, in Room 171 of the Capitol Annex. Senator Ralph Alvarado, Chair, called the meeting to order, and the secretary called the roll.

Present were:

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

Guests: Diane (Schirmer) Gutierrez, Chairperson, Kentucky Chapter, Brain Injury Association of America; Christa Bell, Director, Division of Protection and Permanency, Department for Community Based Services, Cabinet for Health and Family Services; Wendy Morris, Commissioner, Dr. Allen Brenzel, Director, Patti Clark, Program Administrator, Department for Behavioral Health, Developmental and Intellectual Disabilities, Cabinet for Health and Family Services; Lisa Lee, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services; Julie Brooks, Policy Specialist, Department for Public Health, Cabinet for Health and Family Services; Donna Little, Deputy Executive Director, Office of the Secretary, Cabinet for Health and Family Services; Sheila A. Schuster, Ph.D. Licensed Psychologist, Executive Director, Kentucky Mental Health Coalition; Tim Clement, MPH, Director of Legislative Development, American Psychiatric Association; and DJ Wasson, Deputy Commissioner, Department of Insurance, Public Protection Cabinet.

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

Approval of Minutes

A motion to approve the minutes of the October 28, 2020, meeting was made by Senator Buford, seconded by Representative Frazier, and approved by voice vote.

Consideration of Referred Administrative Regulations

The following referred administrative regulation with amendments were placed on the agenda for consideration: **201 KAR 002:311 Proposed** - Compounding drugs for veterinary use; **201 KAR 009:016 Proposed** - Restrictions on use of amphetamine and amphetamine-like anorectic controlled substances; **201 KAR 009:200 Proposed** - National Practitioner Data Bank Reports; **201 KAR 009:210 Proposed** - Criminal background checks required for all new applicants; **201 KAR 009:230 Proposed** - Required registration in the KASPER System; legal requirements for prescribing controlled substances in the Commonwealth of Kentucky; enforcement; **201 KAR 009:240 Proposed** - Emergency orders and hearings; appeals and other proceedings, **201 KAR 009:260 Proposed** - Professional standards for prescribing, dispensing, and administering controlled substances; **201 KAR 009:360 Proposed** - Continuing education requirements for physician assistants; **201 KAR 021:041 Proposed** - Licensing; standards, fees; **201 KAR 021:042 Proposed** - Standards, application and approval of continuing education courses; **201 KAR 021:095 Proposed** - Licensure, registration, and standards of persons performing peer review; **902 KAR 004:110 Proposed** - Abortion information; **902 KAR 050:010 Proposed** - Definitions for milk and milk products; **902 KAR 050:031 Proposed** - Standards for producer eligibility for manufacturing grade milk; **902 KAR 050:032 Proposed** - Standards for farm requirements for manufactured grade milk; **902 KAR 050:033 Proposed** - Standards for enforcement procedures for manufactured grade milk; **902 KAR 100:012 Proposed** - Fee schedule; **907 KAR 001:604 Emergency** - Recipient cost-sharing (Deferred from 10/28/2020); **907 KAR 001:604 Proposed** - Recipient cost-sharing (Deferred from 10/28/2020); and **922 KAR 001:330 Proposed** - Child protective services. Questions and comments regarding 907 KAR 001:604 Emergency, were asked by Senators Alvarado and Meredith. Lisa Lee, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, and Donna Little, Deputy Executive Director, Office of the Secretary, Cabinet for Health and Family Services testified and agreed to send a letter for the withdrawal of 907 KAR 001:604 Emergency. Questions and comments regarding 902 KAR 004:110 Proposed, were made by Representative Gibbons Prunty and Senator Alvarado. Julie Brooks, Policy Specialist, Department for Public Health, Cabinet for Health and Family Services, testified regarding 902 KAR 004:110 Proposed.

