

Behavioral Health TAC
Recommendations to MAC

July 28, 2016

TAC Recommendation Approved at Behavioral Health TAC Meeting on May 4, 2016:

RECOMMENDATION: In light of CMS' final rule establishing the opportunity for Medicaid Managed Care plans to reimburse free-standing psychiatric hospitals for inpatient services of up to 15 days per month, we recommend that DMS proceed as quickly as possible to put this change into effect in Kentucky to allow Medicaid reimbursement for behavioral health services to hospitals which had previously been excluded because of their Institution for Mental Disease (IMD) status. The CMS final rule will go into effect sixty days after it is published in the *Federal Register* on May 6, 2016.

TAC Recommendations Approved at Behavioral Health TAC Meeting on July 7, 2016:

RECOMMENDATION: That the Behavioral Health TAC file comments with Commissioner Miller in response to the proposed 1115 waiver to express the grave concerns of the TAC about using the category of "medically frail" and imposing a monthly premium charge for individuals – including those with SMI, chronic SUD and other disabilities – on those individuals. Concern was noted not only about the financial burden on these individuals but the difficulty they would have in the mechanics of receiving a bill and making a payment. Further, these individuals are not paying copays and the threat of imposing an even greater financial burden is very problematic. The BH TAC also is concerned about the limitation of dental and vision care for others in the Medicaid program and urges the Administration to address these issues.

RECOMMENDATION: That the Acquired Brain Injury (ABI) Acute Waiver continue as a rehabilitation waiver, affording individuals appropriate cognitive retraining for a sufficient length of time to maximize the individuals ability to regain and maintain functioning. Currently, private insurance plans are paying for approximately 22 days of inpatient rehab services for ABI patients. We urge that the MCOs do at least the same.

RECOMMENDATION: In response to significant challenges described by those in attendance about the Medicaid Waiver Management Application (MWMA), we recommend that case managers in the waiver programs, particularly ABI and Michelle P, receive training on the system as soon as possible, and that there be timely response to requests for support when problems are encountered.

RECOMMENDATION: The BH TAC is pleased to see that there are managed care reforms included in the proposed 1115 waiver, and requests that DMS look as soon as possible at the current delays in credentialing providers which are causing potential providers to give up on the process. Uniform credentialing is a priority for the provider community.

BEHAVIORAL HEALTH TAC REPORT TO THE MAC – JULY 28, 2016

Good morning. I am Dr. Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC met on July 7, 2016 at the Capitol Annex with Behavioral Health representatives of all five of the Medicaid MCOs. In addition to the MCO representatives and 3 of the 6 members of the TAC, we had representation from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) including Acting Commissioner Wendy Morris and Medical Director Dr. Allen Brenzel. We also had representatives from the KY Department for Medicaid Services (DMS) and other members of the behavioral health community including members of the KY Mental Health Coalition and others interested in the topics being presented.

We reviewed the **Behavioral Health TAC Report** made at the MAC meeting held on May 26, 2016. Because there was not a quorum, that recommendation could not be acted upon and will be included in this report, along with new recommendations developed at this TAC meeting.

In the invitation to the MCOs to attend the July TAC meeting, we noted that we would like to have each MCO respond to these issues:

- Of your currently-enrolled members, how many would be classified as “medically frail”?
The Waiver proposal defines “medically frail” as: “a person with a disabling mental disorder (including serious mental illness), chronic SUD, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living. MCOs will identify high-risk individuals through the health risk assessment and available claims data. Kentucky will develop a process by which individuals may be evaluated and assigned a risk score based on objective criteria, such as specific underwriting guidelines. Individuals with qualifying conditions and scores would be determined medically frail. The State will ensure that medically frail individuals receive the most robust benefits available, including non-emergency transportation.” Testimony at the Interim A&R Committee included a statement that individuals receiving SSI or SSDI will meet the qualifications of being “medically frail.”
- Of your currently-enrolled members, how many have improved their health status over the past 2 years? What data are you using to assess that?

