

## BEHAVIORAL HEALTH TAC REPORT TO THE MAC – MARCH 26, 2015

Good morning. I am Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on March 12, 2015. All five (5) of the Medicaid MCOs and their Behavioral Health representatives were in attendance. In addition to the MCO representatives and the four of our six TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition. We also had staff from the KY Department for Medicaid Services and representatives from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, including the Medical Director.

A copy of the Behavioral Health TAC report presented to the MAC on January 22, 2015 was disseminated and briefly reviewed.

In the invitation to the MCOs to attend the March TAC meeting, a request was made for them to provide the following information:

- We would like an update from each MCO and from DMS on the progress to date for reducing the use of psychotropic medications for children, especially those in foster care.
- PRTF providers indicate that they are continuing to see children discharged before they are ready (due to denial for additional days by the MCO) and then the children are re-referred and/or readmitted. What is the data that has been reported by each MCO to DMS for 2014 regarding readmissions to psychiatric hospitals and to PRTFs?

Dr. Allen Brenzel, Medicaid Director for DBHDID, began the discussion on the issue of psychotropic medications for children. Under the leadership of Dr. John Langefeld, Medicaid Medical Director, this issue has been – and continues – to undergo significant scrutiny. In addition to the data provided by the MCOs and the claims data that Medicaid has, there will be additional research conducted by UofL aimed at prescribers. The goal is to interview prescribers to determine that factors contributing to the problem. Is it a lack of resources and access to other treatments or interventions? Is there adequate training of prescribers in this area? Is it influenced by parental expectations? By input from educational settings?

In addition, each of the MCOs is doing a Performance Improvement Project (PIP) in this area and each described their project, which included data-gathering and then an intervention to try to reduce the use of psychotropic medications for children. Each of the MCOs collects their data so that it can be differentiated for foster children, who have a higher rate of prescriptions and more polypharmacy. Dr. Brenzel pointed out that each MCO's PIP presented a "laboratory" to test various interventions so see which might be the most effective. This information would then be disseminated among all of the MCOs. Dr. Brenzel suggested that he and Dr. Langefeld would be available to present their data to date to the TAC at a future meeting, and there was widespread interest in having that presentation.

Each of the MCOs then responded to the question about discharge and readmission data. Some were able to give the information, broken out by children vs. adults and some were not prepared to do so. The data is difficult to analyze, as it is largely reported as claims data and there is a lag in getting and recording the data. It appears from the discussion that the number of admissions that are denied by the MCOs is small, but the number or %age of readmissions is difficult to

determine. A question was raised about the “industry standard” for readmissions to an inpatient acute hospital setting for a Medicaid population and for a non-Medicaid population. This will be researched and brought back to the TAC at our next meeting.

A question that had been asked previously about access to Abilify when it comes on the market in generic form (projected in April) was discussed. All of the MCOs will follow the CMS rule to use the generic form, unless specifically directed otherwise by the prescriber. Passport and Humana will not have a Prior Authorization (PA) for the generic Ability, while the others will.

Another issue that had been discussed previously regarded the NCIC coding and whether previously-billed services would have to be resubmitted to the appropriate MCO. DMS has sent out one memo on this issue and another memo is expected. It appears that some of the MCOs are requiring rebilling and some are not – a situation which is difficult for behavioral health providers, most of whom have contracts with all five MCOs.

A new issue was discussed which involved inconsistent communications about the rate for Intensive Outpatient (IOP) services. DMS has stated that the rate is \$58.26/day. However, providers have also been told that this was in error, and that the rate is \$174.78/day in the SPA. This latter rate makes more sense, as IOP is provided for 3 hours/day, 4 days/week. It is not financially feasible to provide IOP for the \$58.26/day rate!

The Behavioral Health TAC agreed on these recommendations to be submitted to the MAC:

**RECOMMENDATION:** In order to expedite the work of the TAC, that the Behavioral Health TAC be provided a copy of the Commissioner’s data binder at each MAC meeting, as it is presented to the MAC members.

**RECOMMENDATION:** That the rate of \$58.26/day for Intensive Outpatient (IOP) services be revisited, as it appears to be in error. This would appear to be the rate for one (1) hour of service, while IOP is, by definition, at least three (3) hours of services.

The Behavioral Health TAC also agreed that these recommendations previously submitted to the MAC, but when no action could be taken on them because of a lack of a quorum at the MAC meeting, should be resubmitted:

**JANUARY 22, 2015 MAC MEETING:**

**RECOMMENDATION:** That the NCCI billing edits issues be resolved quickly, with a standardized implementation timeframe and with a minimum of administrative burden on providers.

**RECOMMENDATION:** That data from the MCOs reported on the DMS dashboard be made available to the Behavioral Health TAC, specifically: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage Denials for each behavioral health service: inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units; and HEDIS measure reported by each MCO of ambulatory follow-up post discharge from acute level of

care. We request that the data in each instance be separated by children (up to age 18) and adults.

**RECOMMENDATION:** That the data being used by Dr. Langefeld for addressing the “Super-Utilizers” of the ER be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That DMS work with the Behavioral Health TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

**RECOMMENDATION:** That the enrollment numbers of members across the MCOs be shared with the Behavioral Health TAC.

**RECOMMENDATION:** That a date certain be established for making the ABI waiver slots actionable and be communicated to the Behavioral Health TAC and the IDD TAC.

**RECOMMENDATION:** That all of the MCOs communicate with DMS and with the Behavioral Health TAC their policy with regard to access to Abilify in its generic form (expected date: April 1st). Will prior authorization continue to be required for each member for whom it is prescribed?

**NOVEMBER 20, 2014 MAC MEETING:**

**RECOMMENDATION:** That DMS work with the BH TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

**RECOMMENDATION:** That the NCCI billing edits inconsistency be resolved quickly.

**RECOMMENDATION:** The Hospital recommendations were reviewed and the Behavioral Health TAC is endorsing these recommendations: To waive the IMD Exclusion; To have the MCOs report on admissions to psych hospitals, re-admissions, Lengths of Stay in psych hospitals, and denials of IOP and Partial Hospitalization services.

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.

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TO THE MAC – JANUARY 22, 2015**

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**BEHAVIORAL HEALTH TAC RECOMMENDATIONS TO THE MAC –  
MARCH 2015**

**On March 12, 2015, the Behavioral Health TAC agreed on these recommendations to be submitted to the MAC:**

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## Children's Health Technical Advisory Committee

Presented on March 26, 2015

Hello, my name is Tara Grieshop Goodwin and I am serving as the new chair for the Technical Advisory Committee for Children's Health. Our TAC met on March 11 with DMS staff, MCO representatives, and most of the members in attendance.

The Children's Health TAC has been looking at a number of issues, including behavioral health, children who have aged out of foster care, and the use of psychotropic medication for children.

At our March meeting and in previous meetings, we have discussed various reports on behavioral health. DMS staff reported that the behavioral health information we have been receiving at each meeting was going to be reformatted and was not good data for analysis. We understand it will be several months before new reports are available.

The TAC also heard information from each of the MCOs about their PIPs currently underway related to children. We will continue to monitor progress on the common PIP on psychotropic medications among children, especially.

The Children's Health TAC has also been interested in data on grievances and appeals, as well as the outcomes of appeals, for children. While we understood that data was possible to access, DMS shared at the March meeting that it is not available separated out for children.

The Children's Health TAC has also discussed the new provision of the ACA regarding former foster youth eligibility for Medicaid. We understand that foster youth are being enrolled in Medicaid before they age out of care. The TAC has discussed ways we can implement automatic renewal/recertification each year to help this high-risk population keep their medical coverage. Many former foster youth experience greater chronic health issues and need ongoing care, and this could be interrupted if automatic renewal is not in place.

The TAC will continue to assess what data we have and will continue to try and secure quality data.

Thank you for your time this morning.

**Children's Health Technical Advisory Committee Meeting**  
**James F. Thompson Conference Room**  
**275 East Main Street**  
**Frankfort, Kentucky**  
**January 14, 2015**  
**2:00 p.m. EST**

TAC members in attendance: Chair Mary Burch, Tara Grieshop-Goodwin, Dr. Charlotte Haney, Dr. Jessica Korhonen, and Dr. Kelli Whitt.

Managed Care Organization (MCO) representatives in attendance: Beth Goodin, Carolyn Kerr, Liz McKune, David Hanna and Marcelline Coots, Passport Health Plan; Lee Ann Magre, WellCare; Peg Patton, David Crowley, Mary Maupin and Matt Fitzner, Anthem Blue Cross-Blue Shield; Kimberlee Richardson and Dr. Fred Tolin, CoventryCares; Pamela Lawless, Humana-CareSource .

Medicaid staff in attendance: Stephanie Bates, Cindy Arflack and Becky Walsh. Others in attendance: Stephen Lin, Maria Hafer and Dennis Yaste with Kentucky Youth Advocates; Dr. Julia Richerson with AAP-KY.

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The meeting was called to order by Ms. Burch, Chair. Introductions were made by those in attendance.

Approval of Minutes:

A motion was made by Dr. Haney and seconded by Dr. Korhonen to approve the September 10, 2014 meeting minutes. Motion passed.

Elect Chair and Co-Chair:

A motion was made by Ms. Burch and seconded by Dr. Haney to approve Ms. Grieshop-Goodwin as Chair and Dr. Korhonen as Vice-Chair. Motion passed unanimously.

There was discussion about the availability of telephone conferencing at future meetings for those members who are unable to attend meetings but the member(s) appearing by phone would not count towards a quorum. A motion was made by Dr. Korhonen and seconded by Ms. Burch to amend Section III-C of the Bylaws to read: A quorum for any meeting of the TAC shall consist of half of the appointed members plus **one**. The number "ten" will be omitted from the Bylaws. Motion passed.

Ms. Grieshop-Goodwin also suggested that TAC designees be involved in all communications.

Cabinet Updates on Medicaid & KCHIP:

Ms. Arflack reported that former foster care children have to recertify every twelve months. Ms. Bates stated that is no way to access the information requested concerning the number of former foster youth **ages 18 to 26 that are now eligible for Medicaid that weren't eligible before the Affordable Care Act**. Ms. Arflack noted that everybody has a different status code and there is not a different status code for this population.

Ms. Bates noted that information was furnished to the TAC concerning the Performance Improvement Project (PIP) that all MCOs are involved in on the topic of Appropriate Use and Management of Antipsychotics for Children and Adolescents. A spreadsheet concerning the CMS 416 data was also furnished to the TAC.

Ms. Bates stated that DMS and the MCOs have begun an oral health initiative that is very general and preliminary at this point, and she will have more to report at the next meeting. Dr. Haney noted that on January 31<sup>st</sup>, **a meeting will be held in Lexington on Children's Access to Care that will involve oral health issues**, and she asked Ms. Bates to let her know if there are any updates on this oral health initiative prior to the upcoming meeting. Ms. Arflack stated that DMS would supply to the TAC the MCO quarterly updates on this initiative.

Ms. Arflack announced that Medicaid Commissioner Lawrence Kissner will resign effective February 1<sup>st</sup> and Ms. Lisa Lee will be the new Commissioner.

Review Reports from DMS:

**Ms. Arflack discussed the Children's BH Report for October and November, 2014 and stated these** are claims-driven reports. The report does not include denials but Ms. Arflack stated when that report is available, it will be furnished to the TAC.

Ms. Grieshop-Goodwin asked about the status of the request concerning a special run being done just for children on prior authorizations and appeals. Ms. Arflack stated DMS is still combing through the report and she will furnish it to the TAC as soon as the review is completed.

Dr. Richerson asked if there were other PIPs being done that impact children's health. **Ms. Bates stated that** there are new focus studies being done on childhood obesity and medically fragile children.

**Anthem reported that they are working on PIP's concerning psychotropic medications and reducing** emergency room rates, especially for the adult population. On oral health, Anthem only picked up children in July. Effective January 1, 2015, Anthem changed dental providers from Scion Dental to DentaQuest. Anthem is working on the no-show codes and reimbursing screenings through the Department of Health for children and for fluoride treatments as well.

Mr. Crowley reported that fifty-nine foster care children are currently assigned to Anthem. Of those, one is receiving acute psychiatric services and three are receiving residential services. Three of those foster children are on three or more psychotropic medications and two of those are on four or more psychotropic medications.

CoventryCares reported that they are working on a PIP addressing children with ADHD and educating families on contract therapy and medication interventions. There are over 5,000 foster care children enrolled with CoventryCares.

