CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

September 25, 2014
10:00 A.M.
Room 125 Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Donald Neel
Sharon Branham
Susanne Watkins
Peggy Roark
Jonathan Van Lahr
Chris Carle
Barry Whaley
Richard Foley
Peggy Roark
Karen Angelucci
COUNCIL MEMBERS PRESENT

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CHAIR PARTIN: We do have a quorum today, so, that's great news. The first thing on the agenda is approval of the minutes, and we have meetings from March, May and July to approve. So, hopefully people have had an opportunity to review those. Would anybody like to make a motion to approve?

DR. RILEY: So moved.

DR. NEEL: Second.

CHAIR PARTIN: All in favor, say aye. Any opposed? So moved. Thank you.

Under Old Business, we don't have a lot today because we haven't had a quorum for the past three meetings but we do have a couple of things.

So, first is that we would like to see where the Department for Medicaid Services and the MCOs are as they were going to work together to start creating some uniformity in preauthorization forms. Is there anybody here who could speak to that? Commissioner.

COMMISSIONER KISSNER: Sure. We have met with the MCOs to start that conversation. It's more difficult than you would expect. We've started the conversation. We don't have a draft or anything to share. We just started the conversations.

There's a lot of complexity

1 surrounding the prior authorization with respect to
2 national managed care companies and what they do and how
3 they do it.
4 CHAIR PARTIN: Well, I'm glad that
5 the conversation has started; and maybe in November, we
6 might have a little more information. Thank you.
7 At the previous meetings, we had
8 some reports from the TACs. And, so, I would just like
9 to lump those together right here and maybe ask that
10 staff could provide us again with copies of those
11 recommendations - probably Barbara has those - in case
12 some of us don't have them and just take a vote now to
13 approve the recommendations from the TAC meetings that
14 were presented at the previous meetings in March, May
15 and July so that we can get moving on those. Would
16 somebody like to make a motion to that effect?
17 MR. VAN LAHR: I'll so move.
18 MR. CARLE: I'll second it.
19 CHAIR PARTIN: Any discussion?
20 So, if you could just email us the copies of those
21 various recommendations from the various TACs so that we
22 can look at those again. Everybody in favor? Opposed?
23 So moved. Thank you.
24 And then a question about the
25 upcoming open enrollment. When are the dates for the

open enrollment going to be, the start and finish?

COMMISSIONER KISSNER: October 27th to December 10th, I believe. The end date we've got to confirm. It starts October 27th through I believe December 10th. Someone is frantically looking on their cell phone to get that information.

CHAIR PARTIN: Thank you.

COMMISSIONER KISSNER: It's a passive enrollment. So, if they don't do anything, there's no change, no required change.

DR. NEEL: May I ask a question?

CHAIR PARTIN: Sure.

DR. NEEL: Is Lee Guice here? There you are, Lee. We had a discussion last week about I guess it's a computer glitch or whatever but it has to do with enrollment. Many, many, many of our patients are being inadvertently apparently moved to a different MCO when they recertify.

And that has created a big, big problem because there are so many providers who are not yet enrolled or credentialed with the new MCO companies, and these people did not choose to be disenrolled from their old MCO and put in a new one. And, so, I'm having the problem five or six times daily, and Lee tells me that that's been fixed but I'm still having it.

1 And what's happening with the
2 patients' parents, for example, let's say they were with
3 WellCare and they're being changed or they were changed
4 over to Humana. So, they call Humana. Humana says you
5 have to call WellCare. They call WellCare. They say
6 you have to call the State. When they call the State,
7 they're number 216 in line to be answered, and after
8 hours they hang up.
9 So, there must be some problems
10 still happening. So, can somebody speak to that?
11 MR. WISE: We are aware of the
12 problem. And you are correct that its origin, initially
13 when recertification of members started through the new
14 HBE, there was not a block put on the person changing at
15 that time even though it wasn't an open enrollment
16 period.
17 There are other little minor
18 issues that are causing similar things. It's not just
19 one problem that you find and fixed. Lee was relaying,
20 I think, that the problem has been fixed, but all of the
21 instances where that happened before the problem was
22 fixed have not been corrected yet. That's a systematic
23 process of looking back at everybody, but I think the
24 problem should not be in the future. It's correcting
25 the ones that have already had that issue.

1 And you're right. It can be fixed
2 by calling our Member Services but they are really busy
3 because they're doing a lot of things. The system will
4 eventually fix it but it can be fixed by calling Member
5 Services.
6 DR. NEEL: Okay. I wanted to make
7 sure you were aware because it's a pretty good size
8 problem for us. Thank you. Sorry.
9 CHAIR PARTIN: No problem. That's
10 a good point.
11 COMMISSIONER KISSNER: Point of
12 clarification. It's December 12th is the end.
13 CHAIR PARTIN: Thank you. Next on
14 the agenda is a report from the Commissioner.
15 COMMISSIONER KISSNER: In your
16 binders, I'm going to have you skip ahead because most
17 of it is the same stuff that you're used to seeing and
18 jump to Section 6. This is a new report that I don't
19 think you've seen before.
20 This is the Network Provider
21 Changes by Provider Type by County by MCO. So, you can
22 see, you go through all 120 counties and you can see
23 where they are by provider type by MCO. So, that's sort
24 of a good summary document.
25 And we're looking for trends there

1 to see if all of a sudden, we see a significant
2 departure of a provider type, dentists or chiropractors
3 or whatever in a given market. That's what we're using
4 that for and we can also compare the MCOs there.
5 CHAIR PARTIN: Can you say again
6 what this is? This is new?
7 COMMISSIONER KISSER: It's just a
8 different view roll-up of the information that's been
9 provided in the other documents that are behind this.
10 So, you have on the very first page, you've got Adair
11 County. Anthem had one change in Adair County where
12 they had a change in pharmacy.
13 This is just a roll-up of the
14 backup reports. So, it just gives the county and then
15 it runs from right to left. It runs through all of the
16 counties.
17 CHAIR PARTIN: So, when you say
18 change, so, for instance, under Adair County, under
19 APRN, it says one. Does that mean one has withdrawn or
20 one has been added?
21 MR. DOMINICK: One means that
22 there was one added. A negative one means that there
23 would be one dropped.
24 COMMISSIONER KISSNER: So, this is
25 net.

1 MR. DOMINICK: That's the net
2 change to the network by provider type by county.
3 COMMISSIONER KISSNER: Right.
4 Positive is good. Negative would be bad.
5 CHAIR PARTIN: Okay. And then
6 there's another report somewhere that tells us the total
7 number.
8 COMMISSIONER KISSNER: Well, it
9 tells you the actual people. That's the backup. So, if
10 you go to the next section, it actually lists all the
11 providers.
12 CHAIR PARTIN: Okay. Great.
13 Thank you.
14 COMMISSIONER KISSNER: The next
15 section, Section 7, there's three major reports here.
16 These are where we have sent, on two of them, we've sent
17 official notification to the MCOs. Those letters are
18 before the actual IPRO report. The first one is on
19 ESPDT screening encounter data validation, that the
20 final report was issued in May of 2014.
21 The second report is on Kentucky
22 Behavioral Health Study which is again an IPRO report on
23 the Behavioral Health Study, and that's been sent out to
24 the MCOs. I'm not going to go through all the reported
25 detail there with you but lots and lots of good

1 information worth reading. It will all be published on
2 our website.
3 The last one, which I don't
4 believe we have formally communicated with the MCOs yet
5 but that's something that will happen in the next cycle,
6 is the July report which is the Comprehensive Evaluation
7 Summary of the whole assessing and improving quality of
8 managed care service. So, that was sort of the EQRO,
9 External Quality Review Organization, that's their roll-
10 up there. So, good reports.
11 We have the good news stories.
12 I've asked the MCOs to step it up in terms of providing
13 these good news stories. The Humana one there on page
14 one there for July, that's an interesting one. A lady
15 went to the doctor complaining of a spot on her back and
16 the doctor said, don't worry about it, it's a benign
17 fatty tumor, and then actually gets in and sees another
18 doctor, changed and went to a different doctor and they
19 removed it. It was malignant and now she is undergoing
20 some chemotherapy, but it basically saved her life.
21 And, then, another one, the second
22 one there on Humana - I just raise these - all of these
23 are good and interesting to read - but the blood clots
24 and high blood pressure, really didn't understand his
25 medications. I think this is common for people who are

1 under blood-thinning thinners. They really don't
2 understand how to manage that, what's the management,
3 what's the drugs, how is it going which is alarming
4 because the compliance with blood thinners, it's of
5 upmost importance. So, that was one where now I think
6 through a lot of education and cajoling and a variety of
7 things, the patient is better-served. So, lots of
8 stories there for July and August.
9 Section 9, just by a show of
10 hands, how many people attended one of the MCO, managed
11 care forums? Okay. I got one.
12 This is all of those
13 presentations. All those presentations are here and
14 they're also published on our website. They have been
15 on our website for a while now. So, you can go through
16 there and look at the Powerpoints that were presented by
17 each of the MCOs, by the Department of Insurance, by
18 Behavioral Health - again, an interesting read,
19 definitely worth reading.
20 Section 10, that's the Member
21 Guide. We made a decision because we're trying to deal
22 with members and we have to through the flush testing of
23 communication material, we try to keep it simple. So,
24 we used the exact same methodology that we used last
25 time to compare the MCOs. We tried to simplify it.

1 This is based on their HEDIS scores and it does a star
2 ranking of one, two or three stars to keep it simple.
3 So, that's something that we included in the member
4 packets.
5 Section 11 is the performance of
6 our fee-for-service HP contract and they provide a
7 monthly report. So, we've included that as well.
8 Again, it tells you lots and lots of information about
9 how they perform their contract in terms of claims
10 payment and a variety of things.
11 The last section is really where I
12 want to spend a little bit of time. The first one is a
13 Suboxone update. In 2012, we ran all the claims data
14 for the MCOs and we found that Suboxone was number one
15 in cost for all of the managed care companies. It's not
16 number one in fee-for-service.
17 So, we said this is interesting.
18 We're trying to figure this out. I asked the guys to
19 give me January, July and December. Give me three
20 points in time, give me all the Suboxone - Suboxone is a
21 drug used for opiate addiction - but give me all the
22 prescriptions for that.
23 There were 290 physicians. In
24 that data set, there were 290 physicians that had a
25 script for Suboxone, but 81 of the physicians accounted

1 for 80% of the prescriptions. So, it was an 80/20 rule,
2 if you will, and 81 physicians treated 75% of the
3 members.
4 So, we looked at the pharmacies.
5 And the top 20 pharmacies, they tend to be independent
6 pharmacies, not the big box stores, which I don't know
7 what that means. Maybe that's where the people are
8 going.
9 Five hundred and ninety-two
10 pharmacies filled 100% of the scripts. The top 20
11 filled 80%, 79%. Seven percent filled 55%. So, there
12 is a clustering of dispensing pharmacies in this.
13 I gave you a list of the top 20
14 providers. According to the FDA, you go through an
15 eight-hour course. You get your Suboxone dispensing
16 sort of certification and you're supposed to have no
17 more than 100 active people in a month.
18 So, the number one doc there had
19 395 over the three-month period which may not be a
20 problem if, in fact, you had people coming and going in
21 the same month, but we used 300 as the example because
22 it's three months' worth of data. So, you should have
23 had no more than 300 unique prescribers.
24 So, we ran the top ten docs and
25 they had 1,300 Medicaid members, 18,000 prescriptions.

1 We looked at the cost, the pills, the cost per script,
2 the cost per pill. We looked at those 1,300 members and
3 17% of them are getting another opioid prescription.
4 So, they're getting treated for opioid dependence and
5 they're also getting a script for an opioid like
6 Percocet or Hydrocodone or Ativan or Klonopin.
7 CHAIR PARTIN: So, somebody is not
8 checking KASPER reports?
9 COMMISSIONER KISSNER: Yes. It
10 doesn't smell right, right? Forty percent of the spin
11 was drugs. Seventy-five percent of that is narcotics.
12 Twenty-one percent is independent labs. Twelve percent
13 is inpatient. Ten percent is outpatient hospital. Four
14 percent physician offices, and 2% CMHC's. And CMHC's,
15 in 2013, that was really where you went to get
16 outpatient services for mental health and a variety of
17 things. So, they probably weren't getting a lot of
18 counseling there.
19 We looked at the top ten providers
20 and we said where did their patients come from? And we
21 had three providers whose 100% of their patients came
22 from another county. And in total, 85%, 85% of the
23 patients came from another county. Does that sound
24 right to you?
25 MS. BRANHAM: There may not be

providers----

COMMISSIONER KISSNER: Right. So, dig a little deeper.

MS. BRANHAM: Yes, because, I mean, there are big box stores here.

COMMISSIONER KISSNER: There's some, yeah. Not in the top ten, but, yeah, in the top 20. So, yeah.