An additional question was sent to the MCOs from Dr. Fareesh Kanga:

- Why are all of the MCO’s denying vistaril (hydroxyzine, a noncontrolled substance anti-histamine that we use in psychiatry for anxiety), with the preferred options being alprazolam (Xanax), Clonazepam (Klonopin), or Buspirone (Buspar - totally different mechanism of action drugs)?

Each of the MCOs indicated that they used the term “medically fragile” as defined by DCBS for children with especially complex health needs. The interpretation of the term “medically frail” was inconsistent at best, and in some cases, nonexistent. The MCOs generally stated that they did not use that terminology to assess their members and were unclear about what the exact parameters were in making that assessment. They made it clear that they would have to have much more direction and guidance from DMS about what criteria to use. There was also some

discussion at the TAC meeting about whether the classification of “medically frail” would be seen as an eligibility determination; in that case, the determination would have to be made directly by DMS.

We then had a discussion of the proposed Medicaid 1115 waiver and shared information, answered questions where possible, and expressed our concerns. Questions about how the determination of “medically frail” would be made were raised, as well as concerns about the burden that paying a monthly premium – both financially and in terms of management – would pose for those in that category. Support for the SUD waiver was expressed, as well as an interest in assuring that those with co-occurring SUD and MI would be included in that inpatient or residential program.

The MCOs forwarded by email their description of HEDIS measures that they are gathering on their members and described how they would put those together to assess the improved health status that they are seeing.

Dr. Kanga was at the TAC meeting and was able to talk with MCO representatives to answer her question and resolve her concerns regarding the use of vistaril.

We will use the September Behavioral Health TAC meeting to have each of the MCOs report out on their progress on the issue of integrating physical and behavioral health care as part of their PIP. At that meeting, we will also follow up on the implementation of SB 120 from the 2016 KY General Assembly session.

Home Health TAC
Recommendations to MAC
July 28, 2016

Recommendation:

Provide update to participating providers of HCBW.

Recommendation:

Provider letter of communication to waiver recipients that changes for services are in place. They must choose a provider of services and a case manager. Facilitate what provider of services will be discussing with them at their next certification.

Pharmacy TAC Recommendations

Presented to MAC

July 28, 2016

The Pharmacy Technical Advisory Committee discussed many pertinent topics at its meeting and decided to present the following recommendations to the MAC:

1. POS coverage should be provided from MCOs for the Narcan[®] 4mg Nasal Spray so that patients have access to needed rescue therapy. PTAC is asking for this consideration with the patient's safety in mind. This is the easiest rescue method to train individuals to use because it requires no assembly, but it is at a higher cost. Narcan[®] 4mg Nasal Spray is now the only FDA approved product to reverse the opioid overdose via nasal route. It contains double the potency of the off label Naloxone 2mg nasal spray in each dose, potentially saving lives due to the powerful nature of the illicit street drugs being used today. The current acquisition cost difference between products is approximately \$40 per prescription kit (2 doses of each product). Narcan[®] 4mg does not require a separate nasal atomizer as the off label Naloxone 2mg requires.
2. Kentucky has a valuable resource in our community of pharmacists. The PTAC recommends that DMS review the legal statutes that recognize pharmacists as health care providers with respect to being a provider in their own right eligible for reimbursement for covered services. The PTAC would like for Medicaid to be able to recognize and further define pharmacist provider payment codes to assist MCO and FFS payments for cognitive medication services such as medication therapy management (MTM).