Dr. Fred Tolin addressed the oral health issues and stated that are identifying their membership in two groups - children under the age of five who are eligible for services but have not had appropriate treatment such as fluoride varnishes and children six and older who have permanent teeth and are looking at sealant rates for this age group. CoventryCares is addressing network adequacy by utilizing dental hygienists who are in place with Public Health Departments and by using primary care physicians for fluoride varnishes.

Humana-CareSource reported that they have 149 foster care children enrolled. One is out of state acute care and three are in-state acute care. Ms. Lawless stated she is working on children with polypharmacy and antipsychotics.

Passport reported that are looking at under-utilization of psychotropic medications for those children who are not getting prescriptions filled in a timely manner, as well as over-utilization of these medications. A new PIP has been added on reducing re-admissions of postpartum members.

WellCare reported that the PIPs they are working on are the reduction of emergency room usage, ADHD medication administration and adherence and follow-up after hospitalization requirements for appointments within seven days. Ms. Magre noted although these may not be PIPs, the MCO has done work around asthma, obesity, COPD, diabetes and neonatal care and postpartum.

For foster care and adoptive children, Wellcare has over 6,100 children enrolled. A focus study is in development around foster care utilization of acute and sub-acute and PRTF level-of-care and the rapid re-admissions going on with that. WellCare will launch another focus study on foster children and their care gaps.

Ms. Magre requested that if the TAC has specific items they would like the MCOs to bring to the meetings, to let them know ahead of time. Ms. Arflack said PIP updates would be on future agenda items, and if TAC

members have other items they want the MCOs to address, they should get that information to Ms. Arflack or Ms. Gullion and they will forward it to the MCOs.

General Discussion:

Dr. Richerson asked if community health workers are approved in a State Plan Amendment (SPA) to get reimbursed and Ms. Arflack said DMS is working on this issue. Dr. Richerson also asked about the status of **the asthma educator issue and Ms. Bates stated that the Medicaid Commissioner's Office** is still working on this issue.

Dr. Richerson asked what the best forum is for working with all the MCOs at one time when there are child advocacy issues to be addressed. There was discussion that these types of issues can be brought to the TAC who could then make recommendations to the Medicaid Advisory Council (MAC). It was suggested that this topic be discussed at the next TAC meeting.

Discuss Recommendations to MAC:

There were no new recommendations to be made to the MAC.

Next Meeting Date:

The next meeting will be March 11, 2015, 2:00 p.m. in the James F. Thompson Conference Room, CHR Building. The November 11, 2015 meeting date is changed to November 4, 2015.

A motion was made by Ms. Grieshop-Goodwin and seconded by Dr. Haney to adjourn the meeting.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this 16<sup>th</sup> day of January, 2015.)

## **DENTAL TAC RECOMMENDATIONS TO MAC**

### **03/26/2015**

1. Some dental providers have provided services to Medicaid recipients in good faith after verifying on both the KYMMIS and MCO websites that the recipient is eligible and participating with said MCO. Copies of these eligibility verifications were saved by the provider. DMS then retro-terminates the recipient, so the MCO does not pay the provider despite several appeals, presenting his documentation that he has followed the rules. The MCO states that the provider cannot be paid due to the retro-termination.
  - Recommendation – The TAC recommends that this be a matter between the MCO and DMS. The provider should be paid and not penalized when he provided services in good faith and followed all the guidelines for verifying patient eligibility. The only entity suffering in this scenario is the provider. He should be made whole.
  
2. Oral pathologists at the University of Louisville and the University of Kentucky have not been paid for services provided to Medicaid recipients since the inception of MCOs in the state. UK representatives state that they are owed in excess of \$3Million. U of L's outstanding claims are less, but still significant. No MCO has paid them, claiming a "quirk" in the wording of the regulations that does not authorize payments. The TAC does not believe that the regulations were intended to have victims of oral cancer going undiagnosed.
  - Recommendation – The TAC recommends that DMS and representatives from each MCO meet with the representatives from both UK and U of L to resolve this matter. In addition, regulations impacting the payment for oral pathology services should be clarified so that this will no longer be an issue going forward in the new contracts.

## DENTAL TAC RECOMMENDATIONS (01/22/2015)

1. It has been reported to the TAC that one of the MCO Dental subcontractors is reporting dentists to the National Practitioner Data Bank (NPDB) when the dentist decides to no longer participate in the plan, but fails to notify the plan in writing. **And providers have not been notified of this tactic.** Most are too busy trying to comply with ever-increasing rules and regulations to write an additional letter. They just stop seeing the patients covered by the plan. This use of the NPDB is a bastardization of the intent of the Bank. Failure to file paperwork has nothing to do with the clinical practices and actions of the provider. The NPDB is supposed to be a repository of claims and malpractice actions against providers. The TAC recommends that DMS have the plan cease and desist from these reports to the NPDB. Terminating the provider from the plan and no longer processing his or her claims is sufficient sanction for failure to submit paperwork.
2. It is the understanding of the TAC that the MCO Dental subcontractors are required by contract to have a Kentucky licensed Dental Director . This is not the case for each MCO plan. The TAC recommends that DMS review this contractual requirement and mandate any necessary changes. In addition, the TAC requests that these state-licensed dental directors participate in the quarterly TAC meetings as well as the monthly Medical Directors meetings.

# Home Health Technical Advisory Committee Meeting 1/21/15

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## **Technical Advisory Committee Members present:**

Billie Dyer- KY HomeCare Association  
Sharon Branham- KHCA  
Rebecca Cartright- KHCA  
Susan Stewart- KHCA/ARH

## **Department for Medicaid Services staff present:**

Erin Varble- Division of Community Alternatives- Director's Office  
Gregg Stratton- Division of Community Alternatives- Branch Manager- HCBS Branch  
David McAnally- Division of Program Quality and Outcomes  
Earl Gresham- Division of Community Alternatives- Assistant Director

## **Managed Care Organization Representatives present:**

Holly Garcia- Coventry  
Matt Fitzner- Anthem  
Mary Hieatt- Humana Care Source  
Pat Russell- Wellcare

## **Others present:**

Carmel Comendador- Deloitte  
Angela Morgan- Deloitte  
Pam Smith- HP  
Tracy Treat- Carewise Health  
Nikki Martin- HP  
Arianna Afshari- KHCA

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The Home Health Technical Advisory Committee met on January 21, 2015 at 11 AM. Meeting was chaired by Sharon Branham, KHCA.

- I. Meeting was called to order.
- II. Introductions were made.
- III. Have a special guest speaker. Angela Morgan and Carmel Comendador from Deloitte to speak about the Medicaid Waiver Management Application (MWMA) training. (see presentation handout)
  - a. Collaboration between CHFS and KY Dept. for Health and Information Technology.
  - b. Two different release dates: Spring and winter 2015. 1<sup>st</sup> release will be April 17, 2015.
  - c. Classroom training will be available all over KY for 9 weeks beginning in February. Online training available as well.
  - d. This program will be used for online assessments, CDO budgets, waiver applications, etc. This has nothing to do with the HCB Final Rule.
  - e. Sharon encouraged everyone to sign up for trainings.

# Home Health Technical Advisory Committee Meeting 1/21/15

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- f. Have a mailbox set up for any questions you have. Will sent PowerPoint to Erin to send out with minutes.
  - g. Application will be used by all levels of people. Will be in correspondence with KYNECT in an effort to have single portal for Waiver applications.
  - h. Ultimately reduce paperwork, "Real time" access to documentation. Person centric system- guiding principles for the application.
  - i. Patients, Guardians will be able to access POC on the portal- on second release.
  - j. Families will eventually be able to apply for waiver services, SNAP, Medicaid services online.
  - k. Eventual integration with Enterprise Systems- will interface with records.
    - i. Some paper forms will still be used and then uploaded to the system.
    - ii. Providers will need to invest in scanners.
    - iii. System accepts PDF's, TIF's and TIFF's.
  - l. Will have some dual documentation if provider has own filing system.
    - i. This system will become the norm, and will have to be used.
  - m. Families, Case Managers, Providers will be able to track waiver status in real time. Forms will be available to view immediately.
    - i. Keep people informed of key elements in waiver application process.
    - ii. Does have all the needs of a web based application- must have internet access.
  - n. Classroom Trainings- 2 day course. 16 hours a day. Mon-Tues or Thurs.- Fri.
  - o. Reserved computer labs in all 9 DCBS regions for trainings and simulations.
    - i. 14-20 seats in each class.
    - ii. Still finalizing the rosters, will release in next few weeks.
  - p. Training itself is free- cost would be for any travel only.
  - q. Sharon- Can they set up training in March, in Lexington, to catch the people who can't make currently scheduled trainings?
    - i. Currently scheduled to train every week from February to first week of April. Hopefully that will cover everyone.
  - r. ECU will be hosting the online courses and simulations.
    - i. ECU has access to the 300 page manual.
  - s. Learn more at MWMA web page on the CHFS website.
  - t. Overall life cycle of the process.
    - i. Software will take into consideration personal preferences when it comes to which waiver a person applies/qualifies for.
    - ii. Possible issues with Conflict Free Case Management.
      - 1. Appears that the Case Management agencies and providers of care are the same?
      - 2. Who should Sharon contact about this?
    - iii. Earl to provide a list of case management agencies.
      - 1. List of 150-200 CMA's
      - 2. How do you get on this list?
- IV. Motion to accept minutes- Accepted, seconded.
- OLD BUSINESS**
- V. Enrollment of Private Duty Agencies:
  - a. Currently no new providers.
- VI. Updated enrollment fo Public Health Department Home Health Agencies.
  - a. Billy's group been working on getting contracts with MCO's.

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- i. Health Departments usually go through Department for Public Health.
  - ii. Independent providers can contact liaison's to do contracts.
  - iii. MCO's submit contact information to Sharon for people to contact for contracts.
- VII. Welcare follow up regarding information Pat Russell was researching:
  - a. Discharge planning and authorization in place for PA.
    - i. Not true. Some confusion around QE. Situation didn't have HH on discharge form.
  - b. Limits on normal saline.
    - i. No one should ever reach that limit- Pat Researching further
  - c. Supply co-pays.
    - i. All claims have been reprocessed.
  - d. Codes for ulcers. Why denied?
    - i. Requested more information. Code depending on where ulcer is on the body.
  - e. Therapy visit limits/no limits.
    - i. All based on medical necessity.
  - f. Skilled Nursing limits?
    - i. Medical necessity.
    - ii. Private duty nursing is different- have to check the regulation.
- VIII. Wellcare Follow up to requested contracts for DME providers.
  - a. Have reached out, currently in communication.
- IX. Carewise follow up for PRO for HCBW requiring assessments prior to submission of financial information.
  - a. One time glitch? Nothing has changed in the procert process.
- X. EOB required for Medication Prefills? Any Resolution?
  - a. Holly to check on it. Sharon to get info to Holly.
  - b. May have been a human error.
- XI. Therapy Limis (Coventry) in-patient and out-patient.
  - a. No limits for HH Services. Doesn't combine.
- NEW BUSINESS**
- XII. Limits for KY Benefit Limits 25 per calendar year?
  - a. Info to Pat. Soft Limits?
- XIII. WellCare- not sending Authorizations.
  - a. Info to Pat.
- XIV. Requirements for who completes a Prior Authorization.
  - a. Clerk or a nurse. Who faxes PA's?
  - b. Does this really matter?
- XV. Dates for authorization not matching with request (dates requested)
  - a. Human Error. Lack of communication.
- XVI. Carecore not providing Prior Authorizations (PA numbers but no PA in writing with both EPSDT and PT)
  - a. Locate Pediatric form-not online
- XVII. Slow PA (wellcare and Anthem)
  - a. Really long time on the phone (up to 2 hours). Then still don't get anywhere.
  - b. Get denied because they didn't get the PA on the day the care started.
  - c. Online process doesn't work or takes ridiculous amount of time to see if PA will go through.