MS. BRANHAM: But it depends on where they reside and who can prescribe this, if it's the next county or whatever. On the top, in my opinion, just listening, looks like there are issues; but when you dig a little deeper and you see how many prescribers are in what counties and where's your cluster of prescribing physicians might be a little more enlightening than just----

COMMISSIONER KISSNER: Four of them were Breathitt in the top ten. So, 85% of a commute pattern. That's something we've got to dig deeper into, 85% of your patients because I don't know if anybody here has that sort of commute pattern in their practice where 85%of the people come from another county, but we'll dig deeper there.

We looked at the number of pills per prescription. Madison as a county was 54 pills per

1 prescription. To put it in perspective, Fayette, one of
2 the largest counties, Lexington, was 16 per script. The
3 average was 23. I don't know.
4 MS. BRANHAM: What's the reg?
5 They're going to get a script for 30 days.
6 COMMISSIONER KISSNER: These are
7 30-day scripts. They're just writing longer scripts.
8 MS. BRANHAM: Or Fayette County
9 docs may make them go back more often, every two weeks.
10 COMMISSIONER KISSNER: Right,
11 which might be appropriate. We did the top 400 docs and
12 some of them are prescribing three pills and four pills
13 at a time. That's their average script is come back and
14 see me.
15 This is one of those drugs.
16 There's certain drugs for alcohol addiction that if you
17 take it and you drink alcohol, it will make you throw
18 up. This one, you can actually get a DUI on this drug.
19 It's an opioid. It does have a narcotic effect. And we
20 don't know what we don't know.
21 MR. VAN LAHR: Two questions for
22 you real quick, Commissioner. One, do you include the
23 film tabs in this?
24 COMMISSIONER KISSNER: No. The
25 first analysis was just one NDC. I only looked at one

1 NDC because I wanted to get a quick--I just wanted to
2 see where do we need to dig deeper? What does it look
3 like? So, this was just one NDC; but if you get through
4 the rest of it, I'll show you the rest of the NDC's.
5 So, we ran a KASPER report which
6 is there and we see that there's been a 65.4% increase
7 in two and a half years of this drug. We ran all of the
8 KASPER scripts. So, 23% of the scripts were from
9 Medicaid and 20% of the population Medicaid. So, I
10 don't think that's out of whack.
11 The number of docs went up when
12 you look at all prescriptions because not every doctor
13 participates in Medicaid. So, you can see Oxycotin,
14 Oxymorphone, that has actually dropped and kind of
15 leveled off. Then you see Oxycodone prescriptions by
16 quarter. That's kind of dropped and leveled up, maybe a
17 little uptick in the second quarter, but we also had
18 more people covered for insurance in 2014. So, we have
19 to look at this on a per member/per month basis to get
20 some normalization.
21 Then you get Hydrocodone and
22 that's kind of dropped down and then Methadone has
23 dropped down.
24 So, we are now pulling all of the
25 drugs which you can see here on this last page, I think

1 it's page 19, you can see all the prescriptions. So, we
2 had just pulled the one that was the highest Suboxone
3 prescription NDC code. That's what we did for our
4 quicky analysis, but I think it indicated we need to dig
5 deeper.
6 We need to understand this, what's
7 going on. Is there diversion, possible diversion going
8 on? Are they being managed appropriately? Should there
9 be counseling? I think you would agree that if you're
10 treating them for opioid addiction, there should
11 probably be some counseling. We've checked other
12 states. We've checked other requirements for prior
13 authorization, and this is one of those things where
14 there should be something other than a script.
15 When we dug a little deeper - this
16 is not in the report - on one of the findings, 50%, in
17 one of the providers that we looked at, 50% of the
18 people had no other claim. They just had a
19 prescription, and that doesn't seem right, right? Does
20 it? No other claim, no 99213, 99212, no office visit,
21 no other claim submitted for that patient, for that
22 doctor, other than here's a script.
23 MR. CARLE: And that was 50%?
24 COMMISSIONER KISSNER: Of one
25 provider we looked at when we were digging deeper.

1 MS. BRANHAM: They're paying out
2 of pocket.
3 COMMISSIONER KISSNER: They're
4 paying out of pocket to go to the doctor. There's
5 something there. I don't know if we understand it
6 enough, but we're digging deeper and we're pulling more
7 data. We're looking at KASPER. We're looking at it to
8 say is that right and what's going on, and is that a
9 widespread thing that everybody is paying cash for this
10 or is that just something that a few providers are
11 doing?
12 MS. BRANHAM: A lot. Walk-in
13 doctors' offices that are prescribing.
14 CHAIR PARTIN: Suboxone is a
15 problem.
16 COMMISSIONER KISSNER: I am glad
17 you say that. We want to dig deeper and provide you
18 with information and say this is what we're looking at.
19 I think Van Ingram from the Office of Drug Policy, he
20 believes we've got an issue here. I think the KBML
21 believes we have an issue here. So, we've got a lot of
22 people together to try to help figure something out
23 here.
24 CHAIR PARTIN: The Board of
25 Nursing thinks it's a problem, too.

1 COMMISSIONER KISSNER: Okay. So,
2 the Medicaid Integrity Institute, one of our team
3 members went out and did a presentation, was asked to do
4 a presentation at a national to talk about our
5 recoveries and what we do. So, I put that in there
6 because it was a national presentation that one of
7 Veronica's team did.
8 You guys probably don't see this.
9 I get it, this next one with the green cover here. This
10 is comparative data of Medicaid which I thought you
11 might find interesting. This is from the Southern
12 Legislative Conference. So, it doesn't include all
13 states. It's like Kentucky and South is the states that
14 participate.
15 They put out basically where you
16 spend money, how do you spend it, and I highlighted in
17 here Kentucky. So, you can see compared like in the
18 Southern Region which is Georgia, Virginia, Florida,
19 Alabama, South Carolina, Oklahoma, Texas, North
20 Carolina, Maryland, Tennessee, Kentucky, Missouri,
21 Arkansas, Louisiana, Mississippi and West Virginia, you
22 can see what's the average spend per capita on Medicaid.
23 The lowest is Georgia at $862 and
24 the highest is West Virginia at $1,544, and we're
25 slightly north of the Southern Legislative Conference

1 average which is the white bar.
2 Then you get into different pieces
3 like what do you spend per recipient per service, what
4 do you do with general hospital costs, skilled and
5 intermediate nursing facilities? Kentucky is number one
6 in ICF/MR facilities, more than double the SLC average.
7 We're at $226,000 per person, per recipient.
8 CHAIR PARTIN: Any idea why?
9 MS. BRANHAM: Per year?
10 COMMISSIONER KISSNER: Per year,
11 yes.
12 MS. BRANHAM: Two hundred and
13 twenty-six thousand dollars per recipient per year?
14 COMMISSIONER KISSNER: Per
15 recipient per year, right. I'm not sure we know why,
16 but the average is $105,000 and there are states that
17 are doing it for fifty, so, something we've got to dig
18 into.
19 So, I give you all that
20 information. The DSH payment is trending down. Twenty
21 thirteen went down pretty substantially but that's for
22 all the states. It stayed relatively flat, up slightly
23 for the mental hospitals.
24 Right after that section, there's
25 a members hearings and the performance there and we have

1 been tracking it. We found that for the second quarter
2 of 2014, we had a significant percent increase in the
3 amount and overall met within the time frames, and I
4 think really data reporting was the problem.
5 If you're going through the
6 process and you go through a member appeal and you're
7 going to go before the Administrative Hearings Branch
8 and everybody agrees, let's extend it like twenty days,
9 we can get in to see the judge or whatever, we need some
10 more information, if everybody agrees to extend it,
11 then, it's not late, but we weren't getting all that
12 information in our database. We were just getting sort
13 of a start date and a closure date and we were assuming
14 that if it lasted longer than a specific time frame, it
15 was wrong.
16 So, that's what that is. We'll
17 continue to monitor that and make sure that we're
18 getting the information that we need.
19 I did a red/green analysis, the
20 team did because they know my fondness of red/green to
21 show where is it performing at.
22 The State Medicaid Profile of
23 Kentucky, that was part of that green presentation. It
24 just got inserted with this other thing between it, but
25 I copied the entire Kentucky state information from the

1 Southern Legislative Conference so you can see where we
2 are on total Medicaid expenditures and all those dollars
3 that rolled up into that report that you were looking at
4 that compared us to those other states.
5 It's all in here in terms of how
6 much is hospital and mental health and skilled and
7 intermediate care and all that sort of stuff, and you
8 can see the dollars associated with that. And, then,
9 they have payment by type of service and average payment
10 per recipient, and that's where it gets the intermediate
11 care and the ICF/MR. That's the $226,000 amount in
12 there.
13 MS. BRANHAM: Commissioner, when
14 you look at average payment per recipient in skilled and
15 intermediate facilities for Kentucky, we're at 21. So,
16 we're kind of towards the bottom. Then you look at the
17 intermediate care and it's two hundred. I just have
18 trouble comprehending what that would be comprised of.
19 COMMISSIONER KISSNER: I think
20 that might be something that you want to assign to the
21 TAC. Let's do an investigation and figure out what
22 services are being rendered. I can pull what reports we
23 can pull on that to see what that looks like, but I
24 agree with you. That seems to be a lot of money, right,
25 to take care of somebody for a year. Maybe not.

1 MS. BRANHAM: Obviously it is if
2 we look at our other southern states. We probably need
3 some direction on that.
4 COMMISSIONER KISSNER: We'll keep
5 digging. We'll do it as a take away to do a deeper dive
6 and report back to you when we can get some data and try
7 to figure it out on what exactly are the services
8 rendered there and maybe do a pie chart of the services
9 rendered and how much is for drugs and hospitalization.
10 MS. BRANHAM: Because if you look
11 at drugs and you look at intermediate care and you look
12 at physician payment, you would expect us to be high in
13 all of those which would calculate to have the two
14 hundred plus per recipient, but that isn't what these
15 other graphs show. So, I'm just very curious about that
16 because it's in facilities.
17 COMMISSIONER KISSNER: Right.
18 It's Oakwood, Outwood, those facilities. And I think
19 what's happened over time is in the presentations from
20 the MCO forums, there's a presentation from Dr. Brenzel
21 and Mary Begley, Commissioner Begley from BH/DID and it
22 talks about years ago, we ran these big facilities and
23 we had a census of, I don't know, four or five thousand
24 people daily census and now we're at a daily census of a
25 few hundred. We still have that big giant facility,

still have the care and feeding of a big giant facility. And, so, the unit cost keeps increasing, right.

It's like saying I've got a Marriott Hotel and I built it in Downtown D.C. and I only have 10% occupancy. What's my room rate? I mean, there's not enough Groupons to get people in there to do that. All of a sudden, it's just to keep the building open, I need $500 a night and nobody is paying $500 a night.

And that's kind of where some of this information is because you're edging up on $1,000 a day, right, is what some of this is showing you. So, at some point, the last ten people you have in that facility will cost you half a million dollars apiece of a million dollars apiece because that's what is left to pay the--you're not fundamentally changing the cost structure.

MS. BRANHAM: Right, your administrative and general.

COMMISSIONER KISSNER: There's some staff but the building doesn't change and the air-conditioning and the electricity unless you go dark on certain pieces of the building. There's lots of strategies for managing a fixed cost asset, but it's just one of those things where we're at that point.

1 Many states have just completely gotten out of this
2 business and said I'm going to sell it off or I'm going
3 to outsource it or I'm going to do something and not
4 have any more of those facilities actually run and
5 operated by the State. We have contracts. I think one
6 of the CMHC's handles one of them for us where they
7 actually do the work of managing it.
8 I give this to you because I don't
9 want to be the only one who gets this information and
10 says, um, I don't know if that makes sense or does that
11 smell right or does that look right.
12 So, I want you guys to be thinking
13 abut this and saying let's dig a little deeper there
14 because I don't know if you've ever seen this. It's
15 something that comes out like every six months or so.
16 Actually it's a thin paper report that comes out. It
17 probably is available online somewhere at the Southern
18 Legislative Conference's website, but I just thought you
19 guys should see it and spur the questions and for us to
20 dig a little deeper.
21 MR. CARLE: Commissioner, if I
22 could go back to your red light/green light report, the
23 cover page of that. I don't quite understand overall
24 percentage met for the last quarter went from 11% to 98,
25 and an overall percent that's not met went from 89 to 2.

COMMISSIONER KISSNER: Right.

MR. CARLE: What is that referring to?

COMMISSIONER KISSNER: The inverse. So, one is met and one is not met. And what I'm saying is when you look over the historical, it was bad data that was causing it. So, I got the start date. I got the end date. And if it wasn't in the time frame, it's red. It failed.

But if, in fact, the lawyers and the judges and the Administrative Hearings' people, if they say I'm going to extend it twenty days to get more information from a provider or for whatever reason, but we all agree, we're all in agreement, yeah, okay, then, we do twenty days.

All I know is that I got that end date which is outside the parameter which I was counting that as a failure when, in fact, it wasn't because they all agreed. So, it was data that was causing those numbers to sort of a miscue on the data.

MS. ANGELUCCI: I had a question about why Kentucky is so high on the in-service. And you were talking about some were outsourcing. So, is that why they're lower than us? Are they already outsourcing?