Pharmacy Technical Advisory Committee (PTAC) Recommendations to the MAC and Meeting Notes Tuesday, July 19, 2016

Meeting held at the Kentucky Pharmacists Association Headquarters
96 C Michael Davenport Blvd., Frankfort, KY 40601

The Meeting of the Pharmacy Technical Advisory Committee (PTAC) was called to order on Tuesday, July 19, 2016 at 9:30 a.m. by Chair Jeff Arnold. Those present for the meeting were as follows: Jeff Arnold, Chris Betz and Suzi Francis: PTAC Members; Owen Neff representing Humana CareSource; Paul Kensicki representing WellCare; Andrew Rudd representing Anthem; Tom Kaye representing Aetna; Trista Chapman, Samantha McKinley, Leeta Williams and Jennifer Robbins representing DMS; Kasie Purvis representing DMS OATS; Bob McFalls, KPhA Executive Director and Angela Gibson KPhA Director of Membership and Administrative Services; and, Trish Freeman, UKCOP and KPhA President, Dr. Shawn Ryan, Brightview, and Fred Morlan, UKCOP Student.

The minutes and report from the May 13, 2016 meeting were reviewed by Jeff Arnold. Suzi Francis moved to approve the minutes and report as presented. Motion was seconded by Chris Betz and carried.

Updates from the MCOs/MCO Pharmacy Directors:

MCOs had no major updates at this time.

Updates from DMS—Samantha McKinley:

The next Medicaid FFS P&T for DMS will be held on September 15th. They re-bid their contracts at the end of the summer. DMS is hoping to see some changes and movement in the HepC category, and is hoping to create enhanced coverage of the new FDA-approved Narcan[®] 4mg nasal spray.

Additional Discussion Topics/Reports/Action Items:

Buprenorphine MTM Work Group Update: Suzi reported on the work group's findings after the MCOs requested help in getting a best practice to ensure buprenorphine is accessible and is being used appropriately and cost effectively. Dr. Shawn Ryan, a board certified addiction specialist and emergency physician, provided subject matter expertise. His insights on the medical side of the issue have helped to identify steps to ensure that best practices are used by physicians and pharmacists alike. Top priorities of the buprenorphine MTM workgroup include identifying the need for treatment and referring appropriately (SBIRT), best practices for addiction treatment and medication assisted treatment, identification of suspect prescribing patterns and limiting diversion, and reimbursement structure for pharmacists who provide these services. Samantha reported that there is not an existing framework to pay pharmacists or pharmacies for the MTM services for the buprenorphine. SBIRT reimbursement is currently structured for medical claims; and pharmacy claims are not processed for these type of services. In addition, pharmacists are not recognized as Medicaid billing providers for SBIRT services. MCOs reported that there is also the barrier of helping the patients to see the importance and helpfulness of MTM services, for any condition. Dr Ryan pointed out that with buprenorphine, pharmacists do have the medication that they want, so it could be helpful to have required MTM services in order to get their medications.

Dr. Trish Freeman stated that pharmacists were statutorily defined in 2015 as a healthcare provider to initiate the dispensing of naloxone and provide associated naloxone education. Pharmacists are also recognized as health care providers by the Department of Insurance. The next step is to have pharmacists be reimbursed on the medical side as providers. This could be done as a recommendation to the MAC. With pharmacists recognized as providers by DOI and DMS, this would go a long way in securing payment portals from MCOs. Next

steps are to have physicians' groups support the recommendation that pharmacists can greatly improve patient outcomes by being providers and thus securing a payment model. Discussion ensued as to where the money would come from for payment—the Federal or State Government? A legal review of Kentucky statutes could be requested from DMS in terms of helping to form an opinion on what those statutes mean for pharmacists as providers.

References for Pharmacists as Providers:

- KRS 304.17A-005 (23) – insurance code which defines pharmacist as a health care provider
- KRS 217.186 (1) which defines pharmacist as health care provider for purposes of dispensing naloxone and (5b) which mandates pharmacist to provide education
- KRS 304.17A – any willing provider law

DMS Pharmacy Dashboard: DMS's plans are coming together with a fee-for-service Dashboard. This has been in the works for a while now, and Samantha reported she will bring a draft to the PTAC soon. The target date right now is early fall. Input is still welcome on what the PTAC would like to see in terms of the design of the dashboard.