# Home Health Technical Advisory Committee Meeting 1/21/15

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- d. Goal is 2 days at the max.
- e. Submit them online, but then try to speed them up by calling as well. Still takes 2-3 hours.
- XXVIII. Susan- Anthem- Denied supplies.
  - a. Any supplies used by nurse in home, cannot leave extra wound care supplies in the home.
  - b. Says client must go through DME.
  - c. Violation of CON?
  - d. Susan to get info to Anthem.
- XIX. Billy- Holly to call Billy/Tara about codes/billing/collections.
  - a. Billy to email info to Holly.
- XX. Billy- Issues with Diagnosis of sensory integration disorder.
  - a. Resolved once, now resurfaced. Insufficient scientific evidence.
- XXI. Billy- EPSDT- denials for therapy- in home vs. outpatient therapy.
- XXII. Billy- Wellcare- EPSDT special services- find a pediatric form online.
  - a. Can't find anything.
  - b. Can't be more than 7 days old, but can't be faxed in more than 7 days before.
  - c. Authorize for max 30 days. Not enough visits.
- XXIII. Letters from DMS- Mass Adjustments
  - a. Sheila and Mary Ann are taking care of this, result of the Pickle Amendment.
  - b. Letters come from Lee Guice's department. Not all letters have been sent out.
  - c. Send all claims to Mary Ann, she does a mass adjustment, then refund is send to provider. Provider to send refund to client.
  - d. Refunds to go into a spend-down account or something to keep them from being kicked out of Medicaid eligibility.
  - e. Sharon to contact Lee and Sheila about the Pickle amendment.
- XXIV. DCBS 1-855 number. Still doesn't work well. Wait time is way too long.
- XXV. Sharon wants to invite Leslie Hoffmann, new Director for Community Alternatives to TAC meetings. Would like to meet her.
- XXVI. Ellenore went to Program Integrity end of November 2014. New ADHC nurse, Beth Coffey, started beginning of January.
- XXVII. HB 144- Presumptive eligibility for HH. Several meetings scheduled. Going to tighten up the language.
  - a. Expand Home Care and reduce Nursing home costs.
  - b. Within 10 days of referral.
  - c. Significant cost reduction for those states who have implemented this same plan.
- XXVIII. Meeting dates:
  - a. January 21<sup>st</sup>
  - b. March 25<sup>th</sup>
  - c. May 27<sup>th</sup>
  - d. July 22<sup>nd</sup>
  - e. Sept. 23<sup>rd</sup>
  - f. Nov. 18<sup>th</sup>
  - g. Dates subject to change.
- XXIX. Anthem- Duplicate authorization letters.
  - a. Skilled and Therapy letters. No concerns being voiced at the moment.
- XXX. Adjourned.

## **Home Health TAC Recommendations to the Medicaid Advisory Council**

January 22, 2015

Recommendation: DMS staff be present at the Home Health TAC meetings to respond to questions on the agenda, expedite conversations and achieve needed resolutions.

Recommendation: Letter from Veronica Cecil, Chief of Staff, DMS, be further explained in detail to home health agencies providers regarding the EPSDT provider numbers becoming useless and instruct agencies on how to either terminate or leave off the provider number from the Disclosure Of Ownership form.

Recommendation: DMS provide a step by step plan of activity related to the Pickle Amendment and inaccurate liabilities collected by home health agencies as not to harm the continuing services of waiver patients.

Recommendation: Deloitte presentation is clarified as to the purpose of training for home health agencies and other providers as well as definition of Case Management Agency language.

Recommendation: That the Cabinet consider the HB 144 related to presumptive eligibility of patients entering home health for traditional services or waiver services to expedite care and prevent providers from having to wait, at times, weeks for approval of services prior to delivering needed care.

Agenda: March 13, 2015

Deloitte update: training/case managers

Final Rule update (independent case management)

Participant Directed Services (PDS): anything new? In transition plan?

Employment costs for PDS. (re: PDS representative as Employer of Record?)

MPW (status): New waiver being written?

*Participant will always be the employer.*

Allocation letters/number of slots?

HCBS waiver: submitted to CMS?

*Apr. 1st*

Pickle amendment FAQ sheet? Did it get posted?

*D*

*A*

A Technical Advisory Committee on Intellectual and Developmental Disabilities consisting of nine (9) members,

One (1) of whom shall be a consumer who participates in a nonresidential community Medicaid waiver program; **VACANT**

One (1) of whom shall be a consumer who participates in a residential community Medicaid waiver program; **VACANT**

One (1) of whom shall be a consumer representative of a family member who participates in a community Medicaid waiver program; **-CHRISTAN STEWART**

One (1) of whom shall be a consumer representative of a family member who resides in an ICF/MR facility that accepts Medicaid payments, all of whom shall be appointed by the Governor. **VACANT?**

One (1) member shall be appointed by the Arc of Kentucky **PATTY**

One (1) member shall be appointed by the Kentucky Council on Developmental Disabilities. **VACANT?**

One (1) member shall be appointed by the Kentucky Association of Homes and Services for the Aging.

**VACANT- TIM VENO INQUIRED AS TO HOW TO FILL THIS POSITION. -Chris Stevenson.**

Two (2) members shall be appointed by the Kentucky Association of Private Providers.

One (1) of whom shall be a nonprofit provider. ~~CHRIS STEVENSON~~

One (1) of whom shall be a for-profit provider. **JOHNNY CALLEBS**

**LOOKS LIKE WE HAVE 5 VACANCIES. IF I HAVE ANYONE IN THE WRONG PLACE, PLEASE LET ME KNOW, THIS WAS THE LAST UPDATED VERSION I HAD. I HAVE APPLICATION OF ONE PERSON WHO IS INTERESTED IN BECOMING A MEMBER FOR THE NON-RESIDENTIAL COMMUNITY MEDICAID WAIVER PROGRAM. (I THINK)**

*Patty | Chris*

*Chastity Ross*

# Intellectual and Developmental Disabilities Technical Advisory Committee Meeting Minutes 3/13/15

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## **Technical Advisory Committee members present:**

Johnny Callebs- Independent Opportunities/ KAPP  
Chris Stevenson- Leading Age  
Patty Dempsey- Arc of Kentucky  
Chastity Ross- Bluegrass

## **Department for Medicaid Services staff present:**

Ann Hollen- Division of Community Alternatives- Behavioral Health Specialist  
Lori Kays- Division of Community Alternatives- KY Transitions  
Erin Varble- Division of Community Alternatives- Director's Office  
Sheila Davis- Division of Community Alternatives- MH/IDD Branch Manager  
Cynthia Lee- Division of Program Quality and Outcomes  
Gregg Stratton- Division of Community Alternatives- HCBS Branch Manager  
Lyris Cunningham- Division of Community Alternatives- MH/IDD Branch, Michelle P Waiver

## **Other State Staff present:**

Janet Beatty- Department for Developmental and Intellectual Disabilities (DDID)  
Justin Tapp- OSBD/GOPR  
Kelli Sheets- Department for Aging and Independent Living (DAIL)  
Tonia Wells- Department for Aging and Independent Living (DAIL)

## **Others present:**

Nikki Martin, RN- HP  
Pam Smith- OM Supervisor, HP  
Marylee Underwood- CCDD

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The Intellectual and Developmental Disabilities Technical Advisory Committee met on Friday, March 13<sup>th</sup>, 2015. Meeting was co-chaired by Patty Dempsey and Chris Stevenson.

- I. Meeting called to order.
- II. MAC meeting- Patty was there. Patty gave them copy of minutes and agenda and the handout Chris had brought to the November MAC meeting.
  - a. Discussed Pediatric assessment tool.
  - b. MAC gave a written response. : Must submit and get approval from CMS in order to develop such a tool.
    - i. As they write the new waivers, should include it in there.
    - ii. Is there a tool to include?
  - c. Currently depends on the worker on whether children get approved. Some say all kids qualify, some say the tool is N/A and deny all children.
  - d. Sheila- Looking at several tools, and in the process of deciding.

# Intellectual and Developmental Disabilities Technical Advisory Committee Meeting Minutes 3/13/15

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- i. One is currently in trial basis.
    - ii. Have to take money into account; there is always a cost for these assessment tools.
      - 1. Does that cost go to the case management agency, state pay?
      - 2. ICAP is about \$5 per assessment.
    - iii. SCL renewal must be sent in to CMS by June of this year.
    - iv. MPW sent in August of 2016.
    - v. Then there is a comment period. Requests for Additional Information (RAI's)
  - e. Chris, would like to have TAC members present at the meetings regarding the pediatric assessment tool.
  - f. Second item: Create a separate waiver for Children.
    - i. Response- Beyond MAC.
      - 1. Cost lots of money, and collaboration between several state agencies.
      - 2. Would need to bring up in a budget year.
  - g. Sheila to send an email to Leslie and Earl about Chris wanting to meet to discuss a Pediatric Assessment tool.
  - h. Lisa Lee is the new Commissioner of Medicaid- may want to try her next, since already gone through MAC.
- III. Motion was made to accept minutes from previous meeting. Approved and Seconded.
- IV. Back page of handout. Concerning the members of the TAC.
  - a. Erin has received an application for someone interested in becoming a TAC member.
  - b. First 4 slots are appointed by the Governor.
  - c. Never found anyone in Governor's office that does the TAC.
  - d. Contact someone in Boards and Commissions.
  - e. Tim Veno contacted me about Terry's vacated position.
    - i. Chris taken over that slot.
  - f. Chastity Ross has taken the KCDD slot.
  - g. Chris and Johnny meeting about the KAPP slots; will update us next meeting.
  - h. If interested in applying for membership, candidates need to fill out application at the Boards and Commission's link: <http://governor.ky.gov/office/Pages/bc.aspx>
  - i. Been trying to find who in the Cabinet takes responsibility for TAC member applications.
    - i. Can find people for the MAC, but no one claims the TAC.
- V. Deloitte Update:
  - a. Presentation last meeting, trainings occurring all over the state.
  - b. Case management training.
    - i. All trainings are currently full- encouraging at least one member of their company attend the training.
    - ii. If unable to attend, there will be online courses available.
  - c. Patty invited Deloitte to attend the Arc's conference this coming week and do a presentation.
    - i. Ended up declining, they weren't ready to make presentation public yet.
  - d. Tonia- It is highly recommended that everyone use the MWMA system. It is not a requirement.

# Intellectual and Developmental Disabilities Technical Advisory Committee Meeting Minutes 3/13/15

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- i. What about in the future, when it houses all the waivers.
  - ii. System is not and will not be a universal medical record. Not set up to bill.
  - iii. Used to keep electronic case notes, PAs, etc. up to date and available to all case managers.
- VI. Final Rule update
  - a. Hand out that has dates of Final Rule forums. –Many cancelled due to snow. (see handout- Final Rule)
  - b. Presentation will be available online.
  - c. Draft Compliance plan template that will be sent to your facility. Then will be personalized for the agency based on the survey questions answers.
    - i. Now have an email box- [CMSFinalHCBRule@ky.gov](mailto:CMSFinalHCBRule@ky.gov)
  - d. Language from Federal Final Rule: “Providers of HCBS for the individual must not provide case management or develop the person centered plan, unless the provider is the only willing or qualified provider in the geographic area within 30 miles of the individuals residence.”
  - e. In SCL, there is still the relationship exclusion. The Final rule, will not allow that. Will have to be changed.
  - f. Will start drafting regulation in April. Will open up for comments. Hope to get implemented by November.
  - g. Not that the provider can’t provide both services, they just can’t provide the two services to the same individual. Unless you are the only provider within a 30 mile radius of an individual’s home.
    - i. Will have a transition period for everyone to get in compliance.
  - h. 2019 is when all of the Final Rule should be implemented.
  - i. Have a bunch of people from all different offices doing presentations at the Final Rule Forums.
  - j. Forum at the Brain Injury Alliance of Kentucky (BIAK) in Louisville, April 1<sup>st</sup>.
    - i. Regional training in April? In Glasgow. On calendar but no one definitive attending yet.
  - k. Patty attended a guinea pig session. They did a great job, went really well.
  - l. Service changes for children?
    - i. Doesn’t delegate services, more interested in the inclusion and the overall overview of what the programs are doing. How that is implemented will depend on the provider.
- VII. Participant Directed Services (PDS)
  - a. Cost of employment costs;
    - i. Always looking for more efficient ways for people to receive the services without the higher cost.
      - 1. Started out with 159 people utilizing PDS, now up to 222 people.
      - 2. Cost hasn’t stopped people from accessing the services.
- VIII. Employment cost for PDS. (re: PDS representative as Employer of Record?)
  - a. In PDS, the participant is ALWAYS the employer of Record.
  - b. May choose to have a representative help, but participant is still the employer with a representative.
  - c. Same for children, legal guardians. Child is the employer of record. Representative for client who cannot represent themselves.