Brain Injury Waiver Update

Diane (Schirmer) Gutierrez, Chairperson, Kentucky Chapter, Brain Injury Association of America, stated that falls are the leading cause of non-fatal traumatic brain injury (TBI). Falls also contribute to 24 percent of all TBI related deaths. She stated that 84 percent of TBI related fall fatalities were adults over 65 years of age. In 2019, hospitals billed for over $322 million in charges associated with TBI in Kentucky. Each week, there are 224 emergency department visits, 63 hospitalizations, and 18 deaths due to TBI among

Kentucky residents. The cause of TBI varies across with three levels of severity. Suicide was the leading cause of TBI, among those who died where TBI was reported as the cause of death on the death certificate. TBIs are often treated and released from the emergency departments. In 46 percent of fatal TBI cases, firearms were the leading cause of death, with 7 out 10 were deemed suicides.

Ms. Gutierrez stated that information regarding Acquired Brain Injury (ABI) waivers was gathered through careful review of the current waivers in Kentucky, review of other state waivers for brain injury, discussion with Brain Injury Association of America (BIAA), the American Congress of Rehabilitation Medicine, the American Academy of Physical Medicine, and the Rehabilitation review of the Commission of Accreditation of Rehabilitation Facilities standards. The costs to society affects two areas. First are the costs for the reduction or loss of productivity, the loss of earning potential, payment of taxes, and the reinvestment of earnings into the economy. The second cost to society involves the insufficient or inappropriate diagnosis, treatment, and care that result in emotional and behavioral disorders, psychiatric hospitalizations, substance misuse, and loss of relationships, criminal activity, and homelessness.

Ms. Gutierrez stated that the recommended changes to the ABI waivers are: to expand acute slots for medically complex and neurobehavioral-challenged individuals with programs and rates adjusted on individual needs; to change the definition of brain injury to encompass all types of acquired brain injuries including stroke, and to not exclude individuals because of substance misuse or mental health issues; to add clinical expertise within the Acquired Brain Injury Branch (ABIB) to assess a candidates for service; to provide guidance and expertise to waiver providers to help Kentucky stay current with evidence-based brain injury rehabilitation practices; to conduct standardized and consistently applied audits across providers; and to add the Academy of Certified Brain Injury Specialists (ACBIS) training model, curriculum, and competencies. She stated that TBI is a medical model, the plan of care is the central plan developed at admission and runs through discharge in rehabilitation programs across the country. The model incorporates initial and ongoing assessments completed by team members addressing behavioral, cognitive, communication, cultural, educational, functional, recreational, medical, physical, psychological, sexual, social, spiritual, vocational domains, important life events and life experiences, routines, decision making capacity and the usability of the living environment. The goals for the TBI patient are established from these domains with input from the person served, family or guardian, or their circle of support.

Ms. Gutierrez stated that there is a need for appropriate measurable, realistic goals that can result in an anticipated outcome. Providers should have a consistent method of reporting program evaluation data and patient outcomes. Adult day treatment should be a combination of structured therapy services and community-based programming. Often working with the TBI person in their typical environments help anchor skills not learned in group settings. Individual supportive counseling and psychotherapy is recommended for

the TBI person served and family to rebuild relationships, work, intimacy and self-esteem. Resource Facilitation is a means of helping an individual achieve their avocational or vocational outcomes. TBI participants do not follow the same model as other disability categories. TBI participants may be a smaller group but often present with more substantial medical, cognitive, and behavioral challenges. She stated that it is time to design quality services that meets the needs of Kentuckians who are affected by brain injury.

Update on Child Welfare

Christa Bell, Director, Division of Protection and Permanency, Department for Community Based Services (DCBS), Cabinet for Health and Family Services (CHFS), stated that in October 2020, there were 9,383 children in the custody of or committed to CHFS. DCBS' priorities for youth in out-of-home care are: to ensure that children are maintained safely in the least restrictive setting whenever possible; that children are receiving quality services and achieve permanency timely; and to improve services and outcomes for older youth who transition from care upon turning 18 or 21 for youth who choose to extend commitment. She stated that children are kept in the least restrictive setting by: the expansion of in-home services to prevent entry into care; an improved relative service array; increasing the availability of quality foster homes that allow children to remain in their schools and communities; increasing placement stability; and by reducing the use of congregate care. She shared a graph that displayed the number of DCBS and private foster homes. As of October 2020, there were 5,548 foster homes in Kentucky.