1 COMMISSIONER KISSNER: You know, I
2 don't know. I don't know. I know that some states
3 basically don't have any mental hospitals, facilities,
4 state-owned facilities anymore. It's all been shifted
5 to the private market or they sold the assets or they
6 turned them into outpatient centers. There's a lot of
7 issues there.
8 Really, that would be a much
9 better conversation for the Behavioral Health and DID.
10 Dr. Brenzel could probably talk off the top of his head
11 on all those changes that have happened over the last
12 twenty years to say we don't want prisoners. They
13 should be in the community. They should be driving to
14 home- and community-based services. They should be more
15 outpatient-based.
16 It all starts back with Olmstead
17 and all those other changes that happened that said
18 we've got to reduce the daily census here, and we've
19 made great strides in that. I think the downside of
20 that is we still have a fixed-cost structure with fewer
21 and fewer people.
22 And, then, the very last thing was
23 the TAC meeting. There was a letter there that we stuck
24 in that was about our NEMT. I think we're asking for an
25 extension there, the waiver application for the NEMT.

1 And then the last piece was one of those TAC meeting
2 documents you were looking for. That was the Dental
3 TAC.
4 DR. RILEY: Commissioner, the
5 minutes that are in there are the original version.
6 Those were corrected on July 17th. I didn't realize
7 until this morning that the original minutes had been
8 submitted rather than the corrected final draft, and I
9 submitted those to Barbara this morning.
10 COMMISSIONER KISSNER: Okay. If
11 it was this morning, Barbara is out today. It probably
12 didn't make it into the binder.
13 MS. ROARK: Commissioner, I want
14 to add that I'm a parent. My daughter started off with
15 heroin and she went into one of those Suboxone clinics.
16 I have been in front of a judge in Jessamine County four
17 or five times to get the Casey Law for him to sign it so
18 I can get her into rehab.
19 She has abused the Suboxone
20 clinic. It's like three or four hundred dollars. In my
21 town, it's going for $25 a strip and then they take them
22 to the eastern part of Kentucky and they're $40 a strip.
23 My question is, I would rather see
24 her doing that as on the needle, but I've been down
25 there talking to the Suboxone clinic. How long do you

1 stay on that? They're not following up with support
2 groups, counseling. They're giving them the medicine.
3 They're not following up with what they're giving them.
4 And now I heard, I'm blessed and
5 thankful that I guess the medical card is going to pay
6 for that or they're going to switch the formula to
7 something like Suboxone. So, therefore, I think that
8 might cut down on them trying to sell it on the street
9 because the medical card is paying for it. I don't
10 know.
11 Right now my daughter is in jail
12 waiting to get a rehab. I have been calling everywhere
13 and it's a big epidemic.
14 I'm trying to encourage her to go
15 on to Vivitrol shot. To me, if you're on Suboxone, I
16 don't know how long--I don't think five years you should
17 be on that, that you should be kind of weaning off to go
18 into some type of positive, getting jobs and get back on
19 your feet. And taking the Vivitrol shot is one time a
20 month. You can't abuse it. You can't sell it. You
21 can't do anything.
22 That's the problem. These
23 Suboxone clinics are getting a lot of money and I don't
24 think they care about these patients. And now my
25 daughter says that she has went down there and I think

1 I'm going to go to CoventryCares because they're paying
2 for it and my doctor don't seem like she cares. I said,
3 well, I think she found out you're abusing it. You're
4 not following through with what you're supposed to do.
5 So, as a parent, I can really
6 touch on this subject about Suboxone.
7 COMMISSIONER KISSNER: It's
8 interesting. The Methadone clinics for heroin addiction
9 - there's seventeen or eighteen clinics in the state -
10 they're overseen by Behavioral Health.
11 So, prior to 1/1, we didn't cover
12 any--we covered pregnant women and children who had
13 substance abuse, and now we actually have substance
14 abuse covered. It was one of the things of the ACA that
15 said you've got to cover this.
16 So, now we actually have tools to
17 deploy. So, all the MCOs have been covering Suboxone.
18 It's on their Formularies. They all cover it. Some
19 start with strips, some start with the pill, but it's
20 always covered.
21 With Methadone, it's like a daily,
22 as I understand it - this has been explained to me by
23 Dr. Brenzel - it's daily dosing. So, you have to show
24 up and they give it to you and they watch you take the
25 drug. And, then, over time, they try to do tapering.

1 They try to sort of wean you down and you can earn the
2 right for like Thanksgiving or Christmas, I'll give you
3 two pills and I'll let you take one home so that you can
4 take it tomorrow, that kind of stuff. You earn the
5 right to do that.
6 They start with you have to come
7 to the main clinic and then you can earn the right to go
8 to a satellite clinic that's a little closer to your
9 home, and it's very, very regulated, managed. They
10 require that you do treatment, that you do counseling,
11 and all of that is monitored and tracked; whereas, as we
12 look around other states with Suboxone, some states are
13 saying, well, we're not going to fill the next
14 prescription unless a claim comes through the system
15 that says you actually are doing some therapy, some
16 counseling, because it's not just here's the drug. That
17 can't be the answer.
18 I agree with you. That's not
19 probably a good, long-term medical outcome for the
20 medical professionals in the room, I'll just give you
21 the drug. Best practice from what we understand is that
22 it should be coupled with counseling, with therapies,
23 group therapies, individual therapies. There's lot of
24 stuff there that you need----
25 MS. ROARK: Monitored with drug

1 testing.

2 COMMISSIONER KISSNER: Drug

3 testing, right, all of that. And that's all stuff that

4 the Methadone clinics do. They do random drug testing.

5 They do periodic drug testing. They make sure the drug

6 you're supposed to be taking is in your system at the

7 appropriate levels, and they also confirm that there's

8 no other drugs in your system that shouldn't be there.

9 And the Methadone clinics actually

10 have a very high success rate. For the people that stay

11 in it and do it, they will eventually get back to

12 they'll get a job. They work in the community. They're

13 back on track - high success rate.

14 And I don't know if we have any of

15 those statistics because we really haven't provided the

16 coverage. We haven't provided counseling for substance

17 abuse in the Medicaid Program. So, now that we have it,

18 we want to make sure that people are using it, but we're

19 learning more on this all the time.

20 So, we know it's an issue, and I

21 think as we shut down--you know, we had 30, 35%

22 reductions in Oxycotin and other stuff, KASPER and we've

23 done things to drive down some of the diversions of

24 those other products. We've seen heroin go up and now

25 we're seeing Suboxone is increasing all the time, too.

1 MS. ROARK: And another thing, on
2 the Suboxone, they crush them. They shoot them up -
3 that's scary - the strips or gel and that can get
4 clogged up in your arms.
5 I know it's a thing, but my
6 daughter suffers from mental health, so, that's the
7 problem. And once you get that cleared up, and I
8 noticed the side effects to Suboxone, she's up all night
9 long and sleeps to five or six o'clock the next day.
10 What kind of life is that? And she is only 24 years old
11 and she's already got anxiety and the side effects of
12 Suboxone, that's just worse.
13 Thank you. I appreciate that.
14 CHAIR PARTIN: Thank you, Peggy.
15 Thank you very much. I think that's very helpful.
16 The other thing on this report, it
17 said 81 physicians wrote 80% of the prescriptions for
18 the Suboxone.
19 COMMISSIONER KISSNER: Yes.
20 CHAIR PARTIN: But I thought that
21 that was regulated and that only the physicians that
22 went through the course and had established the program
23 were able to write that. So, it should be 100%.
24 COMMISSIONER KISSNER: Let me
25 clarify that. There's about 600 providers in the state

1 that have gone through the certification, actually have
2 the ability to write a Suboxone script. When you start
3 running those scripts, there's a clustering, and 81
4 providers are writing 80% of the scripts.
5 So, a doctor that has the ability
6 to write a script may see one or two patients. They're
7 not seeing 100 patients. When you start getting that
8 level of clustering, it seems to be unique and we want
9 to investigate further as to what's going on.
10 MR. VAN LAHR: Are these docs in
11 pain clinics?
12 COMMISSIONER KISSNER: We don't
13 know yet. We looked at one doc and he was operating out
14 of four different clinics. One of them was a rural
15 health center, and the rural health center, the claims
16 data looked like a normal provider in a rural health
17 center, encounters and seeing people for a variety of
18 things.
19 And then it's the other three that
20 we haven't done a deep dive as to what's going on, and
21 that looks like where all the prescriptions are
22 happening in those other three clinics.
23 CHAIR PARTIN: So, at our next
24 meeting, can you bring back more information to us for
25 that?

1 COMMISSIONER KISSNER: Yes.
2 CHAIR PARTIN: And then also the
3 long-term care costs.
4 COMMISSIONER KISSNER: Yes. The
5 cost of that is exactly--that is the fundamental basis
6 of our Waiver Programs is you can get Home- and
7 Community-Based Services, Supports for Community Living.
8 You can get home and do it a whole lot cheaper, and in
9 many instances increase the quality but do it for less
10 money if you get it done in the community with home
11 health services. There's a lot of things you could
12 provide for that kind of money.
13 The same thing is true for nursing
14 homes or long-term care and nursing homes. If we can
15 get somebody back to the community, we could save some
16 money.
17 MR. WHALEY: So, Commissioner, I
18 think your report had said 3.2% decrease in populations
19 across that entire area. Are we keeping pace with that
20 in terms of reduction of population in those ICF/MR's?
21 COMMISSIONER KISSNER: Yes. We're
22 moving a lot of people.
23 MR. WHALEY: We're keeping pace
24 with the other states, then, in terms of a reduction of
25 population for returning people in the community?

1 COMMISSIONER KISSNER: Yes, I
2 believe so. They might have leap-frogged us by getting
3 rid of their facilities. They might have changed
4 something there. The comparison of other states I found
5 is sometimes difficult because there's no--Medicaid is
6 Medicaid is Medicaid for each state. The mandatory
7 services are mandatory. Optional services you don't
8 have to provide.
9 When we did our dental comparison,
10 we found a lot of the states around us, they provide
11 emergency dental only for adults. That's all you have
12 to do. They look at squeezing the balloon somewhere
13 from the budgeting perspective. What levers do you
14 pull? Well, the optional levers are ones that a state
15 can make a determination I'm going to pull that back a
16 little bit.
17 And, so, when you look at like the
18 unit cost comparison across states, sometimes they pay
19 more per unit but all they do is emergency dental
20 services. So, those are the kind of things that make a
21 comparison. They might have 12 visits. They might have
22 a limit on services, the number of services. So, that
23 dampens the per recipient or the per member/per month
24 result. You've got to kind of figure all of that out.
25 It's not the easiest thing to do.

1 CHAIR PARTIN: Thank you very
2 much.
3 COMMISSIONER KISSNER: Thank you.
4 CHAIR PARTIN: We'll go ahead and
5 move on to the reports and recommendations from the
6 TACs. First up Behavioral Health.
7 DR. SHEILA SCHUSTER: Good
8 morning. Sheila Schuster from the Behavioral Health
9 TAC. And actually we don't have a formal report for you
10 because we did not meet the last cycle before this
11 meeting. Many of our folks went to the Medicaid
12 Provider Forums and we felt like we had a lot of
13 opportunity to interact.
14 I do want to bring to you, though,
15 the same question that I asked back in May when there
16 was open enrollment and that is my concern about an open
17 enrollment that's starting in a month and two days for
18 one million people, and I'm wondering if there aren't
19 other possibilities for people to change their MCOs
20 other than to make a phone call.
21 Let's think about this, folks, and
22 I think Dr. Neel talked about people not getting through
23 and then getting discouraged.
24 That's a huge volume. Can they do
25 it online? Can they do it back through the way they got

1 into Medicaid to start with which is back through the
2 Connectors or DCBS? Most of us, if we want to change
3 our insurance, go back to where we got the insurance to
4 start with which is our agent or whoever signed us up.
5 So, the logic in me says, number
6 one, we need multiple ways of people being able to
7 change their MCOs, and one of those ways would be to go
8 back through the Connectors or the Assistors and even
9 the agents and so forth. Just an idea.
10 We are always concerned about how
11 Medicaid members will know that there's an open
12 enrollment process. I believe when we were here in May,
13 at that point, there was no notification on the website.
14 The providers had not been notified and so forth. I
15 don't know if the plan is again to do a mailing.
16 For people with significant mental
17 health problems, they don't open their mail. They're
18 sure that it's going to hurt them or there's something
19 in there. Most of them do not have guardians so that
20 their family members are not aware. We have all kinds
21 of groups, namely the NAMI groups, National Alliance on
22 Mental Illness. We have lots of ways of getting the
23 information out there. It would be helpful for us to
24 have that information as early as possible to help in
25 that process.