# Intellectual and Developmental Disabilities Technical Advisory Committee Meeting Minutes 3/13/15

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- d. MAC response to our desire to create a fund in order to assist with these costs.
  - i. Individual must work within a budget. Items must be service related, and these costs are not.
  - ii. DMS cannot pay for these items with Medicaid funds.
  - iii. Maybe go to General Assembly next? Ask Cabinet to include this in budget?
- IX. MPW (status):
  - a. Waiting list is still growing, currently over 3800 members on waiting list.
    - i. In fall of 2014, about 3200.
  - b. Waiting on approval to send out next go round of allocation letters.
    - i. 250 slots to be sent out after July 1 or next waiver year.
    - ii. By end of March, will allocate 442 slots that were vacated, or never used.
    - iii. Grand total of 10500 slots will be available to MPW recipients.
  - c. Children- 70% of kids under 21.
    - i. 7 under the age of 1 yr.
    - ii. 710 are 1-5 yrs.
    - iii. 770 are 6-10 yrs.
    - iv. 607 are 11-15 yrs.
    - v. 513 are 16-20 yrs.
  - d. Can we request more slots? Growth of waiting list started on 2/15/14 has been enormous.
    - i. Must go through Legislature.
    - ii. Must take into consideration that no one is assessed before being placed on the MPW waiting list. Many of the 3800 on that list, will not meet LOC.
    - iii. Only CMHC's can submit the application, was hoped they would screen out people who wouldn't be a good fit for the MPW.
  - e. SCL and ABI applicants are screened prior to being placed on the waiting list.
- X. HCB waiver: Submit to CMS?
  - a. Will be submitted on April 1<sup>st</sup>.
  - b. Summary available online. <http://chfs.ky.gov/dms/>
  - c. Changes are available for viewing. 2 biggest additions are:
    - i. Personal Service Response: service like LifeLine for participants.
    - ii. Meals on wheels.
    - iii. Combined several services into one.
    - iv. Therapies have been moved to state plan. (regular Medicaid)
      - 1. Children cannot get therapies at an ADHC, they must be 21 and older.
  - d. All our waivers are 1915c Home and Community Based Waivers.
  - e. Anytime someone is in a waiver, they get the waiver services; they also get the state plan services.
- XI. Pickle Amendment:
  - a. Still working on the mass adjustments.
  - b. Few weeks ago, eligibility sent out another 500 letters.
  - c. No FAQ's on the website yet.
  - d. IF participant never paid their patient liability, then the agency keeps the refund.

# Intellectual and Developmental Disabilities Technical Advisory Committee Meeting Minutes 3/13/15

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- e. Chastity has a client that is about to lose services due to lack of payment for patient liability. Chastity to send info to Sheila and see if she qualifies for Pickle Amendment.
  - f. Named Pickle Amendment for its congressional sponsor.
  - g. When FAQs be available.
    - i. Hopefully within the next few weeks.
- XII. Able Act-Allow people with disabilities to create savings accounts in order to pay for certain items.
- a. Received legislation this year.
  - b. Still in the works. Would have a set monetary limit, and only be able to be used for certain things, pretty broad coverage.
  - c. MaryLee met with Kentucky Higher Education Authority to find out how their current 529 trusts operate. \$14,000 a year, total of \$100,000.
  - d. This new one would be a smaller monetary amount, tax free, doesn't count against client for Medicaid eligibility.
  - e. Medicaid pull back clause is included.
  - f. MaryLee to send Erin a FAQ sheet about the program.
- XIII. MaryLee- EPSDT issues
- a. It is NOT going away.
  - b. Eliminating EPSDT provider/billing numbers and giving them state plan provider numbers. In hopes to simplify billing.
  - c. EPSDT has been really struggling with PA's for therapy services.
    - i. Normally do it in 6 month blocks, now getting only 12 wks. At a time and not getting enough sessions.
    - ii. PT and OT specifically.
    - iii. MCO's going to see if they can extend the time frames.
  - d. EPSDT providers will need to apply for a regular Medicaid provider number by July 1.
    - i. PA's are being end-dated on 6/30.
  - e. If only service they provide is EPSDT, they will keep their EPSDT number.
  - f. Pam already has seen some clients transitioning from EPSDT to independent therapies.
- XIV. Next MAC meeting: March 26<sup>th</sup> from 10-12.
- XV. Adjourned

# Rescheduled Medicaid Waiver Changes

## Notice of Community Forums

Because of changes in federal rules related to Medicaid, Kentucky's Medicaid Waiver Programs will soon be undergoing numerous changes. Changes are intended to improve the lives of people with disabilities through better community living. Changes will be made over the next 5 years, and will apply to all waivers, including the Home and Community-Based Services, Supports for Community Living, Michelle P., Acquired Brain Injury & Acquired Brain Injury Long Term Care.

**If you are an individual with a disability or a family member, you are invited to a Community Forum to learn more.**

<p><b>March 5, 2014</b> 1-4:30 pm EST Capitol Annex, Room 113 702 Capitol Ave. <b>Frankfort, KY</b></p> <p><i>Cancelled Thanks to snow.</i></p> <p><i>This Forum is part of the HB 144 Commission Meeting. Other issues will be discussed first.</i></p>	
<p><b>March 17, 2015</b> 3-5PM EST Big Sandy Area Development District 110 Resource Court <b>Prestonsburg, KY 41653</b></p>	<p><b>March 26, 2015</b> 3-5PM CST Four Rivers Behavioral Health 425 Broadway Street <b>Paducah, KY</b></p>
<p><b>March 25, 2015</b> 3-5PM CST LifeSkills, Inc. 380 Suwannee Trail Street <b>Bowling Green, KY</b></p>	<p><b>March 31, 2015</b> <b>5-7PM EST</b> (Note different time) Florence Government Center 8100 Ewing Blvd <b>Florence, KY 41042</b></p>

**These forums will be an opportunity to learn and give feedback. There will be a presentation by representatives of the Kentucky Cabinet for Health and Family Services, followed by a group discussion.**

The forums are presented by the Community Integration Subcommittee of the Kentucky Commission on Services & Supports for Individuals with Intellectual & Other Developmental Disabilities ([HB 144 Commission](#)).

For more information about upcoming waiver changes, visit <http://chfs.ky.gov/dms/> or <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Sponsored by: The Commonwealth Council on Developmental Disabilities  
32 Fountain Place, Frankfort, KY 40601 ♦ [www.kyccdd.com](http://www.kyccdd.com)

**For more information or to request a disability-related accommodation, contact: [shelley.runkle@ky.gov](mailto:shelley.runkle@ky.gov) or (502) 782-8604.**

## MAC Recommendation

Jan. 22, 2015

### **Pre-authorization requirements for group home visits**

Currently, there are billing codes set aside for residents of nursing home and residential facilities that allow providers to bill for services within those settings (Domicillary/Nursing Home Code 99334-99337).

Under the MCO requirements, providers are required to obtain pre-authorization for visits to residents of group homes. Due to the nature of the patient load in these facilities, a provider may not know who needs to be seen prior to arriving at the facility. Facilities place the patient's name on the provider's list of those needing to be seen, and the provider is given a "facesheet" which may not have the correct MCO on the sheet; most often they simply have Medicare or Medicaid numbers listed.

Providers round alone and do not take support staff to those facilities and are unable to pre-cert a visit on those patients prior to being seen. If the facility does not have the correct MCO listed, there is a delay and a retro authorization may not be obtained because the provider is outside of the timely filing limit.

Mental health providers in these facilities are extremely rare. Adding a prior authorization requirement for these visits reduces access to care for the patients, and for providers, limits already low reimbursements.

The request is for Medicaid and the MCOs to not require pre-authorization for visits to group homes.

Medicaid Nursing TAC  
Recommendations  
March 20, 2015

1. It has come to our attention that WellCare is requiring nurse practitioners who practice in urban areas, but not rural areas, to have a supervising physician. The physician is also required to participate with WellCare.

Nurse practitioners (NPs) are not dependent providers and are considered Licensed Independent Providers. This requirement by WellCare is contrary to Medicaid requirements; is not consistent with Kentucky law; and appears to be arbitrary. No APRNs are required to maintain a prescribing agreement for non-scheduled drugs after four (4) years. Therefore, many NPs who are establishing practices do not have a prescribing agreement with a physician. The decision by WellCare to apply their rule to NPs who are not practicing in a rural area has no foundation in law or in the WellCare manual. Finally, and perhaps most significantly, WellCare is limiting access to care.

**Recommendation:**

WellCare not require APRNs to have a supervising or collaborating physician in order to credential with their company.

2. Enhanced payments for primary care  
Current Medicaid MCO reimbursement to all providers is very low and not sufficient to allow those providers to cover the overhead costs of providing care to participants. Well documented information is available that shows the Medicaid MCOs are making significant profits. Medicaid and Passport, the only non-profit organizations, have agreed to continue the enhanced payments.

**Recommendation:**

All MCOs continue the enhanced payments for primary care services and that APRNs and physicians be included in those programs.

3. We have been advised of a situation where a psychiatric “lock in” patient was assigned to a primary care provider who did not see patients in the outpatient setting and had not practiced in Kentucky since 2012. Therefore, the patient went without medication and eventually required hospitalization for suicidal ideation.

This situation is an example of the dire consequences that can occur when there is no process in place to verify that assigned providers are following locked in patients.

**Recommendation:**

Medicaid, and all the Medicaid MCOs, should be required to verify that locked in patients are assigned to a provider who is practicing in Kentucky and that the patient is receiving care. Patients cannot be forced to receive care, but at least the MCO or Medicaid should be required to contact locked in patients who are not presenting for regular visits.

Medicaid Nursing TAC  
Recommendations  
January 16, 2015

The Nursing TAC has been informed of multiple cases where the issuance of provider numbers with the Medicaid MCOs are delayed, after applications have been accepted, beyond reasonable time frames. One provider has been waiting since January 2014 for a provider number. Since the provider has been seeing patients in good faith, anticipating issuance of a provider number, those visits that are more than a year old will not be reimbursable.

Recommendation: The TAC recommends that DMS require the MCOs to issue provider numbers within 120 days of receiving a completed provider application.

Nursing TAC  
Recommendations Presented to MAC  
November 20, 2014

**Summary of Agenda Items:**

1. MCO Refund Requests

Many practices are receiving notices from the Medicaid MCOs requesting refunds for over payments. These requests arise after the MCOs audit their records and determine that overpayments have been made on regular visits or that the provider has been paid for more than two (2) level four/five visits. Some of the refund requests are for significant amounts. Practices run on a very tight budget and these unexpected requests for refunds could, in some instances, be enough to cause the practice to close. No one wins when that happens- not patients, not providers and not Medicaid.

It is almost impossible for providers to determine if they are being overpaid. The MCOs set their rates and the EOBs reflect the rate that the MCO has paid to the provider. The provider does not know that the rate recorded on the EOB is incorrect. Secondly, it is not possible for providers to determine if a patient has had more than two level four/five visits in a year.

2. Limitation on Level 4/5 Visits

Kentucky struggles to meet health standards (United Health Foundation, 2012). This is especially true with regard to chronic, complex health problems such as diabetes (41<sup>st</sup>), cardiovascular disease (43<sup>rd</sup>), premature death (44<sup>th</sup>), obesity (40<sup>th</sup>), and smoking (50<sup>th</sup>). Patients who have chronic problems require more attention and higher levels of scrutiny at health care visits. Kentucky providers are expected to provide evidence-based care and meet nationally accepted standards of care, or they will be penalized by the Physician Quality Reporting System (PQRS) if standards are not met. The Center for Medicaid and Medicare Services (CMS) has established national standards for level of care, documentation, and reimbursement for all patient visits. These standards are based on extent of history, physical examination, diagnosis, treatment and overall complexity of the visit. As previously noted, many people in Kentucky suffer from diabetes, heart disease, COPD and obesity. Providing appropriate care for these individuals is a Level 4 visit. While providers are required legally and ethically to provide the appropriate level of care to the patient and document that care, the situation created by this limitation continually forces providers to down code visits. The down coding results in inaccurate data on patient visits.

### 3. Physical Exams

Currently, Medicaid and the MCOs limit participants to one physical exam per year. Many people require more than one physical exam per year. This is particularly true for children who are required to receive school physicals and six months later may be required to receive a sports physical. Additionally, there are children who are placed in foster care who require a physical exam each time they are placed in a new home. There are a myriad of other reasons that a person may require more than one physical exam in a year's time. The requirements for some of the exams are different, so it is not a matter of providing a "one size fits all" exam.

Further, if the person has had a physical exam performed and billed by another provider, and the second provider is not aware of previous exam, the second provider's claim will be denied.

It was interesting to note that Anthem, in a recent DMS publication that compared the services of the MCOs, listed "Free annual sports physicals for members 6-18". This advertisement is encouraging parents to bring their child in for a sports physical, for which the provider may not be reimbursed.