Ms. Bell stated that the number of children in the custody of or committed to CHFS in private residential settings, 799, is the lowest number since 2014. DCBS continues to focus on recruitment and retention of qualified staff to maintain manageable caseloads. DCBS continued the exploration of performance based contracting measures to include in contracts with providers. DCBS is focusing on placement stability and working to ensure that children in care achieve permanency timely. She shared a graph that shows the average number of child protective services (CPS) caseload. The average number of CPS cases per worker not at full capacity with past due cases from January 2020 to July 2020, is 27 cases. The next graph showed the number of adoptions per year for state fiscal year (SFY) 2015 to SFY 2020. DCBS increased the number of adoptions finalizations in SFY 2019 and SFY 2020. In SFY 2020, there were 1293 finalized adoptions. The average number of months to permanency for all exit reasons from DCBS is 17.9 months. Ms. Bell stated that the time increased in SFY 2020 because of the impacts from the COVID-19 pandemic.

Ms. Bell stated that placement stability was added as a performance based measure to agreements with private child placement agencies. DCBS staff are working with agencies and tracking progress on placement stability. DCBS is partnering with other entities to find adoptive homes for waiting children, most recently the Head Start program. There are 302 children registered with Kentucky Adoption Profile Exchange (KAPE), and can be viewed at https://prd.webapps.chfs.ky.gov/kape/ . DCBS has expanded the prevention services such as Kentucky Strengthening Ties and Empowering Parents

(KSTEP) program through partnerships and grant opportunities. In 2018, DCBS created a transitional services branch to focus on ensuring that the needs of older youth in foster care are met. DCBS staff is working to identify committed lifelong supports for youth who leave state custody. DCBS partnered with youth villages to bring Lifeset to Kentucky. Lifeset is an evidence based intensive case management program implemented on July 1, 2020. Kentucky was one of 25 jurisdictions that was invited to participate in a Youth Engagement Summit at a national level.

Ms. Bell shared the impacts from the COVID-19 pandemic. Monthly caseworker visits were conducted via videoconferencing platforms. Face to face visits were still required if there were any safety concerns or a family was in crisis. Face to face parent and child visitation resumed in a phased approach with additional health and safety measures in place. Foster parent trainings are conducted via videoconferencing platforms. The Just in Time training platform for foster and adoptive parents launched in March 2020. The court closures caused reduced entries into care and exits from care. The reopening of courts and increased use of virtual hearings increased the achievement of permanency for children. DCBS requested and received federal waiver for fingerprinting requirements in order to continue approving foster families. DCBS made efforts to ensure no youth has to leave state custody at age 18 or 21 during the state of emergency.

Ms. Bell shared a chart that displayed the number of intakes with allegations of child abuse and neglect by month comparing 2019 and 2020. The next chart showed Kentucky's data with regard to substantiation rates for SFY 2020 by reporting sources. Social services personnel had the highest of percentage of allegation substantiations and school personnel had the lowest percentage of reports that were substantiated. She stated that because of the concerns for reduced reporting, DCBS partnered with Prevent Child Abuse Kentucky (PCAK) to develop a training specific to reporting maltreatment during COVID-19, including what to look for using virtual platforms. Additional information has been shared through the Department of Education and Kentucky School Board Association related to reporting maltreatment and resources available for families.

Ms. Bell stated that the plan to build a 21st century DCBS consists of three phases. The first phase is a stabilization phase, the second phase is an innovation phase and the third phase is the thriving phase to sustain the positive changes made within DCBS. There are also five pillars in the plan to rebuild DCBS. She shared that pillar two is about resiliency and secondary trauma, which is an important focus for the DCBS staff to maintain a healthy workforce.

In response to questions and comments from Senator Alvarado, Ms. Bell stated that the pandemic electronic benefits transfer (PEBT) cards were intended for children who are eligible for free or reduced lunches. The PEBT benefits were issued because schools were virtual.