1 Just a comment on the ICF/MR from
2 a clinical perspective. These are very complex folks
3 with the most significant needs, and most of them have
4 been in these institutions most of their lives.
5 So, while I am all for community-
6 based services, moving people out, I think the bulk of
7 people that are going to be able to be moved out where
8 the families were okay with their moving out, have, in
9 fact, been moved out. I agree with the Commissioner
10 that you have these huge facilities and a much reduced
11 number of people, so, your per person cost.
12 I don't know in other states when
13 they just willy-nilly closed the facilities. When we
14 did that with the psych hospitals, it didn't work out so
15 well. People ended up homeless which they are now and
16 people ended up in jail and people ended up committing
17 suicide and so forth.
18 I will say that the TAC continues
19 to be concerned and I'd like to set up a meeting, I
20 guess, with Erin Hobin and others who gave us some
21 initial information. We still are concerned about the
22 lack of access to medications. We were told by at least
23 one of the MCOs at our last meeting, yes, people have to
24 fail twice. People have to fail on two different drugs
25 before we're going to authorize the drug that was

1 prescribed.
2 These are real people, folks.
3 These are people that when they go get their medications
4 are haunted by hallucinations and delusions and
5 psychotic thinking. And, so, a fail first, we're
6 failing these people. We're failing in providing them
7 the care that they need.
8 Little things like consistency of
9 forms across the MCOs drives up the administrative cost
10 and every one of you understands that. If you've got a
11 PA form that's this way for WellCare and this way for
12 Passport and this way for CareSource, you've got five
13 different things to learn, so, your administrative
14 costs, and that certainly has been true for the
15 community mental health centers.
16 And the final question that I
17 would raise on behalf of the Behavioral Health TAC, we
18 argued for a carve-out. I'm going to be real honest
19 with you. When managed care was talked about, we argued
20 and argued and argued.
21 We're 3% of the Medicaid budget
22 but we have a very unique population of folks that need
23 to be cared for and we argued and argued and argued that
24 we should be carved out. And the reason that we were
25 told we were not carved out is because this is the only

1 way to get integrated care, to make sure that the
2 physical health and the behavioral health were talking
3 to each other, were coordinating and contributing to
4 increased care.
5 And I'm here to tell you, we have
6 yet to see integrated care for our folks. I don't know
7 where it is. I don't know what it looks like, but I
8 haven't seen anything that says to me that that result
9 is actually happening.
10 And I think all of us need to be
11 reminded that we're talking about whole people. I
12 appreciate your courage in talking about your daughter
13 and talking about the kinds of pain that parents have.
14 And you know that she not only has substance use
15 disorders but probably a primary mental health diagnosis
16 that drove her to substance use, and now she's having
17 physical problems if she didn't have them before.
18 So, Suboxone or Methadone alone is
19 not going to do that. We do this with kids with
20 Ritalin. We're not teaching them any better behavior.
21 So, what's the behavioral support? What's the
22 therapeutic support? And what's happening on the
23 physical health side for your daughter? So, I
24 appreciate your courage.
25 MS. ROARK: She also has female

1 cancer and she has neglected that. On touching on that,
2 I personally have ADHD and I have been on medicines for
3 five years.
4 Don't you know that last month, I
5 had to go four days without my medicine because they
6 changed for formula. My doctor said she don't get paid
7 to be on the phone for five hours to get five different
8 patients their medications.
9 So, I'm looking at diabetes
10 medicine now. So, I'm sitting here thinking, who wants
11 to go on a pill and then you don't know if you're going
12 to get it the next month.
13 DR. SCHUSTER: Which is the story
14 that we've told over and over again. Every MCO has a
15 different Formulary and a different P&T process. And
16 when we had a set, again, something we begged for at the
17 beginning of this process, let the Formularies be the
18 same for everybody in Medicaid as they were, have one
19 P&T Committee, and I know the MCOs hate all that.
20 But it is impossible, a family
21 member or a consumer - I don't care how smart you are or
22 how much you know about this system - or as a provider
23 to keep track of those changes in Formulary and to know
24 what was approved this month, you go to the pharmacy and
25 you can't get. This is not good care. I know I'm

1 preaching to the choir, but our little folks - we're 3%
2 of the budget but these are real lives that are not
3 getting their medication and not getting their
4 treatment.
5 MR. VAN LAHR: I can appreciate
6 your comments pertaining to pharmacy. That's what I do.
7 A couple of pieces in there that need to be considered.
8 One is, you have that problem
9 within the same MCO. When you change MCOs, it's a whole
10 new ball game. Looking at my calendar, my concern for
11 this coming year is that a lot of people will have plans
12 take effect January 1.
13 Well, what's going to happen in
14 the pharmacy sector is Part D Plans take effect January
15 1. The changes in MCOs might take place January 1.
16 That's going to be on a Thursday. Everybody will be
17 closed - the state offices. The MCOs will not be
18 functional to some degree on Thursdays. It's short-
19 staffed. They'll be back on Friday but then they're
20 closed on Saturday and Sunday.
21 So, we could have four, five, six
22 days of problems with medications for these patients
23 with no recourse. A lot of the plans will give you an
24 emergency three-day supply. Well, Thursday, Friday,
25 Saturday.

1 So, I think somewhere along the
2 line we need to look at that and give some provisions,
3 especially when you have major changes in plans for
4 these patients that need the medications.
5 The last piece of this just in the
6 conversation here is that understand that when we as a
7 pharmacy and we notify the provider that this medicine
8 is no longer covered and it needs to be preauthorized,
9 for most plans anymore, we don't get the notice. The
10 provider gets a notice it's been approved or
11 disapproved. We don't know, and I think that is another
12 issue.
13 DR. SCHUSTER: A disconnect even
14 between the provider and the pharmacy and the MCOs.
15 MR. VAN LAHR: Yes, and it's a
16 matter of whether the provider--we send the provider the
17 notice. Again, the same kind of problems. We send the
18 provider notice on a Friday.
19 Well, they may not get to the
20 preauthorization until Monday or Tuesday. It may not be
21 preauthorized until Wednesday, Thursday or Friday. We
22 may not know for another day or two after that. So, it
23 could be a week to ten days before we actually know at
24 the pharmacy level that it's been approved or not.
25 And what happens a lot of times

1 with the independent pharmacies, we'll say we'll give
2 you some to get you through at our expense. That's the
3 independent person versus the chains.
4 MR. CARLE: Dr. Schuster, can I go
5 back to your issue with the carve-outs?
6 DR. SCHUSTER: Yes.
7 MR. CARLE: What kind of
8 indicators do you feel that you could recommend that the
9 MCOs could provide in the dashboard to see that that
10 continuum of care is actually happening from the medical
11 side to the behavioral health side because they've got
12 all the information.
13 And I think from a hospital
14 perspective, we see that as well and it's happening, but
15 it seems that we need some documentation to see how well
16 it's being done. And it would be helpful if you could
17 recommend and the Behavioral Health TAC could recommend
18 maybe some indicators that they can include in their
19 dashboards so that we could track that and see how well
20 they are actually doing.
21 DR. SCHUSTER: That's an excellent
22 question. I'm happy to take that back to the TAC.
23 The only thing I know of that's in
24 the MCO contract that even roughly touches on it is a
25 requirement for a report from the behavioral health

1 provider to the primary care provider once every three
2 months. What does that do?
3 MR. CARLE: And, also, since we're
4 talking about that, I'd like to request that for the
5 psych hospitals, we actually include admission rates,
6 average length of stay and re-admissions to psych
7 hospitals because I don't see that we have that
8 information, and that might be helpful as well.
9 DR. SCHUSTER: The other problem
10 that we've had that we've talked about here at the MAC
11 is your stepdown programs, your IOP's have closed in
12 some cases, Northern Kentucky for Children, because the
13 MCOs were not authorizing enough lengths of stay to keep
14 it open.
15 On the people with severe and
16 persistent mental illness, the therapeutic rehab
17 programs or the day treatment programs have closed at
18 Bluegrass, seventeen counties - all gone because the
19 MCOs were not authorizing and not paying for it.
20 And the responses that we've
21 gotten from some of the psychiatrists that look at the
22 requests for outpatient treatment from some of the MCOs
23 is this person can't get any better. Well, no. What
24 kind of a response is that? So, we're going to
25 authorize one-every-three-month medication, but, no,

1 we're not going to authorize any other kind of
2 treatment.
3 MR. CARLE: And while we're on the
4 dashboard, the dashboards are very helpful and I really
5 appreciate everybody's effort to do that because it
6 takes a while to compile this information.
7 But, again, from the behavioral
8 health side, what we'd like to see is more detail. She
9 brought up the intensive outpatient services. We'd like
10 to see detail on the denials, denials of inpatient and
11 denials of the intensive outpatient services contained
12 within the dashboard as well.
13 So, that would be another request,
14 that the Behavioral Health TAC with the Hospital TAC
15 would request that.
16 DR. SCHUSTER: We certainly second
17 that, the Behavioral Health TAC. Our questions have
18 been around denials because we know with our folks, if
19 they don't get their medication or they're put out
20 treatment, they fall off the cliff at that point.
21 And, so, knowing what those
22 denials are, and, quite frankly, if it takes ten days to
23 resolve a denial and get back to the pharmacy or to get
24 back within the treatment, we've lost that person, and
25 more often than not that person has wandered off and

then we spend months trying to get them back into the system to start all over again with taking their meds and getting back in the system.

MR. CARLE: Thank you.

DR. SCHUSTER: Thank you.

CHAIR PARTIN: Chris, could you say again, on the dashboards, you wanted information on the hospital denials and what else?

MR. CARLE: The IOP, intensive outpatient care.

CHAIR PARTIN: Denials for IOP's?

MR. CARLE: Yes, but we'd also, then, like a dashboard for the psychiatric hospitals included for their readmission rates, their average length of stay and their just overall admission rates to just have some detail for the psych hospitals.

DR. NEEL: I have a question for Sheila. You brought up ADHD which to a pediatrician is very important. For us senior pediatricians, we were taught how important behavior modification was along with medication years ago.

That's gradually disappeared almost completely; and with the idea that maybe one in ten children have ADHD - I don't think it's quite that high - there has been a big push in all the news over

1 the last few weeks about how we need to do behavior
2 modification. All of a sudden, there's a resurgence of
3 that.
4 However, what we're finding in the
5 pediatric world is we don't have mental health providers
6 that will do the behavior modification treatment, and
7 most of the new ones we have won't see Medicaid. We're
8 having a huge problem in the community with that.
9 Is that what you're seeing, too?
10 Can you confirm?
11 DR. SCHUSTER: Putting on my
12 psychologist's hat because I'm on the Kentucky
13 Psychological Association, we have some psychologists
14 were very pleased to have the Medicaid behavioral health
15 opportunity opened to them. It has taken much, much
16 longer for them to get credentialed through Medicaid and
17 then start down the path of which of the five MCO's am I
18 going to negotiate with and so forth.
19 Within that population, Dr. Neel,
20 quite frankly, I don't know how many of them see kids.
21 Those of us who see kids are a different breed than
22 those who see adults. So, I think you have all of those
23 issues, and then you have the issue of location,
24 location, location.
25 One of the things that I said at

1 the behavioral health portion of the Medicaid Forum was
2 if you look at the Deloitte information, they were
3 clueless because none of the licensure boards for mental
4 health asked the right questions.
5 I'm a licensed psychologist. I
6 haven't practiced clinically since 2000 except what I do
7 up here with legislators as a child psychologist. So,
8 I'm there as one. I'm sure Deloitte counted me, but the
9 Psychology Board doesn't say are you practicing? Are
10 you practicing full time or part time? What counties
11 are you practicing in? And are you also licensed by
12 another board because we have people that are doubly
13 counted.
14 I'm right with you. You and I
15 have talked about this for years. There's some point in
16 giving a child the medication. It's not nearly as
17 effective as doing it, you know, if we slow them down
18 and we get him concentrating, what is it that he needs
19 to learn in terms of behavior and what does he need to
20 learn in terms of more effective approaches in the
21 classroom or at home or whatever. It's a real problem.
22 DR. NEEL: Thank you.
23 MS. BRANHAM: Dr. Sheila, how much
24 difference is there for the population that we're
25 discussing currently in the care and the continuum of

1 care that they had to now? Did you see that it was
2 easier for these folks to get their meds, to get the
3 treatment?
4 DR. SCHUSTER: Absolutely.
5 MS. BRANHAM: Really, we've taken
6 this small, small piece of the Medicaid budget and gave
7 it to the hands of five basically, and what they are
8 doing is destroying the population that we should be
9 here protecting because they can't get the care that's
10 needed. Is that what you're saying is the bottom line?
11 DR. SCHUSTER: You've said it very
12 well and I would absolutely agree. The Behavioral
13 Health TAC, we've met with the MCOs. We have a good
14 dialogue with them and so forth, but we come up against
15 the same things time and time again.
16 In fact, we're looking at how do
17 we define that continuum of care that Chris asked about
18 actually in terms of the dashboard. Well, there are
19 huge holes in it? Well, guess what? Those holes were
20 created by the system we're in now. Those holes weren't
21 there.
22 We didn't have a perfect system -
23 I'm not saying that - but we had a whole lot more
24 continuum of care for people with severe mental illness
25 than we do now.