### 4. Annual APRN License Renewal

Each year APRNs are required to renew their professional license. Nursing licenses expire on October 31 of each year. Medicaid requires APRNs to mail in notification of their license renewal via the postal service. If the notification is not received by DMS by November 1 of each year, the APRN is considered to have a lapsed license and therefore Medicaid patient prescriptions are denied at the pharmacy and payment claims are not accepted. Clearly, there are problems with this system. It is a huge waste of paper; 2000+ extra pieces of mail coming in to DMS in the month of October has to cause some sort of extra work and handling by staff; and mail can get lost. APRNs worry if their medication prescriptions will be accepted at the pharmacy on November 1, for there is no way to verify prior to that date if the license verification was received at the Medicaid offices.

### 5. Reimbursement

Kentucky is one of only four states that reimburse APRNs at 75% of the physician rate. The majority of states pay at 100%. If Medicare is the metric and pays at 100%, then private insurance pays 110-120% and Medicaid pays physicians at 73%. A 75% reimbursement rate for APRNs translates to 54.75% of the Medicare rate.

In order for APRNs to participate in Medicaid, the reimbursement rate must improve. Currently, APRNs receive about \$23.00 for a Level 2 visit, \$33.00 for a Level 3 visit, and about \$50.00 for a Level 4 visit (which are

limited to 2 per year). These fees are not sufficient to cover the overhead costs of running a practice.

The physician Medicaid rate of 73% is also a low national rate, and hasn't budged since 1993 (Jasper & Hunt, 2012). The Primary Care Medicaid Rate Increase, which applies only to physicians, will provide a temporary bump in payment in order to attract primary care physicians to Medicaid but will stop in 2015. In order to avoid a bait and switch fee system that leads to provider withdrawal and care disruption, Kentucky should consider adjusting the Medicaid physician reimbursement rate higher than the currently low 73% rate.

Low reimbursement levels have multiple bad effects—providers limit Medicaid patient caseloads, providers choose not to participate in Medicaid at all, or systems compensate by having providers just see more and more patients. Certainly it is part of the explanation for the fact that 63% of the primary care need is met in rural settings in Kentucky and that only 22% of primary care provider physicians accept Medicaid (Deloitte, 2012).

Lack of participation limits patient access. Lack of access to care leads to poor health outcomes and increasing health care costs. We are talking about increased hospitalizations, readmissions and use of the emergency room, which are significantly more expensive than outpatient visits.

## **Recommendations**

1. MCO Refund Requests
  - a. On the repayment of refunds, the TAC request that the payback period match the look back period; that payments retained by payers from future remits be equal to the total percentage of claims paid during the look back; and that payments not be withheld at 100% until fully refunded. This would aid with practice cash flows and not jeopardize the providers' ability to continue services.
  - b. The TAC requests that there be more transparency on rates paid to providers, with providers receiving a list of the reimbursement that the MCO is paying to that provider. MCOs should be required to honor the reimbursement rate noted on the EOBs sent to providers. The MCOs should not be permitted to decide two (2) years later that the fee paid and posted on the EOB was incorrect.

2. Limitation on Level 4/5 visits
  - a. The TAC requests a legal justification from DMS for limiting level four/five visits to two visits per patient per year, while at the same time requiring providers to meet nationally accepted standards in the provision of care.
  - b. If the limitation is to remain in place, the TAC requests real time notification from DMS or the MCOs that the patient has exceeded the two (2) visit limitation.
  - c. Does the two (2) level 4/5 visit restriction apply to any level 4/5 visits the patient may have had with any provider, or is it per patient, per provider, per year?
  
3. Limitation to one (1) annual physical per year
  - a. The TAC requests a report of claims denied for well child annual visits because an exam was already done.
  - b. Is the limitation per calendar year or is it a rolling date?
  - c. The TAC requests a minimum of two (2) physical exams per year be permitted
  - d. The TAC requests that providers be notified in real time if a patient has met their limitation on physical exams for the year.
  
4. APRN License Verification

The TAC requests that DMS reduce paper waste and improve utilization of staff time by accepting a single electronic file from the Kentucky Board of Nursing, within 30 days of the deadline for licensure renewal, that lists all APRNs who have renewed their license each year. TAC requests that DMS not automatically drop APRNs from Medicaid on November 1, but extend that deadline to November 30.
  
5. Reimbursement

The TAC requests that DMS and the MCOs provide improved reimbursement for APRNs at 90 % of the physician rate and increase the physician rate to 90% of the Medicare rate.

Respectfully submitted,

Elizabeth Partin DNP, APRN  
Chair

**Commissioner for the Department for Medicaid Services  
Selections for Preferred Products**

This is a summary of the final Preferred Drug List (PDL) selections made by the Commissioner for the Department for Medicaid Services based on the January 15, 2015 Pharmacy and Therapeutics (P&T) Advisory Committee Meeting.

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>New Products to Market: Jardiance®</u></b> Empagliflozin (Jardiance®) should only be approved for patients with a diagnosis of type 2 diabetes who have tried and failed maximum tolerated doses of metformin.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Invokamet™</u></b> Invokamet™ (canagliflozin/metformin) should only be approved for patients with a diagnosis of type 2 diabetes who have tried and failed maximum tolerated doses of metformin.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Xigduo XR™</u></b> Xigduo XR™ (dapagliflozin/metformin ER) should only be approved for patients with a diagnosis of type 2 diabetes who have tried and failed maximum tolerated doses of metformin.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Trulicity™</u></b> Place this product non preferred in the PDL class titled GLP-1 Receptor Agonists.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Auryxia™</u></b> Place this product non preferred in the PDL class titled Phosphate Binders.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Aptiom®</u></b> Place this product non preferred in the PDL class titled Anticonvulsants: Carbamazepine Derivatives.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Striverdi® Respimat®</u></b> Place this product non preferred with similar quantity limits in the PDL class titled Long-Acting Beta Agonists.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>

Description of Recommendation	Final Decision (s)
<p><b><u>New Products to Market: Rasuvo™</u></b>  Rasuvo™ (methotrexate) will only be approved for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Rheumatoid arthritis (RA) after trial and failure of: <ul style="list-style-type: none"> <li>○ NSAID; and</li> <li>○ Corticosteroid; and</li> <li>○ Oral methotrexate; OR</li> </ul> </li> <li>• Polyarticular juvenile idiopathic arthritis (pJIA) after trial and failure of: <ul style="list-style-type: none"> <li>○ NSAID; and</li> <li>○ Corticosteroid; and</li> <li>○ Oral methotrexate; OR</li> </ul> </li> <li>• Psoriasis after trial and failure of: <ul style="list-style-type: none"> <li>○ Topical agents for the treatment of psoriasis (e.g., emollients, corticosteroids, retinoids, vitamin D analogs, and/or topical tacrolimus, pimecrolimus); AND</li> <li>○ Oral methotrexate.</li> </ul> </li> </ul>	<p>The final prior approval criteria will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Zykadia™</u></b>  Place this product non preferred with similar quantity limits in the PDL class titled Oral Oncology Agents.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Zydelig®</u></b>  Place this product preferred with similar quantity limits in the PDL class titled Oral Oncology Agents; however, only approve idelalisib (Zydelig®) for one of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Chronic lymphocytic leukemia (CLL), in combination with rituximab; OR</li> <li>• Follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies; OR</li> <li>• Small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies.</li> </ul>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Akynzeo®</u></b>  Place this product non preferred with appropriate quantity limits in the PDL class titled Oral Anti-Emetics: NK-1 Antagonists.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>New Products to Market: Kerydin™</u></b>  Place this product non preferred in the PDL class titled Topical Antifungal Agents; however, only approve Tavaborole (Kerydin™) for a diagnosis of toenail onychomycosis after trial and failure of one other agent indicated for the treatment of onychomycosis.</p>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>

Description of Recommendation	Final Decision (s)
<p><b><u>New Products to Market: Harvoni<sup>®</sup></u></b>  Place this product preferred with appropriate quantity and duration limits in the PDL class titled Hepatitis C: NS5B Polymerase Inhibitors; however, only approve ledipasvir/sofosbuvir (Harvoni<sup>®</sup>) if ALL of the following are true:</p> <ul style="list-style-type: none"> <li>• Age ≥18 years old; AND</li> <li>• Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician; AND</li> <li>• Patient is treatment-naïve to ledipasvir and/or sofosbuvir. Limited to one course of therapy per lifetime.; AND</li> <li>• Patient is <i>not</i> receiving concomitant therapy with a hepatitis C protease inhibitor (e.g., telaprevir [Incivek<sup>®</sup>], boceprevir [Victrelis<sup>®</sup>], simeprevir [Olysio<sup>®</sup>]); AND</li> <li>• Patient does <i>not</i> have decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C]); AND</li> <li>• Patient has been evaluated for and <i>does not</i> have clinically significant drug interactions (i.e., certain acid reducing agents, antiarrhythmics, HIV Antiretroviral medications, anticonvulsants, antimycobacterials, herbal supplements, HMG-CoA Reductase Inhibitors); AND</li> <li>• Patient does <i>not</i> have severe renal impairment (eGFR &lt;30 mL/min/1.73m<sup>2</sup>) or end stage renal disease (ESRD) requiring hemodialysis; AND</li> <li>• Patient does <i>not</i> have a diagnosis of HCV genotypes 2, 3, 4, 5, or 6; AND</li> <li>• Patient has not actively participated in illicit substance abuse or alcohol abuse for 6 months prior to or during therapy attested by the prescribing physician(s) AND using one of the following confirmation tests administered both randomly and periodically throughout treatment: <ul style="list-style-type: none"> <li>○ Patient has been evaluated for current substance abuse and alcohol with validated screening instruments such as Alcohol Use Disorders Identification Test (AUDIT C) or CAGE alcohol screen, or National Institute on Drug Abuse’s (NIDA’s) drug screening tool; OR <ul style="list-style-type: none"> <li>▪ Acceptable alcohol consumption tests include: Serum gamma-glutamyl</li> </ul> </li> </ul> </li> </ul>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>

transpeptidase (GGT), mean corpuscular volume (MCV), carbohydrate-deficient transferrin (CDT), and urine ethylglucuronide (EtG) tests. Results must be documented in the patient's medical record to include, results of testing, and date tested; AND

- Urine toxicology screen results for substance abuse are acceptable in lieu of the actual laboratory drug screen report. Results must be documented in the patient's medical record to include substances tested, results of testing, and date tested; AND
- If patient has a prior history of substance or alcohol abuse, the patient has completed or is participating in a recovery program, or receiving substance or alcohol abuse counseling services, or seeing an addiction specialist as part of HCV treatment; AND
- Baseline HCV-RNA is submitted. HCV RNA levels will be required at treatment weeks 4, and 12 for renewals; AND
- Have documentation of Disease Severity **AND/OR** Highest Risk for Disease Progression, defined as:
  - Disease Severity (patient **MUST** have one of the following):
    - Liver biopsy showing Metavir score of F3/F4; **OR**
    - Ultrasound based transient elastography (Fibroscan) score  $\geq 9.5$  kPa; **OR**
    - Evidence of any **TWO** of the following:
      - Fibrotest (FibroSure) score of  $\geq 0.59$
      - Fibrosis-4 index (FIB-4)  $> 3.25$
      - Aspartate aminotransferase/platelet ratio index (APRI) score of  $> 1.5$
      - Cirrhotic features on imaging
      - Physical exam consistent with cirrhosis; AND/OR
  - Documentation showing patient at the highest risk for severe complications (patient **MUST** have one of the following):  
Advanced fibrosis (Metavir F3) or compensated cirrhosis (Metavir F4); **OR**
    - Essential mixed cryoglobulinemia with end organ manifestations (including arthralgias, palpable purpura, peripheral neuropathy, central nervous system vasculitis); **OR**

- Proteinuria; **OR**
- Nephrotic Syndrome; **OR**
- Membranoproliferative glomerulonephritis;  
AND
- One of the following diagnoses:
  - For diagnosis of chronic HCV with genotype 1, approve for 8 weeks of therapy IF patient meets ALL of the following criteria:
    - Treatment-naïve; AND
    - Have documented baseline HCV RNA of less than 6 million IU/mL; AND
    - Without cirrhosis (Metavir F4).
  - For diagnosis of chronic HCV with genotype 1:
    - Approve for an initial 8 weeks of therapy IF patient meets ONE of the following criteria:
      - Treatment-naïve with cirrhosis (Metavir F4) or without cirrhosis and baseline HCV RNA greater than 6 million IU/mL; OR
      - Treatment experienced without cirrhosis (Metavir F4).
    - Approve for an additional 4 weeks (12 weeks total) of therapy (Authorization #2) IF patient meets ALL of the following criteria:
      - The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); AND
      - The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; AND
      - HCV RNA levels are < 25 IU/mL at treatment week 4 (TW4).
  - For diagnosis of chronic HCV with genotype 1:
    - Approve for and initial 8 weeks of therapy for treatment experienced patients with cirrhosis (Metavir F4).
    - Approve for an additional 8 weeks (16 weeks total) of therapy (Authorization #2) IF patient meets ALL of the following criteria:
      - The patient has been compliant with drug therapy regimen (per pharmacy