Kentucky HEALTH (Helping to Engage and Achieve Long Term Health): Governor Bevin and his administration have brought forward a proposal to reform Medicaid through a waiver demonstration that will be submitted to CMS for its approval. This is a powerful initiative in the Medicaid population that this is targeted to help improve health outcomes, address substance abuse and manage chronic disease states. Mr. McFalls reminded PTAC and attendees that the public comment period is open until Friday, July 22. It was noted that this program does try to mimic a private pay program that has been brought before CMS. KPhA will be filing its own comments in regard to how pharmacists represent an underutilized resource in the management of chronic disease; moreover, KPhA views pharmacists as part of the solution in helping patients manage their chronic disease states. The accessibility of pharmacists increases the number of touch points Kentuckians with chronic disease could have to members of the healthcare team. It is been proven that this accessibility can change the trajectory of the disease state. KPhA asked for any comments to be submitted from the PTAC by July 21 and encouraged attendees to file their own comments before the deadline of July 22, 2016.

Other: Dr. Freeman provided a report on the coalition work that has been done in providing pharmacists with naloxone training throughout the state. WellCare provided a micro grant to distribute atomizers, which are a component in a naloxone kit, to certified pharmacists throughout the state. Passport has approached the coalition as well to discuss providing pharmacists dispensing naloxone kits an additional admin fee at the POS to cover the costs of the atomizers. Dr. Freeman asked MCO pharmacy directors and representatives if they want to stay with the naloxone kits as the preferred naloxone product, and if so, are they are considering ways (similar to Passport) to cover the cost of the atomizers. The MCOs at the table briefly dialogued this issue. She also asked if there are plans to cover the Narcan[®] Nasal spray as an alternative to the kits if the atomizers are not going to be covered at this time. Physicians are starting to discuss if there is a more appropriate form of antidote for the naloxone epidemic (Narcan[®] 4mg nasal spray) due to the potency of illicit street opioids being abused.

Dr. Freeman called attention to the MCOs that there is still some confusion to pharmacists as to which immunizations are covered and which are not. As a working protocol, Samantha suggested that the pharmacists' first call for clarification be made to the MCO. If the conflict is not resolved there, the next call should be to DMS. At that point, DMS will investigate the issue further. Some of the barriers discussed are that a pharmacist goes online, sees that the immunization is covered, has trouble processing the claim and then calls the MCO only to be told that a specific vaccine is not covered for a patient over the age of 19. There was much discussion

with the MCOs with regard to this issue. MCOs were asked by Chair Arnold to review their website for consistency in communication and to individually provide an update at the PTAC meeting with respect to lining up the online information with what has been presented to PTAC and to MAC as covered immunizations.

The Pharmacy Technical Advisory Committee discussed many pertinent topics at its meeting and decided to present the following recommendations to the MAC:

1. POS coverage should be provided from MCOs for the Narcan[®] 4mg Nasal Spray so that patients have access to needed rescue therapy. PTAC is asking for this consideration with the patient's safety in mind. This is the easiest rescue method to train individuals to use because it requires no assembly, but it is at a higher cost. Narcan[®] 4mg Nasal Spray is now the only FDA approved product to reverse the opioid overdose via nasal route. It contains double the potency of the off label Naloxone 2mg nasal spray in each dose, potentially saving lives due to the powerful nature of the illicit street drugs being used today. The current acquisition cost difference between products is approximately \$40 per prescription kit (2 doses of each product). Narcan[®] 4mg does not require a separate nasal atomizer as the off label Naloxone 2mg requires.
2. Kentucky has a valuable resource in our community of pharmacists. The PTAC recommends that DMS review the legal statutes that recognize pharmacists as health care providers with respect to being a provider in their own right eligible for reimbursement for covered services. The PTAC would like for Medicaid to be able to recognize and further define pharmacist provider payment codes to assist MCO and FFS payments for cognitive medication services such as medication therapy management (MTM).