1 MS. BRANHAM: So, this impacts
2 everything from rehospitalization on down the line. So,
3 what can we do to help you to make an impression that,
4 as we move forward, that this is probably a population
5 and a very small percentage of the population that needs
6 to be backed out of the hands of five?
7 DR. SCHUSTER: Let's all say the
8 same thing. I think we need to be carved out. We've
9 said it all along.
10 MS. BRANHAM: So, what's stopping
11 us from going forward with that, then?
12 DR. SCHUSTER: Well, I think it's
13 called the SPA. I think it's called the
14 Administration's determination that all of Medicaid
15 should be under managed care.
16 MS. BRANHAM: But it's not all
17 under managed care.
18 DR. SCHUSTER: No. The Waivers
19 are not, but my guess is that we're going to move in
20 that direction as well.
21 CHAIR PARTIN: What does the
22 committee think about that? Would we like to make a
23 recommendation to the Department of Medicaid Services to
24 speak to that issue?
25 MS. BRANHAM: Absolutely.

1 MS. ROARK: Yes.
2 DR. NEEL: Yes. They've already
3 spoken before.
4 MS. BRANHAM: Let's speak louder.
5 CHAIR PARTIN: So, then, we would
6 like to ask the Department of Medicaid Services to speak
7 to the issue about a carve-out for behavioral health and
8 then send us a written response by our next meeting.
9 MR. VAN LAHR: Madam Chairman, my
10 suggestion to that or addition to that, one of the
11 things you might want to consider with that is, in lieu
12 of that consistency, it would be required among all five
13 programs.
14 CHAIR PARTIN: Okay.
15 MS. BRANHAM: One way or the
16 other, we need to--I mean, this affects the parent and
17 the families that care for these children. It causes
18 them additional stress. It causes them additional
19 illnesses. It's just like the domino effect that's not
20 going to stop unless we stand up for these individuals
21 that need the voice. So, we should do it.
22 CHAIR PARTIN: So, the two
23 considerations are a carve-out for behavioral health
24 with Medicaid or consistency with the MCOs, that all
25 the MCOs do it the same way.

1 DR. SCHUSTER: Particularly with
2 regard to medications, if I had to put a priority.
3 MS. BRANHAM: Well, let's just try
4 to make it, though, the best. I mean, we went
5 backwards. We didn't go forward with this. We went
6 backward. It's a small, small number of folks that
7 we're talking about. So, let's get creative and let's
8 make this thing work.
9 DR. SCHUSTER: Thank you very
10 much. I appreciate it.
11 CHAIR PARTIN: And one of the
12 questions that Sheila brought up that I'd like to ask
13 also is about how can people change their MCO. What are
14 the options right now?
15 MR. CARLE: I'm glad you brought
16 that up because that was on my list, too. So, thank
17 you, Beth.
18 MR. WISE: Do you want me to go
19 ahead and address that?
20 CHAIR PARTIN: Yes, please.
21 MR. WISE: And we don't talk
22 enough about this probably. Currently, right now,
23 Medicaid eligibility resides on five different systems.
24 With the Health benefit Exchange being implemented, that
25 added to our traditional DCBS system, to the SDX system

1 where Medicare members are enrolled in Medicaid
2 automatically. The fourth system is the system that
3 assigns members to an MCO, and then it all has to get to
4 our Medicaid Managed Information System to be together.
5 The good news there is that what's
6 being worked on now is by December of next year, that
7 Medicaid eligibility systems will all reside in the
8 Health Benefit Exchange. So, there's one place where it
9 is and you can go through there, through that system and
10 change your MCO.
11 What you can do during this coming
12 enrollment is if the member originally enrolled or has
13 been subsequently through the Health Benefit Exchange,
14 they can go online to change their MCO. That's hard to
15 communicate because you have to be on that system to be
16 able to use that now. Future years that won't be an
17 issue. So, they can do that.
18 We are also during open enrollment
19 using individuals who work for the HBE Call Center as a
20 backup to our Member Services' staff. So, in a sense,
21 we're bringing on extra staff in the Call Center during
22 the open enrollment.
23 Now, those staff can't handle the
24 situation you brought up, Dr. Neel, of a misassignment
25 that needed to be corrected, but those staff can take

1 all the requests to switch MCOs during the open
2 enrollment. So, there is some more resources and
3 ability to do that during then.
4 CHAIR PARTIN: So, either if
5 you've been previously enrolled through an Exchange,
6 then, you can use the Exchange. If you haven't been,
7 then, you have to make a phone call.
8 MR. WISE: Yes, and we have extra
9 staff on board during the open enrollment to take the
10 calls.
11 CHAIR PARTIN: Do you know the
12 phone number offhand?
13 MR. WISE: No, I don't.
14 MS. BRANHAM: Where does that
15 phone call go to? Is that like the DCBS phone?
16 MR. WISE: It's our Member
17 Services' staff. The letter that says if you want to
18 change your MCO, call here, that's our Medicaid number
19 that it normally goes to Member Services.
20 CHAIR PARTIN: So, that's the
21 number that everybody would call.
22 DR. NEEL: Neville, we're seeing
23 that—
24 MR. WISE: I'm sorry. Go ahead.
25 DR. NEEL: Do you have the number

1 that she asked for?
2 MS. CECIL: 1-800-635-2570.
3 DR. NEEL: There are a myriad of
4 reasons why people change their MCOs from they offered
5 me diaper bags to I can't get that medication for my
6 child or whatever; but the thing they don't check with
7 is with their primary care provider to see if he takes
8 that MCO, and especially with the new ones, that's a
9 problem, and that's become a daily thing.
10 So, are they being encouraged
11 enough to check with your primary care doctor first?
12 MR. WISE: I think we have that in
13 our letter, that you should check to see which MCO has
14 your providers. It has been there in the past.
15 MR. CARLE: Neville, do you know
16 if it's possible, in a lot of hospitals, we have the
17 KYNect kiosks. Is it possible to use that platform to
18 assist them?
19 MR. WISE: Yes, if they originally
20 enrolled through the HBE using the Health Benefit
21 Exchange to enroll. And what we're doing there is,
22 obviously if you're newly eligible for Medicaid, you
23 most likely enrolled through there.
24 Members who historically had
25 already been eligible for Medicaid, they're being moved

1 to the HBE system as their annual enrollment month comes
2 up. So, if your enrollment was expiring in September,
3 when you came in to DCBS to renew your case, your
4 information was input on the new system. So, it's
5 gradually moving over to where everybody will be there
6 eventually.
7 MR. CARLE: So, what's the
8 existing percentage of people that came through the HBE?
9 MR. WISE: It's getting probably
10 over half because----
11 MR. CARLE: It's over 50%.
12 MR. WISE: There's 300,000-plus
13 new members and then your family and children cases.
14 They started switching them over in January, so, we're
15 now through nine months of those individuals have moved
16 over. So, at the end of December, it will only be your
17 Waiver and long-term care members primarily who are on
18 the old system.
19 MR. CARLE: So, again, I would
20 suggest, then, that there's the appropriate education
21 for the hospital networks that have the KYNect kiosks to
22 provide that service so that it can be done rather
23 easily if, in fact, it is, which - I'm sure you're
24 right, it's over 50% - that's a large number of people
25 that could be entering the hospital to get that done

1 correctly.
2 CHAIR PARTIN: Thank you, Neville.
3 Moving along on the TAC reports, Children's Health.
4 Consumer Rights and Client Needs. Dental.
5 DR. RILEY: The Dental TAC met
6 yesterday but we don't have the report from that yet,
7 so, I'm referring to the meeting on June 18th. And,
8 again, the version of the minutes that are included in
9 the binder is not the correct version but they will be
10 available.
11 For that meeting, Ms. Veronica
12 Cecil was the star. The dentists between March and
13 April experienced mass inactivations, and she came to
14 address the TAC due to why that happened. It was a
15 relicensure year and somehow there were hundreds that
16 did not get updated in the system, and it occurred
17 simultaneously with revalidation and the ADO submission.
18 So, she came to enlighten us on
19 the process and procedure, and she also told us that
20 normally--one of our complaints also was that it takes
21 such a long time for new providers to get credentialed
22 and their goal is currently 47 working days.
23 And also she informed us about a
24 new portal that's being developed to try to cut down on
25 this problem for next year.

1 We had MCO reports from--well,
2 I'll back that up. At that particular meeting, we did
3 not have MCO reports from CoventryCares and from Humana
4 CareSource. I think for Humana, there had been some
5 changes in personnel who were reporting to the TAC and
6 the desired reports had not gotten to them, or the
7 report requests had not gotten to them.
8 Coventry had not reported to us
9 since the second quarter of 2013. So, there were some
10 concerns about that, however, it was corrected
11 yesterday.
12 Dr. Caudill mentioned that he had
13 been meeting with Medical Directors from the MCOs on
14 four different issues. One was nonpayment of UK's Oral
15 Pathology Department.
16 The second one was the attempt to
17 get more discipline on mobile and portable dental units.
18 The dental vans that are operable in some areas tend to
19 cherry pick the Medicaid children for exam and cleaning
20 only but they don't do any follow-up care. And when
21 they go back to their dental home, the dentist is
22 surprised that the exam and cleaning has already been
23 done. So, they're working on getting more control on
24 that.
25 Another area, were CT scans

1 authorized for oral surgeons, and the fourth one was
2 working with the public health d1epartments.
3 Passport reported that they had
4 addressed the difficulty that they were having getting
5 oral surgeons to sign up outside Region 3, and it was
6 really a problem between medical billing codes versus
7 dental billing codes, but they had settled on rolling
8 most of the procedures to the dental codes, so, they
9 were having much more success with that.
10 And the TAC did request that
11 Passport consider sending approval letters to patients
12 when EPSDT or additional services were requested in
13 addition to denial letters because many times the denial
14 is reversed on appeal but the patient doesn't get the
15 letter. So, when the office calls to try to schedule
16 the procedure, the patient is suspicious and often
17 doesn't cooperate.
18 Humana states that they are still
19 addressing their prompt pay issue. They are meeting the
20 state requirement because if it's nearing 30 days, you
21 get an appended claims report, so, it addresses the
22 wording of the law that you either pay or respond within
23 30 days, but sometimes it's a response rather than a
24 payment.
25 And, then, we again discussed the

1 no shows which is a constant, ongoing problem. The
2 Dental TAC in December, 2012 had brought forward to the
3 MAC a recommendation that a no-show procedure code be
4 developed so that those could be tracked. It went
5 forward but we have not ever gotten a response from DMS.
6 And that's it.
7 CHAIR PARTIN: Thank you. So,
8 we'll get the updated report when we get all of the
9 reports.
10 The next report is Nursing Home
11 Care. Home Health TAC.
12 MS. BRANHAM: We met Tuesday
13 afternoon and had a good meeting but I will be
14 submitting tomorrow when I get the minutes done to
15 Barbara for inclusion for next time.
16 I'm happy to report that we have
17 decreasing issues with authorizations and payments.
18 The membership is learning a
19 little bit about particular requests, but a couple of
20 issues that I did point out to them was, for example, on
21 a standard of care perhaps for a PIC line - that's a
22 peripherally-inserted catheter which people receive
23 long-term antibiotics for - typically the care is
24 addressing change one time a week and PRN should
25 something happen.

1 And generally the course of
2 service is six weeks, so, the physician always writes
3 dressing change one time a week, PRN for six weeks. The
4 MCOs will not give that request.
5 So, I did put a formal request in
6 to them on Tuesday to ask if we could have at least six
7 visits approved so that we don't have to call, to make a
8 note to call after visit two to request additional
9 visits for the same dressing change. There is nothing
10 to do on that should the patient have the PIC line
11 discharged. So, they're going to consider that.
12 The other request that we put in
13 is something I think that would benefit us all and that
14 is something even the Commissioner alluded to a little
15 bit earlier on patients and their readmissions after
16 hospital stays due to medication changes and not really
17 knowing what the medications are that they've been
18 discharged on, whether it's blood thinners, foods to
19 avoid or new heart medication.
20 But these folks that have these
21 chronic diseases and are going to be terminal at some
22 point in the near future, whether it be CHF,
23 exacerbation of COPD or anything, if home health could
24 see these folks on a referral for at least two times a
25 week post-hospitalization stay and get in there and see

1 what they know about their medications, see if they know
2 how to take the medications, see if those medications
3 are going to be effective in their treatment, doing
4 things such as weighing them, that would be a huge help
5 to all involved on rehospitalization and education of
6 the patients.
7 They are very stubborn about
8 giving those kinds of visits to home health agencies
9 which, indeed, is just to help the patient and the
10 hospitals on the readmission. So, that was a formal
11 request that we made to them as well that they're going
12 to look at. I believe stabilization post-hospital care
13 would be very beneficial to all of us.
14 We talked a little bit about the
15 open enrollment. We also talked somewhat about how we
16 were very appreciative of the new fee schedules being
17 posted for the private-duty services that were part of
18 the ACA coming forward and the rates as well.
19 I think there's been some agencies
20 in the state that have had issues with the revalidation
21 and not getting those back in timely and believing that
22 if they have been certified within five years by
23 Medicare, that they can submit that for the
24 revalidation, and if agencies have history of no
25 deficiencies, then, they're only surveyed somewhere like

1 36 months to five years, but, indeed, that doesn't work,
2 and there's been a couple of entities that have lost
3 their ability to be a Medicaid provider because they
4 submitted that paperwork.
5 And just one other little comment
6 I have to say about that. That letter that comes for
7 revalidation that says because you have been identified
8 as an entity that--what is the exact wording? Because
9 you have been identified as a provider that has the
10 possibility for basically fraud, that is just not nice.
11 We only have an "x" number of
12 agencies in this state, and look at that wording. I
13 mean, it's simple but it's something that, I mean, if
14 you look historically, there's very few agencies in this
15 state that have been convicted or accused of fraud. So,
16 that's something that I wish you would look at.
17 We have been working with the MCOs
18 on the immediate fax back on prior authorizations, not
19 just for skilled nursing but also for therapies. So,
20 we're getting that information back a little bit quicker
21 which helps all of us that are involved in coordination
22 of care.
23 We were told a little bit
24 yesterday about the Coventry and the migration to Aetna
25 and how that's going to look and the new logo.