<p>paid claims history); AND</p> <ul style="list-style-type: none"> <li>➤ The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; AND</li> <li>➤ HCV RNA levels are &lt; 25 IU/mL at treatment week 4 (TW4)</li> </ul> <p>▪ Approve for an additional 8 weeks (24 weeks total) of therapy (Authorization #3) IF patient meets ALL of the following criteria:</p> <ul style="list-style-type: none"> <li>➤ The patient has been compliant with drug therapy regimen (per pharmacy paid claims history); AND</li> <li>➤ The patient is not actively participating in illicit substance abuse or alcohol abuse during therapy attested by the prescribing physician(s) AND using the same verification documentation listed for original authorization; AND</li> <li>➤ HCV RNA levels are &lt; 25 IU/mL at treatment week 12 (TW12)</li> </ul>	
<p><b><u>Omalizumab (Xolair®) Clinical Criteria</u></b></p> <p>Initial Therapy (6 months): Xolair® (omalizumab) will be approved initially for the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Moderate to severe asthma (step 5 or higher) if ALL of the following are true: <ul style="list-style-type: none"> <li>○ 12 years of age or older; AND</li> <li>○ Positive skin test or in vitro reactivity to a perennial aeroallergen; AND</li> <li>○ FEV1 of &lt;80% while on asthma controller medication; AND</li> <li>○ Has had failure of or contraindication to inhaled corticosteroid in combination with a second controller agent (such as a long-acting inhaled beta2-agonist, ipratropium, leukotriene modifier, or theophylline) for a 60-day trial.</li> </ul> </li> <li>• Chronic idiopathic urticaria if ALL of the following are true: <ul style="list-style-type: none"> <li>○ 12 years of age or older; AND</li> <li>○ The underlying cause of the patient's condition has been ruled out and is NOT considered to be any other allergic condition(s) or other form(s)</li> </ul> </li> </ul>	<p>The final prior approval criteria will be determined after a review of this product at the next P&amp;T meeting.</p>

of urticaria; AND

- One of the following:
  - 3-month trial and failure of two (2) H1 antihistamines at maximally tolerated doses and patient has documented ongoing symptoms of chronic idiopathic urticaria; or
  - 3-month trial and failure of one antihistamine products and one (1) of the following leukotriene antagonists: montelukast OR zafirlukast and patient has documented ongoing symptoms of chronic idiopathic urticaria; AND
- A baseline urticaria activity score (UAS7) is required before approval. Renewals will require submission of a new UAS7 (within previous 30 days of renewal).

Continuation of Therapy:

Xolair<sup>®</sup> (omalizumab) will be approved for continuation of therapy for the following diagnoses:

- Moderate to severe asthma (step 5 or higher) if one of the following is true:
  - During previous treatment with omalizumab, the patient experienced a reduction in asthma exacerbations (e.g., hospitalizations, urgent or emergent care visits, use of rescue medications, etc.) from their pre-omalizumab baseline, OR
  - The patient was receiving maintenance therapy with an oral corticosteroid prior to initiation of omalizumab and the patient has been able to reduce their oral corticosteroid dose to less than their pre-omalizumab baseline or to  $\leq 5$  mg daily, OR
  - The patient was receiving maintenance therapy with an inhaled corticosteroid prior to initiation of omalizumab and the patient has been able to reduce their inhaled corticosteroid dose to less than their pre-omalizumab baseline.
- Chronic idiopathic urticaria if ALL of the following are true:
  - Treatment with omalizumab has resulted in clinical improvement as documented by improvement (decrease) in urticaria activity score (UAS7) from baseline; AND
  - Submitted current UAS7 was recorded within the past 30 days.

Description of Recommendation	Final Decision (s)
<p><b><u>Apolipoprotein B Synthesis Inhibitors</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Apolipoprotein B Synthesis Inhibitors class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p>The final PDL placement will be determined after a review of this product at the next P&amp;T meeting.</p>
<p><b><u>Apolipoprotein B Synthesis Inhibitors Clinical Criteria</u></b></p> <p>Approval of Apolipoprotein B Synthesis Inhibitors will be granted as described below.</p> <ul style="list-style-type: none"> <li>• For initial treatment, approve for 6 months if ALL of the following are true: <ul style="list-style-type: none"> <li>○ Diagnosis of homozygous familial hypercholesterolemia (HoFH) with untreated total cholesterol (TC) &gt;500 mg/dL; AND</li> <li>○ Must be used as an adjunct to a low-fat diet supplying &lt; 20% of energy from fat; AND</li> <li>○ Baseline alanine and aspartate aminotransferases (ALT, AST), alkaline phosphatase, and total bilirubin lab values must be obtained prior to initiating treatment; AND</li> <li>○ Baseline low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high density lipoprotein cholesterol (non-HDL-C) labs must be obtained prior to initiating treatment and required for renewal; AND</li> <li>○ Patient tried and failed at least a 3 month trial of the maximally tolerated dose with two (2) of the following statins: simvastatin 40mg (Zocor<sup>®</sup>), atorvastatin 80mg (Lipitor<sup>®</sup>) OR rosuvastatin 40mg (Crestor<sup>®</sup>), unless contraindicated; AND</li> <li>○ Patient tried and failed at least a 3 month trial combination with both ezetimibe 10mg (Zetia<sup>®</sup>) AND atorvastatin 80mg (Lipitor<sup>®</sup>) OR simvastatin 40mg (Zocor<sup>®</sup>), unless contraindicated; AND</li> <li>○ Despite the pharmacological treatment with statins and ezetimibe, patient's LDL cholesterol ≥ 300 mg/dL (or non-HDL cholesterol ≥ 330 mg/dL).</li> </ul> </li> <li>• For continuation of treatment, approve for one year</li> </ul>	<p>The final criteria will be determined after a review of this product at the next P&amp;T meeting.</p>

<p>if ALL of the following are true:</p> <ul style="list-style-type: none"> <li>○ Documented reduction of low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high density lipoprotein cholesterol (non-HDL-C) from baseline; AND</li> <li>○ Documentation of dosage adjustment if ALT or AST is <math>\geq 3</math> times the upper limit of normal (ULN); AND</li> <li>○ Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: elevations in transaminases (ALT, AST), hepatic steatosis, serious injection site reactions, and flu-like symptoms.</li> </ul>	
<p><b><u>Platelet Aggregation Inhibitors</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least four unique chemical entities should be preferred. Based on the clinical merits, place in therapy and utilization of clopidogrel, it must be a preferred agent.</li> <li>2. Continue to allow ticagrelor products for use in patients with Acute Coronary Syndrome (ACS).</li> <li>3. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>4. For any new chemical entity in the Platelet Aggregation Inhibitors class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><b><u>Selected Preferred Agent (s)</u></b>  Aggrenox<sup>®</sup>  Brilinta<sup>™</sup>  cilostazol  clopidogrel  dipyridamole</p> <p><b><u>Non Preferred Agent (s)</u></b>  Effient<sup>™</sup>  Persantine<sup>®</sup>  Plavix<sup>®</sup>  Pletal<sup>®</sup>  ticlopidine  Zontivity<sup>™</sup></p>
<p><b><u>Anticoagulants</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least one low molecular weight heparin, one factor Xa inhibitor, and two oral anticoagulants should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Anticoagulants class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><b><u>Selected Preferred Agent (s)</u></b>  Eliquis<sup>®</sup>  enoxaparin  fondaparinux  Fragmin<sup>®</sup>  Pradaxa<sup>®</sup>  warfarin  Xarelto<sup>®</sup></p> <p><b><u>Non Preferred Agent (s)</u></b>  Arixtra<sup>™</sup>  Coumadin<sup>®</sup>  Lovenox<sup>®</sup></p>

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>Vasodilator and Nitrate Combination</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least one unique chemical entity should be preferred.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Vasodilator and Nitrate Combination class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u> BiDil<sup>®</sup></p> <p><u>Non Preferred Agent (s)</u> N/A</p>
<p><b><u>Anti-Anginal &amp; Anti-Ischemic Agent</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation.</li> <li>2. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>3. For any new chemical entity in the Anti-Anginal &amp; Anti-Ischemic Agent class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u> Ranexa<sup>®</sup></p> <p><u>Non Preferred Agent (s)</u> N/A</p>
<p><b><u>Anti-Anginal &amp; Anti-Ischemic Agent Clinical Criteria</u></b></p> <p>Anti-Anginal &amp; Anti-Ischemic Agents will be approved if the patient has tried and failed therapy with any one of the following drug classes within the past 90 days (unless ALL are contraindicated):</p> <ul style="list-style-type: none"> <li>• Beta Blocker, OR</li> <li>• Nitrate, OR</li> <li>• Calcium Channel Blocker.</li> </ul>	<p>Anti-Anginal &amp; Anti-Ischemic Agents will be approved if the patient has tried and failed therapy with any one of the following drug classes within the past 90 days (unless ALL are contraindicated):</p> <ul style="list-style-type: none"> <li>• Beta Blocker, OR</li> <li>• Nitrate, OR</li> <li>• Calcium Channel Blocker.</li> </ul>

Description of Recommendation	Final Decision (s)
<p><b><u>Oral Anti-Arrhythmics</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least six unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. For any new chemical entity in the Oral Antiarrhythmics class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u></p> <p>amiodarone 100, 200 mg  disopyramide  flecainide  mexiletine  procainamide  propafenone  quinidine gluconate ER  quinidine sulfate  quinidine sulfate ER  sotalol  Tikosyn<sup>®</sup></p> <p><u>Non Preferred Agent (s)</u></p> <p>amiodarone 400 mg  Betapace<sup>®</sup>  Cordarone<sup>®</sup>  Multaq<sup>®</sup>  Norpace<sup>®</sup>  Norpace<sup>®</sup> CR  Pacerone<sup>®</sup>  Pronestyl<sup>®</sup>  propafenone sustained-release  Rythmol<sup>®</sup>  Rythmol<sup>®</sup> SR  Tambocor<sup>®</sup></p>

<b>Description of Recommendation</b>	<b>Final Decision (s)</b>
<p><b><u>Pulmonary Arterial Hypertension (PAH) Agents</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least one agent representing three of the unique mechanisms of should be preferred.</li> <li>2. Sildenafil and tadalafil should be subject to prior authorization criteria to ensure they are being used for PAH.</li> <li>3. If riociguat is not selected as a preferred agent, it will be available for a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH).</li> <li>4. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>5. Allow continuation of therapy for non preferred single source branded products via a 90 day look back.</li> <li>6. For any new chemical entity in the Pulmonary Arterial Hypertension Agents class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><b><u>Selected Preferred Agent (s)</u></b>  Letairis™  sildenafil  Tracleer®  Ventavis®</p> <p><b><u>Non Preferred Agent (s)</u></b>  Adcirca™  Adempas®  Opsumit®  Orenitram™  Revatio™  Tyvaso™</p>
<p><b><u>Proton Pump Inhibitors</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities should be preferred. Additionally, at least one dosage form suitable for pediatric use should be preferred.</li> <li>2. Continue current quantity limits on all agents in this class.</li> <li>3. Agents not selected as preferred will be considered non preferred and require PA.</li> <li>4. For any new chemical entity in the Proton Pump Inhibitors class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><b><u>Selected Preferred Agent (s)</u></b>  Nexium®  omeprazole capsules  pantoprazole</p> <p><b><u>Non Preferred Agent (s)</u></b>  Aciphex®  Dexilant™  esomeprazole strontium  lansoprazole  omeprazole suspension  omeprazole/sodium bicarbonate  Prevacid®  Prilosec®  Protonix®  rabeprazole  Zegerid®</p>

Description of Recommendation	Final Decision (s)
<p><b><u>Histamine<sub>2</sub>-Receptor Antagonists</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least two unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. For any new chemical entity in the Histamine<sub>2</sub>-Receptor Antagonists class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u>  cimetidine  famotidine tablets  ranitidine tablets</p> <p><u>Non Preferred Agent (s)</u>  Axid<sup>®</sup>  famotidine suspension  nizatidine  Pepcid<sup>®</sup>  ranitidine capsules  Zantac<sup>®</sup></p>
<p><b><u>Anti-Ulcer Protectants</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based upon economic evaluation; however, at least two unique chemical entities should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. For any new chemical entity in the Anti-Ulcer Protectants class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u>  Carafate<sup>®</sup> suspension  misoprostol  sucralfate</p> <p><u>Non Preferred Agent (s)</u>  Carafate<sup>®</sup> tablets  Cytotec<sup>®</sup></p>
<p><b><u>H. pylori Treatment</u></b></p> <ol style="list-style-type: none"> <li>1. DMS to select preferred agent (s) based on economic evaluation; however, at least one agent containing a Proton Pump Inhibitor (PPI), clarithromycin and either amoxicillin or metronidazole should be preferred.</li> <li>2. Agents not selected as preferred will be considered non-preferred and will require Prior Authorization.</li> <li>3. Agents in this class should have quantity limits based on the FDA-approved maximum dose.</li> <li>4. For any new chemical entity in the <i>H. pylori</i> Treatment class, require a PA until reviewed by the P&amp;T Advisory Committee.</li> </ol>	<p><u>Selected Preferred Agent (s)</u>  Helidac<sup>®</sup>  Prevpac<sup>®</sup>  Pylera<sup>®</sup></p> <p><u>Non Preferred Agent (s)</u>  lansoprazole, amoxicillin, clarithromycin  Omeclamox-Pak<sup>™</sup></p>



## **Technical Advisory Committee on Physician Services (Title XIX) Meeting Notes and Recommendations**

### Members

Donald R. Neel, MD, Owensboro, Chair – Present  
Renee Girdler, MD, Louisville – Present  
Richard S. Miles, MD, Russell Springs – Present  
Naren James, MD, Stanford – Absent  
Ira Potter, MD, Lackey – Present

### Medicaid and MCO new member enrollment update

The cabinet provided the latest Medicaid enrollment member data.