The meeting ran under two hours. The next PTAC meeting will be Friday, September 16, 2016 at 9:30 a.m. It will be held at the Kentucky Pharmacists Association headquarters located at 96 C. Michael Davenport Blvd., Frankfort, KY 40601. All interested parties are welcome to attend, and we are happy to report that representatives from all of the MCOs are participating on a consistent basis.

Respectfully submitted,

Jeff Arnold, Chair, Pharmacy Technical Advisory Committee
Trish Freeman, President, Kentucky Pharmacists Association

Primary Care Technical Advisory Committee

Recommendations to the MAC

July 28, 2016

The Primary Care TAC met on July 14, 2016 and a quorum of members were present.

The following are recommendations the TAC approved for presentation to the MAC and we ask the MAC's concurrence in these recommendations.

1. We recommend that DMS and the MCOs work together to develop a common approach for submission of dual eligible, cross-over claims. CMS is paying the claims, transmitting them to the MCOs but CMS is stripping items from the claims including taxonomy codes as well as other information which leads to them not being paid by DMS unless the clinics rebill or submit paper claims to the MCOs. This process requires significant additional work on the part of clinics adding cost and detracting from the intent and purpose of electronic medical records and electronic billing. DMS staff attending the TAC meeting agreed to initiate the process. Our membership is willing to work in partnership to provide direction and understanding of the issues faced by the clinics in the process.
2. Because of the issues with the cross-over payments we recommend that DMS work with the TAC to begin the development of a reconciliation process that will meet the needs of DMS and the clinics. We would prefer not to wait until the end of the year and be confronted with a manual process and short time frames. Rather we would like to assist and participate in developing a process that meets the needs of DMS and is realistic and possible for the clinics to understand and respond to appropriately and timely.
3. Some MCOs have recently changed prior authorization requirements for ultrasounds for prenatal services effecting the timing of care for high risk pregnancy patients. The TAC recommends that DMS establish rules requiring all prior authorizations for prenatal patients follow ACOG standards for all prenatal services, especially high risk patients. Special attention should be given to the number of ultrasounds, as well as other recommended services for high risk patients in accordance with ACOG Standards.

Additionally, the TAC addressed the proposed Medicaid waiver and have included those for submission to the MAC along with submission through the process designated for filing official comments. To summarize our comments:

As a group, we fundamentally agree there are needed changes to be made to the Kentucky Medicaid Program for financial reasons. With these changes our common goal should be the continued improvement of the health of all Kentuckians.

While we do not want to dwell on what we perceive as obvious problems and barriers for primary care providers serving patients, we feel that the administrative obstacles placed on medical providers in this waiver will not allow primary care providers to assist in accomplishing the laudable goals set forth in this proposed waiver. Limiting the access to care, by programmatic design or cumbersome processes medical providers must follow, is not the way to reach the fundamental goals of this waiver. Our common goal, it is suggested, needs to focus on creating healthy communities, healthy citizens and a healthy Commonwealth. We offer our input and assistance in designing a truly workable waiver program that will reach these goals and drive improved health, lower costs for the state, as well as improved care and health status for the patients/citizens we all serve.

THERAPY SERVICES TECHNICAL ADVISORY COMMITTEE

**Transportation Cabinet
Room C122, 200 Mero Street
Frankfort, Kentucky
July 12, 2016
8:30 a.m.**

The meeting of the Therapy Services Technical Advisory Committee (TAC) was called to order by Beth Ennis, Chair.

The TAC members in attendance: Beth Ennis, Charlie Workman, Linda Derosssett (telephonically) and Leslie Sizemore (telephonically).

Medicaid staff in attendance: Stephanie Bates (telephonically), Charles Douglass (telephonically), C.J. Jones, Jeana Jolly, Jessica Jackson.