1 And, really, the other big topic
2 yesterday, and we keep hearing this all the time about
3 the value of taking care of the patient in the home
4 under our particular Waiver services, and we have a very
5 small committee that is working with Commissioner Debbie
6 Anderson, Department of Aging, on the new we term it
7 Super Waiver - we don't know what else to call it -
8 because we're excited about being able to take care of
9 more patients in the home.
10 Did you have a question,
11 Commissioner? You look a little puzzled about that.
12 Some genuine concerns just to make
13 part of the record have to do with the fact that home
14 health was brought in after the Waiver really was
15 submitted, and the agencies that provide Waiver in the
16 state are Medicare-certified agencies, and we haven't
17 seen the Waiver that was submitted and approved. So,
18 it's really hard to know what's there other than what we
19 have been told.
20 And the issues that we know that
21 are coming is conflict-free case management which we
22 don't have a problem with because that's going to be
23 across the board for all providers, but the fact that,
24 as I said, most agencies are Medicare-certified, we have
25 certain regs because of that that we have to follow.

1 And with that, not everybody has
2 the ability to step outside of a traditional certified
3 agency and have a subagency to provide this care for
4 this new Waiver that's coming forward.
5 I guess it's been stated that a
6 lot of the case management is going to come through the
7 Triple A's or the Area Development of Aging and we don't
8 have a lot of confidence in that case management.
9 Agencies have voiced to me about
10 concern about what is the liability going to be with an
11 outside case management and you're providing the care,
12 and how are you going to get information to somebody
13 that's really not medical should there be a medical
14 need.
15 There's lots of things that we are
16 putting together for a meeting with Secretary Haynes and
17 I think Commissioner Kissner as well as Commissioner
18 Anderson here in about a week or so.
19 And it's always been that any
20 patients that were under a Waiver plan of care, if they
21 had a skill that would arise, that they would have to go
22 back to a Medicare plan of care. Yet, therapies which
23 would be a skill are going to be paid under the new
24 Waiver.
25 So, there's lots of incongruent

1 issues because, again, we weren't brought to the table
2 until later that we are trying to work with and help you
3 all fix, but it's going to be difficult to get this
4 program up and running like you want it to be for the
5 reasons that I have mentioned.
6 So, I would ask that you all
7 listen to what we have to say when we have our next
8 meeting and not look at home health as folks that are
9 not happy because we don't do Waiver and services and
10 things like that, but there are issues that relate to
11 being a Medicare-certified agency that we can't do
12 legally for the care that you all want provided to
13 switch this budget from long-term care to community-
14 based care. That's it.
15 CHAIR PARTIN: Thank you.
16 Hospital.
17 MR. HERDE: No report. We meet a
18 week from tomorrow.
19 CHAIR PARTIN: Thank you.
20 Pharmacy and Therapeutics.
21 MR. VAN LAHR: I think we have
22 finally been granted the ability to have a committee but
23 I don't think they've formed it yet, but I do have three
24 points that I would like to have addressed real quickly.
25 I guess I've been on this

1 committee for about a year and a half maybe now, and I
2 believe at the first meeting, I asked for some pharmacy
3 data to be included in the dashboard report and I have
4 yet to see that included which included
5 preauthorizations.
6 One issue we have particularly in
7 retail pharmacy dealing with hospitals are the residents
8 in hospital settings which will write a prescription for
9 a patient, in my area, from a Lousiville hospital or a
10 Lexington hospital. We get the prescription and the
11 resident, of course, is not approved by Medicaid.
12 Well, there is no provision for us
13 at that point in time. We have to call the hospital
14 emergency room hopefully at some point in time and get
15 an other physician to co-sign a prescription basically,
16 and I would like to see some provision granted to cover
17 us in those instances.
18 And, then, I guess the final issue
19 that I would like to bring up is, as we mentioned
20 earlier, for pharmacy's sake anyway and for the
21 patient's sake more than anything else would be a
22 consistency of drug coverage among all the MCOs.
23 We addressed that. I think one of
24 the persons on the Board, I think Dr. Neel mentioned
25 earlier an issue they have with not knowing whether the

1 provider is covered. Well, if you think that is an
2 issue, try to see the patient and see if their drug is
3 covered. So, they have no idea. They look if their
4 hospital is covered, their provider is covered and if
5 pharmacy is covered, those three things which are really
6 nice, but they have no idea whether the drugs are going
7 to be covered or not.
8 And the other piece of that in
9 that same conversation is that if a drug is covered for
10 the patient at the start of their year, it should
11 remained covered for that patient during the entire
12 year. Several plans have a tendency at some point in
13 time during the year to change. This was a covered drug
14 three months ago when you signed up for the plan. It's
15 no longer covered. And, again, that creates a nightmare
16 for the pharmacy, for the patient, for the provider.
17 So, again, those consistencies need to be placed within
18 the system.
19 CHAIR PARTIN: So, you're saying
20 if the drug is approved, then, it should be covered for
21 one year even if the patient changes MCO?
22 MR. VAN LAHR: If you have
23 consistency among the Formularies, that would be fine,
24 but my issue is that you have a patient who chooses an
25 MCO based on those factors in December, and then in

1 March, the drug is no longer----
2 CHAIR PARTIN: That MCO changes
3 their Formulary.
4 MR. VAN LAHR: Within the MCO
5 even. Again, there are multiple layers of insulation
6 right now between us, the pharmacies, and the PBMs. We
7 have the Commissioner, we have the MCOs then the PBMs.
8 So, there's like we're three steps away from actual
9 contact of anybody.
10 CHAIR PARTIN: That's a problem
11 clinically. That's a problem anyway even if you've got
12 them on it for a year and then they change the
13 Formulary. Thank you.
14 There's no Nursing TAC report.
15 Optometry.
16 DR. WATKINS: Optometry didn't
17 have a TAC meeting in this last quarter, but it was
18 brought to my attention at our last meeting this past
19 weekend that we had at our convention that in our last
20 regs that we had formed this past summer, we had made
21 sure that it was in those regs just as it was before
22 that all of our patients, all of those that are
23 constituents, they do have one exam per year per
24 provider coverage on their medical card and that should
25 be for every MCO out there.

1 And we are finding that both
2 Avesis and Passport are not in compliance with this, and
3 we are receiving denials with that. This has been
4 brought to the attention of the Department and we have
5 not received any way that this has been--it's still
6 being done okay - I'll put it that way - and we are
7 still receiving denials.
8 The main problem with this, we
9 have a group that is going to schools and they are doing
10 mass eye exams, several in a day where they are doing
11 what they consider to be comprehensive exams. They're
12 not prescribing glasses, they're not giving out
13 prescriptions, but they're turning this in as eye exams.
14 And, then, those children are
15 going to their eye doctors and actually receiving an eye
16 exam. And, then, when that doctor is filing for an eye
17 exam, it is being denied saying that they've already
18 received their eye exam for the year.
19 Well, that is a different
20 provider. And even though we do not agree with what is
21 happening, that's not the point. This is a different
22 provider. It should still be covered. It's the same as
23 them receiving a second opinion, or if it's a
24 consultation, it should be covered, and that's something
25 that they should be compliance with. And we just wanted

1 to make sure that they should be aware that that is in
2 the regs that were approved this past summer.
3 CHAIR PARTIN: Is this problem
4 just with Passport?
5 DR. WATKINS: It's with Passport
6 and Avesis.
7 CHAIR PARTIN: So, can somebody
8 from Passport speak to that?
9 MS. CHRISTY SPENCER: Hello.
10 Christy Spencer, Vice-President of Operations for
11 Passport and it's going to be short. I have no idea.
12 So, I'll have to find out what is going on with that.
13 CHAIR PARTIN: Thank you very
14 much. Can you send us something back in writing?
15 MS. SPENCER: Sure, after I find
16 out who is attending their TAC.
17 CHAIR PARTIN: Thank you very
18 much. Therapy Services.
19 MS. ENNIS: Good morning. I'm
20 Beth Ennis. I'm the Chair of the Therapy TAC.
21 We had our most recent meeting
22 this morning, so, the latest minutes will get to you
23 next month, but we did send Barbara today, so, you'll
24 get those soon our July and June meeting minutes.
25 We are managing to problem solve

1 some things through the TAC which I love, but there are
2 a couple of things that I just kind of want to put on
3 the radar.
4 The question that we submitted at
5 the last TAC meeting as far as the differential for
6 assistant versus therapist is still pending. So, I
7 think that's getting moved on now that we have a quorum
8 here and we ask that that be discussed with the Cabinet.
9 Really, the only issues that we're
10 seeing with MCOs right now deals with one, and we're
11 seeing lots of issues with that one MCO and it has to do
12 with requesting peer-to-peer contact on a prior auth
13 which we were told there shouldn't even be a prior auth
14 for therapy services. It's a 20-visit benefit. It
15 should just go.
16 And they want a peer-to-peer
17 discussion with either the physician or the parent, not
18 the therapist that's requesting the services. So, we're
19 going to try and get in touch with that particular MCO
20 because they were not at our meeting and figure out
21 what's going on with that, but there are a number of
22 providers across the state who are dropping that
23 particular MCO for all of the reasons - reimbursement,
24 authorization, difficulty becoming a provider to begin
25 with. And, so, we're afraid there's going to be a

1 number of members across the life span that are not
2 going to get covered, are not going to be able to be
3 treated because there will not be in-network therapists
4 for that particular MCO.
5 CHAIR PARTIN: Do you want us to
6 ask that MCO to respond to that?
7 MS. ENNIS: It's Coventry.
8 CHAIR PARTIN: Coventry.
9 MS. ENNIS: And I'm sorry. We
10 scheduled kind of last minute, so, I don't know if you
11 got left off the list.
12 MS. JENNIFER HATCHETT: I did. I
13 looked to make sure it wasn't on my calendar. So, we
14 apologize if we weren't there. The two of us that
15 typically would attend Therapy just got back from Tampa
16 last night, and, so, we didn't get the invite.
17 CHAIR PARTIN: Can you say who you
18 are?
19 MS. HATCHETT: I'm sorry. I'm
20 Jennifer Hatchett. I'm the Director of Operations for
21 CoventryCares of Kentucky.
22 The benefit, there is a 20-visit
23 limit but for kids it's unlimited, but we do prior
24 authorize it because there's a medical necessity review
25 done for every service under Medicaid. And, so, that's

1 what we do, the prior authorization. We use InterQual
2 criteria and would answer those questions. So, I will
3 get Dr. Tolin who is our Medical Director to contact you
4 and have that conversation.
5 MS. ENNIS: I guess the concern is
6 that they're not wanting that conversation with the
7 therapist that's requesting visits.
8 MS. HATCHETT: Yes. The policy is
9 it's the prescriber that you have the peer-to-peer with.
10 The parent doesn't make sense.
11 MS. ENNIS: That didn't make sense
12 to me at all.
13 MS. HATCHETT: The parent doesn't
14 make sense, I understand that, but I will follow that.
15 Dr. Frank Tolin is our Medical Director and I'll have
16 him contact you.
17 MS. ENNIS: I appreciate that.
18 CHAIR PARTIN: So, you're going to
19 get----
20 MS. HATCHETT: Yes, exactly. Dr.
21 Tolin is our representative for the Therapy TAC, and
22 like I said, he got back from Tampa late last night, but
23 we will have him attend the future meeting.
24 MS. BRANHAM: What's peer-to-peer?
25 CHAIR PARTIN: That's when you

have to talk to----

MS. BRANHAM: I understand that but what has the family got to do with it?

MS. ENNIS: That's the piece that's confusing to both of us.

CHAIR PARTIN: She's saying that it shouldn't be that way.

MS. BRANHAM: But you're seeing this across the state?

MS. ENNIS: And the other issue is they're being told it has to be done within two days, and if a physician has written a prescription for that, getting that physician on the phone with somebody within two days is a challenge.

MS. HATCHETT: I'm going to check that. I know that our peer-to-peer policy does have a time limit. I thought it was five days. Parent doesn't make sense. The two days doesn't make sense. I'll follow up.

MS. ENNIS: And I'm getting some specific information, too, that I can share and we can talk.

CHAIR PARTIN: Thank you very much.