### Coding and payment for physicals done with less than one year intervals follow-up

This outstanding issue which involves physicals being denied when a child is seen in less than one year for the annual physical, as well conflicting information on “how to” code a sports physical. *This issue will be discussed at the next Medicaid Advisory Council (MAC) meeting on March 26, 2015.*

### Recommendation

A recommendation to form a coding and billing sub-committee for the MAC was made previously and is still on the table.

### Fee Schedule – Prevention Services

Physicians have received conflicting information on which Managed Care Organizations will be using the 2015 revised fees for many of the prevention services including vaccines. *This issue will be discussed at the next Medicaid Advisory Council (MAC) meeting on March 26, 2015.*

### Recommendation

All the MCOs except PassPort decided not to extend the primary care incentive payments. A recommendation from the TAC suggests the use of specific quality measures to provide incentives to physicians instead.

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on March 26, 2015

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, March 12, 2015. A majority of TAC members were present along with DMS staff and representatives from the MCOs were present for the discussion. Agenda items included:

- The automated wrap payment process from 7/1/14 forward.
- Wrap payment reconciliation from 11/1/11 – 6/30/14.
- The need for an electronic remittance process for automated posting.
- Issues related to the lock-in program.
- Issues related to eligibility status, re-certification delays and retroactive enrollment.
- Improving the accuracy of member addresses.

Since our last report to the MAC in January, we have made significant progress on the initial wrap reconciliation. On January 30<sup>th</sup>, we held a joint workgroup meeting with DMS, primary care providers, an MCO and their dental subcontractor. This meeting was extremely productive and resulted in a better understanding of what was causing dental claims to be kicked out of DMS's system, thereby not triggering a wrap payment.

Another topic of discussion at that meeting related to issues with the auto-wrap process that are causing inconsistent and delayed payments. While we weren't able to resolve all of these issues at the meeting, we started a process of collecting examples and sharing them directly with DMS, MCOs and the dental plan. This process has helped DMS and the Plans to identify and resolve many issues, including some incorrect screens and edits in DMS's system that were unintentionally keeping claims out of the system. We have been asked to continue sending in examples of claims that have not received a timely wrap payment and we will continue to monitor these payments until all issues are resolved.

One of the most significant hurdles that has caused the reconciliation process to be largely manual and continues to put a significant workload on providers, is the absence of an electronic EOB or explanation of benefits. While DMS has this in place for their direct fee-for-service payments, they do not have their system set up to do this for wrap payments connected to claims paid by the MCOs. Instead, providers are receiving paper EOBs and must post them manually one-by-one into their systems. One billing staff person described it as "looking for a needle in a haystack" when trying to find claims that did not receive a wrap payment from DMS to enter into the excel spreadsheet DMS requires for the reconciliation process. This has led to a very lengthy reconciliation process that is still ongoing. While DMS cannot provide these EOBs electronically for past claims, we have requested that DMS develop this capability going forward. DMS representatives have acknowledged this request and have told us they are

planning to meet with their contractor Deloitte to explore the options for upgrading their system.

A final note on the wrap reconciliation process – While DMS has already pushed back the deadline for submission of reconciliation spreadsheets to April 13th, we have been told that requests for extensions will be accepted.

Switching gears from wrap payments, two other important issues affecting primary care providers were raised at the last TAC meeting. The first is a lack of notification of members who are enrolled in a lock-in program. While the lock-in PCP, ER or pharmacy is notified that their patient has been assigned exclusively to them, other providers are not notified. We have been told that this information is available on the MCO portals, but it can be difficult to find and is handled differently by each Health Plan. We have two concerns with this process. The first is that PCPs will not be paid for providing services to a member that has been locked-in to another PCP. Because notification is not clear and consistent among Health Plans, it's easy to miss this information, treat the patient and find out after the fact that your claim was denied due to their lock-in status. Another issue is that without working closely with providers to manage these patients, the program will not be effective. If the lock-in provider is the only one alerted to their patient's status, that patient can easily continue to receive services elsewhere. We think that lock-in status should be discretely provided on the patient's ID card – using another color or symbol – and more clearly displayed on the MCO portals. According to the MCOs, DMS does not allow them to include this information on the card, so we have asked DMS to reconsider.

Another concern we brought to the TAC was related to recoupments based on member eligibility. Providers have recently told us that they have had payments recouped sometimes 1-2 years after providing services to a member that was deemed eligible on the date-of-service. When this occurs, the explanation from the MCO is that DMS determined the member was not eligible retrospectively or that the member was re-assigned to another MCO. If the member has been assigned to another MCO, the provider is able to bill that plan. However, if DMS determines retrospectively that the member was not eligible for that date-of-service, the provider does not seem to have any recourse and gets stuck with an unpaid claim. Since DMS is ultimately responsible for determining eligibility and communicating eligibility status to providers through their portal, we believe this is an issue DMS must resolve.

This also brought up a more systemic issue of the inconsistencies between the DMS and MCO portals that is tangentially related to both the lock-in program and eligibility. As they stand now, the DMS portal and MCO portals sometimes have conflicting information about eligibility status. And the DMS portal does not provide an alert related to lock-in status. So during patient registration, both portals must be checked and any discrepancies must be investigated by the clinic to make sure they are going to get paid before providing services. To avoid the delay this causes and streamline the process, we have asked DMS to work with the MCOs to ensure eligibility and lock-in status are accurate, up-to-date and easy to find.

Finally, we raised the issue of member addresses with DMS. As Medicaid providers, we all realize that members are often transient and don't always have stable addresses. However, in working closely with some of the MCOs to coordinate care and provide more outreach to patients, we have discovered that there is not a good system for updating and correcting member addresses. What we have learned is that any updates made by the MCOs are overwritten by DMS monthly with the original information. According to DMS, this can only be changed if a member updates their information through kynect. While it's good for members to have this option, we think there should be another process for updating contact information that can be completed by the Health Plan or provider with member approval.

**The Primary Care TAC submits the following recommendations for the MAC's consideration:**

1. In light of the manual nature of the wrap reconciliation process and continued issues with missing claims data, the Primary Care TAC recommends that DMS continue to approve requests for extensions past the April 13<sup>th</sup> deadline.
2. To improve the automated wrap payment process and decrease administrative burden on providers, the Primary Care TAC recommends that DMS provide EOBs electronically with the necessary identifiers to allow clinics to reconcile payments more efficiently. These identifiers should include: MCO Member ID, claim number, subscriber number and patient name.
3. To avoid unnecessary recoups based on eligibility status, the Primary Care TAC recommends that DMS provide more timely and accurate eligibility information to providers and MCOs. Additionally, we recommend that DMS have a clear process in place for communicating re-certification delays to the assigned PCP so that the PCP can engage a kynector to assist members in completing the re-certification process.
4. To assist providers and Health Plans in making lock-in programs more effective, the Primary Care TAC recommends that DMS work with the MCOs in a coordinated effort to provide lock-in alerts to providers in a more clear and consistent manner.
5. Finally, in order to improve the MCOs' and providers' ability to more effectively outreach to members, the Primary Care TAC recommends that DMS work with the MCOs and providers to develop an alternative process for updating member information that does not require the member to use kynect exclusively. This could be a form that requires the member's signature.

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on January 22, 2015

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, January 8, 2015.

A majority of TAC members were present along with DMS staff. Additionally, representatives from each of the MCOs were present for the discussion. Agenda items included:

- The automated wrap payment from 7/1/14 forward.
- Wrap payment reconciliation from 11/1/11 – 6/30/14.
- Creation of a joint workgroup to address issues related to the reconciliation process.
- DMS's response to recommendations accepted by the MAC.

Shortly after we reported to the MAC in November, the first phase of reconciliation for claims with dates of service from 11/1/11 – 6/30/14 began. Letters were sent to providers with claims data for that period. For the majority of these clinics, their spreadsheets include hundreds of thousands of lines of data. The letter required a 60-day turnaround for the reconciliation process to be completed in order to determine whether money is owed to the provider or must be repaid to DMS. As you can imagine, these spreadsheets are daunting and, upon closer inspection, are missing thousands – and sometimes tens of thousands – of claims for medical, dental and behavioral health visits. Because the spreadsheet does not include many patient identifiers, practices are required to manually search for each claim, which is extremely time intensive. After starting the process, one large practice estimated that it would require re-allocating a number of staff away from their regular duties and working around the clock to complete the process within the 60-day timeframe. For large practices this is a huge burden, but for small practices, it's simply impossible.

When this was initially addressed with DMS, we were told that providers could request an extension, which many have done. However, DMS is currently only granting 30-day extensions. In many cases, this is still not enough time to complete the process. We raised this issue again at the TAC meeting on January 8<sup>th</sup> and were told by DMS that they would consider granting additional extensions.

There have also been two very positive developments this month that have the potential to lead to a greatly improved and more streamlined reconciliation process. The first is that each MCO as well as Avesis have agreed to work with these clinics to address missing data. One MCO in particular has agreed to share claims data directly with practices in order to complete the missing fields. This has been tested with one clinic and was very successful, however, it took four weeks for this MCO to run the report and get the data file to this clinic. With this in mind, we believe it is critical that DMS grant additional extensions to any clinics with a substantial amount of missing data. The second positive development is that DMS agreed to meet with us this past Tuesday to review the spreadsheet and determine which elements were absolutely

essential for this process, which would eliminate most of the data points that our members are currently having to search for and enter manually. It was a very productive meeting and led to a better understanding of the reconciliation process from both sides. While this does not solve the issue of missing claims data, it is a big step in making the process more efficient and will greatly reduce the burden on providers.

As we've reported since September, the TAC has been asking DMS to convene workgroups with providers and MCOs to proactively identify issues with the process and work to address them from all sides. While DMS has not agreed to initiate these meetings, they have since accepted the TAC's invitation for a meeting we set up with one of the MCOs to address the issue of missing data. This meeting is scheduled for next week and we should be able to report on our progress at the next MAC meeting.

It is our understanding that there will be a final reconciliation process starting as soon as March. At this time we do not have much information about what this process will entail or require of providers. We expect there will continue to be challenges and issues that must be addressed between providers, DMS and the MCOs and hope that we can continue working together to address them.

One final issue that we want to raise before the MAC is the process for recommendations accepted by the MAC. It's our understanding that recommendations accepted by the MAC and made to DMS should receive a response within 30 days. However, the response to our September recommendations was dated November 19<sup>th</sup> and wasn't posted online until December 8<sup>th</sup>. We think it would be extremely beneficial for all TACs to receive these responses once they are completed and within the required 30-day timeframe. This will allow us to prepare for our next TAC meeting and use the time more effectively.

**Because a quorum was not present at the November MAC meeting, the Primary Care TAC would like to re-submit the following recommendation generated from our November 6<sup>th</sup> TAC for the MAC's consideration:**

1. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.