Others in attendance: Kathleen Ryan, Anthem; Mary Hiatt and Cathy Stephens, Humana-Caresource; Dell Frazee, Passport; Pat Russell, WellCare; Laura Crowder, Aetna Better Health; Marcie Fawver (telephonically), Mariposa Place Therapy Services.

REVIEW AND APPROVAL OF MAY 23, 2016 MEETING MINUTES:

There were no changes or corrections to the minutes. Dr. Ennis accepted the minutes as written.

OLD BUSINESS:

- (a) Waiver Transition: Mr. Douglass stated that the HCB waiver changes will roll out around September 1st. A change order has been written to remove the prior authorization request for OT, PT and speech so that for the first 20 visits, there will not be a requirement to get a PA. PA's will start at the 21st visit. Dr. Ennis asked for a notification if this rolls out sooner than September 1st. Mr. Jones stated that the SCL waiver changes will roll out next and then the ABI will roll out in February of 2017.
- (b) Passport and MPPR: Dr. Ennis stated that it is a requirement to use the MPPR for Medicare but not for Medicaid and that the concern for therapies is that they are taking a rate that is already cut from the Medicare fee schedule and applying further cuts to it that are going to make it impossible to provide services. Ms. Jones stated that the Medicaid rate is based upon a discounted percentage of the Medicare rate. Ms. Frazee will ask the reimbursement people at Passport to contact Dr. Ennis and discuss this with her.
- (c) Fee Schedule Changes – adding 97113 to OT/ST: Ms. Jones noted that a change order was already in process to add 97113 to OT but that it would not be added to speech. Dr. Ennis asked for the reasoning behind not adding it to speech, and Mr. Douglass stated that if she could submit information as to where that would come into play with speech, he would review it.
- (d) Other Old Business: Dr. Ennis asked about the TAC receiving usage data from the MCOs and DMS regarding the provision of services and asked about how this information should be requested. Ms. Jones stated that for fee-for-service, it should be requested by CPT code and specialty group. The request needs to be specific as to whether it is a request to fee-for-service or to the MCOs. Any requests to the MCOs will need to go through Stephanie Bates. Dr. Ennis will talk with members of the TAC and with speech representatives to come up with a comprehensive list of requests and will forward this to Ms. Jones and Ms. Bates.

NEW BUSINESS:

Dr. Ennis asked if there were any thoughts with the new State Plan Amendment for the State Plan to remove the differential, and Ms. Jones stated she has not heard any discussion about the State Plan side of it yet.

Mr. Workman asked about the requirement from the MCOs and Medicaid for physician electronic signatures. WellCare and Aetna stated that as long as it says electronically signed it will be accepted. Humana, Anthem and Passport will check on this and report back.

Mr. Workman asked if speech therapy's use of 97535, Self-Care/Home Management Training, needs to strictly be isolated to PM&R levels of care or can it be in an acute environment versus in an outpatient environment. Ms. Jones will have to check on this for fee-for service

PUBLIC COMMENT: Marcie Fawver with Manposa Place, an SCL provider, noted that the agency has applied for a mobile health service which has not been approved to date and, therefore, they cannot apply as a multiple-therapy agency provider type and receive a Medicaid number to begin billing by August 1st. Ms. Jones again noted that the SCL waiver

changes will not take effect by August 1st and this would allow time for the application to go through the process.

Ms. Fawver asked for clarification concerning individuals transitioning from the waiver to traditional Medicaid and automatically being approved for the units that they had under the waiver for a period of six months or will a new evaluation be necessary. Mr. Workman also asked if a new physician order would be required in this transition to continue with the therapies or would it suffice if the physician or referring provider signs the recertification. Ms. Jones will research these questions.

RECOMMENDATIONS TO MAC: There were no recommendations to be made to the MAC.

The meeting was adjourned. The next meeting date is Tuesday, September 6, 2016 at 8:30 a.m., location to be determined.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 20th day of July, 2016.)