MS. ENNIS: We are seeing people

1 being able to enroll with less difficulty which is good.
2 There are some issues with not paying for services on
3 the same day. If they have OT and speech on the same
4 day, it gets kicked back sometimes which doesn't make
5 sense because they're using different codes. If it were
6 PT and OT, it would make sense to me because sometimes
7 there's code overlap with those two.
8 MS. BRANHAM: One provider, all
9 providers?
10 MS. ENNIS: That one is a couple
11 of them. So, we're looking into that. We've got folks
12 from those MCOs working on that.
13 And, then, we're also working on
14 the issue of an automatic denial for more than once a
15 week. I think the default has been especially on the
16 kid side because early interventions model has gone to
17 once a week, that everybody is pushing for once a week,
18 and there are times where kids might be once a month.
19 There are times where they may have an intensive episode
20 where they need three to four times a week for a short
21 burst.
22 So, we're working on some
23 education avenues with the payors to help address that
24 and hopefully make some headway on that and we'll get
25 back to you.

1 CHAIR PARTIN: Are those going to
2 be on your recommendations for us to act on or are you
3 working on that?
4 MS. ENNIS: At this point, I just
5 wanted to put them on the radar that we're working on
6 them and we may come back in November with some
7 specifics if we don't make much headway.
8 CHAIR PARTIN: All right.
9 MS. BRANHAM: Have you talked to
10 the MCO liaisons as well about all these specific issues
11 and are they addressing them?
12 MS. ENNIS: They are starting to,
13 yes. For the most part when we have had more time than
14 we did on this last meeting to schedule, they have been
15 attending the meetings and have intermittently been
16 responding. We've had some good feedback. We're moving
17 forward. If we have issues, we'll specify them next
18 time.
19 CHAIR PARTIN: Thank you.
20 Physician Services.
21 (Mr. Richard Foley leaves)
22 DR. NEEL: The Physicians TAC met
23 last week and discussed a number of issues. Some we've
24 already talked about today. One was the misassignment
25 of patients to different providers when they already

1 have a provider. We've had that over and over. That
2 seems to be getting somewhat better.
3 Then we discussed the
4 recertification of patients and whether the card is
5 retroactive for two or three months. That's been an
6 issue. That seems to be getting a little better. There
7 had been some problems about how that was happening,
8 whether people had to say that they actually had bills
9 due. I think that's been removed from that. Is that
10 true, Neville, as far as you know?
11 MR. WISE: Yes.
12 DR. NEEL: We're now receiving a
13 lot of HEDIS provider. The MCOs have been pushed really
14 to do that by Medicaid. We understand that and the
15 importance of quality care and HEDIS data.
16 The problem is the HEDIS data is
17 based on claims, and there seems to be a big disconnect
18 between what we're actually seeing and claims. Part of
19 that is that a lot of the providers do not know that
20 certain things should be put into the claims for well-
21 child exams and that sort of thing. We're gradually
22 learning.
23 And, so, I'm hoping that that
24 HEDIS data is going to get cleaned up and will be more
25 meaningful, but, still, there's a big disconnect between

1 what we're seeing, what we think we're doing quality
2 wise and what we seem to be getting credit for.
3 It was mentioned in your letters
4 in Section 7, I think, Commissioner, to each of the MCOs
5 about how to address improvement of EPSDT and that sort
6 of thing. And we think we're doing that, and it
7 mentions in there, for example, that having an
8 electronic medical record makes it more likely that they
9 get accurate data.
10 Well, unfortunately, electronic
11 medical record, everything is perfect. You checked for
12 everything and that's the thing that we're seeing in
13 electronic medical records that that's not necessarily
14 true that they did that. It makes it more difficult for
15 those of us who don't have those records, and I think
16 there are a lot of us who probably won't have electronic
17 medical records for a long time.
18 The major thing that we discussed,
19 however, was future reimbursement for primary care
20 physicians. I've beat this drum for a number of months
21 through this committee and the TAC wanted to talk about
22 that, too, in that we feel that the uncertainty about
23 whether the enhanced payments will continue under ACA
24 continues, and it looks like that decision is not going
25 to be made until close to the end of the year.

1 And I can tell you that it's
2 unsustainable for a primary care practice to continue,
3 particularly in small practices, after January if those
4 enhanced payments do not continue.
5 Realizing that, I see a few weeks
6 ago, the State of Alabama's Legislature voted to
7 continue on its own the enhanced payments to providers
8 for I believe at least a year, and I just wondered what
9 plans we have. I know we've talked about the
10 possibility of reinstating something like KenPAC,
11 something to change other than just legislative
12 approval. So, that's one of the main things the TAC
13 would like to see talked about was future reimbursement.
14 That's all I have from the TAC.
15 CHAIR PARTIN: Thank you. So, you
16 will have a report?
17 DR. NEEL: Yes, we will have a
18 written report.
19 CHAIR PARTIN: Thank you.
20 Podiatry. Primary Care.
21 MR. BOLT: I'm David Bolt
22 reporting for Chris Keyser, the Chair of the Primary
23 Care TAC, and I'm joined by Emily Beauguard and we'll be
24 staffing the KPCA TAC, Primary Care TAC going forward.
25 It's only a page and a half. It's

1 large print. So, it shouldn't take me too long.
2 The Primary Care Technical
3 Advisory Committee met at 10:00 a.m. on Thursday,
4 September 11, 2014. So, the reports are not in your
5 packets yet.
6 The only agenda items concern the
7 automated wrap payment reconciliation back to 11/1/11
8 and dual eligible payments to rural health clinics and
9 community health centers, and CMS has determined it's
10 the responsibility of the State.
11 DMS has been making wrap payments
12 to the more than 150 community health centers and rural
13 health clinics based on estimates calculated via a
14 State-recommended process tying eligible face-to-face
15 patient encounters to MCO paid claims.
16 On July 1, 2014, this process was
17 automated by DMS and reconciliation for the previous two
18 years and eight months began. The automated system
19 exposed a number of issues, not the least of which was
20 that many claims paid by the MCOs are not in the DMS
21 system.
22 We see a number of reasons for
23 this and actually are not pointing fingers or blame at
24 any party. We view this as a problem that is a
25 partnership to be resolved by MCOs, DMS and the

1 providers represented by the TAC, KPCA and those other
2 primary care providers. We believe it will take all of
3 us working together to resolve the problem.
4 At the September 11, 2014 meeting,
5 a majority of the TAC members were present along with
6 DMS staff. Additionally, four of the five MCOs were
7 present for the discussion. The fifth MCO was in
8 contact via email during the meeting.
9 The affected providers and the
10 Kentucky Primary Care Association were directed by DMS
11 to bring the problem they perceived as incomplete claims
12 data submission to the attention of the MCOs.
13 This was done with a series of
14 individual meetings, phone calls, personal discussions
15 and a formal letter to senior management of each MCO by
16 the Kentucky Primary Care Association requesting that
17 the MCOs comply with claims data transmission
18 requirements contained in the contracts between the MCOs
19 and the State.
20 After a lengthy discussion with
21 DMS and the MCOs at the TAC meeting, the following
22 recommendations are forwarded to the MAC for your
23 consideration.
24 Number 1: The Primary Care TAC
25 requests that DMS recognize and approach these issues in

1 partnership with the providers and the MCOs and work
2 together on a commonly-shared problem affecting over 180
3 clinics across the state.
4 The Primary Care TAC requests that
5 there be joint meetings between DMS and the MCOs and the
6 affected parties to work on a resolution of the wrap and
7 outstanding issues related to the Medicaid/Medicare dual
8 eligible claims.
9 The Primary Care TAC requests that
10 DMS deal with a resolution of the issues with Kentucky
11 Spirit since there is a formal court ruling involving
12 the contract DMS held with Kentucky Spirit and the State
13 and it does not appear that providers can intervene even
14 on their own behalf.
15 The Primary Care TAC also
16 recommends that a working group including the TAC, DMS
17 and the MCOs be established to sample, test and resolve
18 the reconciliation process, that is, all claims prior to
19 June 30, 2014, to ensure all data is being captured and
20 to avoid misunderstandings by any party and to avoid
21 confusion as well as duplication of effort which will
22 all result in extending the length needed to resolve the
23 matter.
24 And, finally, the Primary Care TAC
25 recommends that for dual eligible claims, DMS instruct

1 the MCOs to transmit a zero paid amount instead of a
2 denial when the claim is processed to DMS. Questions?
3 Clear. I'm out of here. Have a good lunch. Thank you.
4 CHAIR PARTIN: Thank you very
5 much. Intellectual and Developmental Disabilities.
6 MR. CHRIS STEVENSON: Good
7 afternoon. My name is Chris Stevenson and I am Co-Chair
8 of the IDD TAC. I co-chair with Patty Dempsey who is
9 the Executive Director of the ARC of Kentucky.
10 We met on September 9th and you
11 may have already received the minutes of that. The TAC
12 is really concerned. And what a couple of big issues
13 right now for us is that we're concerned that the 10,000
14 individuals that are served through the Michelle P.
15 Waiver, which, as you recall, in 2002, there was a
16 class-action lawsuit that was filed on behalf of the
17 families for adults that weren't getting services.
18 And, so, they actually made a
19 special Waiver to allow individuals to receive services
20 for IDD but not residential. So, it made it less
21 expensive.
22 What we found is that 70% of those
23 that are actually currently being served are children in
24 that waiver. And while it's a great thing to serve
25 children, the original intent was for adults. And

1 actually the assessment tool, the MAP 351, was made to
2 assess adults.
3 So, the concern that we have is
4 now we currently have almost 3,000 people on the waiting
5 list. And, again, reflective of today, it's 70% who are
6 children. So, we don't want to keep using this adult
7 assessment tool getting children into this.
8 So, what we're suggesting and
9 recommending is that we finalize an appropriate tool for
10 the assessment of children for this waiver or a separate
11 waiver, whatever you decide to create.
12 But we believe that if--and I know
13 that House Bill 144 Commission has made a recommendation
14 already but we'd also like to second that to say if a
15 special task force could be made of members of the TAC
16 committee, House Bill 144, Department of Behavioral
17 Health and Intellectual Developmental Disabilities,
18 family members of children with IDD, that we feel that
19 within six months, we could come up with something to
20 provide you so that we can get moving on this because
21 I'm really disturbed that of the 2,900 individuals on
22 this waiting list, it's creeping up to 1,000 adults that
23 were hoping to get services from this original 10,000
24 that were going to potentially get served.
25 Five years we've depleted that

1 waiting list. It was supposed to serve for potentially
2 a decade. So, we just want to make sure that adults
3 certainly are getting services, children as well, but we
4 want to make sure that there's an appropriate assessment
5 tool for the children, not assess them like adults.
6 The other recommendation was to
7 consider developing a separate waiver for children. So,
8 people said what about an autism waiver - there's a vast
9 majority that are autistic children - but allow for
10 carrying them with their distinct needs. There's a lot
11 of behavioral health needs that are needed. So, can we
12 provide services for them through that?
13 Also with EPSDT, that was a great
14 move getting them therapies. Also a behavioral health
15 and substance abuse program that's going to provide some
16 behavioral health. So, some things are moving in that
17 direction to help the children, but let's not forget the
18 adults that this was originally intended to serve.
19 Secondly, the IDD TAC was
20 concerned about some of the impact of the revisions of
21 the Supports for Community Living SCL II on participant-
22 directed services. These are individuals and family
23 members who can choose and direct their services and
24 they get funding for that.
25 What they're finding is that

1 there's some undue hardships placed on them because they
2 have to pay for drug screening of their employees that
3 they employ, background checks, CPR training and the
4 completion of numerous modules provides through
5 something called the College of Direct Supports, an
6 online system and it's almost $400 per employee. Well,
7 as you know, it sometimes requires multiple employees
8 and there's high turnover.
9 So, what we're asking is to
10 establish a mechanism to assist individuals who choose
11 this participant-directed services with costs associated
12 with those employment requirements. It could be a
13 separate fund specifically to help pay for those costs
14 or really evaluating the purpose of that altogether to
15 determine if it's an undue burden.
16 Those are the recommendations that
17 we make for the MAC. I've got one more thing. Any
18 questions regarding that?
19 One last thing is the piggybacking
20 on terms of carve-out and threats of managed care for
21 this specific population. I think we all can agree that
22 the original intent for Medicaid was for those most
23 vulnerable, and folks with intellectual disabilities did
24 not ask for that disability. They didn't make any
25 particular choice.

1 So, we ask that you, just kind of
2 piggybacking on Dr. Schuster when it comes to behavioral
3 health, that there are co-occurring disorders for folks
4 with intellectual disabilities that also have mental
5 illness and we ask for your consideration as well to
6 consider protecting them and carving them out from
7 managed care in the future. Thank you.
8 CHAIR PARTIN: Can you tell me
9 what the percentage is of that population that we're
10 talking about of the Medicaid population?
11 MR. STEVENSON: No, I can't. I
12 apologize. I don't have that number.
13 CHAIR PARTIN: That would be
14 really helpful for us in asking for that.
15 MR. STEVENSON: Sure. I can get
16 that to you, absolutely.
17 MR. WHALEY: Chris, do you have an
18 idea in terms of the cost to agencies, as you mentioned
19 before? How much money are we talking about in terms of
20 covering the expense of training, background checks?
21 MR. STEVENSON: I don't know the
22 direct cost, but I know it's around $372 per employee
23 for participant-directed services.
24 MR. WHALEY: And then looking at
25 the cost of attrition to those agencies, I'm just

wondering how much money we're talking about. That becomes significant.