**In addition, we submit the following recommendations from the January 8<sup>th</sup> TAC meeting:**

1. In light of the fact that the reconciliation process for 11/1/11 – 6/30/14 includes a tremendous amount of paid claims data and requires a very manual process to complete the spreadsheet developed by DMS, we recommend that DMS adopt and disseminate a revised spreadsheet including only the essential data elements we selected together on January 20<sup>th</sup> to reduce the burden on providers.

**These elements include:**

1. Patient First and Last Name
2. Billing Provider (Clinic) NPI
3. Billing Provider (Clinic) Medicaid ID
4. Rendering Provider Medicaid ID
5. MCO Name
6. Patient MCO ID
7. Date of Service
8. Procedure (E&M) Code
9. MCO Paid Amount
10. MCO Paid Date
11. Primary Payor Amount (Commercial Carriers), if any.

**In addition the following two elements will be required for Medicare Cross-over claims:**

1. Medicare Co-Insurance Amount
  2. Medicare Deductible Amount
- 
2. In light of the magnitude of this process, including the lack of adequate claims data provided by DMS and given that we are dealing with both the wrap payment and the Medicare dual eligible issue, the Primary Care TAC recommends that DMS provide additional extensions beyond the initial 30 days to allow providers sufficient time to complete the process. While we would like to have it completed quickly, we feel it is much more important to accomplish the reconciliation in the correct and equitable manner for all parties, DMS, the clinics and the MCOs. It is after all a partnership.
  3. Our final recommendation concerns the process for responding to recommendations made by the TAC through the MAC. We realize responses must be publicly posted, but there is no notification that responses have been provided to the group who made the recommendations. The Primary Care TAC recommends that each TAC be sent a copy of the responses to their recommendations directly and within the required 30-day timeframe.





Non-Crossover Fields	Crossover Fields	Field Description	Expected Returns
Billing Provider NPI	Billing Provider NPI	RHC/FQHC National Provider ID	10 characters - numeric
Billing Provider Taxonomy	Billing Provider Taxonomy	RHC/FQHC Taxonomy Number	10 characters - combination of alphabetic/numeric
Billing Provider Medicaid ID	Billing Provider Medicaid ID	Medicaid provider number for RHC/FQHC	8 or 10 characters - numeric
Provider Tax ID	Provider Tax ID	RHC/FQHC Tax ID Number	9 characters - numeric
Rendering Provider NPI	Rendering Provider NPI	National Provider ID of provider performing the service	10 characters - numeric
Rendering Provider Taxonomy	Rendering Provider Taxonomy	Taxonomy of provider performing the service	10 characters - combination of alphabetic/numeric
Rendering Provider Medicaid ID	Rendering Provider Medicaid ID	Medicaid provider number for provider performing service	Numeric
Member First Name	Member First Name	First name of Medicaid recipient/patient	Unlimited characters - alphabetic
Member Last Name	Member Last Name	Last name of Medicaid recipient/patient	Unlimited characters - alphabetic
Member ID	Member ID	Medicaid number for Medicaid recipient/patient	10 characters - numeric
MCO Billed	MCO Billed	Name of MCO billed for the service	Unlimited characters - alphabetic
Date Submitted to MCO	Date Submitted to MCO	Date claim submitted to MCO for reimbursement	Numeric (for example XX/XX/XXXX)
Date of Service (DOS)	Date of Service (DOS)	Date service rendered	Numeric (for example XX/XX/XXXX)
MCO Claim Number (CN)	MCO Claim Number (CN)	Internal Control Number assigned to claim by DMS	13 characters - numeric
Claim Detail Line Number	Claim Detail Line Number	Detail line number of a claim record	Numeric
Procedure Code	Procedure Code	CPT code billed for service performed	5 characters - numeric (may have additional alphabetic characters)
	Medicare Coinsurance Amount	Amount of Medicare coinsurance applicable to claim	Dollar value - numeric
	Medicare Deductible Amount	Amount of Medicare deductible applicable to claim	Dollar value - numeric
Date Payment Received from MCO	Date Payment Received from MCO	Date payment received from MCO for service	Numeric (for example XX/XX/XXXX)
MCO Paid Amount	MCO Paid Amount	Amount paid by MCO for service	Dollar value - numeric
Other Primary Insurance Paid Amount	Other Primary Insurance Paid Amount	Amount paid by non-Medicare third party for service	Dollar value - numeric

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on November 20th, 2014

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, November 6th, 2014. A majority of TAC members were present, along with DMS staff. Additionally, four of the five MCOs were present for the discussion. Agenda items included:

- The automated wrap payment.
- Wrap payment reconciliation back to 11/1/11, including the reconciliation spreadsheet, timeline, Kentucky Spirit claims, and the claims resubmission process.
- Dual eligible payments to RHCs and FQHCs.
- EOB data received by clinics.
- Billing for 99211 nursing visits.
- Past recommendations accepted by the MAC.

Since September, significant progress has been made in addressing the automated wrap payment process. KPCA facilitated the scheduling of meetings between primary care providers, MCOs and DMS, which assisted all parties in identifying and resolving issues that were hindering the submission and processing of clean claims. As part of this process, DMS has asked providers to complete reconciliation spreadsheets for the months of July and August. This has been an incredibly time consuming task, but should improve the automated system moving forward.

Primary care providers have also been waiting for DMS to begin the wrap payment reconciliation process for dates of service going back to November 1, 2011 through June 30, 2014. We have been told that providers will begin receiving data on paid claims starting the end of November and will be asked to complete a similar reconciliation spreadsheet to identify any claims that are due a wrap payment. As part of this process, we discussed with DMS staff how to handle the reconciliation of Kentucky Spirit claims and the re-submission process for claims that were incorrectly denied or reimbursed.

The issue of dual eligible payments was also discussed. While CMS has determined that these payments are the State's responsibility, reconciliation has still not occurred. The primary concern raised by providers is that some claims that should be processed as \$0 pay by the MCO in order to receive a wrap payment from DMS have instead been denied. DMS requested that KPCA raise this issue with the MCOs at our monthly operational meetings.

One final issue that we want to raise before the MAC is the status of recommendations accepted by the MAC. We are concerned that formal recommendations made by the TAC and

accepted by the MAC are not being addressed or followed-up by DMS. We would appreciate clarification on this process.

The following recommendations were accepted by the MAC in September and have not been addressed by DMS to our knowledge:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a commonly shared problem affecting over 180 clinics across the State.
2. The Primary Care TAC requests there be joint meetings between DMS, the MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.
3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.
4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.
5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

**Finally, the Primary Care TAC submits the following recommendations to the MAC:**

1. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.
2. The Primary Care TAC recommends that DMS add a legend to the reconciliation spreadsheet to provide clear definitions for the column headers to ensure accuracy when completing the spreadsheet.
3. The Primary Care TAC recommends DMS extend the current timeline for providers to complete the wrap payment reconciliation process from 30 days to 60 days to allow clinics more time to review their data.

**Kentucky Therapy Technical Advisory Committee  
March 3, 2015 Meeting Minutes**

**Advisory Committee Meeting 8:30 am-9:30 am**

**Members in Attendance:** Dr. Beth Ennis,

**Members Attending via Conference Call:** Bethany Berry, Charlie Workman, and Leslie Sizemore

**Others in Attendance:** Peggy Hagan, C.J. Jones, Stephanie Bates, Cynthia Lee, Pat Russell, Del Frazee, Carrie Anglin

**Other Conference Call Attendees:**

Pam Marshall, Dale Lynn, Cynthia Lee, Karen White

**Issues from Previous Meeting:**

**Questions to MAC:** It was discovered that the MAC did not have a quorum in January after all -- legal ruling that it is majority of possible members, not actual members. Questions will be resubmitted for March Meeting.

**30-day recert Issue with Fee-for-service Medicaid:** Still trying to figure this out -- no word on resolution with carewise

**EPSDT Transition:** There remains a great deal of concern regarding the transition in billing, and how this will occur. Will new provider types be used for billing or the old EPSDT one? Billing will use CPT codes rather than the current visit code -- this is a significant cut, especially related to speech services. Set for July 1, but awaiting clarification on how providers should transition.

**OT member for TAC:** discussed with Mr Lynn and Ms Sizemore that we still did not have a recommendation from KOTA for Teresa's replacement -- they will contact Eric Deyoung who is the new KOTA president for that letter.

**Denials from Coventry related to billing:** Wheelchair assessment was clarified as needing prior auth, and we discussed that this was a timed code, not a visit code. Coventry to check their system and make sure 97542 is listed as a per 15 minute code. No one from Coventry present to verify if this has been checked. Dr. Ennis to follow up.

**Wellcare Issues related to billing:** Mr Lynn discussed issues with prior auth through Carecore, requiring wait until 7 days prior to expiration and then significant delays in turn-around time, with 6 visits authorized initially and 4 after than, no matter what you ask for. Supposed to be a 48 hour turn around, but never is. Ms Marshall agreed that this was the case for her as well. Pat Russell to

**Kentucky Therapy Technical Advisory Committee  
March 3, 2015 Meeting Minutes**

look into this, and it will also be addressed at the Medicaid Forum in April by KPTA, KOTA, and KSHA.

**Certificate of Need Issues:** All comments were submitted, and a forum is being held if people want to add to that. Word from KPTA, KOTA, and KSHA is our comments stand as sent. We will wait and see what happens with modernization.

**New Issues**

Dr. Beth Ennis solicited participant concerns.

Charlie Workman reported hearing Coventry-related concern in that payments were not being received accurately, and the reason was that Coventry cannot see prior authorizations. They can see the most recent, but not the prior authorizations. This will need to be addressed next time. In their system they can only see the most recent authorization and that which the payment is being received for, but not prior.

Bethany Berry reported no concerns but appreciated the heads up on the Seven Counties First Steps issue. Brief discussion of this situation occurred.

Leslie Sizemore reported hearing no concerns.

**S Codes:** Discussion occurred regarding the transition of EPSDT services and the impact this will have on providers. This transition is very unclear to providers.

**Questions for MAC to ask Cabinet:**

- 1. Is the authorization for 20 visits or for 30 days? Cabinet responded in an email that it was 20 visits, but carewise still says 30 days and no one has provided any solution.**
- 2. Concerns regarding Therapist/Assistant differential – no way to know when facilities are billing who provided the service, and people are concerned about being accused of fraud.**
- 3. Shift in EPSDT billing which is to occur in June – do you use provider type 45 and switch to CPT code billing or use specific therapy provider types? Providers would like the cabinet to recognize the significant impact of the rate shift on facilities.**

**Next Meeting**

Members agreed to meet on Monday, 5/4/2015 at 8:30 am. Dr. Ennis asked members to email her with issues.

## Therapy TAC

### **MAC RECOMMENDATIONS**

**Presented to MAC on Jan. 22, 2015**

1. Shift in EPSDT billing which is to occur in June – do you use provider type 45 and switch to CPT code billing or use specific therapy provider types? Providers would like the cabinet to recognize the significant impact of the rate shift on facilities.



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

March 23, 2015

TO: Medicaid Advisory Council (MAC)  
FROM: Department for Medicaid Services  
RE: U1 Modifier for Claims for the Provision of Physical Therapy, Occupational Therapy and Speech Therapy Services to Medicaid Members

Dear MAC:

This is in regards to the recommendations submitted by the Therapy Technical Advisory Committee to the MAC on September 25, 2014. The following recommendation was submitted:

Concerns regarding Therapist/Assistant differential – no way to know when facilities are billing who provided the service, and people are concerned about being accused of fraud.

*Updated Response:* The issue has been resolved. Assistants should bill using the U1 modifier to indicate that the services were provided by the assistant. Please see the following billing manuals for specific instructions:

Speech Language Pathologist, Provider Type 79:

[http://www.kymmis.com/kymmis/pdf/billingInstr/PT79\\_v1.1\\_\(09-26-2014\).pdf](http://www.kymmis.com/kymmis/pdf/billingInstr/PT79_v1.1_(09-26-2014).pdf)

Physical Therapist, Provider Type 87:

[http://www.kymmis.com/kymmis/pdf/billingInstr/PT87\\_v1.1\\_\(09-26-2014\).pdf](http://www.kymmis.com/kymmis/pdf/billingInstr/PT87_v1.1_(09-26-2014).pdf)

Occupational Therapist, Provider Type 88:

[http://www.kymmis.com/kymmis/pdf/billingInstr/PT88\\_v1.1\\_\(09-26-2014\).pdf](http://www.kymmis.com/kymmis/pdf/billingInstr/PT88_v1.1_(09-26-2014).pdf)

Sincerely,

Erin Hoben