In response to questions and comments from Representative Burch, Ms. Bell stated that including foster children placed with relatives, there are 130 Kentucky children in out-of-state care. There are 10 or less children placed out-of-state care for treatment purposes in psychiatric facilities. DCBS focused on this number because four to six years ago there were more than 100 children who were placed out-of-state for treatment purposes. The children placed in out-of-state care are counted in the total of number of children in out-of-home care in Kentucky.

In response to questions and comments from Representative Moser, Ms. Bell stated that the KSTEP program was piloted by DCBS under the Title IV-E demonstration project. KSTEP is similar to the START program. The START program focuses efforts on children ages 5 and under. The KSTEP serves additional children up to the age of 10 and is focused on providing evidence-based practices to families who may struggle with substance use issues. KSTEP is an intensive program that is aimed at keeping children safe in their homes. The services are delivered in partnership with DCBS community mental health agencies. KSTEP is more than 93 percent effective. KSTEP is focused on prevention and the services are provided to families so the children do not come into out-of-home care. A foster parent or out-of-home care providers are not involved with the family. Ms. Bell stated that in regards to children in out-of-home care, DCBS has staff who are tracking progress on placement stability. DCBS has that as a performance based measure in the private child placing agreement. DCBS partners have made improvements such as updating the home study model to ensure they are providing better quality services to the children in out-of-home care.

Mental Health Update

Wendy Morris, Commissioner, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Cabinet for Health and Family Services, stated that the impact of COVID-19 on DBHDID facilities has been significant. DBHDID operates or oversees the operations of multiple facilities. The census in the facilities has remained relatively stable. The average daily census is 800 people. DBHDID temporarily suspended admissions at two psychiatric facilities due to COVID-19. The Community Mental Health Center (CMHC) crisis and diversion services created enhanced crisis and diversion services. DBHDID had four deaths related to COVID-19. Staffing challenges remain a critical issue. CMHC partners serve over 165,000 individuals per year with an increased demand for crisis services. Telehealth has been crucial for access to services. DBHDID administers the Supports for Community Living (SCL) Medicaid waiver and oversees health, safety, and welfare of almost 4,900 individuals in small, community residential settings. There have been 113 SCL waiver participants who tested positive for COVID-19 and three deaths.

Commissioner Morris stated that DBHDID is focusing on trauma and secondary trauma. The COVID-19 pandemic and racial inequity have tremendous impact on resilience and well-being. DBHDID is working to raise awareness, provide resources and

tools, and helped coach on how to build resiliency. DBHDID has weekly meetings with all the SCL providers to give information, interpret the guidance that comes from various sources, and to provide emotional support. She shared a graph that displayed the number of Kentucky resident drug overdose deaths from January 2017 to August 2020 by month. The number of drug overdose deaths are trending downward but are still very high. Kentucky is in the midst of an opioid epidemic and access to substance use disorder treatment continues to be important. The Kentucky Opioid Response Effort (KORE) serviced 35,469 individuals who received opioid use disorder treatment or recovery services. She stated that 53,509 free naloxone kits were distributed through KORE. The SFY 2019 Kentucky Medicaid core set measure shows the percent of adults who initiated treatment for opioid abuse, alcohol, or other drug dependence scored above the national rates. The higher rates shows how Kentucky has increased access to services and prevention efforts.

Commissioner Morris shared a chart with the suicide trend numbers in Kentucky from 2015 to 2019 categorized by the age of the decedent. In Kentucky, suicide numbers have been trending downward for the past five years. The DBHDID has been building resiliency and enhancing protective factors to try to reduce the number of suicide deaths. DBHDID is working to increase the capacity and the number of behavioral health providers trained to address suicide risk. The DBHDID is seeking additional partnerships between providers to close safety net gaps and improving surveillance to create real-time responses. She stated that the DBHDID needs continued and sustainable funding. The DBHDID wants to enhance the public behavioral health safety net. The DBHDID supports the continued expansion of telehealth services.

In response to questions and comments from Senator Alvarado, Commissioner Morris stated that the suicide rates are up in some communities and down in other communities. The graph in the presentation is a statewide total number of suicides. Patti Clark, Program Administrator, Department for Behavioral Health, Developmental and Intellectual Disabilities, Cabinet for Health and Family Services, stated that the DBHDID is not seeing an increase in number of attempted suicide.