MR. STEVENSON: Sure, it can. I know that some organizations experience anywhere from 50 to 70% turnover. So, I'm happy to get that to you as well.

MR. WHALEY: Please.

CHAIR PARTIN: So, when you send in your report, if you could include that percentage number. And did you ask him for other information as well, Barry?

MR. WHALEY: Yes.

CHAIR PARTIN: So, could you include that in the report because we're going to vote on this and then we will include that in asking for a response from DMS.

MR. STEVENSON: Thank you.

CHAIR PARTIN: That's all the TAC reports.

We still have a quorum. So, we need to vote to approve the recommendations from the TACs and request a response from DMS on all of the recommendations. So, would somebody like to make a motion?

MS. BRANHAM: I'll make a motion.

MR. WHALEY: Second.

CHAIR PARTIN: Any opposed? Thank you. So moved.

Is there any other business to be brought forward?

MR. CARLE: I maybe should have brought this up under Hospital, but I did have a request - I don't know if it's ever been done - related to network adequacy and audit that might be done related to compliance with the time standards.

So, for the rural areas, there's this issue of sixty miles or sixty minutes, and I think there was some change in the regs. Neville, do you know, have we ever done, or Commissioner, have we ever done any kind of audit related to all the networks and their adequacy, their coverage in the rural areas and can people get to the physician within sixty minutes or sixty miles because there's a big difference there in a rural area?

MR. WISE: It's done monthly.

MR. CARLE: You've tested the adequacy or you just have somebody state that?

COMMISSIONER KISSNER: We've got a software program where we actually run from the employee's home ZIP Code to the provider ZIP Code, to

1 the address. It's an address-specific software program.
2 MR. CARLE: Great. Thanks.
3 MR. VAN LAHR: So, address, not
4 ZIP Code.
5 COMMISSIONER KISSNER: Address,
6 not ZIP Code. The only time it makes an adjustment is
7 if you're like 5302 Country Road and it can't find it in
8 the MapQuest kind of data that they're using, can't find
9 like where exactly is that because it's not in the
10 database. And those are just a few. There's like a
11 hundred of those where it actually goes to the ZIP Code.
12 It goes to the center of the ZIP Code for that specific
13 rural address. If you're in a mapped-out area, that's
14 good. It will get your actual address.
15 MR. CARLE: Thank you.
16 CHAIR PARTIN: And Peggy had
17 something.
18 MS. ROARK: I just have a couple.
19 I wanted to touch back to the pharmacy. I went to the
20 Emergency Room and went to the pharmacy to get my
21 medicine, and the provider that wrote it out was not in
22 my network. So, therefore, I'm like, what? I've got to
23 sit there and wait.
24 So, do I got to go back to the
25 Emergency Room and see another doctor? How am I going

1 to get my medicine? So, the pharmacy has to call back
2 over to the hospital to get someone else to write the
3 prescription that's in my network.
4 I've never heard of such in my
5 life that you go to an Emergency Room to see a doctor
6 and they write out the prescription and it's no good.
7 You get to the pharmacy. I just don't understand that.
8 And, then, also they told me with
9 WellCare that you only get like three visits per year.
10 Is this something that has changed or is it with every
11 MCO? And when I went to my family doctor, they're
12 booked up. You just can't walk in and get an
13 appointment.
14 CHAIR PARTIN: Three ER visits a
15 year?
16 MS. ROARK: Yes. That's not true?
17 COMMISSIONER KISSNER: I think you
18 should have WellCare come up and talk about your issue.
19 MS. ROARK: Is WellCare in the
20 room?
21 MS. REBECCA RANDALL: Good
22 afternoon. Rebecca Randall with WellCare.
23 MS. ROARK: Did you hear my
24 question?
25 MS. RANDALL: Could you repeat it,

1 please?
2 MS. ROARK: When I went to the
3 Emergency Room, they told me I only get three visits per
4 year for WellCare now.
5 MS. RANDALL: No. Emergency
6 visits are covered. There is no limit on Emergency Room
7 visits. For emergency situations, that is a requirement
8 in federal and state law. There are no limits on
9 Emergency Room.
10 MS. ROARK: I'm allergic to
11 spiders and I got spider-bit and I went to my family
12 doctor. And the way that they are, you can't just walk
13 in. You have to make an appointment. It's expensive to
14 go to the Emergency Room. So, in an event, do you go to
15 an urgent treatment center? Is it okay to go to the
16 Emergency Room?
17 MS. RANDALL: Yes. We do cover
18 urgent treatment center care as well. We have a vast
19 majority of urgent treatment centers in our network.
20 I'm sorry. I'm not familiar with what part of the state
21 that you live in but I'd be happy to go back and look
22 into that for you.
23 MS. ROARK: It's in Jessamine
24 County, the Emergency Room. And, then, I don't know who
25 to address this. When you go to the Emergency Room,

1 we've got five MCOs. You don't ask the doctor, are you
2 under CoventryCares or whatever. And they write your
3 prescription out and you get to the pharmacy and they
4 say they can't fill it because the doctor who wrote it
5 is not in the network.
6 MS. RANDALL: There could be a
7 couple of things at play. I'd have to look at your
8 individual situation and the claim, the authorization
9 that the provider submitted or the prescription that was
10 written.
11 The provider, I would note, has to
12 be a participating Medicaid provider, first and
13 foremost. There are situations, for example, where you
14 might have been seen by an intern in the ER, whereas,
15 that would present some problems. Again, I'll be happy
16 to look at the particular circumstances of your
17 situation and get back with you on that.
18 MS. ROARK: Thank you. I
19 appreciate it.
20 CHAIR PARTIN: I think that's a
21 similar issue that Jonathan brought up, and I know
22 personally I've experienced that where I get calls from
23 pharmacies saying will I approve a prescription that's
24 been written by another provider because that provider
25 isn't covered, and usually it's an ER or a hospital, a

1 patient discharged from the hospital.
2 And that puts us in an
3 uncomfortable position, the primary care providers,
4 because we're being asked to prescribe something for a
5 patient that we haven't seen or seen the patient for
6 that problem.
7 MR. VAN LAHR: And it also delays
8 care.
9 COMMISSIONER KISSNER: Is is a
10 requirement now and it has always been a requirement
11 that the provider be as Medicaid participating provider
12 for us to cash the script. We won't fill a script if
13 it's a provider that doesn't have a Medicaid ID number,
14 and that has always been the requirement.
15 So, if that's the issue, that's
16 completely separate from is that provider participating
17 with the MCO or not. So, it's two distinct. One of
18 them has always been there. You have to have a Medicaid
19 ID.
20 CHAIR PARTIN: Thank you. That
21 has answered the question with WellCare.
22 So, I guess the issue is what do
23 we do when the patient is discharged from the hospital
24 by a resident? How do we get the residents covered as
25 providers with Medicaid since obviously they're not

1 doing that in the residency programs?
2 COMMISSIONER KISSNER: They need
3 to enroll. Residents can enroll.
4 CHAIR PARTIN: Would the school
5 need to enroll them?
6 MS. VERONICA CECIL: I'll be happy
7 to look into this a little closer. My understanding is
8 that residents can get a certain license from the KBML
9 and get their DEA certification to be able to prescribe
10 and then enroll with us. We have plenty that do that.
11 CHAIR PARTIN: The residents are
12 already licensed and they already do have a DEA. The
13 interns don't but the residents do.
14 MS. CECIL: The interns cannot
15 write a prescription and have Medicaid pay for it.
16 CHAIR PARTIN: Right. But if the
17 patient is discharged from the hospital by a
18 resident----
19 MS. CECIL: I think it's up to the
20 hospital. Their policy should be the intern, if it's
21 going to be paid by Medicaid, should not be writing the
22 prescription. That would be my suggestion, but we can't
23 do anything. CMS is very clear. The ordering physician
24 has to be enrolled in Medicaid, and if interns cannot
25 enroll, we can't cover that.

1 MR. VAN LAHR: These are
2 residents. These are not interns. These are residents.
3 These are physicians who have a Kentucky license with a
4 DEA number. It's in the same category as they're
5 supposed to have the prescription name printed legibly
6 on the prescription as well, too, which is a dream from
7 Heaven someplace.
8 CHAIR PARTIN: That's a whole
9 other issue.
10 MS. CECIL: But, again, as the
11 Commissioner mentioned, a resident has to be enrolled
12 with us.
13 CHAIR PARTIN: But how do we get
14 to that? Is it the university?
15 MS. CECIL: The resident just
16 enrolls like a regular Medicaid provider. They come to
17 our website. They fill out the enrollment application
18 and they get enrolled. They do it all the time.
19 MR. VAN LAHR: But her question
20 is, is there something we need to do with the medical
21 schools to require them to complete that?
22 MS. CECIL: I can't require it.
23 You all certainly can encourage it but they do it. UK
24 and U of L, they enroll their residents.
25 MR. VAN LAHR: Not always.

1 There's a large percentage of residents we fill
2 prescriptions for that are not approved.
3 MS. CECIL: It's up to the
4 resident and to the provider to ensure that they are
5 enrolled.
6 DR. NEEL: Let me take that back
7 to the KMA and see if I can get a definitive answer.
8 I'm also disturbed about somebody
9 coming away from an Emergency Room with a prescription
10 they can't get filled. I'd like for Chris to respond.
11 If the hospital is enrolled, I can't imagine that docs
12 working in the Emergency Room aren't somehow enrolled.
13 What's happening?
14 MR. CARLE: That's the first time
15 I've ever heard of anything like that because the
16 physicians there, unless they are some type of a
17 moonlighter in an Emergency Room that's attached to that
18 DEA and then they're doing separate billing, that that
19 would occur. Usually they work under the provider
20 number of a hospital as well.
21 DR. NEEL: Jonathan, are you
22 seeing that?
23 MR. VAN LAHR: Emergency Room
24 some. More than likely it's discharge from the
25 hospital. They've been seeing Dr. Smith but he's

1 discharged by Resident Jones. The name on the
2 prescription is the resident.
3 MR. CARLE: So, that's the
4 resident's program. Whatever program they're in, usually
5 it's their responsibility to sign them up; but, again,
6 they might be moonlighting as a hospitalist at another
7 hospital to his scenario and discharging that patient
8 and that's really not the hospital's responsibility.
9 It's as you mentioned. I think it's the resident's
10 responsibility or the resident's program.
11 We actually have a family practice
12 residency program at St. Elizabeth Healthcare and we
13 interact with the student, if you would, or the resident
14 to provide them with that.
15 DR. NEEL: That's different from
16 the Emergency Room issue.
17 MR. CARLE: Correct.
18 DR. NEEL: That's what I was
19 asking Jonathan, if he had seen that.
20 MR. VAN LAHR: Yes, I have.
21 CHAIR PARTIN: I have. I get
22 patients come in with prescriptions that aren't filled
23 because they wouldn't fill them.
24 Anything else?
25 DR. WATKINS: Just a point of

1 clarification on what I was speaking of when I mentioned
2 Avesis because that name may be just foreign to you all.
3 They are the vision care provider that WellCare and
4 CoventryCares uses. So, when we called Passport
5 forward, that's who really needed to address when I was
6 speaking about Avesis.
7 CHAIR PARTIN: We don't have
8 anybody----
9 DR. WATKINS: Not directly from
10 Avesis but it would be the responsibility of
11 CoventryCares and WellCare to make sure that Avesis is
12 actually taking care of that. So, I just wanted to make
13 them aware of what was going on there.
14 CHAIR PARTIN: Thank you.
15 MR. VAN LAHR: One more think,
16 Madam Chairman, just real quickly here.
17 My point earlier that I have asked
18 for a year and a half to how to get data and have not
19 gotten it yet, I would like the Commissioner or someone
20 to tell me if we're ever going to get the data or if
21 it's not available from the PBMs or the MCOs or what.
22 COMMISSIONER KISSNER: Let us get
23 back and we'll address it later.
24 MR. VAN LAHR: That's what we said
25 a year and a half ago.

1 COMMISSIONER KISSNER: We asked a
2 lot of questions about prior authorization and I gave
3 you a data run of ten million prescriptions, of which
4 1.68% of the prescriptions required prior auth. So,
5 98.4% of the prescriptions have no prior auth. I went
6 through the data, went through the time, went through
7 the hours it takes to get those resolved.
8 MR. VAN LAHR: I never saw the
9 data. I'm sorry.
10 COMMISSIONER KISSNER: So, I have
11 provided to the MAC lots of information about prior
12 authorization specific to drugs.
13 CHAIR PARTIN: Anything else?
14 Thank you. Our next meeting is Novwember 20th. Please
15 try to attend.
16 MEETING ADJOURNED
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