Discussion of 2021 Regular Session Prefiled Bill Request 61

Representative Kimberly Poore Moser stated that mental health issues often underlies other health conditions, addiction, and social conditions if left unchecked or untreated. Kentucky continues to see problems with addiction and overdoses related to substance misuse. Kentucky sees the harm created by restricting coverage for mental health conditions as compared with other medical and surgical conditions. The 2021 Regular Session Prefiled Bill Request (BR) 61 legislation requires insurers to audit its procedures for deciding nonquantitative treatment coverage and limitations for all health conditions. The Department of Insurance has the expertise to assist insurers in compiling the information for an annual report.

Sheila A. Schuster, Ph.D. Licensed Psychologist, Executive Director, Kentucky Mental Health Coalition, stated that there have been problems with equality in coverage for behavioral health or mental health, and substance use disorders for many years. The Medicaid program did not cover substance use disorders for anyone, other than pregnant women or youths served through early and periodic screening, diagnosis and treatment (EPSDT), until 2014 when coverage was required by the Affordable Care Act. Stigma is the leading cause for people not to seek treatment for mental health issues. Many people are reluctant to continue treatment because the copays for behavioral health issues care are higher than other health services.

Dr. Schuster stated that in 1998, the behavioral health community began working on legislation to correct the issue. In 2000, Regular Session House Bill 268, AN ACT relating to mental health and substance abuse, was passed. The Kentucky Mental Health Coalition continued to monitor and ensure that insurers were following the parity law. Kentucky, along with the insurers, have continued to struggle to know how to make parity work in terms of the limitations on visits, cost-sharing, and medical network adequacy. In 2018, the American Psychiatric Association took on the issue of parity to bring it to the attention of legislators nationally. The Kentucky Mental Health Coalition is ready to work with legislators and the Department of Insurance to make sure there is full equality for behavioral health. She stated that as a preventive measure to enact this legislation so that people who have coverage have access to services without barriers.

Tim Clement, MPH, Director of Legislative Development, American Psychiatric Association, stated that President George W. Bush signed the Mental Health Parity and Addiction Equity Act into federal law on October 3, 2008. The law was designed to make insurance coverage for mental health and addiction no more restrictive than insurance coverage for other medical conditions. He stated that the concept was simple but the law itself extraordinarily complex. States have jurisdiction over individual and group policies sold by insurers. State and federal regulators consistently find non-compliance with insurers' managed care practices regarding prior authorization and other utilization controls, provider network design and maintenance, and medication access. Insurers struggle because of how complicated the law is and not intentional non-compliance. In November 2017, President Trump's Opioid Commission recommended that states collect information from insurers about their managed care practices. A key recommendation from the final report was implementation of the federal parity law was that states should collect data from insurers on how they apply the managed care practices and if that complies with the law. The term used in the federal parity law is non-quantitative treatment limitations. The parity law does not cost the state any money.

Mr. Clement stated that BR 61 is not about new coverage but ensuring compliance with the existing law. BR 61 requires insurers to submit comparative analyses about how they design and apply managed care practices for compliance. BR 61 should not be difficult for insurers because the federal parity law is a comparative law. Insurers would not know

if they are in compliance without doing comparative analyses. BR 61 is asking insurers to submit work that should already be completed.

DJ Wasson, Deputy Commissioner, Department of Insurance (DOI), Public Protection Cabinet, stated that BR 61 is an issue that DOI starting discussing early in 2020. DOI's review of insurers' practices have been focused primarily on reviewing the benefit language, reviewing the cost-sharing in plans, and responding to consumer complaints. The approach of getting an annual report will allow DOI to do analysis of the business practices of insurers upfront and to compare trends across the marketplace. DOI thinks that BR 61 would be very helpful in its ability to determine compliance.

In response to questions and comments from Representative Gibbons Prunty, Representative Moser stated that BR 61 requires a report and an audit from insurers. BR 61 would not affect payments regarding prescriptions or claw-backs to medication-assisted treatment programs.

Adjournment

There being no further business, the meeting was adjourned at 2:51 PM.